



# Healthcare Systems: Switzerland

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Updated by Emily Clarke (December 2011) and Elliot Bidgood (January 2013)

## The Swiss Healthcare System

The Swiss healthcare system has much in common with the system adopted by the Netherlands in 2006.<sup>1</sup> Both uphold the principles of universality and equality by mandating individuals to purchase health insurance on the private market, providing financial assistance to those on lower incomes and regulating the insurance market in order to protect those with poor health. The result appears to be high quality care for all, excellent patient satisfaction,<sup>2</sup> strong uptake of new technology and drugs, short waiting lists and impressive health care outcomes. This has led to an increasing number of admirers and even exportation of the system to other countries.<sup>3</sup> A high-profile example of this transfer process is the US, where economist Paul Krugman has described the Obama healthcare reforms as "a plan to Swissify America, using regulation and subsidies to ensure universal coverage", noting that this will be a "vast improvement" on the existing US system.<sup>4</sup> Some admirers of the Swiss system have specifically touted the relatively low public expenditure in the Swiss system compared to much of the developed world. OECD figures suggest that 65.2 per cent of health spending in Switzerland is public, somewhat below the OECD average of 72.2 per cent and well below the UK figure (83 per cent), demonstrating that a relatively large proportion of private spending can still be compatible with high-quality, universal government-backed care under the right conditions. For these reasons, though the Swiss system is not without its problems, it is worth exploring the system further in the hope of identifying lessons that the NHS could learn from.

### Overview

The current Swiss healthcare system came into effect in 1996 under the Health Insurance Law (LAMal) of 18 March 1994, which sought to "introduce a perfect managed competition scheme across Switzerland, with full coverage in basic health insurance".<sup>5</sup> The LAMal enlarged the package of services previously covered by statutory health insurance and made this 'basic package'— defined by the Swiss federal government and regulated by the Federal Office of Public Health – *compulsory* across the Swiss confederation.<sup>6</sup> The idea behind this new law was to define the level of health care that patients may expect as given, but allow competition between insurers to drive up standards and drive down the cost of the insurance premiums. In order to avoid discrimination insurers must accept all applicants ('open enrolment') and cannot vary premiums based on the health of each consumer; nor can they make a profit on basic package plans. Beyond the basic package individuals are still allowed to purchase supplementary insurance to fund any additional health care, but the same regulations do not apply with regards to open enrolment, for-profit status and premium variations.

The Swiss system is highly decentralised, meaning that the 26 Swiss cantons are largely responsible for the provision of health care and insurance companies operate primarily on a regional basis. Meanwhile, the role of national government is restricted by the constitution to one largely of public health and regulation.<sup>7</sup>

### The 'basic package'

The basic package is restricted to medical treatment deemed appropriate, medically effective and cost effective.<sup>8</sup> Individuals can only seek treatment in their canton of residency and may not be treated in hospitals that aren't accredited to receive reimbursement for providing 'basic treatment.' This inevitably cuts back on choice, but is seen as a necessary cost-saving measure.<sup>9</sup>

The 'basic' package is in fact very extensive and has expanded over time.<sup>10</sup> The basic package is divided into three categories: *Sickness Insurance*, *Maternity Insurance* and *Accident Insurance* and below are some examples of the treatment covered:<sup>11</sup>

- Hospital stay and outpatient care in any general ward of the canton of residency;
- Nursing care, of up to 60 hours per week at home or in a nursing home;
- Examination, treatment and nursing in a patient's home by a physician or chiropractor;
- Rehabilitation ordered by a physician, including health resorts;
- Physiotherapy and ergotherapy (max. 9 sessions)\*;
- Nutritionist/diabetic consultation (max. 6 sessions)\*;
- Emergency treatment abroad;
- Transportation and rescue costs (50% of emergency transport costs up to CHF 5,000 per year and 50% of non-life threatening transport up to CHF 500 per year);
- Legal abortion;
- Maternity costs, including 7 routine examinations, post-natal examination, childbirth and 3 breast-feeding consultations;
- Serious and inevitable dental treatment;
- Contribution to spectacles and contact lenses of CHF180 per year for children and CHF 180 over 5 years for adults.
- Complementary medicines (alternative and homeopathic remedies)  
\*After physician referral.

