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Healthcare – always a work in progress

Switzerland provides its citizens with a very high standard of medical care. Everyone is covered by mandatory insurance, there are few bottlenecks and medical professionals deliver outstanding services. Despite this, the Swiss healthcare system is ill-equipped for the future. For instance, who is going to provide care for the 220,000 dementia patients anticipated by 2030?
By Seraina Gross

The Swiss healthcare system is a reflection of Switzerland itself – good quality but expensive. "The Swiss healthcare system in one of the best in the OECD", according to the Organisation for Economic Co-operation and Development and the World Health Organization (WHO) in 2011. The verdict was: "The population has access to local healthcare services, a wide range of service providers and insurance companies and extensive coverage of basic medical services and medicines." High life expectancy is an indication of the outstanding quality of the healthcare system. People live longer in Switzerland than in almost any other country in the world. In 2011, a 50-year-old man could expect to reach the age of 83 and a 50-year-old woman had another 35.9 years ahead of her on average.

But quality comes at a price. In 2009, healthcare expenditure stood at 11.4 % of gross domestic product. By international comparison, that puts Switzerland on a par with Canada in seventh place among OECD countries. The number-one spot, by a clear margin, is occupied by the USA at 17.4 %. The Federal Statistical Office calculated Switzerland's healthcare expenditure at CHF 62.5 billion in 2010. With a population of just under eight million, that is the equivalent of CHF 661 per capita per month.

The burden of premiums is increasing

High health insurance premiums are therefore a constant political issue. The Swiss people have a significant burden to bear despite the relatively moderate rates of increase in recent years. Those insured have spent an average of CHF 353.10 per month on health insurance since January. The inhabitants of Nidwalden have paid the least (CHF 172.10), while the people of Basel have had to dig deepest into their pockets to find CHF 461.40. According to the OECD, a middle-class family with two children spent 9.8 % of their household budget on premiums in 2007, compared to 7.6 % in 1998. This does not include the costs that patients have to bear themselves in the event of illness. 10 % of treatment costs are paid by patients, though only up to an amount of CHF 700 per year. Each insured person must also cover treatment costs of CHF 300 to CHF 2,500 at the beginning of each year, depending on the insurance model, before the health insurance fund is liable to pay.

Even in wealthy Switzerland far from everyone is able to pay their premiums themselves. Low-income households are therefore entitled to financial support. Almost one in three of those insured now makes use of premium reductions. These subsidies cost federal and cantonal government four billion Swiss francs in 2010.

More market or more state control?

The Swiss healthcare system is still in good shape for now. But the future prospects are less bright. There are increasing signs that Switzerland is unfit to meet the great challenges of the future. Switzerland is one of the most rapidly ageing societies in the world. The OECD and WHO have been warning that reforms are necessary for years. But Switzerland struggles with reforms. Politicians have made little headway since the introduction of mandatory health insurance in 1996.

There are various reasons for the impasse in healthcare policy. One is the lack of consensus on one key issue. What does the healthcare system need? More market or more state control? The predominantly conservative Parliament tends to favour competitive models, but the Swiss people are clearly sceptical, as evidenced by the defeat of the managed-care bill drawn up by Parliament last June. In contrast, there is a reasonable chance that the Social Democratic Party (SP) initiative for a unified health insurance fund will be approved by the Swiss people. Political failings have also played a part. In recent years, politicians have not succeeded in establishing an effective distribution of risks between the health insurance funds. Only the insured party's

