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Understanding The 'Swiss Watch' Function Of Switzerland's Health System

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Note from PNHP: This interview makes it clear that in the Swiss system, which is based on private health insurance, the government nevertheless plays a big role. The minister said, when asked who set drug prices in the Swiss system: "I set the prices for drugs."

BY TSUNG-MEI CHENG

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As the United States rolls out its sweeping health reforms, the Swiss could justifiably say: Been there and done that. In 1996 Switzerland undertook a restructuring to turn the existing system of private voluntary health insurance into what officials there describe as a mandatory private social health insurance system.

As a result, the Swiss system today is based on competition among eighty-four highly regulated private health insurers, which cover the basic benefit package and also sell supplemental insurance. There is a nationwide mandate for Swiss citizens to have the basic package, enforced by the nation's twenty-six cantons—and, as a result, there is universal coverage. There is no government-run health insurance plan, although the national and cantonal governments do provide premium subsidies for low-income individuals and help finance the nation's hospital sector.

The reasons that reforms were undertaken will be familiar to Americans: Women were being charged a great deal more than men, and preexisting condition restrictions were imposed on coverage. Now those problems have been solved, but the Swiss face others.

Few understand as much or more about the Swiss health system as Thomas Zeltner, M.D., who served as head of the federal Office of Public Health (for national duties) and as secretary of health (for international activities) for nineteen years, from January 1991 to December 2009. He sat down recently for a candid interview with Tsung-Mei Cheng to explain what he described as the "Swiss watch" functions of the model: how the Swiss private health insurance system works, the significant regulatory role that the government plays in Swiss health care, the strengths and weaknesses of the Swiss health system, and what lessons his

experience with that system holds for the United States. Excerpts of that interview follow.

Tsung-Mei Cheng The U.S. Congress recently passed President Obama's health reform bill, and America is now poised to make major changes in its troubled health care system. Switzerland also went through important health reforms a decade and a half ago. What were the reasons for your reforms at that time, and what did they change? Did Switzerland attain universal health insurance coverage only after 1996?

Thomas Zeltner Before 1996, 98 percent of the population already had some type of health insurance acquired from private companies on a voluntary basis. But that coverage could exclude preexisting conditions, and benefits could vary quite a bit among policies.

There were two aspects of the major shift in 1996. One was that everybody was mandated to have health insurance for a specified benefit package. The second was that insurers had to take everyone, irrespective of their health status and age. To this day, insurers can offer that basic package with different deductibles. Although premiums for the basic benefit package with a given deductible could vary among competing private insurers, an insurer must charge all of its customers the same premium for that policy, regardless of the customer's health status and age.

Cheng Is there no government-run insurance plan?

Zeltner There is not. The system relies exclusively on private health insurance plans, although these are highly regulated.

Cheng What political pressure drove the Swiss reforms at that time?

Zeltner A major reason was that women had to pay substantially more for their health insurance plans than men, because women were considered higher insurance risks. They live longer, and they have higher health expenditures. The second major reason was the exclusion of preexisting conditions from coverage, which, I take it, Americans do not like, either.

Cheng Why did Switzerland go the private health insurance route rather than the single-payer route?

Zeltner We already had all these private health insurance companies—very small ones and bigger ones—and merely used them as vehicles to implement a genuine social health insurance system, which the 1996 reforms created.

Because there is confusion about this in the United States, I should emphasize that, yes, they are private companies. But they are not allowed to earn profits on the basic benefit package they provide in what we describe as "social insurance." They can only earn profits on supplemental coverage for items not included in the mandated social insurance benefit package.

This is a big difference from the role of private insurers in the U.S., where private insurers are allowed to make profits from performing payment and other functions related to social insurance programs like Medicare and Medicaid.

Swiss Social Values

Cheng Part of the fierce, recent debate on health reform in the U.S. has been to what extent Americans should be financially responsible for one another's health care. Americans have never reached a consensus to adopt the Principle of Solidarity for health care, which guarantees financial protection against life's contingencies for everyone. Does the Swiss system obey this principle?

Zeltner It does. In Switzerland, rich and poor share the same insurance plans, and physicians and hospitals are paid the same fees for rich and poor alike. But in the U.S., fees paid vary by type of insurance. Fees for the poor in your Medicaid are much lower than fees paid by commercial insurance.

I think that is an interesting difference. We don't want the poor to be stigmatized in associating them to a specific plan. So, indirectly, we come to the same result—we help the poor—but it makes a huge difference when it comes to personal dignity as a patient. In Switzerland, the doctor and hospital do not even know whether you're subsidized or not. They get the same fee, regardless of who you are.

Mandate As A Civic Value

Cheng The Swiss health insurance law mandates that every Swiss resident individually buy basic health insurance. As of 2014, this will now be required in the United States as well, subject to certain limitations. There will also be new requirements on employers to contribute to workers' coverage. Do employers play any role in the Swiss health system?

Zeltner We got the employers totally out of their employees' health insurance in 1996. Before that, quite a few, but not all, health insurance plans had the employers pay part of the employees' premiums.

Cheng Many Americans bristle at the idea of being mandated to purchase health insurance and see it as a violation of their individual freedom. The Swiss are known for jealously guarding their individual freedom, too, yet they accept their own mandate to have adequate health insurance. As one such freedom-loving Swiss individual, would you defend the Swiss mandate?

