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Review Article

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Review of "Health Care in Switzerland: A Closer Look at a System Offered As a Model for the United States"

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Shortly after the passage of the Patient Protection and Affordable Care Act of 2010 (ACA), the American health economist, Rachel Kreier, and the Swiss health economist, Peter Zweifel, wrote an interesting article in which they noted the shortcomings of the American health care system and particularly the insurance aspects of that system and examined whether the Swiss system with its extensive use of a number of private, non-profit insurers would provide the practical model for reforms in the U.S. health care system. This review and critique will discuss the relevance of their piece a decade later.

Is Switzerland's Health Insurance the Right Model?

Kreier and Zweifel's paper is perceptive in its criticism of the fragmented negotiation process between U.S. health care deliverers of services and a multiplicity of insurance payers "different rates for the same services from different payers" resulting in issues of equity and unnecessary costs in billing and administration of health care services --- and in which "the weakest payers, including small employers and individuals without insurance, [often] end up paying the highest prices." Also, the authors suggest that using non-profit private insurance companies as the mechanism for creating a more equalitarian approach is an avenue that might be the most politically feasible route for creating a fairer and more affordable American health care system.

In examining the Swiss system today one might note that the original appeal of applying the Swiss model to the reform of the American health care system still remains. Adoption of the Swiss system would improve the American health care system in terms of its ability to achieve inclusive health equity for vulnerable low income groups. Also, a Swiss health care system model would provide more portability and public accountability than that currently available in the United States. Also, as the Swiss system is a federal system, and a system that is characterized by an extensive public/private sector mix, it may provide a useful model for addressing some of the problems that face the health care system in the United States.

In order to examine more granularly whether the complex U.S. health care system could in actuality utilize the Swiss health care insurance system as a model for reform, one needs to review the Swiss system and also the complex U.S. system as it currently exists The potential advantage suggested for following the Swiss system as a model is that this health care system under the Health Law of 1994 provides that everyone legally in the country is covered by a package of health care benefits that is nationally determined. These benefits provide a national package of medical, hospital and pharmaceutical services, Also benefits are portable as none of this coverage is employer-based insurance coverage so no health insurance coverage is lost when one looses one's employment or changes one's job. In the Swiss system all individuals including children have

separate social insurance. The premiums for children age up to age 18 and for young adults age 19 to age 25 are substantially lower than for other health insurance holders. However one must examine the complex financial and organizational characteristics of the U.S. health care system to consider whether in practical terms the Swiss system is applicable to reform of the U.S. health care system.

The Swiss Health Insurance System

The Swiss national benefit package is implemented at the canton level by the nation's 26 cantons. All legal residents are required to have the nationally mandated benefit package. Payment for these benefits is largely by premiums to private health insurance companies that are not actuarially determined and are provided irrespective of health status. Also, as has been noted, such private insurance must be provided on a non-profit basis. Participating insurance companies can provide supplementary insurance for discretionary services such as private rooms and choice of physician in a hospital.

The price of pharmaceuticals is determined nationally by a procedure known as reference pricing. In Switzerland such pricing is ultimately determined by Switzerland's Federal Office of Public Health based on pricing in 9 European countries. Hospital costs are determined by a non-profit Swiss corporation, Swiss DRG-AG, which sets provider payment levels for inpatient services based on a Diagnosis-Related Group formula per procedure. There are several sources of financing of Switzerland's health care system.. In 2016, 35.6 percent of total financing was provided by premiums, 17.3 percent involved public taxes --- with 15 percent provided by cantonal taxes, 1.8 percent by municipal taxes, and .4 percent by federal taxes. Cofinancing for about 25 percent of spending involves out-of-pocket costs that are covered by patients.

The U.S. Health Insurance System

The U.S. system is much more costly, far more complex in its system of delivery and much less a publicly accountable system in terms of the delivery of the public/private mix of services. It is necessary to discuss the structure and financing of the U.S. health care system and some of the problems facing the current U.S. system in order to address the subject of the Swiss system providing a model for positive changes in the U.S. system.

The U.S. health insurance system involves a very complex and multi-level arrangement of health insurance. The largest source of health insurance is employer-based. This insurance may be very different for different groups of employees and the benefits provided by employers including the co-share from subscribers may vary greatly. The insurance providers may be non-profit or proprietary providers depending on the different employer-based coverage and variable state statutes covering such insurance.

Prices for retail pharmaceuticals under such employer-based plans are largely influenced by a mix of market forces and some negotiations with private insurance companies and in many cases with the private management companies that disburse pharmaceuticals. Also bargaining takes place between drug companies and hospitals and hospital systems.

Another significant program is Medicare which is the primary health insurance provider for the elderly. It pays health insurance for those over 65, for some of the disabled and for individuals needing kidney dialysis. Medicare is paid for by federal general revenues, employer/employee payroll taxes and the premiums of participants. Many eligible low-income participant are also eligible for means-tested Medicaid benefits and coverage of Medicare deductibles and coinsurance payments as well as a variety of other services that differ from state to state. These participants are known as "dual eligibles". Also Medicare participants in Medicare Advantage (Title 18C of Medicare) --- constituting one third of Medicare participants --- receive benefits from a variety of private companies which may provide more comprehensive benefits than conventional Medicare with little or no premiums or copayments. These private health insurance companies are significantly subsidized by the previously mentioned national government revenues. In 2003, optional outpatient pharmaceutical coverage was added to Medicare. This amendment to Medicare (Title 18D) prevents the national government from bargaining with the pharmaceutical industry to determine drug prices or to establish a national formulary of pharmaceuticals.

Another significant program is the federal/state Medicaid program based on the principle of means-testing. This program provides health insurance coverage to 20 percent of Americans. It is the principle source of funding for long-term care. Moreover, it covers almost 20 percent of personal health care spending and is a significant source of funding for hospitals, community health centers, physicians and nursing home.

In 2010, the Patient Protection and Affordable Care Act (ACA) expanded Medicaid by providing coverage for non-elderly adults without children with income levels up to 138 percent of the federal poverty level. Under this law, states may not charge premiums for Medicaid beneficiaries with incomes of less than 150 percent of the Federal Poverty Level and out-of-pocket costs are generally limited to no higher than 5 percent of the family income. Some exceptions are allowed under Section 1115 waivers. Due to a Supreme Court decision, states may choose not to participate in this program. Currently 39 states (inclusive of the District of Columbia) have chosen to participate. The non-participant states have more restrictive eligibility and benefit levels for their consumers of health services. Also, 8.5 percent of Americans have no health insurance.

In addition, the U.S. has Children's Health Insurance Program that operates as a state-administered program for children of low-income families that are not financially eligible for Medicaid but cannot afford to purchase private insurance. The U.S. also has a nationally run Veterans Administration Program and has national responsibility for the Indian Health Service.

Some Conclusions

The adoption of the Swiss system to the United States would end employer-based health care insurance and have everyone in the same national system while allowing choices with regard to particular insurance companies and different insurance delivery arrangements. This would provide almost complete horizontal health care equity and complete portability with regard to changing insurers or types of policies.

However, existing sunken costs and the significant political clout of the private interests such as insurance companies and the pharmaceutical industry in opposing changes in the current U.S. health care system make such reforms difficult to put in place in a major way. Building on the market-based reform of the ACA with the addition of a greater national public role in establishing pricing standards would be a step in the right direction. That would provide an incremental step toward using the Swiss health insurance system as a model for reforming the complex of American health insurance systems.