High-tech, state-of-the-art medicine is extremely expensive

Photo: Adrian Moser

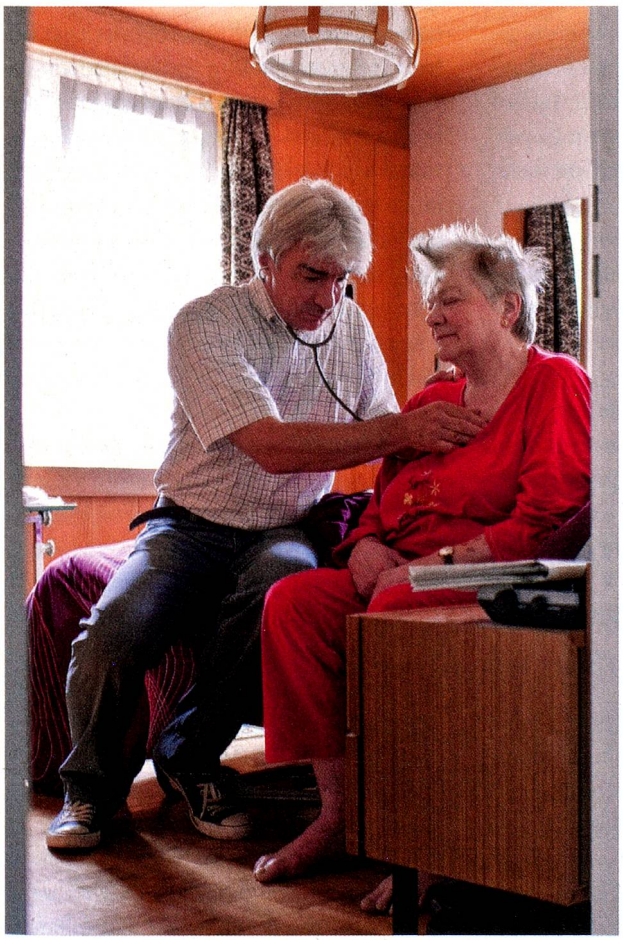
age and gender are taken into account, not their state of health. As a result, competition between the health insurance funds is primarily limited to going after the "good risks" – the young and healthy. That does not generate savings for anyone. On the contrary, every change of insurance fund produces costs, and the money for advertising health insurance funds also has to come from somewhere.

The political gridlock is a consequence of the many individual interest groups, which include doctors, the health insurance funds, the pharmaceutical industry and patients, to name but a few. In no other policy area are so many different players involved in consultation as in healthcare. The two main interest groups, the health insurance funds and the doctors, have even had a voice in Parliament in recent years. The funds have been represented in the Council of States in the form of Christoffel Brändli (SVP) from Grisons as president of the health insurers' association Santésuisse and Eugen David (CVP) from St. Gallen as president of Switzerland's largest health insurance fund, Helsana. The president of the Swiss Medical Association, Jacques de Haller (SP) from Geneva, has given the doctors a voice in the National Council.

Shared responsibility

Shared responsibility for the healthcare system has also proven an obstacle to reform. Health insurance is a federal issue, while healthcare provision is a matter for the cantons. They decide, for example, on hospital provision. However, only around half the costs incurred in the hospitals are covered by the cantons. The remainder is paid for by health insurance. Shared responsibility has produced a situation of "muddling through", according to observers such as the ethicist Ruth Baumann-Hölzle from Zurich (see interview). The verdict of the OECD and WHO on the Swiss decision-making mechanisms is not quite as harsh. They even consider the "local flexibility" of the 26 cantons to be one of the system's strengths. The role of direct democracy is also viewed positively: "The uniquely high degree of direct political involvement at all levels of government provides Swiss citizens with the opportunity to have an impact on the direction of healthcare policy." Both organisations nevertheless warn that "differences between the cantons in terms of funding and access (...) may mask disparities".

Healthcare has brought little good fortune for the Federal Councillors responsible for it in recent years. Pascal Couchepin, a volatile Free Democrat from Valais, found it difficult to perform the task of ensuring a balance of interests. Neuchâtel's Didier Burkhalter, another Free Democrat, left the Department of Home Affairs after just two years to return to the Department of Foreign Affairs without really getting to grips with healthcare policy.



Far too few young doctors want to become general practitioners today – the job is stressful and poorly paid

Alain Berset's first steps

Alain Berset, a Social Democrat from Fribourg, has now been responsible for the constant work in progress that is healthcare for over a year. The Federal Councillor, who is just 40 years old, is regarded as a quick-thinker and a courageous pragmatist. It is still too early to assess whether he will be able to resolve the major issues. The first projects he has initiated nonetheless appear to be heading in the right direction. Berset is finally dealing with the issue of the lack of general practitioners. Rural regions have been affected by this for some time. GPs have for years struggled to find successors for their practices before entering retirement. As a result, retirement often means the closure of the practice.

However, in more recent times, people in urban areas and regions close to cities can also consider themselves fortunate to find a good general practitioner. There are six GPs for every 10,000 inhabitants on average in Switzerland. By comparison, there are 16 in France. Experts say that Switzerland trains around 400 fewer GPs each year than it actually needs. The Swiss Health Observatory, a politically neutral organisation, estimates that Switzerland will be without a third of the GPs it requires by 2030.