Zeltner That's easy. We will not let people suffer and die when they need health care. The Swiss believe that in return, individuals owe it to society to make provision ahead of time for their health care when they fall seriously ill. At that point, they may not have enough money to pay for it. So we consider the health insurance mandate to be a form of socially responsible civic conduct. In Switzerland, "individual freedom" does not mean that you should be free to live irresponsibly and freeload from others, as you would put it.

Cheng What if you do not have a job or are poor? How do you own up to the mandate then?

Zeltner If you do not have a job, then, obviously, there are two options. Either you're very rich or on a pension, and you don't need public assistance. Or you're poor—in which case you will get a subsidy from the government to help pay for the insurance.

Cheng How is the subsidy financed?

Zeltner Half of the money comes from the federal government and half from the taxes assessed

by the twenty-six individual Swiss cantons. The system therefore resembles the one you have in the United States to finance Medicaid.

Cheng How do you enforce the mandate?

Zeltner Compliance with the mandate is surprisingly high, which is something we are happy about. But if you don't pay your premiums, after a certain time the health insurance plan will tell you that it will stop reimbursing you for medical bills. This helps in most cases to restore payment discipline.

Also, in Switzerland, when you move to a new community, you have to register with the local authorities, among other reasons for tax purposes. They will remind you that you need health insurance. And if you then don't buy coverage, the local authorities pick a health plan for you and force you to pay for it.

Cheng And does that apply to immigrants as well, legal or illegal?

Zeltner Yes, it is for anyone. If illegal immigrants lack insurance coverage, there are a couple of charitable institutions in Switzerland that provide care for them. Of course, once they are known to the authorities, their immigration status will be scrutinized.

Cheng So as long as you're in Switzerland, legal or not legal, you are entitled to the protection of health insurance and mandated to pay for it if you can.

Zeltner That's it. It goes to the notion that health care should not be something that only some parts of the population have access to. But these questions continue to be debated in Switzerland. On the other hand, since the number of illegal immigrants in Switzerland is much smaller than in the United States, it is a less heated political issue for us than for Americans.

The Mandated Benefit Package

Cheng Let's turn to the mandated benefit package. Must every insurer offer the same benefit package? Can cost sharing vary only within prescribed limits?

Zeltner Yes. To explain further, the benefit package actually consists of three parts. First, whatever a doctor prescribes, the health insurance plan deems appropriate and therefore covered.

Second, for items such as pharmaceuticals, there are "positive lists," or what are termed formularies in the United States. To be included in the basic benefit package, an item has to be on the positive list. Everything on this list is covered by every health insurance company anywhere in Switzerland.

Third, if there is controversy over whether a particular product or service is effective, it can be put on a positive list by the national health authority, too. We don't have, as England does, the National Institute for Health and Clinical Effectiveness [NICE], but we have committees looking into these questions, and they give advice to the government.

In addition to the basic package, you can have additional, complementary health insurance. Most

dental care is not covered in the basic package. Part of rehab is not covered, and there was a long debate on what is paid for in long-term care. So the benefit package is large, but it doesn't comprise everything.

Cheng What is the "negative list"?

Zeltner The negative list is for products or services expressly excluded from the basic benefit package. We had a long debate over whether complementary or what in the United States you call "alternative" medicine should be covered or not. Acupuncture and some herbal medicines are covered. But, for instance, homeopathy or anthroposophical medicine [which approaches disease as an imbalance in the biological organism and employs homeopathic and physical therapies, including massage] in general is not paid for. So the negative list is an express listing of what is not covered.

Cost Sharing By Patients

Cheng You said insurers can offer the basic package of benefits with different degrees of cost sharing by patients. How large are the deductible and coinsurance in Swiss health policies? In the U.S., deductibles go up as high as \$10,000 for a family.

Zeltner People can lower their premium by choosing a policy for the same benefit package, but with a higher deductible, up to a maximum of 2,500 Swiss francs [about US\$2,350]. But everyone must have at least a minimum prescribed deductible of 300 Swiss francs [about US\$280]. Once the deductible the insured has chosen is met, patients pay 10 percent coinsurance for services, up to a maximum of 700 Swiss francs [US\$655] per year.¹

For a brand-name drug for which a generic substitute is available, coinsurance can be 20 percent, unless the physician expressly prescribes the brand-name drug. Finally, there is also a nominal copayment of 10 Swiss francs per day for inpatient hospital care.

All told, cost sharing by patients under the social insurance system and other out-of-pocket payments accounts for about 28 percent of total Swiss health spending. The latter includes most dental care, as well as some rehab and long-term care services not included in the basic benefit package.

Cheng You mentioned that insurers can make profits on supplemental insurance they can sell alongside the basic policies under social insurance. How many people buy it, and what does it cover?

Zeltner About 70 percent have some kind of additional health insurance. It covers mainly two things: private rooms and hospital care bought outside the patient's canton and not covered by the patient's canton-based basic insurance. The second benefit, by the way, won't be needed after 2012, when people can go to any hospital included in a nationwide list established by the cantons.

Cheng For supplemental insurance, can insurers discriminate against people who are bad health risks?

Zeltner Yes, supplemental insurance is priced on actuarial principles, like commercial health

insurance sold to individuals in the U.S.

Private Insurance

Cheng Let us now turn to the organization of the Swiss health insurance system. For starters, how many health insurers are there in Switzerland?

Zeltner We now have eighty-four. There is a trend to fewer health insurance companies, each getting bigger, like in most countries. The six biggest of them have 80 percent of the market.