### Universal coverage

A number of provisos attached to the basic package ensure that "vulnerable groups have good access to healthcare," thus maintaining the principle of universality:<sup>12</sup>

- All individuals *must* purchase a basic package insurance plan or face a penalty.<sup>13</sup>
- Insurers must charge the same price to every individual that buys a particular health care plan: in other words they cannot vary premiums based on the health status of each consumer. To ensure that insurers abide this rule a *risk equalisation* solidarity body called 'Foundation 18' (named after the law that created it)<sup>14</sup> redistributes funds from those health plans with lower health risks to those with higher, based on the age and sex of enrolees.<sup>15</sup>
- Individual cantons provide tax-financed, means-tested subsidies *directly* to those unable to afford basic package premiums (*not* to the insurer).<sup>16</sup> According to the Federal Office of Public Health (FOPH) 30.5 per cent of insured individuals required this financial assistance in 2009.<sup>17</sup>

### Choice of insurer and health care funding

To facilitate government monitoring of health insurance companies, insurers must register with the Federal Office of Social Insurance (FOSI)<sup>18</sup> to sell the basic health insurance package. The number of registered companies fluctuates between 80 and 90<sup>19</sup> and they offer a range of different premiums and types of health plans that individuals are free to choose from. Consumers also have the choice of switching provider up to twice a year if they wish and informed choice is supported by good levels of public information on health insurance companies. For example, there are several online health insurance comparison sites and journals such as *Beobachter* publish comprehensive ratings on customer satisfaction, quality systems, financial reports and the level of required reserves.<sup>20</sup> Good consumer information about the insurance market along with the ability to switch insurance companies provides a

powerful incentive to the health care industry to continually improve. Unfortunately, it is not matched by equivalent levels of public information about the quality of providers.<sup>21</sup>

## **Premiums**

So long as a health plan meets the requirements of the basic package and insurers don't risk select,<sup>22</sup> insurance companies are allowed to compete on price.<sup>23</sup> Unlike in the Netherlands where the standard nominal premium is defined by the central government and premiums therefore vary little, in Switzerland the only strict regulation applies to permissible deductible levels (see below). As a result there is substantial variation in the cost of health insurance both within and between cantons. Price variations are generally based on the level of deductible offered and whether or not an individual opts for a managed care plan (see below). In 2001 for example, premiums ranged from \$119 per month for high-deductibles, to \$159 for a managed care plan and \$199 per month for low-deductibles.<sup>24</sup> However, in 2005 it was found that the difference between the lowest and highest premiums with a 300 CHF deductible was 89% in the Zurich area.<sup>25</sup> This suggests that factors other than deductibles are affecting the price of plans and many believe that it is in fact predominantly the result of a poor risk equalisation system (see below).

## **Deductibles**

A deductible, or 'franchise' as it is sometimes called, refers to the excess that individuals must pay over and above their flat-rate insurance premiums: individuals who opt for higher deductibles pay lower flat-rate premiums. To safeguard solidarity the scheme is regulated by the Federal government, which sets a minimum and maximum deductible of 300 CHF and 2,500 CHF respectively; (for children these figures are 100 CHF and 600 CHF.)<sup>26</sup>

Costs exceeding the deductible are paid for by the insurer, although patients still have to pay 10 per cent of all remaining costs, called a co-payment or co-insurance. To prevent catastrophic costs this co-payment is capped at CHF 700 per year by cantons<sup>27</sup> (CHF 350 for children).<sup>28</sup> Prescription drugs approved by the Federal Office of Public Health are subject to the standard cost sharing arrangements, (minimum 300 CHF deductible and 10% co-insurance), but the co-insurance goes up to 20% for brand drugs if a generic drug is available.<sup>29</sup>

## **No-claims bonus scheme**

To discourage over-utilisation of services, individuals who do not submit health insurance claims receive an increasing reduction in their insurance premiums each year. After 5 years this can reach as much as 45% - a clear incentive to adopt healthier lifestyles.<sup>30</sup> Of course, individuals with health problems will not be able to get such reductions, and this does lead to a certain level of inequality, but there are plans in place to help those with long term health problems and high health care costs and none can be refused insurance or charged higher premiums as a result of their condition.<sup>31</sup>

## **Managed care organisations (MCOs)**

Insurers can offer health plans that employ MCOs to cut costs by reducing the patient's choice of health care provider: an option chosen by 12% of enrollees in 2007.<sup>32</sup> A health insurance policy run by an MCO will selectively contract providers – quite often their own self-financed

medical centres.<sup>33</sup> Most will also use ‘physician networks’<sup>34</sup> with GPs acting as ‘gatekeepers’ in the same way that they do for the NHS.<sup>35</sup> One particular MCO (‘Telmed’) even requires enrolees to call an information line akin to NHS Direct before they can visit a physician.<sup>36</sup> Outside of MCOs individuals can choose from ‘any willing provider’ within their canton and can self-refer to specialists.

