Effective, Efficient Health Care Reform

The United States and Swiss health care systems: A comparative analysis

What can the U.S. learn from the Swiss experience?

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Abstract

Home to 45 million people without health insurance while still spending 17% of its GDP on health care expenses, the United States has been in need of a massive health care overhaul for quite some time. Some have speculated that the Swiss system may be an ideal model for health care reform, and in fact, many aspects of the newly instated Patient Protection and Affordable Care Act (ACA) do reflect areas of LAMal, Swiss health care law. This paper evaluates the Swiss and United States health care systems (under ACA), their similarities and differences, and the pros and cons of each system. It concludes that U.S. health care reform is not finished, and, while the Swiss system may not be perfect, it is nevertheless an excellent model for the U.S. Thus, the United States should detach health insurance coverage from employment in order to ensure consistent coverage of the entire U.S. population at all times; the U.S. can then use individualized health care as leverage for justifying compulsory coverage. The United States must re-evaluate its method of financing health care reform, namely by focusing on reducing system waste, and should consider cutting the Medicare program.

Keywords: health care systems; employer-provided coverage; Medicare

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Introduction

With the cost of the United States health care system nearing 17% of the nation's gross domestic product while 45 million Americans remain uninsured, the United States has been in need of a massive overhaul to its health care system for quite some time (Joyce, 2011). On March 23rd, 2010, Barack Obama signed the Patient Protection and Affordable Care Act, the first major piece of health care legislation signed into law since Medicare in 1965 (Joyce, 2011). The Patient Protection and Affordable Care Act (ACA) functions under three main objectives: to reduce system costs to ensure that it works for the people and the businesses, not just insurance companies; to secure affordable access to coverage for all Americans; and to promote and strengthen preventative public health measures (Alexander, 2009).

As talk of health care reform began to dominate the U.S. policy arena, many looked to the experiences of the Swiss health care system as a potential model for the United States. A health care system that guarantees universal coverage through private, competing health insurers, and no public option, the Swiss system achieves much of what the United States aims to accomplish (Kreier & Zweifel, 2010). The system appeals to American Republicans by mandating that individuals select a health insurance plan from among a variety of private health insurance companies, but also appeals to Democratic appeals by guaranteeing coverage for all while allocating subsidies to those who cannot afford care (Rovner, 2008). However, despite commentary on the value of the Swiss system as a U.S. model, the similarities between Switzerland and the United States and the potential effectiveness of implementing the Swiss system in the U.S. remains to be deeply explored.

On the surface, the Swiss health care system does indeed appear a perfect option for the United States. The decentralized political structure of the country is such that the 26 cantons have independent control over organization of their respective health care systems, a model that could easily be replicated to ensure autonomy among America's 50 states. Again, the insurance system is such that each citizen must purchase insurance from one of 82 competing health insurers, appealing to this non-single-payer approach that is so deeply contended in the United States (Ghent 2010; Harvard Business School, 2010). The Swiss system is envied for its high standard of

care and no waiting lines, a rare phenomenon in countries with universal coverage (Ghent, 2010). As stated by Dr. Wolfgang Klietmann, lecturer at Harvard Medical School and president of the HBS Health Industry Alumni Program, "the Swiss health care system delivers many of the features we are longing for in the U.S.—universal coverage, good access, free choice, and high quality customer driven care…like a Swiss timepiece the quality of the healthcare system is high and reliable" ranking within the top 20 most efficient health care systems in the world (Harvard Business School, 2010; Tandon, Murray, Lauer & Evans, 2002). So, as such a highly regarded system, should the Swiss health care system have been more strongly considered when developing the Patient Protection and Affordable Care Act as an option for the United States? Just how perfect is the Swiss health care system, what aspects of the system can we see reflected in the ACA, and could the system plausibly function within the context of the United States?

Before the passage of the ACA, the United States had the distinction of being the only industrialized country without universal health care coverage (Carpenter, 2009). Thus, the ACA can be considered a monumental accomplishment for the United States, and not because it is the first time that a national health reform has been proposed in the United States, but rather because it is the first time that anything so substantial has passed (The Henry J. Kaiser Family Foundation, 2009). Since the 1930s, 6 different health care reform proposals have surfaced in the U.S. political arena, all of which have included national health insurance (NHI) in one way or another, and none of which have passed (Carpenter, 2009).

After President Lyndon Johnson signed Medicare and Medicaid into law in 1965, no substantial health care legislation has been passed in the United States, perhaps other than the State Children's Health Insurance Program that Congress signed in 1997 and the Medicare expansion overseen by the George W. Bush Administration in 2003. In 1993, the Clinton Administration did make a strong effort for NHI with individual and employer mandates under the Health Security Act. Hypothetically, this piece of legislation had ideal timing as it was coupled with rising American fears of the attachment of insurance to employment and concerns over the inability to individually pay for health insurance in the event of unemployment. However, the lobbying efforts of

the Health Insurance Association of America and the National Federation of Independent Business successfully killed the legislation (Carpenter, 2009).

Historians have suggested a variety of reasons that universal health care proposals have failed in the past, including the complexity of the issue, the strength of lobbies and special interest groups, ideological differences, and a weak presidency or decentralized congressional power (The Henry J. Kaiser Family Foundation, 2009). Therefore, based on the history (or lack thereof) of successful health care system changes in the United States, the enactment of the ACA should be considered a monumental feat. However, America's health care efforts are not nearly complete. An article published in the Economist titled "One step closer to nowhere" reports that 49% of respondents to a Henry J. Kaiser Family Foundation poll were unsure of the legal status of the Patient Protection and Affordable Care Act (C. H., 2011). NHI remains so debated in the United States that the Supreme Court will rule on its constitutionality in June, and major institutions are struggling with surging health care costs as a result of economic pressures created by the ACA, a piece of legislation that was supposed to reduce health care system costs (Abelson, Harris & Pear, 2011). Doctors are shaken by its implications and fear what this legislation will do to the stability of the medical field (R. Dittrich, Personal Communication, November 23rd, 2011)

Therefore, while the United States deserves accolades for finally passing a much needed piece of legislation to initiate a massive overhaul in the United States health care system, the efficiency and effectiveness of the new health care system created by the ACA remains up for debate. While a few aspects of the Swiss health care system are reflected in the ACA, many aspects are not, aspects, which, perhaps should have been considered more thoroughly. A life-course model of how a citizen of Switzerland and the United States travels through his or her respective health care system shows that an American citizen is still drastically more vulnerable to getting lost in the health care system than a Swiss citizen as a consumer of health care, and that even with the changes implemented under the Patient Protection and Affordable Care Act, the United States health care system still has much to learn.

Methodology

Literature review was an essential method used to collect data for the purpose of the enclosed research. The author used her University's digital library to collect academic articles on the topic of research. Almost all articles used to analyze the Swiss and United States health care systems were accessed via the Cornell University library web portal. The majority of articles were downloaded from peer-reviewed journals in health economics, health management, health policy, and health law. Intermittently, articles from popular news sources such as "The Economist" and "The New York Times" were used in order to also acquire real-time, current, and up-to-date information on political and public health care sentiments. Other literature was retrieved from major, highly esteemed research institutions such as The Henry J. Kaiser Family Foundation.