Cheng Do the private insurers all compete for enrollees on a nationwide basis or only a cantonal basis? I ask because health reform legislation in the United States could now expand insurers' ability to compete across state lines.

Zeltner They compete at the cantonal level. But—and I know this may be confusing—a particular insurance company can operate in more than one canton, but always subject to the rules and regulations in force in that canton. Those rules, and the premiums, vary across cantons.

Cheng I take it from your earlier remarks that within a canton, a particular insurer must charge all of its customers the same premium for a policy with a given level of cost sharing, regardless of customers' health status and age. In the United States, we call that "community rating." Furthermore, in Switzerland, an insurer cannot refuse to sell a policy to anyone willing to pay that insurer's premium. What then happens if an insurer ends up with mainly high-risk customers?

Zeltner There is a risk equalization scheme among insurers that forces insurers with a relatively favorable mix of risks to cross-subsidize insurers who end up with a relatively unfavorable risk pool. The scheme does not work perfectly, but we are working to improve it over time, as they are doing in Germany and the Netherlands and as the United States will do under health reform.

Setting Premiums

Cheng When you say that premiums for a given policy with the same deductible can vary among insurers in a canton by as much as 20 percent, what drives these variances?

Zeltner The price difference in the premiums is mostly a question of the composition of the customers in a given health insurance plan. If there are many elderly or sick people in a plan, the costs will be higher. And if you have just very young people, then they don't consume a lot, and the premium will be lower.

It is therefore tempting for health insurance plans to do what we call risk selection and you call "cherry picking": to go and look for healthy people, to get their premiums down.

To counteract that, as I have already mentioned, we have a risk equalization scheme, but it does not adjust 100 percent for differences in risk pools.

Cheng In Germany, the contribution adults make toward their health insurance is based strictly on ability to pay—a percentage of gross wages. A nonworking spouse is automatically covered by the working spouse's policy, for no extra premium. The German government pays for children out of general tax revenues. But in Switzerland, your premiums are charged on a per capita

basis. Are children in Switzerland covered by government?

Zeltner No. The household has to buy coverage for each child, but the premiums for children up to age 18, and young adults ages 19–24, are much lower than for adults.

Subsidies And Cost Sharing

Cheng Do the premiums collected from individuals finance the whole Swiss health care system?

Zeltner No. They actually cover only about one-third of the whole system. Another third is paid by taxes in the form of premium subsidies and to cofinance the hospital sector. Finally, out-of-pocket spending by patients covers the rest—actually about 28 percent now.

If you are very poor, you get all of your premiums paid. Once your income reaches about 30,000 Swiss francs, or roughly US\$28,000, then you have to pay yourself. By now 45 percent of the Swiss population gets subsidies, which is a lot.

Cheng If that many people get subsidies, then why doesn't the government pay for everyone and make it simpler?

Zeltner Because, as a matter of fact, the whole system is still considered a highly regulated market model, and we believe that the market is a good way to get quality into the system. We fear that the already existing inertia of the system would increase if the government was financing all of health care.

So at the end of the day, what you really pay varies—as a poor person you pay no premiums, and then as a middle-class person you pay the full premium plus out-of-pocket spending plus taxes to finance the subsidies for the poor.

Cheng So it is progressive financing?

Zeltner It is a progressive system because of the taxes and the subsidies.

Cheng Now, given that premiums are per capita, does that not penalize large families?

Zeltner Large families are in one sense penalized if they are middle class and have no right to subsidies. Then they pay quite a bit. If you're very poor, then you get, of course, subsidies for the family and for your premiums. "Penalized" may not be the right word, but the burden for paying the premiums is highest for large families.

We had a long debate about whether children should be free or not, and that comes up again from time to time. But so far the Parliament said no, no free kids, so to speak. And the reason, which I do not completely agree with, is that it would send the wrong signals. You would then say children and adolescents get initially all medical services for free, but then suddenly they have to pay for services when they are older. These are cultural changes that are not considered appropriate.

Cheng So how much does the average Swiss person pay in premiums for a family of four? On average, in the U.S. in 2009, an insurance premium for a family of four in an employer-provided

plan cost \$12,500, and then they also have to pay an average of about \$4,000 out of pocket. So the total cost for the family is about \$17,000, but the median household income in the U.S. as of 2008 was just over \$50,000. So you can see—health care is quite expensive here relative to people's income.

Zeltner Yes, it is expensive. In Switzerland a family of two adults and two kids probably would pay on average somewhere between \$8,000 and \$10,000 a year. It varies between regions and depends on the health plan. So it's not cheap, either.

Cheng It is not. Because on top of the premium, the Swiss pay a lot out of pocket.

Zeltner And then, for all but the poor, taxes to finance the subsidies as well.

Paying Providers

Cheng How are physician services organized in Switzerland?

Zeltner Most Swiss physicians in ambulatory care are self-employed. However, a growing fraction of doctors are working together in group practices to share some of the practice's infrastructure. In these groups, some of the doctors may be salaried employees of the self-employed doctors. But most Swiss doctors are independent. They're paid on a fee-for-service basis.

Cheng Can every physician set his or her own fee?

Zeltner No, within a canton all physicians are paid the same fees, and every insurer pays according to a fee schedule. The schedule is negotiated collectively between the association of physicians and an association of all of the insurers at the national level. The fees for a specific position in the schedule are set through negotiations at the cantonal level. If the negotiations break down, the cantonal government sets the fees.

So physician fees for the same service do not vary within a canton, but they do vary across cantons.