### Supplementary Insurance

Supplementary insurance is voluntary and refers to health care beyond the scope of the basic package. There is no obligation on the part of individuals to purchase it, although many in Switzerland do, and the provisos attached to the basic package don’t apply here: the market is regulated by the Federal Office of Private Insurance (FOPI)<sup>37</sup> but the Office does not prevent companies from charging higher premiums to those individuals they deem to be of higher health risk.

Examples of supplementary insurance packages include:

- most dental care;
- The freedom to choose *any* hospital for ‘basic’ treatment;
- Ensuring increased comfort and privacy during treatment; such as “privat”, a one-bed room;
- Guarantees of receiving treatment from the most senior physicians.
- A non-smoker package, which offers savings of up to 20%. Since its introduction in 1995, this option has attracted about 30% of that particular insurer’s new members.<sup>38</sup>

### Provision

The provision of healthcare, (hospital services in particular<sup>39</sup>) is generally organised at the cantonal level, although the Federal authority maintains some oversight. For example, the *National Association for Promotion of Quality in Health Care* is charged with managing and monitoring provision<sup>40</sup> and health care professionals can enrol in Federal and Cantonal Medical Associations.<sup>41</sup>

### Primary care:

Primary care providers are funded through reimbursement from insurers and primarily consist of independent practices of GPs and specialists. Although most individuals register with a permanent GP in a particular hospital unit or polyclinic, individuals not in a managed care plan have the freedom to choose between *all* primary care providers in a given canton<sup>42</sup> and doctors are paid by insurers on a ‘fee-for-service’ basis for services encompassed by the basic package.<sup>43</sup> All doctors are required to inform patients which services their basic package covers and which they must purchase supplementary insurance for or pay out-of-pocket to receive.

### Secondary and tertiary care:

Unlike primary care, cantons have extensive authority over the hospital sector. Cantons are responsible for planning the provision of services according to local needs, negotiating uniform prices for medical treatment (payable by insurers to providers) and compiling a list of hospitals eligible for reimbursement of ‘basic treatments’.<sup>44</sup> This decentralised authority means that hospital provision varies hugely across Switzerland because cantonal objectives differ in terms of focus on delivering high quality services, ensuring cost-efficiency and curbing excess capacity.<sup>45</sup>

Currently hospitals are paid on a per diem basis with flat, all inclusive daily fees for a specific service or outcome, regardless of cost.<sup>46</sup> There are also substantial differences in the funding of private for-profit hospitals and public hospitals as the latter are eligible for cantonal funding whereas the former are not.<sup>47</sup> As of 2012 however this system will be replaced by a nationwide Diagnosis Related Group (DRG) system which, instead of paying using a traditional fee-for-service model, remunerates hospitals on a case basis. Each medical case is divided into a category based on diagnostics and has a pre-agreed cost based on the likely services required by a case, including possible complications.<sup>48</sup> This scheme is intended to discourage inefficiencies in hospitals and introduce greater standardization, making it easier to compare providers. The DRG system, overseen by SwissDRG, represents an extension of the 'Tarmed' fee schedule, introduced in 2004 which set federation-wide prices for medical services based on the time spent on each patient, the competence of the doctor and the type of treatment provided.<sup>49</sup> The DRG system, which has already been adopted by some cantons, will apply equally to public and private hospitals.<sup>50</sup>

## 'Big Issues'

Despite its undeniable effectiveness in terms of health outcomes, there is, as always, a fairly consistent debate about how to achieve the familiar triumvirate of objectives when it comes to healthcare systems: equitable access, high quality and low cost:<sup>51</sup>

Key areas of concern within the system:

- **Affordability:** Concomitant with health expenditure climbing to 11.4 per cent of GDP over the last decade, 'basic package' premiums have increased by an average of 5% per year and out-of-pocket expenditure is high compared with the OECD average. The Swiss system has not been very effective at containing costs and unsurprisingly there are now concerns that the premiums may be 'unaffordable for many people'.<sup>52</sup>
- **Comprehensiveness of basic package:** Many argue that costs are escalating predominantly because the basic package has become too comprehensive. Benefits included in the package have increased by over a third since 1985 and it is argued that this has artificially raised costs for everyone. Thus it is possible that better value for money could be achieved by shifting some of the more marginal treatments to supplementary coverage, where the market is more competitive.<sup>53</sup> Given the ability of the supplemental insurance market to risk-select however, any reforms of this nature would have to simultaneously ensure that those with chronic diseases, for example, were not prevented from getting the treatment they need simply because it was no longer included in the basic package.
- **Inadequate risk equalisation:** In a competitive market, the incentive for insurers not to 'cream skim' – to try to self-select the healthy – will only be removed if risk-equalisation is adequate. This is not the case in Switzerland, where risk equalisation is only based on sex and age, which are insufficient measures.<sup>54</sup> A better model would be to use prospective pooling and include health status in risk equalisation – as is the case in the Netherlands. Some improvement has already been made with the introduction in January 2012 of a risk formula that takes account of hospital or nursing home stays of more than 3 days in the previous year. Arguably however, this still may not be enough to

rectify the problems of poor risk equalisation and more reforms may be needed, even at the risk of increasing bureaucracy.

- **Restricted choice:** At the most basic level, choice is restricted through cantonal hospital lists, which – for health care covered by the basic package – stops patients from choosing hospitals in other cantons and most private, for-profit, hospitals. There is also a risk that MCOs will artificially crowd out the consumer control that helps to achieve such a responsive system.<sup>55</sup>
- **Excess supply and cost-shifting:** This has partly been addressed by standardising the payment system through DRGs but there is still a fear that the DRG system will lead hospitals to cost-shift or risk select. In other words they will try to prioritise ‘cases’ (patients) whose costs are likely to be lower in order to achieve maximum profit. Currently there are also few incentives for creating more efficient and integrated pathways of care.<sup>56</sup> A reimbursement category for such programmes may provide a solution to this.<sup>57</sup>
- **Fragmentation:** There is some concern about the inefficiencies spawned by the decentralised nature of the Swiss healthcare system. The OECD recently concluded for example that one of the principle reasons for which the Swiss system suffers from “regulatory problems”<sup>58</sup> is that the cantonal structure somewhat undermines attempts to create national standards in health care. Furthermore, *real* competition is hindered by fragmented markets and inconsistent regulation across the Confederation.<sup>59</sup> The OECD therefore recommended an “overarching framework law for health which would include existing legislation on health insurance, future policies on prevention, gathering national health data, and oversight of health-system performance.”<sup>60</sup> A national system for long term care would also be beneficial as high out-of-pocket payments and poor risk equalisation falls particularly hard on those with chronic conditions and the elderly. In the Netherlands there is a separate universal national social insurance program for long term care, the AWBZ, and a similar system may well be advisable in Switzerland. At present, Swiss public funding for long term care is quite limited and financed at the level of cantons with responsibility split among health insurers, means tested public assistance and payment by individuals.
- **Cartels:** Although there is theoretical competition amongst purchasers and providers, the low level of switching between health insurers and the de facto cartels that exist between insurers and primary care providers with regard to fee schedules means that the consumer ends up with little influence over the price of their medical care.<sup>61</sup> Government regulation of hospital prices also removes the role of the consumer and therefore hampers the efficient working of consumer-driven market forces.

## Citizen Referenda on Healthcare

The Swiss system of government includes regular popular referenda, some of which have affected the Swiss healthcare system. For example, the 1994 insurance reforms had to survive a vote in order to be implemented and in May 2009, Swiss voters overwhelmingly voted yes to enshrining in law a requirement that complementary medicines (alternative and homeopathic remedies) should be part of the package of treatments that private insurers are legally required to offer. This can serve as a very useful barometer of exactly where the public, political parties

and institutional stakeholders in the Swiss healthcare system stand on certain issues, but it can also be a roadblock to reform: since 1974 nine healthcare reform proposals have been defeated at the ballot box and in the last few years two reform packages intended to deliver greater cost-control were overwhelmingly defeated.

