



Review of the Swiss health system by OECD/WHO
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by

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Minister Burkhalter, Mme. Jakab, Ladies and Gentlemen

It is a great pleasure to be with you today to launch this Review of the Swiss Health System, undertaken jointly by the OECD and the WHO. This is the second such joint review by OECD and WHO of the Swiss health system.

We first looked at the Swiss health system in detail in 2006. I would like to thank the Swiss authorities for their renewed confidence in our expertise, as well as their financial and technical support which made it possible for us to produce this new report. In it, OECD and WHO reflect on progress achieved in Switzerland since the release of the first review in 2006 and on-going or emerging challenges.

Our bottom line could be summarised briefly as follows:

Switzerland has a world-class health system.

But it could be even better.

First, let me stress the 'world-class' elements.

The Swiss health system offers universal coverage to Swiss residents and covers a wide range of health services.

It offers choice -- consumers can choose their insurer and their provider within their canton.

Health care supply is, broadly speaking, abundant and responsive to population needs.

Most importantly, *the proof of the pudding is in the eating* -- population health is very good: Swiss residents live longer than almost anywhere else in the world, and almost 90% of them consider their health to be good or rather good.

Let me now turn to 'what could be better?' in the Swiss system.

The starting point for our review is that the system is costly: Switzerland spent 11.4% of its GDP on health in 2009, well above the OECD average of 9.6%. It now ranks 7th among OECD countries for this indicator.

Switzerland is a very rich country. You can afford to spend this much money on health if you want. The problem is not 'is this level of spending sustainable?' Instead, you need to ask 'are we getting value for money?'. Our joint review suggests that you could do better.

Szuzsanna Jakab will present some of the policy areas where we believe you could get 'more health for your money'. Let me focus on the structure of the Swiss system – the insurance market,

payments to providers, the co-ordination of care and the financing of the system.

There were high hopes that competition in health insurance markets would deliver better value for money. Unfortunately, it has not delivered all its promises. Wide variations in premiums persist within and across cantons. Until recently, consumers have only rarely switched insurer.

Indeed, health insurers have few options to reduce premiums other than through selecting healthier people. Prices of health services are most often negotiated at cantonal level between insurers and providers; and insurers are generally not allowed to select providers, except in *managed-care* plans.

There is a need to build on the partial success of managed-care plans. About one third of Swiss residents subscribe to such plans, restricting provider choice to a network of participating providers, in exchange for lower premiums. Studies have shown that health costs for people enrolled in managed-care plans in Switzerland are lower than costs for other insurees. It is true that up to half of the cost differentials reflect risk-selection, but the remaining part can be attributed to genuine efficiency gains.

The introduction of a better risk-equalisation system in 2011 will reduce risk-selection. But there is a need to go further to get competition to work. Insurers should be empowered to contract on prices, volumes and quality of care in order to draw larger benefits from managed competition.

Health care providers can also be encouraged to deliver more value for money.

The average length of stay for acute hospital care is 25% above the OECD average. Only 15% of total surgical procedures are performed on a day-care basis, while this proportion exceeds 50% in Canada, the United Kingdom or the United States.

The introduction of DRG payments for all hospitals from 2012 should improve efficiency. But the reform needs close monitoring: first, to avoid any unwarranted increase in volumes of care; second, to ensure cantons do not subsidise inefficient hospitals.

Switzerland could also increase the efficiency of pharmaceutical spending. Recent reforms have slightly reduced the gap between Swiss and foreign prices and encouraged generic take-up. However, more could be done, for instance by putting more pressure on generic prices or limiting the role of dispensing doctors to underserved areas. Switzerland also needs to make its

pricing and reimbursement system more transparent and evidence-based.

More generally, the Swiss health system, like most others in the OECD, is not as well prepared for population ageing as it should be.

Many Swiss people will be living with several chronic conditions in the future, and will depend on multiple health professionals for their health care needs. For patients to have the best chance of receiving care that is high quality, appropriate to their needs and efficient for the health system, health care providers will need to coordinate their efforts. Governments and insurers should support this: through flexible and innovative payment methods and by developing medical records that can help improve the accuracy of diagnosis and reduce duplication of tests.

Sketching out the directions that the Swiss system ought to follow to meet future challenges requires a solid base of information on health risks, health outcomes and quality of care. Monitoring and reporting on quality of care across Switzerland is currently limited to a selection of hospital indicators, which are not sufficient to empower patients, insurers and governments to make informed choices between all kinds of health services providers and settings. Statistics on outpatient activity must also be developed.

In closing, I would like to turn to the financing of the health care system.

The effective burden of health insurance premiums net of subsidies has increased between 1998 and 2007. For a middle-class family with two children, it increased from 7.6 to 9.8% of disposable income; for a low-income single parent with two small children, it doubled from 3.5% to 7%.

In addition, Swiss patients face relatively high out-of-pocket payments. These are usually for the purchase of health services not covered by mandatory health insurance, such as long-term care and dental care, and may be compensated by cash benefits (notably in the case of long term care). Nevertheless, out-of-pocket payments are by far the highest among OECD countries: at around 1,650 dollars per person per year, they are almost three times as high as the OECD average of just over 550 dollars.

Overall, “effective premiums” plus out-of-pocket payments account for more than 20% of households’ disposable income for the bottom-income quintile and 11% for the top-income quintile.

Such amounts are a heavy burden on households’ budgets. Until now, they have only marginally impaired access to care, which as I noted at the start of my speech, remains excellent. But if health

insurance premiums and out-of-pocket payments continue to increase, this might change. This is why, in this report, we urge Switzerland to monitor the impact of health care financing on access to care, and to deliver greater value for money so that you can continue to deliver a world-class health service at an acceptable price.

Thank you for your attention.