Cheng What about hospitals?

Zeltner Hospitals are paid per diems that also are negotiated between associations of hospitals and insurers within a canton. But some hospitals have shifted to diagnosis-related groups [DRGs], as you have under Medicare in the United States. In fact, under a law recently passed, by 2012 all hospitals will be on DRGs.

Cheng Who actually pays the Swiss providers of health care—the patients or the insurance companies?

Zeltner Patients pay the providers directly and then seek reimbursement from their insurance company, after they have met the deductibles in their policy. You will recall that these deductibles can vary.

Cheng Why not spare patients the hassle and have insurance companies pay providers directly,

letting patients pay only their out-of-pocket share? That is generally how we do it in the U.S.

Zeltner We hoped that with our method, patients would look closely at their medical bills rather than not worrying what the total cost of their care was. Patients are doing it more and more. But many bills are so complicated that often patients do not even bother to look.

Cheng What if patients don't have the money to pay the providers before being reimbursed?

Zeltner If patients are poor and do not have the cash on hand to pay providers first, they can send the bill immediately to the insurance company, get reimbursed, and only then pay the doctor or hospital with the money from the insurer.

Cheng And what if such patients misuse the money advanced to them by the insurer and spend it on other things?

Zeltner That is a matter of trust. But the more we see that people don't behave appropriately, the more frequently the insurers will send the money directly to the doctors and hospitals, rather than to the patient.

Cheng Does an insurance company in a canton have contracts only with doctors and hospitals in that same canton?

Zeltner Every insurer will reimburse the patient's bill from every doctor on a nationwide basis, but only with every hospital on the list for the relevant canton. So you can go to another doctor in another canton, but normally you don't do that because why would you travel to another canton? In addition, the insurer will reimburse only the amount the treatment would cost in the canton where you live.

Cheng Is every hospital in a canton on the list of hospitals with which insurers must contract, but no hospital outside the canton?

Zeltner If the canton is small, of course, it will also list hospitals outside the canton. The canton has to provide enough hospital capacity for its population. Sometimes that means contracts with hospitals in other cantons.

The law has been changed so that from 2012 on, you will be able go to any hospital in Switzerland, and insurers must deal with all of them.

Now, there are some private, expensive hospitals doing, for instance, mostly cosmetic surgery or things like that, that are not on the list, partially because of the prices they charge. So there is some competition to get on the list.

Cheng You mention expensive private hospitals. Are most hospitals in Switzerland government-run and owned, private nonprofit hospitals, or private for-profit hospitals, or is it a mixture of all three, as in the United States and in Germany?

Zeltner It is a mixture of the three.

Cheng You must have heard many Americans talking about "bundled fees." A bundled payment is a little bit like DRGs, except it goes beyond hospital inpatient care. It takes a whole case, from

preop, preadmission, surgery, discharge, to rehab—one fee for all of these services. Is that idea on the table in Switzerland?

Zeltner We actually do have that for accidents. We don't have it for illnesses and haven't thought much about it yet. The Dutch have started to do this, and it may be our next step after moving fully to DRGs after 2012.

We want to get rid, at least in part, of the fee-for-service schedule in ambulatory care in the future, and have as the standard model of care in the ambulatory sector what we would call integrated care. This will probably be paid for mostly through capitation. But other models should be allowed, too. For example, if you didn't go to the doctor during a whole year, you might get some money back at the end of the year.

Consumer-Directed Care

Cheng Coming back to consumer choice among insurers, how do the Swiss go about shopping for an insurance plan? What information do they have?

Zeltner Every fall the Federal Office of Public Health publishes on an Internet page information on premiums for all of the insurance plans in the country. In addition, the daily newspapers print what each plan in your region or canton costs. So yes, the information is there. You have to read it if you want to change. But only about 5–10 percent of people change plans each year.

Cheng Ten percent, that's all? Even though premium rates for a given policy with the same deductible vary substantially not only among but within cantons?

Zeltner Yes, premium rates can vary by about 20–30 percent within cantons for the same benefit package with the same level of cost sharing.

Cheng What about among cantons?

Zeltner Among cantons, the variance in premiums can be even higher. It may be almost one to two. So in Geneva, which is the most expensive canton, you pay almost twice as much as you pay in the cheapest canton.

For example, for Geneva, the bottom quartile of premiums in 2007 fell below 380 Swiss francs, the median was 450 Swiss francs, and the upper quartile started at 480 Swiss francs, with one insurer charging as much as 560 Swiss francs. The comparable number for Bern was 280 Swiss francs for the bottom quartile and 350 Swiss francs for the median, and the upper quartile started at 400 Swiss francs. Similar variations are found for all major Swiss cantons or cities.

Cheng So why wouldn't people who live in Geneva or Basel buy plans in the cheaper cantons?

Zeltner They are not allowed to. People have to buy coverage from an insurer in the canton in which they live. The reason for this lies in the fact that part of your health care costs are paid by taxes that are cantonal.

Cheng It's puzzling that such large variations in premiums within cantons survive under what is said to be a competitive system. Is the market not working?

Zeltner People do not seem to be all that price-sensitive in their choice of insurance plans. It may have to do with the fact that the lower 40 percent of the people get subsidies, so they have less incentive to change. The very rich don't care too much, either. It's really mainly the middle third that is interested in switching plans.

Cheng Could the reason so few people switch plans also have to do with habit, comfort with the familiar, and trust in the company one knows?