In June 2012, the Swiss voted on a new plan proposed by the government that aimed to expand Managed Care nationwide (see 'Managed Care Organisations' above), in order to control cost inflation and address the challenges posed by population ageing, chronic disease and the cost of new technology.<sup>62</sup> The reforms were to increase coordination among networks of healthcare providers (doctors, pharmacies, hospitals and social care homes), which would then negotiate binding budgets and contracts with the health insurance companies in order to bring about cost reductions without undermining care. An insured person joining a Managed Care network, and thus giving up their choice of doctors, would benefit from lower costs, while those who decided against joining MCO networks would have to have paid additional costs. Advocates noted the success of the 90 existing Managed Care networks in Switzerland and the fact that 46 per cent of the population were already members, aiming to increase this to around two thirds of the population within three years. The law also had the backing of business groups, consumer groups and family doctors. However, in the referendum the Swiss public voted 76 per cent against the plan. Opponents of the plan, including the Swiss Medical Association and trade unions, had argued it would do little for costs, compromise quality of care and create a two-tier system with regard to physician choice.<sup>63</sup> There were also comparisons made with the experience of the United States with regard to managed care, where Health Maintenance Organisations (HMOs) had sometimes faced criticism due to the restrictions they placed on patient access in a country where, much as in Switzerland, consumers are used to paying substantial amounts for a health system that is responsive to their demands (see the 'Healthcare Systems: USA briefing').<sup>64</sup> This demonstrates that future cost-control and managed care expansion initiatives will require stronger consensus in order to pass.<sup>65</sup> Further, pollsters also found that only one in four Swiss voters understood managed care and that only those with positive personal experiences of it were strongly inclined to support it, signalling that better explanation to the public was also needed.<sup>66</sup>

In June 2008, a proposal to reform the 1994 Health Insurance Act was similarly defeated with 69 per cent of voters opposing, despite polls initially showing that people were relatively supportive.<sup>67</sup> This measure was intended to amend the constitution in order to increase competition, choice and the role of insurers within the system, so as to remedy the observed problems with monopoly power among the insurers. However, concerns existed that the insurance companies would be strengthened, that costs would rise and that patient choice of doctors would be curtailed, leading the Swiss Social and Christian Democratic parties to campaign against. The issue arose after the free-market Swiss People's Party launched an initiative to transfer some of the treatments that were part of the basic package to complementary private insurance, to reduce mandatory contracting, to liberalise fees and to allow health insurers to be the single buyer of healthcare services. Parliament agreed to support a 'counterproposal' containing the market reforms, agreeing that they would increase quality, choice and competition while reducing costs, but they also removed the benefit package reduction, a proposal that the Swiss People's Party agreed to support in the referendum.<sup>68</sup> Much as in 2012, the opposition of stakeholders (doctors, pharmacists and local cantonal authorities in this case) to the changes was considered a factor in the decision of the electorate to vote against reform. This again demonstrates the current barriers to effective reform and cost-control in the Swiss system.

## Lessons for the NHS

The facts and figures associated with the Swiss healthcare system show a system that consistently produces some of the best health outcomes and patient satisfaction<sup>69</sup> in the world (see Statfile below). As a nation they have achieved universal health coverage whilst avoiding substantial regional health inequalities and ensuring that everyone has good access to top quality and high-tech medical services.<sup>70</sup> The question therefore is how have they achieved this and what price did they pay for it?

It is undeniable that health care costs and expenditure in Switzerland are quite high – the Swiss spend 11.4 per cent of their GDP on health compared with the OECD average of 9.5 and health spending per capita is even further above the OECD average at US\$ 5144ppp (OECD average = US\$ 3223ppp). More worryingly from the perspective of an average Briton accustomed to a 'free' health service is the fact that out-of-pocket expenditure accounts for 25.1 per cent of total health expenditure in Switzerland (in the UK it is 8.9%). In relation to this, it is also important to consider that by a number of metrics, Switzerland is a very wealthy country. GDP per capita (adjusted for PPP) is higher than in the UK, unemployment is lower and on the 'Better Life Index' published by the OECD, Switzerland scores better than the UK on average income, income inequality, job security and level of disposable income. This could mean that the introduction of universal private insurance in the UK would require the British government to pay out significantly more in subsidies in order to cover those on lower incomes than the Swiss government does. More generally, a culture shift would be needed in Britain in order for us to accept the additional individual involvement and costs associated with mandatory private insurance. Having said this, Swiss health spending as a percentage of GDP is on a par with countries such as France and the Netherlands who have similar systems and it is significantly less than America spends, despite America suffering from poorer health outcomes and a lack of universal coverage. In 2010, Switzerland also spent less per capita on health than social-democratic Norway did on its single-payer public system, which has far higher waiting times. Furthermore, these Swiss expenditure figures probably reflect to a large extent the aforementioned general wealth of the Swiss nation, which allows its citizens to choose to spend more on health care than in nations and do so without great difficulty.<sup>71</sup> For the Swiss therefore, although rising costs are a concern, they could legitimately argue on the basis of their outcomes, that they are getting value for money.