An invaluable amount of data and information for the purpose of this project was collected via personal interviews with a variety of experts in the fields of health care economics, health care policy, and health systems. Said experts hail from well-renowned institutions including but not limited to the University of Luasanne, the World Health Organization, and the University Hospital of Geneva. The above-mentioned experts were discovered and contacted through two methods. The author's advisor, Dr. Astrid Stuckelberger, was essential in providing contacts to experts in the field of the research enclosed in these pages. Other experts were contacted through the author's personal research of organizations. The author engaged in independent correspondence with individuals who were perceived as reputable experts able to shed enlightenment on the research. Both forms of contact yielded successful interview appointments on more than one occasion. The author also employed contacts from her sending University, Cornell. Having been a student of a course titled "The U.S. Health Care System" given by lecturer Professor Sean Nicholson, the author was able to include personal opinion of the U.S. health care system from an American perspective and not only include input from experts located in the Geneva area and surrounding regions.

The final method used for data collection was less conventional but questionably most fruitful. The author approached the research that has led to the development of this paper with open ears and an open mind, constantly engaging in random

conversation with consumers of both United States and Swiss health care. These conversations enlightened the author as to varying beliefs and sentiments of each respective citizen towards his or her health care system. These analytical conversations were also perpetually helpful in illuminating strengths and weakness in each system based on a variety of consumers' opinions. They consistently motivated the author to think harder about her interpretations of the systems and preconceived notions of a variety of issues within each system.

Using a combination of literature review, professional interviews and informal conversations, the author was able to collect a magnitude of information from a multitude of perspectives in order to develop the final product presented here today.

Results

The Swiss Health Care System

Structure

All Swiss citizens have been purchasing compulsory health insurance under the Swiss system since 1996, when the 1994 new law on health insurance "LAMal" went into effect (Squires, 2009; Zweifel, 2006). LAMal just barely passed popular referendum but was eventually adopted with the argument that health insurance premiums would decrease unanimously when competition between insurance companies was enhanced with an influx of health insurance consumers (Zweifel, 2006). LAMal has initiated a system in which virtually all Swiss residents are insured by opting into an individual, independent basic not-for-profit insurance plan that covers fundamental health services (Squires, 2009). Under LAMal, a federal subsidy is paid to individuals whose health care premiums are larger than a certain share of their taxable income (Zweifel, 2006).

Basic Insurance Coverage

This mandatory package of benefits is in fact quite comprehensive, providing coverage in sickness, maternity, and in case of accident. Its components are constantly expanding. The basic benefits package insures (Daley & Gubb, 2007):

- "Hospital stay in any general ward of the canton of residency
- Semi-inpatient treatment, e.g. eye or psychiatric clinic;
- Outpatient care;
- Nursing care, of up to 60 hours per week at home or in a nursing home;
- Examination, treatment and nursing in a patient's home by a physician or chiropractor;

- Rehabilitation ordered by a physician, including health resorts (of up to CHF 10 per day);
- Physiotherapy and ergotherapy (maximum nine sessions);
- Nutritionist consultation (maximum six sessions);
- Diabetic consultation (maximum six sessions);
- Psychiatric consultation;
- Emergency treatment abroad;
- Transportation and rescue costs (50% of emergency transport costs up to CHF 5,000 per year and 50% of non-life threatening transport up to CHF 500 per year);
- Legal abortion
- Maternity costs, including seven routine examinations, post-natal examination, childbirth and three breast-feeding consultations;
- Serious and inevitable dental treatment;
- Contribution to spectacles and contact lenses of CHF180 per year for children and CHF180 over five years for adults"

A household may choose its not-for-profit basic coverage package from among almost 90 different health care providers that compete according to price packages (Reinhardt, 2004). Swiss residents are required to purchase "Compulsory Basic Social Insurance" (CBSI) with government-mandated, standardized benefits (Kreier & Zweifel, 2010; Squires, 2009). Basic coverage is regressively priced, such that all residents pay the same premium, regardless of income level (P. Zurn, Personal Communication, November 24th 2011). Insurers are not allowed to deny anyone coverage and cannot vary premiums. Employers are expressly forbidden from providing basic insurance and advertising of basic health coverage packages is not allowed (A. Holly, Personal Communication, November 9th, 2011; Kreier & Zweifel, 2010). In order to motivate insurance companies to provide the highest care, consumers are permitted to switch coverage plans on an annual basis (Kreier & Zweifel, 2010). However, with little difference between insureres, most Swiss residents enroll for insurance under the company that covered their parents, and very few citizens actually change health care providers (A. Holly, Personal Communication, November 9th, 2011).

Supplemental Coverage

Consequently, by its inherent nature the mandatory basic insurance package does not allow Swiss residents to express individual health preferences (Zweifel, 2006). Thus, health insurers also offer for-profit supplemental coverage that Swiss residents may purchase in addition to their basic coverage. This supplemental coverage insures a

range of additional services such as free choice of doctor when hospitalized (Squires, 2009). Unlike basic insurance, employers may offer supplemental coverage to their employees and insurers may deny coverage. About one-third of the Swiss population purchases this supplemental insurance (Kreier & Zweifel, 2010).

The 26 Swiss cantons have primary responsibility over controlling the health care of their residents (Reinhardt, 2004). Only recently did the Confederation (the federal government) gain legislating power over the health care system, by imposing unanimous national standards on the cantonal health systems and mandating higher levels of solidarity—before LAMal in 1994, the Swiss health care system was a mosaic of varying systems under 26 cantons (Reinhardt, 2004). Today, the cantons are responsible for acceptance of new providers, hospital planning, provision of subsidies to institutions and organizations, and much of inpatient care (Squires, 2009).

Financing

In congruence with this decentralization, each canton sets a fixed price for insurance premiums within its own respective district. To ensure that health care costs are never unaffordable for a family, premiums are capped at 8 to 12% (depending on the canton) of the household income, beyond which the individuals will be supported by tax-financed health insurance subsidies (Esmail, 2006; Zweifel, 2006).

Swiss residents are given the liberty to choose from a variety of insurance providers in their canton and to select their provider and benefit package amongst 4 different insurance plans (Esmail, 2006):

- Ordinary Insurance: The standard plan, including a CHF230 deductible (amount paid before coverage kicks in) and 100% payment of the premium (amount paid per month) set in a person’s respective canton
- Increased deductible: Where deductibles increase and premiums fall in relation to the increase in the deductible. Premiums can decrease to a maximum 40% reduction with a CHF1500 deductible
- Managed Care Plan: Restricted choice of providers and gate-keeping that mandates a referral system to certain types of care. Premium reductions depend on the insurer and can reach up to 20%

- Bonus Insurance: Provide premium reductions in years when said individual makes no insurance claim.