Zeltner People in general do not change their bank, they do not change their hairdresser, they do not change their doctor, and they do not change their health insurance company, even if they can. You could go every time to a different hairdresser, but you probably don't, nor do you change your bank even though financially it might make sense.

Cheng So in the final analysis, then, how much price competition is there among health insurers in Switzerland, given that all insurers in a canton pay providers the same prices and must offer the same basic benefit package? The head of the International Department at your own ministry has said that insurers are partly to blame, because they make the system complex by offering thousands of different plans for people to choose among.

Zeltner That's true. You have almost too many choices, and that's confusing. The human brain has the capacity to choose easily between three or four things. But if you have to choose between hundreds, then it's getting too complicated, and it creates paralysis. It's just not much fun to fill out the forms for your taxes, nor is it fun to fill out your forms for a new health insurance plan. Why would you do that? Life's too short.

Cheng The Swiss health system sometimes is cited in the U.S. as a model for what we call "consumer-directed health care," or CDHC for short. The core of the idea is that individual providers of health care should compete for patients on both the quality of their services and the prices they, as individual providers, charge for these services. The thesis is that such a system obviates the need for government regulation of prices and quality—that the system is truly market-based and "consumer-driven." Does the Swiss system live up to that billing?

Zeltner Swiss patients actually have only limited information on the quality of the care given by different providers of care, especially outcomes. So that part of our system does not match what you have just described as CDHC.

Pharmaceutical prices are regulated by the government, a mechanism that does not match the CDHC model, either.

As I said earlier, Swiss people do have, however, a lot of choice among insurers and providers of health care. But the basic benefit package is to a large degree fixed by government. Patients can choose among different levels of cost sharing, but again only within prescribed limits. And the prices for doctors and hospitals are negotiated collectively by their associations with associations of insurers, and they then apply uniformly to all insurers and all providers in a canton.

The bottom line is that the Swiss system, like the Dutch system, has its roots in the work of Alain Enthoven, whose work is well known to the readers of *Health Affairs*. We define it as a system of regulated competition with a growing number of elements borrowed from consumer-centered

health care models.

Quality Of Care

Cheng Do you have hospital accreditation in Switzerland?

Zeltner Yes, every hospital has an accreditation. Unfortunately, it's not based on quality measures of outcomes. To get an accreditation, a hospital just has to show that it fulfills basic hygiene rules, that safety measures are taken, etc.

Cheng Few data on timeliness, appropriateness, patient safety, outcomes, cost-effectiveness, and so on?

Zeltner Yes. We want to do that, but we haven't done it yet. A report of the OECD [Organization for Economic Cooperation and Development] from 2006 on the Swiss health system came to the conclusion that Switzerland has a very good system—expensive but good. But it has three major flaws. One is that it does not do enough in prevention and health promotion. Second, our system has too little transparency when it comes to quality. Third, its governance, with the twenty-six cantons each operating independently, is too complicated.

Cheng Do you agree with this assessment?

Zeltner Yes, I do agree. There are a number of good and interesting initiatives in the fields of transparency and quality, but we are certainly not the world champion when it comes to the question of quality assurance. There is no reason to believe that the quality of Swiss health care is bad. But because of a lack of transparency, we just don't have proof of its quality.

Cheng I'm sure you are familiar with the famous 1999 report by the U.S. Institute of Medicine, *To Err Is Human*, which estimated the number of avoidable deaths in U.S. hospitals at 44,000–98,000 in 1997. Do you have comparable data?

Zeltner No. The government has, however, recently ordered a report on the quality of the Swiss health care system and on how to improve it. The report comes to the conclusion that it is not enough to charge insurers with quality control, but that the national government has to play a more active role in this field and has to organize national quality assurance programs. The report has been debated in the government, and a detailed implementation plan will come out later in 2010. So we are doing something, but certainly we're not there yet.

Controlling Health Spending

Cheng According to the OECD, and in purchasing power parity dollars, Swiss per capita GDP [gross domestic product] in 2007 was roughly 91 percent of U.S. per capita GDP, yet Swiss per capita health spending was as much as 39 percent lower. This suggests that even after controlling for differences in GDP, Swiss health spending is significantly lower than U.S. health spending. What accounts for this much lower per capita spending?

Zeltner A recent report by the OECD on why the U.S. health care system is so much more expensive than those of other European countries, Switzerland included, came to the conclusion that the key factor is price differences. Prices are much higher in the United States than in most

other countries. The prices you pay for pharmaceuticals are about 30 percent above what we pay. The incomes or salaries of the doctors are just 30 or 40 percent higher than what we pay, and so on. So everywhere, you have higher prices, and that makes up for much of this difference.

Cheng Some American academics attribute the lower per capita health spending in Switzerland to the power of consumer choice. Others think that the lower spending in Switzerland is due mainly to the lower prices that are negotiated between providers and insurers, with strict government oversight.

Zeltner I agree with the latter perspective. Consumer choice can, however, contribute to cost containment. For example, if the copayment for drugs is 10 percent for the generic and 20 percent for the original, patients choose the generic. We did that in Switzerland, and it was a big success.

IT And Cost-Effectiveness

Cheng Health information technology [IT] and comparative effectiveness analysis [CEA] are widely thought to be instrumental in better cost and quality control in health care. Let us start with health IT. Does every Swiss have a national identity number, or what we in the U.S. would call a "unique patient identifier"? And do you use that ID number to track people electronically in health care?

