

Richard Roberts<sup>1</sup>

## Swiss Family Medicine thirty years later: doing better



Thirty years ago, Family Medicine made its entrée into Swiss medical schools in the Faculty of General Medicine at the University of Berne. I am honored to be asked to join in this celebration by offering some reflections on Swiss Family Medicine. From modest beginnings at the University of Berne, Family Medicine now reaches across Switzerland and into all levels of Swiss medical education and qualification.

Swiss family doctors should take great pride in what has been accomplished.

Although I have not earned the right to do so, I must confess that I also take pride in Swiss Family Medicine because sometimes I feel like a Swiss family doctor. For 30 years, I have practiced in a small town in southern Wisconsin in the United States (USA). Some describe the area as the most Swiss part of America in that it contains 7 of the 15 communities in the USA with the highest percentage of Swiss Americans [1].

My practice is comprised almost exclusively of people from those 7 communities. Every day, I remind patients (and myself) to limit consumption of rösti. Many travel frequently to Switzerland to reconnect with extended family. They occasionally develop acute health problems during their travels. I have learned much about the Swiss health system through their experiences. Most instructive have been my many interactions with the Swiss health professionals, including family doctors, who cared for them.

Other experiences have also shaped my impressions of Swiss health care. As a young academic family physician, I worked closely for a year with a Swiss doctor, Dr. Hans Peyer, who joined us to learn about Family Medicine in the USA. In return, he taught me about Swiss medicine. During the years that followed, speaking and teaching commitments in Switzerland provided more opportunities to learn about Swiss medicine. Most recently, my 3 years as President of the World Organization of Family Doctors (WONCA) meant frequent travels to the World Health Organization (WHO) in Geneva. When visiting Switzerland, I set aside time to observe Swiss family doctors with their patients.

I have a favorable view of the Swiss health system. The professionals seem well trained, dedicated, and compassionate. Health care facilities and access to cutting edge technology appear to be excellent. Perhaps I am so comfortable with and confident in the Swiss system because it seems so similar to my own American system. And that is a problem, for both our countries, because we can do better.

### The problem: worse outcomes at greater cost

Switzerland and the USA are among the top 10 wealthiest countries in the world. Each has an annual per capita gross domestic

product (GDP) of about \$46,000 in US dollars (USD), adjusted for purchasing power parity [2]. Each spends more of its GDP on health care than nearly every other country – roughly 12% for Switzerland and 18% for the USA. Given our skilled professionals, excellent facilities and technologies, and considerable investment in health care services, one would expect our health care systems to be top performers when it comes to results. Yet the 2000 World Health Report rankings of the world's health care systems rated Switzerland at number 26 in the overall health of its people and 20 in the performance of its health care system [3]. The USA was even worse, at 72 and 37, respectively.

Why do these two top spending health care systems do worse than other systems that spend less? I believe it has to do with the way that health care is organized and promoted in Switzerland and the USA. The lack of integrated care models in both systems results in fragmented care. Fragmentation leads to duplication of services, wasted resources, and disparities (inequities) in service delivery. Both systems also promote the notion that the best care is the most specialized care. More narrowly focused specialists do not necessarily provide better outcomes for the general population.

A compelling body of evidence shows that health care systems built on a strong foundation of primary care have better outcomes, lower cost, and greater equity [4]. For example, when the number of primary care physicians is increased by 1 doctor per 10000 people, the death rate goes down 5% [5]. Even more impressive is that when those primary care physicians are family doctors (versus general internal medicine or pediatric doctors), the death rate goes down 9%. Conversely, when the number of other more narrowly focused specialists is increased by 1 doctor per 10000 people, the death rate goes up 2%. This is most likely because systems that emphasize primary care do more prevention and early detection of diseases. Systems that promote more specialized care have more interventions (with their risk of iatrogenic injury) and later stage diagnosis of disease (with their worse prognosis).

### The solution: affordable care and better care models

Top rated health systems find a way to assure that every citizen has financial coverage for health care services. In this regard, Switzerland was a global leader with passage in 1911 of the Federal Law on Sickness and Accident Insurance (LAMA). Modifications to the law in 1994 (LAMal) addressed the cost, quality, and equity of insurance coverage. Yet even with universal coverage, the Swiss pay out-of-pocket each year for health care about three times (USD 1650) the OECD average. Those Swiss in the lowest income quartile pay 20% of their disposable income on health care. The financial burden of health care costs on Swiss families is likely to grow given the aging population and rising prevalence of chronic, or non-communicable (NCD), diseases.

Even with universal coverage, a model of care dominated by specialists is not sustainable. Specialist-centered care is more fragmented and expensive, and less effective. The financial crisis of 2008 continues to remind us that in a Darwinian global economy, health care services that cost too much and deliver too little will not long endure. As WHO Director General Margaret wrote in her mes-

1 Richard Roberts, MD, JD, FFAFP, FCLM, FRCGP (Hon), FRACGP (Hon), is Professor of Family Medicine at the University of Wisconsin, USA and was President of the World Organization of Family Doctors (WONCA), 2010-2013.

sage for the 2008 World Health Report [6], "Primary health care also offers the best way of coping with the ills of life in the 21st century: the globalization of unhealthy lifestyles, rapid unplanned urbanization, and the ageing of populations."