Each insurance fund is required to offer a minimum annual deductible of CHF300, unless the enrollee opts for a plan with a higher deductible and lower premium. Each plan "requires patients to cover an annual deductible and incorporate a 10% coinsurance rate after the deductible is reached to an annual ceiling" of CHF700 (Esmail, 2006, p. 23). To ensure cost-sharing, all residents pay a 10% coinsurance charge for all services, or each visit, and a 20% coinsurance charge for all brand name prescription drugs with a generic alternative (unless specifically subscribed). Maternity services and a few preventative services are exempt from deductibles, and insurers have the ability to lower or wave co-pay fees for managed care plan consumers (Squires, 2009). However, less than 10% of the Swiss population is enrolled in managed care plans (Harrington, 2006). As a safety net, co-pay charges are waived if an insurance enrollee reaches CHF700 in one year in order to protect individuals in the event of catastrophic illness (Squires, 2009). To avoid adverse risk selection by insurers, "costs are redistributed among insurers from a central fund according to a risk equalization scheme based on age and gender" and prior hospitalization and premiums may not vary for other social reasons or pre-existing health conditions (P. Zurn, Personal Communication, November 24th 2011; Squires, 2009, p. 1).

In a given year, the maximum that a Swiss resident living in Geneva can expect to pay for basic health care coverage, under an ordinary insurance plan, is CHF6,212—CHF426 monthly premium, minimum CHF300 annual deductible, and CHF700 coinsurance ceiling (Esmail, 2006). Under LAMal, annual cost sharing is capped at $3,200 (Kreier & Zweifel, 2010).

Vulnerable Populations

Children

Children are covered under their parents' household insurance up to the age of eighteen, at which point they independently enter the insurance industry and theoretically would receive government subsidies if they could not pay insurance costs independently (A. Holly, Personal Communication, November 9th 2011). The annual insurance deductible does not apply to children under 18 years of age and their

coinsurance ceiling is reduced from CHF700 to CHF300. Some insurance companies offer deductible-free coverage for young people up to the age of 25 (Esmail, 2006).

Unemployed

In the event of unemployment or some other drop in income notably recognizable in taxation reports, Swiss residents will be automatically sent applications for health care subsidies. Anything above Switzerland's pre-determined cost of living is considered a luxury; however, if, accounting for tax and health care payments, a person's living expenses drop below this minimum standard, he is subsidized. Changes in living standards are automatically calculated each month and subsidies are provided accordingly (A. Stuckelberger, Personal Communication, November 16th 2011).

Elderly

As a result of the risk equalization scheme, health insurers with a high proportion of young people are required to pay an equalization amount into a central fund that is then used to subsidize insurance companies covering a large proportion of elderly people (Shoenenberger & Stuck, 2006). Community-based home care nurses visit Switzerland's elderly population regularly. Switzerland is seeing a rising demand for ambulatory home care that is funded in half by public contributions and in the other half through basic insurance.

The United States Health Care System

Structure

Similar to the Swiss system, health insurance in the United States is provided primarily through private, competing insurance companies. Both systems "impose requirements on insurers designed to insure that individuals with health problems have access to coverage on the same terms as those without such problems" (Kreier & Zweifel, 2010). According to the ACA, this equality is achieved by mandating that the insurance companies guarantee access and renewal to all insurance applicants, premium ratings can only vary according to age, family composition, and tobacco use (The Henry J. Kaiser Family Foundation, 2011). Both plans also mandate compulsory health care coverage. For the first time in United States history, most citizens will be forced to purchase health insurance under the Patient Protection and Affordable Care Act (ACA). Those who do not purchase insurance coverage will be forced to pay a tax

penalty. Individuals in financial hardship, with religious objections, those without coverage for less than three months, American Indians, undocumented migrants, and incarcerated individuals will be exempt from the compulsory health care coverage mandate (The Henry J. Kaiser Family Foundation, 2011). To be noted, however, the constitutionality of mandating compulsory health care coverage in the United States is a greatly debated issue and will be heard by the Supreme Court in June (Abelson, Harris & Pear, 2011). Like the Swiss system, health care will be subsidized under ACA for those U.S. residents whose incomes are between 133% and 400% of the federal poverty level (The Henry J. Kaiser Family Foundation, 2011).

However, there are also a variety of dramatic differences between ACA and LAMal (Kreier & Zweifel, 2010). For one, the legal structures of the two pieces of legislation are quite different. While it is illegal under LAMal for Swiss health insurance companies to earn a profit selling basic coverage packages, ACA mandates that, in a more market-oriented manner, health insurers must spend 85% of large-group premiums and 80% of small-group premiums on coverage of real and palpable medical costs (Harrington, 2010; Kreier & Zweifel, 2010). Other differences between LAMal and ACA include that the Swiss system "provides for regulated or negotiated prices for pharmaceuticals, medical devices, and the services of health care providers, and places primarily responsibility for funding hospital care on cantonal governments" (Kreier & Zweifel, 2010). Still yet, two of the most important differences between the Swiss and U.S. systems are the U.S emphasis on employer-provided care and the dynamics between public and private health care.

Employer-Based Coverage

One of the largest differences between LAMal and ACA is that while LAMal forbids employer-provided basic insurance coverage, the U.S. health care system functions under the Bismarckian model by encouraging (by allowing employees to purchase tax-free insurance through their employer), mandating, and further expanding the employment-insurance interconnection (S. Nicholson, Personal Communication, November 8th, 2011). In an effort to expand employer-provided coverage, all businesses with more than 50 employees will be subject to a fine if they do not offer health insurance coverage (Harrington, 2010). For businesses with 50 or more employees with

access to employment-based coverage but in which at least one employee is still receiving a premium tax credit, the business will be subject to a penalty (The Henry J. Kaiser Family Foundation, 2011). None of this penalization will apply to businesses with fewer than 50 employees; however, businesses with 25 employees or less with annual wages below $50,000 that still offer health insurance coverage will be eligible for tax credits (Harrington, 2010). Businesses with 200 or more employees will be required to automatically enroll their employees into the company's health insurance plan, though employees will have the option of opting out (The Henry J. Kaiser Family Foundation, 2011). More often than not, employers only offer managed care plans (Kreier & Zweifel, 2010). The average employer-provided premium for family coverage costs an employee $4,129 (Tuttle, 2011). As a comparison, purchasing individual non-employer-provided insurance would cost a family $4,968 in a year—almost $1,000 more (Marketwire, 2011).

Medicaid and Medicare for Vulnerable Populations

Almost one-third of health care coverage is provided through government programs (Kreier & Zweifel, 2010). Medicaid, a taxpayer-funded program to cover health insurance for poor Americans, will be expanded to cover those with incomes up to 133% of the poverty line and will newly cover non-disabled, non-elderly adults without dependent children (Harrington, 2010). Medicaid is a state and federal partnership to provide health care coverage for each state's poor population; the federal government provides matching monetary grants to each state to support that respective state's vulnerable population. While coverage criteria of Medicaid plans vary per state, the Medicaid program in every state pays health care providers directly for the services provided (American Medical Association, n.d.) Under the ACA, reimbursement payments to participating Medicaid health care providers are reduced and Medicaid coverage is increased to insure preventative services (Gabble, 2011).