Zeltner Everybody has now a health insurance card with a number on it, and you can actually put some health data on the card, if you want. So if you go to the doctor, you present your ID card, which shows your insurance plan, and it can also show what medications you are on, what your blood type is, etc. It doesn't record diagnoses. We don't have electronic health records in Switzerland. We want to have them by 2015 for everyone, but we are not there yet.

Cheng Turning now to technology assessment and comparative effectiveness analysis, to what extent do you incorporate that kind of research into your coverage decisions? For example, does it influence which drug ends up on your "positive list" [formulary]? Under the new health reform law in the U.S., the results of comparative effectiveness research will not be able to be used to make coverage decisions.

Zeltner We do use comparative effectiveness analysis and cost-effectiveness analysis for coverage decisions. Drug companies, for example, must prove three qualities to gain approval for listing. One is that the drug is effective. Second, that the drug is cost-effective. Third, that the drug is appropriate—really needed for a given disease.

For more complex interventions, we use cost-effectiveness analysis sometimes, like in transplant surgery, but so far we don't use it systematically.

There is a debate in Europe on how better to coordinate technology assessment among countries. The Germans have their institute for technology assessment—the IQWiG [Institute for Efficiency in Health Care]; the Swedes have one; and of course England has NICE. We don't think it makes sense for every country to duplicate that work. We favor a network solution, in which different European countries coordinate and cofinance existing institutions.

Strengths And Weaknesses

Cheng What do you think are the major strengths and weaknesses of the Swiss health system from your perspective as the former minister of health?

Zeltner The most important strength is that nobody in Switzerland has to be worried about falling into a financial crisis or even catastrophe by becoming sick. It removes one of the big burdens people may have when ill.

The second major strength is that you have access to a very extensive benefit package. You receive health care from world-class, well-trained, well-equipped doctors, nurses, and hospitals.

Third, you can choose among a wide variety of health plans and health providers. But you have also a few obligations. You need to pay taxes, and you need to get your insurance coverage.

Finally, all of these benefits come to you at a high level of comfort.

The major flaw is that you could have all of those advantages for less money. Because of its fragmentation and the small units functioning in the system, our system could deliver more value for the money, as the experience of some other countries shows.

Cheng But maybe people don't mind paying, knowing that it costs money to be comfortable.

Zeltner That's what people say. They truly complain just once a year, when they get the premium bill for the next period. But during the rest of the year, they actually do not want to change the system and reduce the comfort level.

And that turns out to be a second flaw. Our system has extremely high structural quality, as distinct from known outcome-based quality. Many of our hospitals look like five-star hotels, and there are no waiting times. There are a lot of doctors and clinics around. What you see of the system is wonderful. But you don't see the outcome, and that's really the last flaw, I think.

I don't want to say by this that the quality of Swiss health care is bad. Doctors and hospitals have all they need to perform well. But, unfortunately, we lack the outcome results as proof of their performance.

Prevention Reforms

Cheng After the major reform of 1996, what reforms are now under way in Switzerland?

Zeltner Like other countries, we are way too focused on health care rather than on health. We could do much better when it comes to prevention and health promotion. There is a big unmet potential in these areas. We want to strengthen prevention and health promotion in Switzerland. We have very strong programs in some areas like AIDS prevention and prevention of illicit drug abuse. But there certainly is room for improvement in other areas, such as prevention of alcohol overuse and tobacco consumption. The rate of smoking in Switzerland is considerably higher than it is in your country; 27 percent of Swiss ages 14–65 smoke, versus 21 percent of adults age 18 and over in the United States. Thirty percent of Swiss men and 24 percent of women smoke.

On the other hand, obesity is less of a problem in Switzerland than it is in your country. The

prevalence of a BMI [body mass index] above 30 is only 8.1 percent. In your country it is, I think, 32 percent. Prevalence is on the rise in Switzerland, too, and we have no miracle solution to stop this epidemic, either.

Cheng There is a raging debate among policy analysts on whether, on the whole, preventive care will actually lower per capita health spending over the long run. People may be healthier and use less health care every year they live, but they will live much longer and, in their last few years of life, will still use much health care. What are your thoughts on that debate?

Zeltner If health spending is all that matters, then the ideal health system is the one in which everybody dies or commits suicide at age fifty-five or sixty. Then all of the costly health problems of older age groups will not happen. That is the line of argument brought forward by some against tobacco prevention. Of course, if you do not smoke, you live longer, and the longer you live, the more chronic diseases you may have. And if you look at the cohort of smokers, they are cheaper for the health system than a cohort of nonsmokers. But so is the cohort of those who commit suicide. They're cheaper for the health system than a cohort of healthy people.

A health system not only generates costs but also produces better health and a better quality of life.

At the end of the day, these questions are questions of societal choice. It is my conviction that modern societies should offer their populations the possibilities for a long, healthy, and productive life.

Other Reforms

Cheng Beside more emphasis on prevention, what other reform measures are under way? You've already mentioned the move to DRGs and the promotion of integrated care models for primary care.

Zeltner A third major reform under way is a move to greater transparency on quality. We steadily work on making the system more transparent and more oriented toward health outcomes. A fourth is an effort to improve the governance of the system. In the last few years, a couple of responsibilities have been transferred from the cantonal to the federal level, like the organization of transplant surgeries. Soon we will have a list of hospitals to which all Swiss will have access instead of only cantonal lists. Everybody should know what is done in what hospital and how often. We hope that consumers will prefer hospitals where interventions are done much more frequently than in others.