### The strategy: a family doctor for every Swiss family

If the solution is family doctors, how has Family Medicine advanced in Switzerland over the past 30 years? The progress in academia has been substantial, with Family Medicine having a presence in all 6 Swiss medical schools. More needs to be done. Every Swiss medical student should have a clinical experience in Family Medicine [7]. Every Swiss medical school should have a department and professors of Family Medicine. These expectations are about more than trying to ensure that every Swiss physician has a sufficient understanding of Family Medicine (or Pediatrics or Surgery). They are also about raising the visibility and prestige of Family Medicine as a career choice for young physicians. In Switzerland and the USA, only 10% of medical students choose to be family doctors. This is not enough to provide the primary care capacity needed, especially given the fact that nearly one third of family doctors in both countries are within several years of retirement. More young physicians will choose to become family doctors when they see the discipline as professionally satisfying, personally fulfilling, appropriately compensated, and sufficiently respected [8]. Achieving these objectives will require a major restructuring of the Swiss health system and a re-orienting of Swiss culture. Permit me to offer below some recommendations based on my experiences with Family Medicine in Switzerland and around the world.

### Making the next thirty years even better

#### 1. Start out right.

Swiss Family Medicine residents spend too much of their training time in hospital, especially since they are unlikely to practice there later. Focus residency training more on the skills actually needed by Swiss family doctors.

#### 2. Get connected.

Swiss family doctors are too disconnected to take advantage of the power of their numbers. Their purchasing and negotiating power will increase if they link themselves through cooperatives or virtual groups. Swiss family doctors should all work off a common electronic health record platform that allows them to connect with each other and to conduct meaningful community-based research. Initiatives like the FIRE project are an excellent step in the right direction [9].

#### 3. Promote continuity and comprehensiveness.

What makes family doctors valuable is our relationship with our patients and the wide range of services we provide. When we limit our patients' access to us ("I'm only available 2 days a week") or limit what services we offer ("I only take care of adults or chronic diseases or whatever"), we also limit our value and impact on health outcomes. The successful family doctors of tomorrow will figure out new models of care delivery (e.g., videoconferencing,

texting) that will keep them virtually and continuously accessible while balancing personal and family needs [10]. They will provide the widest range of services using new technologies (e.g., point of care testing and imaging). In better performing systems, like the Netherlands or the UK, more than 90% of health system encounters take place in the primary care setting [11].

#### 4. Shout it out.

Family doctors tend to be too modest and quiet. We need to communicate to medical students, patients, thought leaders, and policy makers our tremendous value to the health of the people and communities we serve. We have a great story to tell. Let's make sure it gets told.

Family Medicine has made considerable progress in its 30 year ascent up the mountain called Swiss health care. It is appropriate that we should rest for a moment, celebrate the hike, and enjoy the view. Tomorrow we must rope ourselves together and get back on the path knowing that we have an even more challenging climb if we are to reach the summit.

### References

- 1 [http://en.wikipedia.org/wiki/Swiss\\_American](http://en.wikipedia.org/wiki/Swiss_American)
- 2 OECD-WHO Reviews of Health Systems: Switzerland 2011. OECD Publishing, Paris, 2011. <http://dx.doi/10.1787/19789264120914.en>.
- 3 The world health report 2000: health systems: improving performance. World Health Organization, Geneva, 2000.
- 4 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Quar.* 2005;83:457-502.
- 5 Shi L, Macinko J, Starfield B, Wulu J, Regan J, Politzer R. The relationship between primary care, income inequality, and mortality in US states, 1980-1995. *J Am Board Fam Pract.* 2003;16(5):412-22.
- 6 The world health report 2008: primary health care now more than ever. World Health Organization, Geneva, 2008.
- 7 Buddeberg-Fischer B, Klaghofer R, Stamm M. Family physicians in Switzerland: transition from residency to family practice. *Fam Med.* 2011;43(1):29-36.
- 8 Buddeberg-Fischer B, Klaghofer R, Stamm M, Marty F, Dreiding P, et al. Primary care in Switzerland: no longer attractive for young physicians? *Swiss Med Wkly.* 2006;136(27-28):416-24.
- 9 Chmiel C, Bhend H, Senn O, Zoller M, Rosemann T, FIRE Study Group. The FIRE project: a milestone for research in primary care in Switzerland. *Swiss Med Wkly.* 2011;140:13142. doi:10.4414/smw.2011.13142.
- 10 Huber CA, Rosemann T, Zoller M, Eihler K, Senn O. Out-of-hours demand in primary care: frequency, mode of contact and reasons for encounter in Switzerland. *J Eval Clin Pract.* 2011;17(1): 174-9. Doi 10.1111/j.1365.2753.2010.01418.x. Epub 2010 Sep 12.
- 11 Kringos DS. The strength of primary care in Europe. NIVEL, Utrecht, 2012.

### Correspondence:

Richard Roberts, MD, JD  
 Professor of Family Medicine  
 University of Wisconsin  
 1121 BellWest Blvd  
 Belleville, WI 53508  
 USA  
 Richard.Roberts[at]fammed.wisc.edu