Medicare is the largest health care consumer in the United States ensuring health care services for the elderly. At 65 years, an American resident is automatically enrolled in Medicare Part A, inpatient care coverage, and may choose to enroll in Part B, outpatient coverage, and Part D, prescription drug coverage, after agreeing to financial obligations. Consumers may also choose to enroll in Part C, managed care

plans, in replace of Parts A and B. Health services providers annually elect as to whether or not they would like to participate in the Medicare program. If they choose to do so, they must agree to accept Medicare payments as payment in full according to a pre-determined rate schedule and are not permitted to "balance bill"—charge patients an additional fee to cover what said health service provider would consider the full payment (American Medical Association, n.d.). Under ACA, Medicare Advantage (Part C) managed care plans will be prohibited from enforcing higher cost-sharing obligations on enrollees than traditional Part A+B plans. Medicare Advantage plans will also be required to commit at least 85% of their federal payments and beneficiary premiums to medical services (Carpenter, 2011). Payment reductions to Medicare Advantage plans are expected to decrease Medicare output costs by $136 billion by 2020. As such, reductions in Medicare Advantage payments are the main funding source for health care coverage to the uninsured under ACA (Gitterman & Scott, 2011).

Health Insurance Exchanges

Finally, for those American residents not covered by Employer-Provided Insurance, Medicaid, or Medicare, the ACA establishes State-Based Health Insurance Exchanges to provide affordable access to health insurance plans for the uninsured, starting in 2014. All individuals can purchase from their respective state exchanges, and those residents with incomes 133-400% of the federal poverty level will be eligible for premium and cost-sharing credits. Separate exchanges will be created through which small business can purchase insurance as well (The Henry J. Kaiser Family Foundation, 2011). These exchanges will create "an online one-stop shopping mall where consumers, employers and insurance brokers will be able to compare health plans side by side," the goal of which is to hopefully drive down the cost of individually purchasing insurance as insurers will need to compete for business via this transparent, online market (Goldstein, 2011). The Exchanges will offer four plans of tiered benefits—bronze, silver, gold and platinum—as well as a catastrophic plan for those up to the age of 30 (The Henry J. Kaiser Family Foundation, 2011).

<u>Financing</u>

In order to provide health care coverage to an additional 32 million people, the United States Congressional Budget Office predicts that the ACA will cost $938 billion

over the next ten years. This funding will be acquired, one, by imposing an annual fee on the pharmaceutical manufacturing sector, the health insurance sector as well as a variety of other taxes, and, two, by cutting reimbursement rates (The Henry J. Kaiser Family Foundation, 2011; Harrington, 2010). In terms of Medicare payment reductions, the ACA "reduces annual payment updates for hospitals, long-term care hospitals, rehabilitation facilities, psychiatric hospitals, home health agencies, skilled nursing facilities, hospices, and other non-physician providers" (Gitterman & Scott, 2011).

Discussion

The Patient Protection and Affordable Care Act should be considered a great American feat. After six major health care reform efforts were tried and failed in the United States, President Obama was the first to successfully sign a major overhaul on the United States health care system into law. And Obama has much to be proud of. By forcing competition on health insurance companies, the State-Based Health Insurance Exchanges will hopefully serve to make health care coverage more individually affordable—a much needed accomplishment. Prior to the ACA, individual insurance plans were so expensive that very few, if any, American residents would venture to purchase one. The only affordable plans for people in part-time jobs, college students, and other similar populations in need of coverage have low premiums but such high deductibles that purchasing a plan would be worthless—said American would go into debt trying to pay the deductible before coverage even kicked in (A. Olvera, Personal Communication, November 16th 2011). These exchanges on top of the Medicaid expansion and introduction of premium tax credits for Americans between 133 and 400% of the poverty line will help ensure that all Americans can affordably access health care coverage.

However, regardless, there are still problems with the Patient Protection and Affordable Care Act that can be regarded as, one, a failure of the system for not being addressed and, two, a plethora of worrisome implications for the future of United States health care. First, the reliance on cutting Medicare costs in large part to accommodate funding for ACA is a huge mistake. Reductions in Medicare Advantage payments are estimated to decrease output funding on Medicare by $136 million by 2012 (Gitterman & Scott, 2011). What this means is that physicians will be receiving even lower

reimbursement payments for treating Medicare patients than they already do—and they already make little marginal profit for treating Medicare patients. The Center for Medicare and Medicaid Services predict that these cuts will result in “less generous benefit packages” for Medicare Advantage-enrolled seniors, about one-quarter of Medicare beneficiaries (Gitterman & Scott, 2011). With the ACA hanging Medicare service providers out to dry, there is no telling how much the elderly population of the United States will suffer, especially given the growing percentage of elderly people in the United States with the rising age of baby-boomers. It is also safe to assume that medical specialization in geriatrics will become a rare phenomenon as a result.

Furthermore, the United States health care system was already an overwhelming mosaic of varying public and private health insurance systems, and the Patient Protection and Affordable Care Act only makes this confusion of muddled health care systems worse. With Medicaid for the poverty-stricken population, Medicare for the elderly, employer-provided coverage for employed Americans, Exchange availability for the uninsured, and subsidies for those who cannot afford Exchange insurance plans, and separate Exchanges for small companies, the United States health care system is inherently overwhelming and confusing. According to Professor Holly, Honorary Professor of the Institute of Health Economics and Management at the University of Luasanne, this conglomeration of health insurance options creates too much opportunity for overlap that causes inevitable waste in the system (A. Holly, Personal Communication, November 9th, 2011). As a benchmark comparison, four different studies found that the United States could save between $89.1 and $280.4 billion on administrative waste each year by switching to a single-payer system from its complex, fragmented, multi-payer system. The United States spends the highest percentage of its health care expenditure on administrative and insurance costs compared to other countries—7.3% (Bentley, Effros, Palar, & Keeler, 2008).

Not only does this patchwork of health care organizations create waste, but it also promotes vulnerability of populations that are at risk of “falling-out” of the health care system. For example, if a person is to lose her job with a large company, she will then have the responsibility of applying into an insurance Exchange to gain health care coverage. If her job loss drops her income to less than 400% of the poverty level, then

she will also have the obligation of applying for a premium tax credit—and she is expected to take care of all of these tasks while looking for a new job and coping with the other losses that accompany unemployment. A person who falls below 133% of the poverty level will need to apply to Medicaid, and a person who reaches 65 years of age must switch his or her insurance to Medicare. As such, the unexpected yet plausible probability of ones life circumstances changing leaves him at constant risk of being subject to the possibility of “falling-out” of this disjointed health care system.