Right now we publish frequencies of interventions performed at the various hospitals. In the past we adjusted only for severity but not for comorbidities, and hospitals complained about it. But we're working on improving the reporting system, and hospitals have now agreed to sit at the table with us and work on a much more refined system.

Demographics And Workforce

Cheng How will Switzerland cope with its aging population and the rising prevalence of chronic diseases?

Zeltner It is obvious that population aging is a challenge. The burden of mental health is a problem we're not really tackling appropriately, for example. And we worry about the supply of health professionals. I think, in the medium term, that is one of the most pressing problems. The starting point is that by now 25 percent of the personnel working in our hospitals and in health care are foreigners. More foreign doctors come to Switzerland than we train at home. This is not a sustainable solution.

Cheng Why can't you just keep importing them?

Zeltner One of the reasons why health professionals like to work in Switzerland is that they find very good working and training conditions here. Another is that we pay higher salaries. Most of them come from German- or French-speaking countries. They need to be fluent in one of the two languages to work effectively in Switzerland. The pool of doctors or nurses we can recruit from is therefore more limited than it is, for instance, in your case. Furthermore, salaries in Europe are getting closer to each other, thus reducing the attraction for foreign health professionals to come to Switzerland.

Finally, studies predict that by 2020 or 2025, because of the aging of the population, we will need one-third more personnel to cover the needs in long-term care. We must therefore increase our training capacities for students in nursing and medical schools.

We also want nurses to stay longer in their jobs. Often they stop working when they marry and have kids. We must provide better possibilities and incentives for them to come back to work.

Finally, there is a qualitative aspect to this question, too. By now many GPs [general practitioners] are very unsatisfied with their work conditions. They have long working hours, long night shifts when they have to be on call. Of course, they organize locally, but one GP must be around at night, also to prevent people from going to hospital emergency rooms unnecessarily. This brings long working hours and long shifts over the weekends, etc. And their income is lower than that of specialists.

Cheng They cannot negotiate higher fees with the health plans?

Zeltner We asked health insurers to favor general practitioners when negotiating tariffs. But doctors negotiate with the health plans as one group, and the specialists were stronger and won that battle.

Cheng Funny, we have the same problem in the United States. We incessantly lament a shortage of primary care physicians but also pay them much less than we pay specialists.

Zeltner In addition to all these problems, we have the challenge that many of the doctors in Switzerland are around sixty-five and want to quit and sell their practices but can't find anyone who wants to buy them.

You see, the whole question of health personnel is truly a big challenge, one you can't fix with money alone. You need enough time, too: To get a doctor trained will take you seven years of medical school and then another seven years of specialty training.

Cheng Do people still want to become doctors in Switzerland?

Zeltner Yes, they do. The limiting factor is the number of places in medical schools. We are about to expand training capacity by 10–20 percent in the years to come. Even with this increase, there are regularly many more applicants than the schools can take.

In addition to investing in medical schools, we need more teaching hospitals, and we need to recruit more patients for these hospitals so, in effect, they become part of the training. All of these changes are rather slow processes and need, in addition to money, time. The training of doctors is mostly paid by taxpayers in Switzerland, not like in your country. It costs the taxpayer one million Swiss francs, or about US\$935,000, to get a doctor trained. This is a lot of money.

Cheng What all this tells me is that over the long term, you will have to spend more GDP than what you now spend on health care.

Zeltner I agree.

Achievements And Disappointments

Cheng You have been at the helm of the Swiss health system for a very long time—nineteen years. Looking back at your career, what are, say, the three achievements of which you are most proud?

Zeltner First, that we succeeded in constructing a system where health promotion, disease prevention, and care are starting to be considered as *the* complete health system we need. We worked hard to get prevention and health promotion its place in the system. But I think we've succeeded to convince politics by now.

Second, I am proud that we got the question of access to care for everyone fixed, along with protecting everyone from the financial crises that illnesses may cause. Third, we were able to convince the Swiss people that equity in health is a societal value, a civic value, which is important.

We were looking into drug users, prostitutes, and other people at the margin of the society, and we found a consensus that the general public and the general premium payers should pay for these people's health care.

Cheng Would you care to talk about your major disappointments?

Zeltner Yes. One of the disappointments I feel is that every reform step takes such a long time. It's very difficult to build a solid national consensus in the Parliament, first of all. We do see the same thing as you see in the U.S., where you need a bipartisan consensus. In Switzerland we need multiparty consensus, and that is very difficult to achieve. Often it comes down to the question: Do we want more regulation, or do we want more market forces in the system? On this, the left and the right have opposite views, and it's hard to find a consensus.

We also have very strong lobbying groups in the Parliament—the doctors, the health insurers, and the pharmaceutical industry.

Cheng Do you succeed more often than you fail, in spite of these political difficulties?

Zeltner At the end of the day, we do succeed. There still is a broad consensus that the basis of the Swiss health care system should be a model of regulated competition, a view we share in Europe with the Dutch. Together with them, we live it, and we like it.

Once a law has been adopted by the Parliament, we are not finished with the difficulties, however. In the Swiss type of regulated-market model, there is much room given for contractual arrangements between the actors. It's therefore often up to the health insurance companies and the doctors to work out the details of implementation of the regulations adopted by the Parliament. And it will come as no surprise that this process regularly takes a lot of time.

Cheng Any other disappointments?

Zeltner Yes, I think we need to shift the debate over health care away from seeing it only as a financial burden—as a cost issue—toward viewing it also as an investment.