300 more doctors per year

Three hundred extra doctors are now to be trained each year from the 2018/2019 academic year onwards. The number of graduates at Switzerland's five medical schools (Zurich, Berne, Basel, Geneva and Lausanne) is to be increased gradually to 1100 per academic year by then. Even the establishment of new medical schools is under discussion. It is not yet clear who will bear the costs, amounting to CHF 56 million a year, for training the extra doctors. The training of doctors, as with most educational matters, is in fact the responsibility of the cantons. However, federal government is also expected to make a contribution this time. Only, federal government is hardly likely to write out a blank cheque for the cantons. If it is to make a contribution to funding, it may well also want to have a say.

The training of extra doctors alone does not resolve the issue, as too few doctors are

Photo: Keystone

opting to train as general practitioners. The shortfall in doctors actually only affects the basic care providers or, in other words, general practitioners, internists and paediatricians. There is no shortage of specialists. On the contrary, Switzerland has too many. The Federal Council therefore decided once again at the end of last year to restrict the licensing of specialist doctors. From April, the cantons are to be allowed to refuse specialist doctors a practice licence if they believe that the demand is not there. The Federal Council has thus responded to the sharp increase in specialist practices following the expiry of the first medical licensing moratorium at the end of 2011. However, nobody is really satisfied with this solution. The licensing restrictions will therefore only apply for three years. This period of time is to be used to bolster the ranks of general practitioners. Federal Councillor Alain Berset's GP master plan enables prospective general practitioners to join local practices as junior doctors. They have until now primarily undertaken their junior doctor training in hospitals like the specialists. A key factor will nonetheless be whether efforts to make a career as a GP more financially attractive succeed. GPs in Switzerland earn much less than specialist doctors. The Swiss Medical Association calculated the average income of GPs, subject to old-age and survivors' insurance contributions, at CHF 197,500 in 2009. By contrast, a neurosurgeon earned more than twice that amount at CHF 414,650, an eye specialist received CHF 345,150 and a gynaecologist CHF 236,000.

300,000 Alzheimer's patients by 2050

With the bolstering of GP ranks, the reintroduction of the licensing moratorium and the improvement in the distribution of risks between the health insurance funds, Federal Councillor Berset is pursuing a policy of small steps after the failure of large-scale re-

"The question of allocation should not be delegated to the sickbed"

Ruth Baumann-Hölzle is one of Switzerland's leading experts on ethical issues relating to healthcare. She is vehemently opposed to individual patients being refused medical treatment on cost-saving grounds. She instead argues that the services themselves need to be scrutinised.
Interview by Seraina Gross

Ruth Baumann-Hölzle

"Swiss Review": *The maxim that you cannot put a price on health has long applied in Switzerland. Is that still the case today in view of the costs of CHF 661 per person per month?*

Ruth Baumann-Hölzle: That maxim has never held true. Every service has always come at a cost. This attitude has nonetheless resulted in a failure in Switzerland to address the issue of the financial limitations of the healthcare system. But Switzerland too must tackle the question of how much to spend on healthcare.

What is the answer?

I'm not in a position to put that into figures for you. What is important is to look at healthcare costs in relation to other social costs, such as spending on education. Education needs to be improved, not just at university level but basic schooling as well. We know that there is a direct correlation between the standard of education and the state of health. The higher the standard of someone's education, the better their state of health or, in other words, poverty and poor education result in ill health.

Switzerland has one of the best healthcare systems in the world. But what are its shortcomings?

We have good basic care and guarantee access to top medical services. Shortcomings exist in the distribution of resources, which is unfair.

In what way?

We have both over-treatment and a shortage of care services. There are patients who are over-treated and others who do not receive the care they actually require. We know, for example, that lots of unnecessary operations are carried out in Switzerland. There is good money to be earned from operations. The issue of over-treatment primarily exists among those who are privately insured. This is because the treatment of privately insured patients is extremely lucrative.

Which patients do not receive sufficient care?

This is the case for patients who primarily require nursing care rather than medical care. These are multi-morbid patients suffering from several illnesses and patients for whom the medical treatment options have been exhausted. As a general rule, it is true that the higher the level of care required, the higher the risk of rationing. An issue also exists with people suffering from rare diseases. Too little research is carried out here still. The pharmaceutical industry has made some effort in this respect in recent years, but not enough.