On the other hand, the Swiss-system of individualized insurance enrollment acts as a safety net to protect a person’s health coverage, no matter his or her life circumstances. (See Appendix A). From the age of 18 to death, each Swiss resident must enroll in the health care system of his or her choice, and will maintain that coverage, independent of employment, wealth, etc., throughout his or her lifetime (unless he or she voluntarily chooses to switch plans). And in the event that a person’s income falls below the minimum standard of living and he or she requires more subsidies, this need will be automatically calculated each month and additional subsidization, if necessary, will be awarded.

As a result, individualized coverage, as opposed to employer-provided coverage, is a more stable, straightforward, and supportive health insurance system. In the context of “decreasing affordability for employers and employees, the challenge of international competitiveness, and changes in the structure of employment,” the value of employment-based health care coverage is already being questioned as the best option for health care coverage in the United States (Ginsburg, 2008).

Employment-based coverage in the United States is decreasing in affordability as trends in premium rates rise above trends in earnings, making the cost of insurance, be it paid by the employer or employee, unaffordable for an increasing number of workers (Ginsburg, 2008). An American company’s hardship becomes punishment for its employees, as companies often respond by cutting back health care benefits (Kosteas & Renna, 2009). The United States is also seeing an increasing number of workers that are self-employed, employed part-time, or employed by small businesses that do not offer coverage, and so employment-based coverage is declining in the United States anyway (Ginsburg, 2008). Sure, these individuals will now be eligible to access their

State-Based Exchanges to buy health insurance coverage. However, while these Exchanges are intended to make the individual purchase of health insurance more affordable, they are still perpetuating an inequitable system. Competition in the exchanges is not likely to drive down insurance costs low enough to match the premiums and cost-sharing rates that large companies can achieve. As Pascal Zurn, health economist at the World Health Organization, notes, the larger the pool of people insured, the lower the cost to each member (P. Zurn, Personal Communication, November 24th 2011). And large companies have the added benefit of the ability to negotiate with health insurance companies.

In a system of individualized insurance in which each individual purchases health care coverage from among private insurance companies, insurance companies will have the greatest incentive to compete with one another. Residents have a broader choice of health plans and greater incentive to economize, and so the insurance market is subject to market forces that should find balanced price plans where supply meets demand (Ginsburg, 2008).

Undoubtedly, the Swiss health care system is not perfect. Although it did recently drop from the second most expensive to the seventh most expensive health care system in the world, it still struggles to control costs (P. Zurn, Personal Communication, November 24th 2011). One of the reasons that the Swiss system is so expensive is because, until a recent piece of legislation, hospital payments were made as per-day reimbursements, meaning that hospitals had little to no incentive to discharge patients. Switzerland recently adopted Diagnostic Related Groups (DRGs) so that hospitals are paid for the procedure and not the length of time. The United States already has a similar DRG system in place. (P. Zurn, Personal Communication, November 24th, 2011).

In order to control costs, Switzerland is also pushing for a greater prominence of managed care enrollment (A. Holly, Personal Communication, November 9th 2011). Managed care plans are able to achieve lower prices by controlling access to service providers and requiring approval before specialist visits; however, only 6.82% of the Swiss population is enrolled in them (Esmail, 2006). In the United States, Americans are already accustomed to the idea of managed care plans, as they are commonly an employer's plan of choice.

One large difference between the United States and Swiss health care systems that make the Swiss system's commitment to market forces so successful is the existence of Medicare (Graham, 2007). The Swiss system does not force its residents out of their private plans and into a public plan when they turn 65. Because of this, the Swiss system is able to function under competition and a risk equalization scheme. Under this scheme, premiums are pooled and then divided amongst insurers according to the population of young and old that they insure. If the 65 and older age group were to be removed from this scheme, it would be more difficult to balance risk equalization.

Under the Swiss system, senior citizens pay for insurance just as any other resident does and receive subsidies if necessary in the same fashion. Nursing homes, inpatient care, and home visits are covered under their basic health care coverage package, and so their needs are still met in old age without having a specific program catered towards them specifically. Medicare, a massive public health insurance program that is the largest consumer of health care in the United States is a ticking time bomb that is unaffordable and unmanageable in the United States.

United States government is fully aware that with the increasingly aging population of the United States, the country will reach a point in which the Medicare program is no longer affordable (Rich, 1996). Enforcing Medicare and Medicare Advantage reimbursement rate cuts in order to finance the ACA may be more harmful to senior citizens than the actual program itself. Reimbursement rates that are below profit level act as discouragement for physicians to accept Medicare patients, and so it may become increasingly more difficult for senior citizens to find providers in their area. Physicians must see a larger quantity of patients in order to compensate for high overhead costs, which translates into physicians spending less time with Medicare patients, and so a lower quality of care (D. Dittrich, Personal Communication, November 26th 2011). If reimbursement rates are too low, it can be expected that the existence of the Medicare program will act as a disincentive to enter the geriatric field at all. Who would want to enter a medical specialty with knowingly negative marginal profit?

One of the main reasons that major health reform proposals have failed in the past is because of a weak presidency or decentralized congressional power, and the U.S. experience with barely passing the ACA within an extremely decentralized

Congress has proven the contrary. Also, the strength of lobbies and special interest groups to support or oppose major health care legislation has always had a strong influence in the past. However, accommodations can be made to appease the major interest groups that may support or oppose specific aspects of legislation.

Finally, Paolo Piva, Health and Development Adviser of the World Health Organization, states that a major flaw of the financing of ACA is that it fails to incorporate any major cost-control provisions, such as malpractice tort reform (P. Piva, Personal Communication, November 15th, 2011). In the article “It’s the prices stupid: Why the United States is so different from other countries,” Anderson, Reinhardt, Hussey, and Petrosyan (2003) find that while the United States spends more on health, it consumes less health care services. The authors find that the United States’ spending was 44% higher than Switzerland’s but that the country had fewer physician and hospital visits per capita and conducted more expensive procedures such as coronary angioplasties and kidney dialyses. They find that U.S. hospital services are more expensive and patients are treated more intensively, which is undoubtedly related to medical providers’ growing fears of malpractice law suits (Anderson et al., 2003).

Unnecessary prescription and consumption of health care services is a growing phenomenon in the U.S. As a spoof on the overuse of expensive services in the United States, one political cartoon features a man sitting in a doctor’s office with an arrow through his head. After the consultation, the doctor tells the patient “Off hand, I’d say you’re suffering from an arrow through your head, but just to play it safe, I’m ordering a bunch of tests.” This cartoon is depictive of the extra measures that physicians are pressured to take in order to prevent future legal problems with patients. In addition to forcing physicians to over-prescribe precautionary tests, the overwhelming presence of malpractice litigation also reduces the supply of physicians, makes physicians less willing to accept high-risk patients and to perform high-risk procedures, and physicians may share the rising costs of malpractice insurance by increasing the prices of services (Chandra, Durand, & Dickens, 2009; Carpenter, 2006).

