Swiss Social Healthcare: A Clockwork Model that Fails to Keep Promises

By Alphonse Crespo MD
Research Director
Institut Constant de Rebecque
www.institutconstant.ch

Historical Background

Switzerland's pluralist social healthcare system stems from constitutional articles voted in 1890 guaranteeing access to adequate healthcare for all. This was achieved by a delicate blend of social insurance, private enterprise, oligopoly and competition where the State played a subsidiary role and where wide autonomy was left to the cantons. Limited government intrusion, strong and innovative health industries, reputed medical schools and a market economy spared by two world wars, indeed offered quality care to all socio-economical categories for many decades.

Up until 1950, not more than 50% of the population was insured through, subsidised social sickness-funds. These were mainly designed for lower income groups and for various categories of industrial workers. As from the mid-century, middle & higher income groups started gradually insuring through the subsidised sickness fund system. This together with social changes such as ageing of the general population and exponential progress and dissemination of medical technology, brought the first strains on an intricate multi-tiered system that until then had functioned with clockwork efficiency.

As from 1960, ideologues bent on maximizing the regulatory and redistributive functions of the State, repeatedly called for healthcare reforms. After a few bites at LAMA in 1964 and 1981, assaults hit the mark in 1994 through a sickness insurance law (LAMal) that established compulsory insurance and anointed social insurance providers and their government relays with wide regulatory powers. LAMal brought a significant shift of authority away from the cantons and towards federal policy makers. Switzerland's current concern with "euro-compatibility" has considerably accelerated the trend towards central planning, regulation and control. This has affected costs and quality.

Expenditure, Financing and Resources[1]

Global healthcare expenses in Switzerland represented 3.5% of GDP in 1950. By 2004 they reached 11.6 %, placing per capita health expenditures significantly above those of major European countries and second only to those of the USA. The sector employs more than 450'000 persons and is currently worth CHF 50 billion.

[1] G.Kocher, Willy Oggier (2005) Système de santé Suisse 2004-2006 – Survol de la situation actuelle Verlag Hans Huber. Pp105-109

Cantons and federal government directly finance approximately 25% of global expenditures, social insurance covers 35 %, supplementary insurance and contributions from private institutions account for 10%. The rest is met from out of pocket payments from patients and families.

After mandatory deductibles that range from CHF 300 to 2'500 per year, depending on premium options, patients pay for 10% of ambulatory care. Parliament is considering to raise this to 20%. Co-payment for original drugs has already been propped to 20% when equivalent generics are available. Co-payments for hospital care are being discussed.

Switzerland shows no major differences with its neighbours with respect to density of practising physicians or number of acute hospital beds. It was second to Sweden in the ratio of nurses compared to hospital beds though the trend is changing: the rationing of nursing care is now part of the picture in Swiss hospital and nursing home care[2]. On the other hand, in 2001 it counted more IRM scans per 1'000'000 inhabitants(12.9) than France (2.6) or the USA (8.1) but trailed behind Japan (23.2).[3] The private hospital sector, open to citizens with supplementary insurance or to wealthy foreign patients, remains very active and offered 0.7 beds per 1000 population in 2000 (an increase of 17% from 1998). Compared to other European nations, Switzerland still provides a high standard of care. Health policy planners contend however, that it counts too many hospitals, too many doctors, too much hardware.

Hospitals

Hospitals are evenly financed by basic insurance and government subsidies. Parliament is currently discussing a single payer model: i.e. either government or insurance. Withdrawal of state financing rarely implies withdrawal of state control: privatization of public hospitals is not part of the agenda.

Between 1998 and 2000 the number of public hospital beds was hammered down by 6% through forced mergers of regional hospitals, closure of acute care units, centralizing of heavier technology and rationing of nursing care.

The downgrading of regional hospitals creates inequities in access to specialized care and to state of the art medical technology. Patients from small towns or from alpine valleys are often bounced from one local hospital to another before receiving appropriate care. In many instances, ambulances have come to replace elevators as a means of transfer from one specialty unit to another. Waiting lists in University hospitals have increased.

Regulators have also targeted average lengths of stay in acute care hospitals. These have been cut down from 12.9 days in 2000 to 9 days in 2004[4].

[2] Schubert M. et al. Effects of Rationing in Nursing Care in Switzerland on Patients and Nurses' Outcomes : Basel Institute of Nursing Science, University of Basel 2004 (Unpublished report)
[3] G.Kocher, Willy Oggier (2005) Système de santé Suisse 2004-2006 – Survol de la situation actuelle Verlag Hans Huber. Pp 85-87
[4] Office Federal de la Statistique, Statistique Médicale 2004.

Present reimbursement scales encourage outpatient surgery despite higher risks and lower patient comfort while low fees for demanding procedures (linked to longer stays in hospital) dissuade surgeons from performing heavy elective surgery.

Some local health authorities have begun to outsource surgery to neighbouring countries. This endeavour to confront local providers with "foreign competition" remains anecdotal and looks more like siphoning subsidized resources of European neighbours, than letting market competition enter the game.