For example, there is an absolute consensus in Switzerland that education is key for our prosperity, and that the public and politics have a responsibility to keep education good, as it is with research, because we have no natural resources in Switzerland. Our prosperity finds its basis in our capacity for innovation. We therefore do not see education as just a cost issue.

I have not been able so far to convince the Swiss Parliament and public that health is like education—that it is an investment in a healthy, productive, and happy population.

The debate on health sooner or later always focuses on costs. But the mandate of the government goes beyond cost control. It has the mandate to give us a reasonable level of security, allow prosperity to happen, and provide people with the conditions that help them lead a happy and productive life. That is why one should look at health and health care as an investment.

Lessons For The United States

Cheng Many Americans look at the Swiss system as a potential model for the U.S., yet in the past, when I've asked what you thought the U.S. could learn from your system, your response was, "Are you kidding?" Seriously, what can the U.S. learn from Switzerland, if anything?

Zeltner If you told the Swiss people that the U.S. is looking at our health care system as a model, they would think, "How can that be?" The Swiss people are not happy with their system when it comes to the cost and can't believe that anyone wants to copy it!

Cheng Cost aside, what would you tell U.S. policy makers, based on your long experience?

Zeltner Your starting point is very different. Your huge Medicare and Medicaid programs and the deep involvement of employers in your system make things much more complicated to fix than they are in Switzerland. But the expectations of the populations in our two countries are probably rather similar. People ask for and hope for a government that cares for their health and is willing to make reform happen.

The other point I think we all have to learn is that it's not done with a one-step reform. I think the reforms of our health care systems will be going on for the next decades or more. You end one

reform and you start the next one. It's a never-ending task. You in the U.S. will have your 2010 reform and then you may hope you're done. But after your 2010 reform, the next big thing will just be waiting behind the door.

Reforming the health care system is like fixing an airplane that is in the air. It's repairing an engine at full speed, and you're not allowed to let the airplane crash.

That's the reason why I believe you have to advance very carefully, step by step. You can't make a revolution in the health care system, because a revolution would, at least for a couple of months or years, block a system expected to function 24 hours a day and 365 days a year. It's like a Swiss watch. It has to function day by day with a high degree of precision. But when it needs repair, you can't just drop it at the watchmaker's shop and wait until it is fixed in three, four weeks. That's, I think, the big challenge.

Two parallel processes need to be handled: working on a national consensus about the long-term perspective, and implementing measures along the way. Our experience is that people in the trenches can't absorb too many reform steps at once. So when it comes to implementation of universal coverage, if you succeed in getting 92, 93 percent of your population into the system, that may already be OK. Then do the rest later. Maybe the problem of your illegal immigrants is just something you can't solve in the first step. But you have the vision of universal coverage at the end—you keep that as your objective, but the end can be 2020.

I'm convinced that a country like the U.S., with the incredible assets you have, needs a health system with equal and fair access for all citizens. And finally, in your case, it's true, too: You need to invest in a healthy population to remain prosperous.

ABOUT THE AUTHOR: TSUNG-MEI CHENG

Tsung-Mei Cheng is an expert on comparative health systems at Princeton University. She writes and lectures internationally on such topics as single-payer systems, health care quality, financing, pay-for-performance, and technology assessment. Currently she is working on cross-national comparisons of health systems in East Asia, focusing on health reforms in China and Taiwan.

Host and editor of the Princeton University television program "International Forum," Cheng explores global political, economic, and security issues as well as global health. She is also the cofounder of the Princeton Conference, an annual national conference on health policy.

From Cheng's numerous conversations over the years with foreign health ministers—a number of which have been published as interviews in *Health Affairs*—she's developed great respect for "the dedication of the much-maligned health policy makers and government bureaucrats in various countries who are trying to make the health care experience better for their people. It is not an easy job, as we can see here at home," she says. She was also persuaded long ago that transnational learning "is without borders and always useful," she says.

One lesson that the United States could learn from other countries, she says, is how in most other countries, government "unhesitatingly" takes a stronger hand in controlling the payment side of the health care system. "In Switzerland, not known as a socialist country, the government controls prices and strictly regulates the market for health insurance," she says. By contrast, she

notes, in the United States, "the payment side is so splintered that each payer is weak relative to providers. The supply side is definitely much stronger than the demand side and powerfully drives health spending. So I am afraid that if Americans actually seek to have better control of health spending, doing so in our traditional fashion will take a long time, and it may never work," Cheng says. That spending trend could "break the bank in the second half of the decade for many American households, business firms, and government"—an outcome that would then "set the stage for real health reform, not just modifying the system," as in provisions of the recently enacted Patient Protection and Affordable Care Act.

As a native Chinese, Cheng also retains a special interest in the Far East. Chinese health minister Chen Zhu outlined that nation's plans for health reform in an interview with Cheng published in the July/August 2008 issue of this journal. Cheng says she "very much would like to see China's current health reform succeed."

Cheng followed up with an interview with Taiwan's health minister, Ching-Chuan Yeh, in 2009. She points out that "Taiwan's single-payer system serves its people remarkably well, providing universal health care with generous benefits that include ambulatory and inpatient care, drugs, dental care, and traditional Chinese medicine at a cost of just over 6 percent of Taiwan's gross domestic product annually." By contrast, she says, "I doubt that there is a consensus on universal health care in America. My sense is that middle-class Americans may have to become yet more desperate over their ability to pay for health care before the idea of universal health care can take root here, if ever. And I am not alone in this view."

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