While the rising costs of malpractice litigation and insurance coverage can help to explain the expense of the United States health care system, this costly system also has vast implications for the individual consumption of health care services. The

average United States hospital stay is more service-intensive than other countries and costs three times the Organization for Economic Cooperation and Development (OECD) country median (Anderson et al., 2003). What does this imply about the rising expense of the United States health care system? Perhaps American residents are consuming too many services per visit, especially expensive procedures. In 2006, the U.S. wasted $18,210 to $33,333 billion dollars on unnecessary, noninvasive radiological imaging (Bentley et al., 2008). This may be part and parcel of a low level of cost sharing. As a result, the cost of the U.S. health care system has sky-rocketed because Americans do not bear the burden of consuming expensive services and so over-consume, and because of physicians' anxiety about malpractice, they are eager to perform all available tests to diagnose a problem.

Conclusion

While the United States has the most expensive health care system in the world, spending approximately 17% of its GDP on health care services with an uninsured population as large as 45 million, Switzerland achieves universal health care coverage with a health care system that ranks seventh in expense and can claim the second highest life expectancy in the world (OECD, 2011). Switzerland achieves its world-renowned reputation as one of the most valuable health care systems in the world by mandating universal coverage but allowing its residents to choose their health care plan from a variety of private, competing insurance companies, independent of employment. As such, there is much that the U.S. can learn from Switzerland's experience.

While the United States has much to be proud of in having successfully passed a massive piece of health care legislation for the first time since 1965, health care reform in the United States is no where near finished. The mosaic of public and private health insurance systems created under the Patient Protection and Affordable Care Act create system waste and opportunities for vulnerability among the U.S. population. The funding for ACA, primarily through Medicare cuts, is unsustainable and is destined to negatively affect the elderly population. The ACA also does not involve enough financial initiative to control rising health care costs in America.

In order to achieve an equitable system in which all residents are guaranteed coverage no matter their life circumstances, the United States should adopt a health

care system of individualized coverage by detaching employment from insurance provision. In doing so, the United States would simplify its health insurance system, resulting in reduced waste and definite coverage for all citizens, regardless of job transition, poverty level, or age. By detaching employment from health insurance coverage and eliminating the $100 billion subsidy each year that allows residents to buy tax-free health insurance from their employer, the United States could obtain enough tax revenue to fund the expansion and subsidization of individual health coverage—a necessary $938 billion over the next ten years (S. Nicholson, Personal Communication, November 8th, 2011).

Individualized insurance could be purchased through the Health Insurance Exchanges created under the ACA, the best method of ensuring transparency and competition in the health care market. The states would have primary control over the Exchanges, as they do under ACA, and reflecting the way in which the Swiss cantons have primary control over the health care of their respective citizens.

In a time when the constitutionality of compulsory health care coverage is on the forefront of United States health care debates, the implementation of individualized health care coverage could be framed to lessen the blow of coerced coverage. In the abstract, employment-provided coverage contradicts the freedom of choice that Americans commit to so firmly. Employers often offer only one insurance plan, removing all opportunity for employees to express their individual preferences. Though compulsory health care coverage would force American residents to purchase health care insurance, individualized health care coverage would allow said residents to choose among a variety of insurers—a much greater expression of free choice.

While in its current form the ACA cuts Medicare and Medicare Advantage reimbursement rates, these payment reductions are bound to only harm Medicare enrollees by decreasing Medicare insurance benefits and reducing the population of physicians willing to accept Medicare patients. Thus, the United States must cut the Medicare program all together and mandate that senior citizens purchase from their state-based Exchanges instead, just as is done in Switzerland. This is likely to afford the elderly a higher quality of care while still ensuring that they get necessary additional services. And, as learned from the Swiss experience, this does not reduce senior

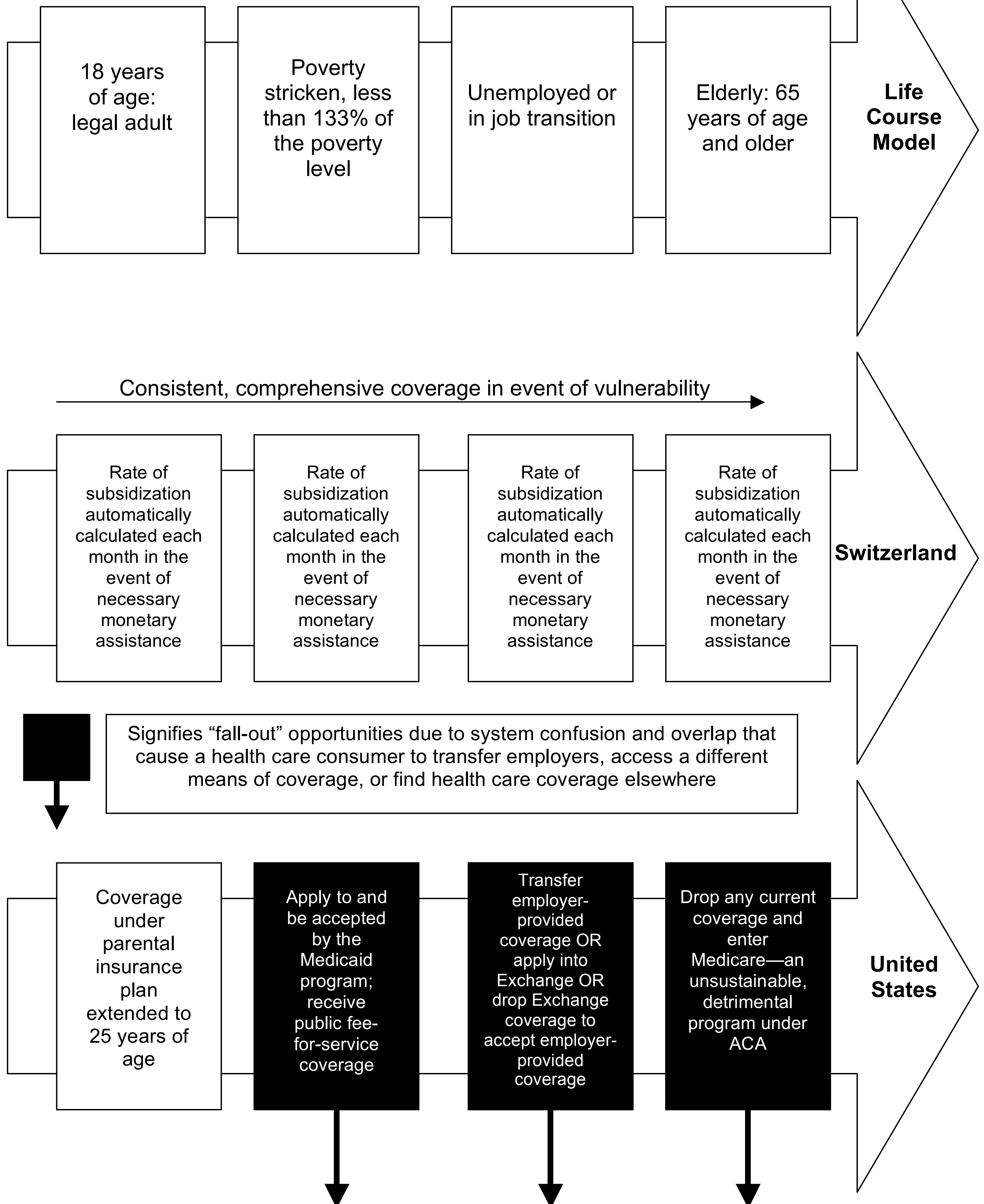
citizens' accessibility to medical services, such as nursing homes, that become necessary during the aging process.