Compared with the NHS, where health care is paid for almost solely out of general taxation, there is a much stronger link between payment for and consumption of health care in the Swiss system. Money, as the saying goes, is very much in the hands of the patient. It is the individual who picks and pays *directly* for the health insurance plan and health providers he/she deems most appropriate. This has three key benefits: there is no artificial cap on health care spending, individuals are motivated to be cost conscious and, with the real threat of losing custom, providers are motivated to constantly improve. Although there are imperfections in the practice of this, with low levels of insurance switching and little consumer influence over provider pricing, the principle of consumer-driven care and cost-consciousness is laudable and in general has the support of the Swiss population. For example, although they have occasionally voted against additional free-market and managed care reforms as outlined above, in a 2007 referendum they also voted 71% against a plan to merge the insurance companies into a single public insurer ('social unity health insurance') with means-tested premiums based on wealth and income.<sup>72</sup> The proposal was intended was to reduce premiums for low income earners,<sup>73</sup>

but the Swiss public were concerned that an insurance monopoly would 'kill innovation and be detrimental to quality'.<sup>74</sup>

Cost consciousness in Switzerland is demonstrated by the fact that paid benefits for high deductible policies were 60% lower than those for a regular deductible one. Competition between Swiss insurers has also lowered annual administrative expenses per enrollee from \$98 in 1996 to \$92 in 2001.<sup>75</sup> Cost consciousness is ensured because premiums are paid directly by each enrollee rather than, as in many other countries, by an employer or third party. The only problem with removing the employer from the equation, as is predominantly the case in Switzerland, is that it reduces the ability to buy insurance 'in bulk.' Switzerland might be advised therefore to follow a system similar to the Dutch rules whereby premiums can be lowered through 'group discounts' generally purchased by an employer, thus helping to keep costs down.

With regards to the NHS, it is unlikely that the British would accept the high out-of-pocket expenditure that the Swiss face. Thus, if compulsory private insurance was ever introduced into the UK, co-payments and caps on out-of-pocket expenditure would have to be kept low in order to make it at all politically palatable. Furthermore, rather than looking solely to the Swiss system for inspiration, it is important to take into account many of the Dutch aspects as well, which may be more popular and effective. This is particularly the case with reference to:

- the comprehensive care the Dutch give to those suffering from long-term illness
- the automatic cover granted to children
- their fairer mode of regulating premiums and risk equalisation
- the rules on price negotiation and selective contracting
- their centralised rather than regional schemes

In conclusion, there are many aspects of consumer driven and private market-based health care that are effective in producing good health care outcomes and high patient satisfaction. Providing those on low-incomes with enough money to purchase health insurance in the same way that everyone else does is also a much more effective system than the "two tier" approach of America where those on Medicaid are often treated differently by providers who know they will not be adequately reimbursed for their services. However, the British are not used to having to pay directly for health care and nor are they at present accepting of 'privatisation' in health care. For this reason, even if reforms are implemented – and increasing numbers of people are recognising that they need to be – it is likely that government financing and involvement in health care would remain higher in the UK than in Switzerland for some time. Furthermore NHS reforms should be gradual and would need cross-party support in order to ensure that the system did not suffer from frequent and damaging reversals in policy.

## Statfile (most recent figures from the OECD unless otherwise stated, most recent UK figure and OECD average given for comparison)

### Funding

**Total health expenditure (% GDP):** 11.5% (UK: 9.6% OECD Average: 9.5%)  
\$5489 per person (US \$, adjusted for PPP) (UK: \$3433.2, OECD Average: \$3265)

**Total public expenditure (% total health expenditure):** 65.2% (UK: 83.2% OECD Average: 72.2%)

**Total out-of-pocket expenditure (% total health expenditure):** 25.1% (UK: 8.9% OECD Average: 19.5%)

### Consumer Powerhouse Index:

The Swiss healthcare system ranked fourth in the 2007 Euro Health Consumer Index (EHCI)<sup>76</sup>, which compares European healthcare systems from consumers' point of view on the basis of 27 criteria including: waiting times, pharmaceutical availability and quality of services.<sup>77</sup> Switzerland scored particularly highly on waiting times and health outcomes; being concerned particularly with the opinion of consumers, that Switzerland came fourth out of 26 countries surveyed clearly demonstrates high consumer satisfaction. This is consistent with previous surveys, such as that by Coulter and Cleary in 2001, which ranked the Swiss system the highest on patient satisfaction.<sup>78</sup>