The "reformiert" newspaper, a Reformed Church publication, recently conducted a survey on the issue of rationing. A narrow majority were in favour of refusing alcoholics a liver transplant. What is your view on that?

> *"That puts us in the middle of a debate about whether or not a life is worth saving"*

I am strongly opposed to addressing the issue of rationing in terms of individual patients or patient groups. I absolutely reject that. That puts us in the middle of a debate about whether or not a life is worth saving. Such a debate is

Photo: donated

forms in recent years. Whether he succeeds in tackling one of the greatest challenges of the future – the increase in the number of patients needing care and of the chronically ill – will prove decisive. The Swiss Alzheimer's Association estimates that there will be 220,000 dementia patients by 2030, with that figure set to reach 300,000 by 2050. Tens of thousands of German, Polish and French nursing staff are already working in Switzerland. They are in short supply in their home countries, just like the thousands of foreign doctors working in Swiss hospitals and practices. The OECD and WHO are calling for a national nursing staff plan.

The proportion of elderly people in the population is rising all the time

The two international organisations are also critical of the lack of healthcare policy data available in Switzerland. Information on the effectiveness of treatments is vital to "knowledge-based" policy, say the OECD and WHO. They are addressing the lack of transparency here, a point that is constantly raised in Switzerland as well. This lack of transparency means that debates on healthcare policy are always a bit of a fumble in the dark. It would be good to know, and frankly it is very important that we know, exactly what we are getting for the large sums of money that we spend on healthcare.

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beneath human dignity and history shows where that leads: to a loss of humanity.

But doesn't Switzerland have to address the issue of rationing?

Yes, but not in terms of individual patients or individual patient groups. It is a question of how we set priorities. We must avoid focussing on whether or not alcoholics should be granted liver transplants. We must instead assess whether the cost-benefit ratio of the services currently paid for by the health insurer is right. Does a new cancer drug launched on the market really justify the additional costs incurred compared to existing treatment? Top-quality research is required to determine this. Switzerland lacks such cutting-edge research, which is one of the Swiss healthcare system's greatest shortcomings.

What do you think about the QALY (Quality Adjusted Life Years) concept where an amount is agreed for the cost of an additional year in good health?

There are currently no real alternatives to QALY as a measure for assessing the effectiveness of medical services. However, QALY should not be used to assess the value of a person. The question of allocation should not be delegated to the sickbed. On the other hand, it is vital that we apply the concept of QALY to the cost-benefit analysis of services.

Even at the risk that expensive services are excluded from health insurance cover?

No, if a service is efficient then it can also be expensive because its cost-benefit ratio is right. By contrast, the cost-benefit ratio of a cheap but ineffective service will be poor.

This means that agreement would be reached on the services to be covered by health insurance and if they are included in the list, then they would be made available to everyone.

Exactly. I like to compare it to a library. The decision on whether a book will be made available to users is made at the time of purchase. Once the book is on the shelf, you do not suddenly turn around and tell someone that they cannot borrow it now. We must look at the make-up of the healthcare "library". I strongly believe that there are tremendous savings to be made here.

"The lack of cutting-edge research is one of the Swiss healthcare system's greatest shortcomings"

But would that also mean assessing who earns what from the services?

The issue of margins is also an ethical one. We know that the margins are extremely high in some cases. The prices for medicines, implants and hospital beds, for example, are very high in Switzerland. Wheelchairs for which the Swiss social insurance schemes pay several thousand Swiss francs can be purchased online for a fraction of the price. Health insurance premiums have also gone up by more than the rate of inflation in recent years.

Why aren't services subjected to close scrutiny?

Because there is no will for transparency as this would reveal the interests of the various players. Hardly any other area of politics is so dominated by strong individual interests and intense lobbying on the scale found in healthcare.

Focussing on a more fundamental question, what is the purpose of a healthcare system? There is often talk about a healthcare market in the political debate.

The healthcare system is not simply a market because a healthcare service is only an elastic commodity to a limited extent. A treatment is not like a car where you can decide for yourself whether you want to buy one and, if so, what model. If you are in an emergency ward suffering from a bilious attack, then you are no longer the one making the decision; others make it on your behalf.

Is making money from healthcare unethical?

No, the players involved in healthcare should, of course, earn money and be remunerated appropriately. But turning a profit is not the healthcare system's raison d'être. The priority must be to provide care for sick people.

Photo: Keystone