It can be expected that insurance companies would strongly oppose any proposition to detach coverage from employment as their business is so strongly intertwined with insuring company populations. Yet, to avoid this, adaptations could be made in order to accommodate the interests of insurers. Businesses, on the contrary, could be expected to respond positively to this proposition due to their frustration with the pressures and costs of insuring their employees.

To implement a system of individualized coverage in the United States, all residents would have to be required to purchase a basic, standardized coverage package so that a risk equalization scheme could function properly by including all members of the population. However, employers could be permitted to contract with insurance companies in order to provide supplemental coverage. And, based on the Swiss experience, employees would likely purchase their basic coverage from the company that they receive supplemental coverage from, so insurers are unlikely to loose all those whom they had previously insured within a company. Insurers could also be permitted to advertise their basic and supplemental packages, unlike under the Swiss system. More research should be conducted to discover more ways that detaching employment and insurance could appease insurance company interests.

Finally, the United States needs to take drastic measures to control the financial overgrowth of its health care system, mainly be capping malpractice litigation and implementing the cost-sharing mechanisms that exist in the Swiss system. Detaching employment and health care insurance such that Americans individually purchase health care coverage will enforce a greater level of cost sharing on American health care consumers. As a result, consumers will be inclined to act more frugally and carefully in regards to necessary health services. Provided that malpractice controls are in place, this increased caution is likely to reduce the public's desire to over consume unnecessary, expensive procedures, also freeing physicians from the pressure to over-prescribe expensive health care services to protect against malpractice litigation. In the end, increased cost sharing and leveled malpractice reform will effectively reign in the overuse of expensive health care services in the United States.

APPENDIX A: A Life-Course Model Within the Swiss and U.S. Health Care Systems



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Work Journal

Date	Details
Aug. 29th 2011	**Meeting** *Dr. Maribel Fehlmann, SIT Office, Nyon, Switzerland* This date marks my first official meeting about my Independent Study Project (ISP) with Dr. Maribel Fehlmann. During office hours, she and I discussed how I intended to write my ISP paper on how sexual education in Switzerland affects teen pregnancy and STI rates.
Sept. 12th 2011	**Meeting** *Dr. Christian Viladent, Ecole Migros, Nyon, Switzerland; christian.viladent@sit.edu* Today was my second meeting about my ISP, this time with Dr. Christian Viladent. In this meeting, he and I discussed how to narrow my topic, specifically deciding that I would examine how the presence of prostitution in a given area affects the sexual health of the nearby youth.
Sept. 13th 2011	Today, I attended our scheduled lecture at the Centre Medical Universitaire by Dr. Astrid Stuckelberger. After her engaging lecture on health systems, I was reminded of how interested I am in this specific topic and decided to change my ISP research. I decided that I would write my ISP as a comparative analysis between the Swiss and U.S. health care systems. At the end of this lecture, I approached Dr. Stuckelberger and requested that she be my adviser, which she accepted.
Oct. 7th 2011	**Meeting** *Dr. Astrid Stuckelberger, Adviser, La Clemence Café, Place Bourg-de-Four in Old City, Geneva; 0763913621; astrid.stuckelberger@unige.ch* This meeting at La Clemence was my first official meeting with my ISP adviser. I requested this meeting with Dr. Stuckelberger in order to ensure that we had a meeting before my departure for Morocco and in order to discuss my project topic, the frustrations that I was experiencing, and the roadblocks that I was experiencing. Dr. Stuckelberger helped me to narrow my ISP topic, such that I decided to specifically focus my research on the vulnerable populations within a health care system.
Nov. 1st	Today was the first official day of the ISP period, and so I decided to spend it

<table>
<tr><td>2011</td><td>researching potential contacts for my research and sending e-mails to the experts of whom Dr. Stuckelberger had already provided me with contact information and whom I had discovered on my own. The persons to whom I sent e-mails included:

Potential Resources Provided by Dr. Astrid Stuckelberger:
• Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health; Office of the United Nations High Commissioner
• Dr. Alberto Holly, Professor Honoraire; Institute for Health Economics and Management at the University of Luasanne
• Dr. Paolo Piva, Health and Development Advisor; World Health Organization
Potential Resources Found Independently Via Online Research:
• Gary Filerman, International Health Systems Expert; Atlas Research Senior Vice President and Chairman of the Health Management and Policy Group
• Dr. Win Van Lerberghe, Director of the Department of Health System Governance and Service Delivery
• Dr William Hsiao, Professor of Economics; Department of Health Policy and Management at the Harvard School of Public Health
• Dr. Rifat Atun, Professor of International Health Management; Imperial College London
• Dr. Peter Berman, Adjunct Professor of Population and International Health Economics; Department of Global Health and Population at the Harvard School of Public Health

On this same day I also received an e-mail back from Dr. Win Van Lerberghe suggesting that I contact his colleague, Dr. Pascal Zurn, health economist at the World Health Organization, instead, as he would be better equipped to answer my questions. Thus, I sent Dr. Zurn an e-mail as well.</td></tr>
<tr><td>Nov. 2-4th 2011</td><td>Worked in cafes in Nyon, Switzerland to research articles on the U.S. and Swiss health care systems via the Cornell University digital library web portal</td></tr>
<tr><td>Nov. 7th - 8th 2011</td><td>Today I visited the United Nations library to continue accessing articles via the Cornell University digital library web portal and Google Scholar. Now that I have begun to accumulate so many articles on top of those that I used for my literature review, it is time for me to start reading.</td></tr>
<tr><td>Nov. 9th 2011</td><td>Interview and Research
Alberto Holly, Emeritus Professor, Institute of Health Economics and Management, University of Luasanne, Vidy Centre, Route de Chavannes 31,</td></tr>
</table>