### Process outcomes<sup>79</sup>

**Practicing physicians (per 1,000 population):** 3.8 (UK: 2.8 OECD Average: 3.1)

**Practising nurses (per 1,000 population):** 16 (UK: 9.1 OECD Average: 8.6)

**MRI scanners (per 1m population):** 17.8 (UK: 5.9 OECD Average: 12.5)

**CT scanners (per 1m population):** 33.7 (UK: 8.9 OECD Average: 22.6)

### Waiting Times<sup>80</sup>

**Percentage waiting four weeks or more for a specialist appointment (study of 11 OECD nations):** 18%, 2<sup>nd</sup> lowest out of 11 (UK: 28%, Average: 37%)

**Percentage waiting four months or more for elective surgery (study of 11 OECD nations):** 7%, 3<sup>rd</sup> lowest out of 11 (UK: 21%, Average: 13.3%)

### Health outcomes<sup>81</sup>

**Average life expectancy (at birth):** 82.6 (UK: 80.6 OECD Average: 79.8)

-Men : 80.3 (UK: 78.6 OECD Average: 77.0)

-Women : 84.9 (UK: 82.6 OECD Average: 82.5)

**Infant mortality rate (per 1,000 live births):** 3.8 (UK: 4.2, OECD Average: 4.3)

**Maternal mortality rates:** 7 (2006) 8.2<sup>82</sup>

**Mortality rate from cancer: 180 199 (2011)**

**Mortality rate from ischemic heart disease: 88 110 (2011)**

**Mortality rate from stroke: 29 42 (2011)**

**Mortality Amenable to Healthcare: N/A (no data)**

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<sup>1</sup> See Civitas Healthcare Systems: The Netherlands. <http://www.civitas.org.uk/nhs/download/netherlands.pdf>

<sup>2</sup> Deloitte Center for Health Solutions 2010 Survey: Health Care Consumers in Switzerland. [http://www.deloitte.com/view/en\\_US/us/Industries/US-federal-government/center-for-health-solutions/health-care-consumerism/0db53922bdeb7210VgnVCM200000bb42f00aRCRD.htm](http://www.deloitte.com/view/en_US/us/Industries/US-federal-government/center-for-health-solutions/health-care-consumerism/0db53922bdeb7210VgnVCM200000bb42f00aRCRD.htm)

<sup>3</sup> The New York Times, by Nelson Shwartz 2009 <http://www.nytimes.com/2009/10/01/health/policy/01swiss.html?pagewanted=all>

<sup>4</sup> Krugman, P., 'The Swiss Menace' (2009) *The New York Times*, August 16 <http://www.nytimes.com/2009/08/17/opinion/17krugman.html>

<sup>5</sup> "The influence of supplementary health insurance on switching behaviour: evidence on Swiss data," by B. Dormont, P. Geoffard, and K. Lamiraud, Institute of health economics and management, Working paper no. 07-02, Lausanne, p2, May 2007

<sup>6</sup> Federal Office of Public Health website, <http://www.eda.admin.ch/eda/en/home/topics/intorg/un/unge/gepri/manins/inshea.html>

<sup>7</sup> Health care systems in Transition : Switzerland, World Health Organisation, [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/96411/E68670.pdf](http://www.euro.who.int/__data/assets/pdf_file/0003/96411/E68670.pdf)

<sup>8</sup> Ibid WHO HIT: Switzerland

<sup>9</sup> OECD Economic Survey of Switzerland 2004: The health sector is suffering from regulatory problems, p3, see [www.oecd.org/dataoecd](http://www.oecd.org/dataoecd),

<sup>10</sup> Hertzlinger and Parsa-Parsi, Consumer-Driven Health Care: Lessons from Switzerland, JAMA, Vol.292, No.10, 2004

<sup>11</sup> Health care systems in Transition : Switzerland, World Health Organisation, p21, [www.euro.who.int](http://www.euro.who.int), Sickness Insurance refers to "impairment of physical or mental health which requires a medical exam, treatment or absence from work", Maternity Insurance to "pre-natal monitoring, delivery and post-natal convalescence" and Accident Insurance to "unexpected and involuntary injury resulting from an extraordinary external cause".