Doctors

Doctor density doubled between 1950 and 2000. Switzerland now counts approximately 25'000 doctors, 55% in private practice. In 2002 federal government suspended the opening of private medical offices. This drastic measure that circumvents constitutional rights stems from the assumption that costs are tied to the number of practicing physicians. The Swiss Observatory of Healthcare demonstrated in 2002 that visits to doctors' offices were unrelated to GP density. This has not stopped federal authority from extending the ban onto 2008. This is shifting primary care from doctor's offices to costlier public hospitals.

In 2004, after long negotiations between the medical professional association (FMH) and the insurance cartel (Santésuisse), cantonal fee rates were replaced by a unified time-based fee scale (TARMED) designed to upgrade "intellectual work". The "neutrality of costs" clause that was part of the deal, involved drastic downgrading of fees for technical procedures. The new tariff has had no effects other than a) recurrent haggling between doctors, doctor associations, hospital administrators and third party payers, b) statistical harassment from Santésuisse, that dissuades practitioners from treating patients with "expensive" pathologies, c) longer waiting lists for heavier elective surgery, linked to fees that barely meet overheads, d) bewildered patients charged by the minute for "intellectual services" that inevitably include small talk.

Repeated exposure to strong-armed regulatory measures and significant decline of average revenues[5] has affected the morale of medical professionals. Their frustrations climaxed in an unprecedented protest demonstration that brought 12'000 doctors to Bern earlier this year.

Pharma

Swiss pharmaceutical industries have traditionally been major contributors to Switzerlands' economic wealth. For many decades their influence on political decision-making processes prevented over-regulation of the sector.

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[5] Hasler Niklaus. Revenu des médecins indépendants de Suisse en 2002 (réévaluation) et 2003 (nouveau), Bulletin des médecins Suisse 2006 ;87 :39

Ongoing federal legislation on therapeutic devices now closely follows trends set by EEC bureaucracies. The inter-cantonal regulatory of body in charge monitoring pharmaceutical products (OICM) has relinquished much of its authority to Swissmedic. This central federal agency is entrusted with wide tasks that range from certification of condoms to drafting laws and standards of surveillance.

Incentives designed to push prescription of generics at the expense of original drugs have lowered prices of medication. The sale of generics progressed by more than 55% during the first semester of 2006 and topped 254 million francs. This is hurting pharmaceutical industries that invest in research. The trend will predictably affect the development of new drugs, slow down advances in curative medicine and ultimately increase the costs generated by disease.

Reforms

In Switzerland, political reform hinges on a complex consultation process aimed at consensus. Dices in healthcare however are heavily piped[6]. A substantial number of parliamentarians are linked to administrations of social insurance funds and weigh heavily on the decision-making process. Doris Leuthard former president of the Christian-Democratic party and a prominent member of the board of directors of Switzerland's second largest sickness fund is now Switzerland's brand new Minister of the Economy. In contrast, there are currently no more than five practicing physicians in parliament, two of whom from socialist and communist ranks.

A constitutional initiative launched in 2004 by trade unions and the socialist party calls for a single national insurance provider and for insurance premiums pegged to revenue. This proposal that would strike out 90 odd existing sickness funds (and possibly an equivalent number of perks) was rejected by parliament. The issue will be taken to referendum vote in 2007. Deep public dissatisfaction with sickness funds and current polls reflect readiness to accept a single insurance provider as a lesser evil.

Assessment

Despite Swiss meticulousness, regulation has failed to live up to expectations. It has not curbed costs. Health insurance premiums have become a burden for most families. Cost containment measures have constricted hospital infrastructures and constrained medical activity with worrisome effects on quality and accessibility.

As from 1890 Switzerland has incrementally moved healthcare away from the market. This logic however has run its time and its rhetoric shows signs of exhaustion. Terms such as competition or freedom to contract are no longer taboo even though they are still severely misused. Although they cannot match the boosts to innovation of an unregulated environment, partnerships

[6] B.Kiefer, Bloc-notes: *Derrière le sourire de Doris*, Revue Médicale Suisse, No 3071, 2006

between public institutions and private industry are opening breaches for research. Recent policy suggestions aimed at separating healthcare (to be left to the free market) from sickness care (where government intervention is deemed desirable) open new inroads[7]. Federal health minister Pascal Couchepin now states that the healthcare sector creates jobs, that its growth responds to the evolution of modern society and that its costs should be seen as investments!

Conclusions

The belief that government can fix fundamental flaws in regulated healthcare systems has yet to come to terms with reason and with reality. Copying failed social experiments from Europe or Canada will not help the United States. The Swiss healthcare model been compared in many ways to that of the US. The heavy price it is paying for centralization and regulation gives a small indication of what awaits the US if it follows the same path.

Medical saving accounts, risk related insurance, mutual help through voluntary pooling and reactivation of private charity and corporate philanthropy, would address sickness care far more efficiently and adequately than any system based on public financing and bureaucratic regulation. Yet such *laissez-faire* solutions remain anathema to most healthcare policy makers. This is not surprising. While a truly free market enhances autonomy personal responsibility and innovation, it also seeds out waste and drives bureaucracies out of business.

[7] L'Avenir du Marché de la Santé, Etude élaborée par S.Sigrist, Gottleib Duttweiler Institute sur mandat du Departement fédéral de l'interieur, Berne, aout 2006