	1015 Luasanne, alberto.holly@unil.ch This morning I traveled to Luasanne for an interview at 14:30 with Professor Alberto Holly. I went into Luasanne early in the morning to use the University of Luasanne library. The questions asked to Dr. Holly were as follows: 1. How does the Swiss system accommodate prenatal care, people just entering the workforce, people in job transition, and the elderly? 2. Who will the Diagnostic Related Groups (fixed costs for treatments) being introduced in Switzerland in 2012 benefit most? 3. Do vulnerable populations struggle to get supplemental coverage once insurers know their pre-existing conditions because of basic insurance? 4. Insurance companies are compensated if their risk profile is over skewed, but is there ever a benefit to getting this compensation since you are getting a guaranteed benefit with uncertain risk? 5. LAMal mandates that Swiss residents be allowed to switch health insurers more than once a year. Does this cause waste in the system, as it is probably expensive to go through the process of taking on new enrollees? 6. In a WHO bulletin, you were quoted as having said “the Swiss system is not an equitable system because it is impossible to control costs”—could you explain this statement? 7. Could you explain the reasoning and motivation for Switzerland’s decision to push forward with managed care plans? 8. What are your feelings on employer-based insurance coverage? 9. In your opinion, could the Swiss system feasibly be implemented in the United States? 10. When LAMal was introduced in Switzerland, how did the Swiss population respond to the universal coverage mandate? 11. What would you consider to be the pros and cons of the Swiss system? The United States system? The interview with Professor Holly was insightful and productive. We spent much time discussing the value of individualized coverage in ensuring supportive coverage for the vulnerable populations. I was surprised and pleased to hear him respond when I asked if the Swiss system could feasibly be implemented in the United States that he “absolutely” thought that it could.
Nov. 10th 2011	**Meeting** *Dr. Christian Viladent, Academic Director, SIT Office* This morning I had a meeting with Dr. Viladent to discuss my ISP. The meeting was quite productive, as we discussed how I have been overwhelmed with the extensiveness of my topic and I presented my ideas on how I intended to narrow the topic of my paper. By the end of the meeting, Dr.

	Viladent and I had decided that I could feasibly and effectively write a paper in which the results section mapped out the Swiss and U.S. health care systems and a life course model as a result, the discussion I decided would review the value of certain key parts of the Swiss system, such as employer-provided coverage, and how the system is more stable, and the conclusion would address whether or not the Swiss system was a feasible health care system model to be implemented in the United States
Nov. 15th 2011	**Interview** *Dr. Paolo Piva, WHO Headquarters, 20, Avenue Appia, Geneva, 0227912702; pivap@who.int* The following questions were asked to Dr. Piva during the interview: 1. How has the political background of Switzerland influenced the system, and how has the system changed as the culture has changed? 2. How has the culture of Switzerland influenced the system? 3. Is there one group in Switzerland that you would call particularly vulnerable in the Swiss health care system? 4. What would you consider to be the value and limitations of employer-based health insurance? 5. Where are the holes in the Swiss health care system? 6. Based on your knowledge of the United States system, will the changes implemented under the Patient Protection and Affordable Care Act improve the functioning of the system? 7. Hypothetically, how would an insurance system function if employment and insurance coverage are not linked, residents purchase insurance through competing, private companies, and health insurance coverage is not mandatory? The interview with Dr. Piva was another insightful and influential one. While I must admit that we were not able to touch on all of my interview questions because we continually got off on tangents about specific topics, Dr. Piva opened my eyes to the financial problems in the United States health care system and the need for the U.S. to implement financial reforms in order to curb the major monsters in health care cost growth such as malpractice and technology. The meeting with Dr. Holly encouraged me to focus my paper on the need to detach employment from health care coverage in the U.S., and my meeting with Dr. Piva made me realize that I needed to spend time discussing the major financial problems burdening the U.S. health care system.

<table>
<tr><td></td><td>Dr. Sean Nicholson, Policy Analysis and Management Professor, Cornell University, New York, United States, sean.nicholson@cornell.edu

Today, I also received responses from Professor Nicholson to interview questions that I sent him in order to get an American academic perspective of the health care systems. The questions that he responded to were as follows:

1. While the PPACA seems to have many provisions to ensure universal health care coverage, it seems to do little to address the exorbitant health systems costs in the U.S. for reasons such as use of technology, malpractice issues, etc. Are there any methods of cost-control (either that I am not aware of or that are implicit) in the PPACA for these major health system problems?
2. What is your opinion on detaching health insurance provision from employment, in an effort to simplify the system and reduce the holes of vulnerability that are created by employer-based coverage?
3. (If you are willing to answer this question), how would you rate the PPACA as an effective piece of legislation to revamp the United States health care system? Do you feel that it is missing anything or that any pieces of action in it are mistakes? If so, what?
4. In your opinion, will compulsory coverage pass in the Supreme Court?
5. If a person loses his or her job but is still required to have insurance (if compulsory coverage passes), is there a safety net or time window of lee-way given to that person to enroll individually for coverage? Is the person entitled to any type of subsidy or prior-employer benefits to assist him or her in paying for insurance?
6. I read an article that emphasizes the value of the Swiss system over the American system because it does not force people out of private coverage and into public coverage when they turn 65. Could you comment on this? Would the U.S. be better to have a system without fragmented insurance coverage for different vulnerable populations (i.e. Medicaid and Medicare) and have a system like that in Switzerland in which all people who cannot afford their own health care coverage qualify for subsidies the same way?</td></tr>
<tr><td>Nov. 16th 2011</td><td>Interview and Meeting
Abi Olvera, SIT Student, Cirque, Geneva, Switzerland
Today, I interviewed Abi Olvera, an SIT students whose family does not have health insurance coverage in the U.S. Our interview was emotionally touching and made me realize just how important affordable access to health care coverage is.

1. Why doesn't your family have health coverage?
2. How do you/how does your family feel about compulsory coverage?
3. How will your family be affected by being required to have coverage?
4. What does your family do in the event of an emergency?</td></tr>
</table>

	5. What is your perspective on the fact that the U.S. does not currently have a system to ensure that everyone have health access? *Dr. Astrid Stuckelberger, Adviser, McCafe, Geneva, Switzerland* I also had a meeting with Dr. Stuckelberger today, in which she and I solidified the best way in which I could structure my paper. As she and I discussed, the results of my paper would present the U.S. and Swiss health care systems in which I would map out a life-course model as a result, the discussion would present the strengths and weaknesses of the two systems, and the conclusion would detail what the United States could learn from the Swiss experience. Dr. Stuckelberger and I also had a conversation in which she clarified a few questions that I could not find answers to, such as Switzerland's relationship with malpractice litigation and the consistency of subsidization in Switzerland.
Nov. 17th - 23rd 2011	**Writing** I spent at least 8 hours per day writing and was able to finish the Intro, Methodology, and Results section of my paper as well begin my Discussion in the Centre Medical Universitaire Library in Geneva and the U.N Library
Nov. 24th 2011	**Interview** *Dr. Pascal Zurn, WHO, 20, Avenue Appia, Geneva, zurnp@who.int* Today, I was able to get a last minute interview with Dr. Pascal Zurn. Although I am nearly finished with my paper at this point and have most of the information that I need, I still took the opportunity to ask him some last-minute questions to receive another expert opinion. I asked the following questions: 1. How has the political background and culture of Switzerland influenced the development of the health system? 2. Is there one sector of the Swiss population that you would consider particularly vulnerable within the context of the Swiss health care system? 3. Why does the Swiss health care system struggle to control costs so much? 4. What are some strengths and weaknesses of a health care system that is based on employer-based coverage?
Nov. 25th- 27th 2011	**Writing** I spent my time working on my discussion, writing the conclusion, and polishing up the parts that I had already written. I also spent a large part of the day preparing and rehearsing my oral presentation that I will deliver tomorrow.