<sup>12</sup> OECD and WHO survey of Switzerland's health system, Press Release, 19.10.06, [www.euro.who.int](http://www.euro.who.int), [Viewed on 22.11.07]

<sup>13</sup> FOPH website- [www.bag.admin.ch](http://www.bag.admin.ch), [Viewed on 23.11.07]

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<sup>16</sup> Cited in: Hertzlinger and Parsa-Parsi, Consumer-Driven Health Care: Lessons from Switzerland, JAMA, Vol.292, No.10, 2004

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<sup>18</sup> Health care systems in Transition : Switzerland, World Health Organisation, p21, [www.euro.who.int](http://www.euro.who.int), [Viewed on 16.11.07], p10,

<sup>19</sup> Health Insurance: Information, [www.ch.ch](http://www.ch.ch), The Swiss portal website, [Viewed on 22.11.07]

<sup>20</sup> Der Schweizer Beobachter, 19/99. Available at: [www.beobachter.ch](http://www.beobachter.ch). See also: [www.camparis.ch](http://www.camparis.ch), which provides information and advice about purchasing Swiss health insurance, [Viewed on 25.11.07]

<sup>21</sup> Hertzlinger and Parsa-Parsi, Consumer-Driven Health Care: Lessons from Switzerland, JAMA, Vol.292, No.10, 2004 (Abstract)

<sup>22</sup> Gardien, L, Geoffard, P, Grandchamp, C, Separating selection and incentive effects: an Econometric study of Swiss Health Insurance claims data, Delta Working paper No. 2003 - 27, Paris, 2003, p3

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- <sup>25</sup> Commonwealth Fund comparison of Dutch and Swiss Health Care Systems [http://www.commonwealthfund.org/usr\\_doc/Leu\\_swissdutchhltinssystems\\_1220.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Leu_swissdutchhltinssystems_1220.pdf?section=4039)
- <sup>26</sup> Federal Department of Foreign Affairs, Information on Health care <http://www.eda.admin.ch/eda/en/home/topics/intorg/un/unge/gepri/manins/inshea.html>
- <sup>27</sup> Federal Office of Private Insurance website, [www.bpv.admin.ch](http://www.bpv.admin.ch), [Viewed on 19.11.07]
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- <sup>33</sup> Health care systems in Transition : Switzerland, World Health Organisation, p69, [www.euro.who.int](http://www.euro.who.int), Most MCOs are owned by insurance companies, but some – such as Medix Zurich and Bubenberge Berne – are doctor-owned.
- <sup>34</sup> OECD and WHO survey of Switzerland’s health system, Press Release, 19.10.06,[www.euro.who.int](http://www.euro.who.int),
- <sup>35</sup> See [www.doktor.ch](http://www.doktor.ch), [Viewed on 30.12.07]
- <sup>36</sup> [www.comparis.ch](http://www.comparis.ch), information about Swiss health care,
- <sup>37</sup> The FOPI budget of CHF 18.2 million for 2007 is funded by insurance companies. See Federal Office of Private Insurance website , [www.bpv.admin.ch](http://www.bpv.admin.ch), Examples of the influence of FOPI include its 2007 review, which called for a 6.4% increase in the price of 30 products offered by supplementary insurance.
- <sup>38</sup> Hertzlinger and Parsa-Parsi, Consumer-Driven Health Care: Lessons from Switzerland, JAMA, Vol.292, No.10, 2004
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- <sup>44</sup> The list is published on the FOPH website, [www.bag.admin.ch](http://www.bag.admin.ch), [Viewed on 22.11.07]
- <sup>45</sup> OECD Economic Survey of Switzerland 2004: The health sector is suffering from regulatory problems, p3, see [www.oecd.org/dataoecd](http://www.oecd.org/dataoecd),
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- <sup>48</sup> Swiss Style magazine, <http://www.swissstyle.com/health-pie-recut>
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- <sup>50</sup> Health Policy Monitor 2009 survey [http://www.hpm.org/en/Surveys/USI\\_-\\_Switzerland/14/The\\_role\\_of\\_cost\\_accounting\\_in\\_a\\_DRG-based\\_system.html](http://www.hpm.org/en/Surveys/USI_-_Switzerland/14/The_role_of_cost_accounting_in_a_DRG-based_system.html)
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