Mental health care across two nations – Switzerland and the United States of America

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Summary

The United States of America and Switzerland are among the world’s wealthiest countries, with high health care spending per capita. This review presents an overview of the health care systems of both countries with a special focus on mental health care, including psychiatric outpatient treatment, psychiatric inpatient hospitalisation, day treatment centres, residential treatment centres and substance abuse treatment. The largest difference between the two countries is that Switzerland has mandatory universal health insurance, more regulation over the health insurance companies and negotiated costs of treatment. As the two countries are in the process of adjusting their health care policies and funding, they could benefit from each other’s experiences, models and mistakes made in the past.

Key words: mental health care; psychiatric inpatient; psychiatric outpatient; Switzerland; United States of America; involuntary commitment; health insurance; health care policy; funding; substance abuse treatment

Introduction

Mental health is a complex construct and can be defined in multiple ways [1]. It is referred to as a state of emotional and psychological well-being in which a person is able to meet the demands of everyday life and function in society, and it is included in the World Health Organisation’s definition of health [2]. Mental health disorders encompass mood disorders, psychotic disorders, anxiety disorders, dementia, organic disorders, eating disorders, attention deficit disorders, personality disorders and substance abuse disorders. Throughout the world, access to mental health treatment and cultural perspectives of mental health disorders vary greatly [3]. It is the goal of this review to give an overview of mental health care in the United States of America (U.S.) and Switzerland, two countries that have similar diagnostic criteria, modes of treatment and medications, but differ in accessibility and quality of treatment, as a result of general differences in the health care systems.

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Health care system – Switzerland

Switzerland is a confederation of 26 cantons with a population of approximately 8 million, located in Central Europe [4]. Cantons are similar to states, in that they are sovereign in all matters not specifically designated the responsibility of the Swiss Confederation. In 2010, the health care spending per capita was 5,270 USD (adjusted for costs of living), and 11.4% of Gross Domestic Product (GDP) was spent on health care [5].

Under the 1996 Health Insurance Law, all Swiss residents are mandated to purchase statutory health insurance (SHI) from competing companies [6]. Residents can choose from about 80 different private insurance companies [7]. Insurers are required to offer a minimum annual deductible of 300 CHF (248 USD) [5]. Enrolled patients pay 10% co-insurance for all outpatient services, excepting a 20% charge for brand name drugs [8], and a 15 CHF copayment per inpatient day. Copayment charges are waived after an enrollee reaches 700 CHF in a given year [9]. Insurance policies are usually purchased by the individual and are not sponsored by employers. The average annual premiums in 2012 for adults varied by canton, but ranged from 3,510 CHF (2,907 USD) to 6,005 CHF (4,973 USD) [5]. If an individual is unable to pay the required premium, the federal government and the cantons provide income-based subsidies to the individuals or households [10].

The mandatory SHI is regulated by law and supervised by the Federal Office of Public Health (Bundesamt für Gesundheit, BAG) [11]. SHI benefit packages cover most general practitioner and specialist services, an extensive list of pharmaceuticals, physiotherapy, some preventive measures, and outpatient and inpatient services. Although inpatient out-of-cantonal services are covered in the case of medical need, many residents purchase voluntary health insurance (VHI) for nationwide coverage of inpatient care. Residents are also able to purchase basic coverage with a managed care insurer, such as a health maintenance organisation, independent practice associations, or fee-for-service plans with gate-keeping provisions. In 2010, 46.9% of residents enrolled in managed care plans [5].

In addition to the mandatory basic health insurance, residents may purchase complementary and supplementary VHI to cover services not covered by the basic packages. These services include improved accommodation and free choice of hospital doctor, such as the most senior physician. The premium health insurers can vary benefit packages, premiums and refuse enrollment to applicants based on
medical history. These complementary insurances are regulated by the Swiss Financial Market (Finanzmarktaufsicht, FINMA) [11].

Health care system – United States of America

The United States of America is a constitution-based federal republic, composed of 50 states and a population of approximately 315 million [12]. In 2010, the health care spending per capita was 8,233 USD and 17.6% of GDP was spent on health care[5]. Health insurance is not universal, but instead composed of multiple private and public insurers [13].

In 2010, 64% of U.S. residents received coverage from private insurers, with the majority (55.3%) receiving it through their employer. Fifteen percent were covered under Medicare, a federal social insurance programme for individuals over the age of 65 years and some disabled under the age of 65. Medicare is administered by the federal government and financed through a combination of payroll taxes, premiums and federal general revenues [14]. Twelve percent of U.S. residents were covered under Medicaid, which is a joint federal-state health insurance programme for certain low-income populations. Medicaid is administered by the states, which must operate within federal guidelines. States receive matching funds from the federal government in varying amounts. A select number of people qualify for both Medicare and Medicaid services and are thus included in both of the above quoted percentages. One percent of residents were insured under military health care programmes. The remaining 16%, almost 50 million residents, were uninsured. Among those who were insured, 29% were “underinsured,” with high out-of-pocket expenses [5, 15].

Private health insurance is provided by around 500 non-profit and for-profit health insurance companies [5]. Most U.S. residents who have private insurance, receive it from voluntary tax-free premium contributions shared by employers and employees on an employer-specific basis. Given the wide variety of private and public insurance coverages, it is difficult to determine average premiums, deductibles and copayments. Different insurance policies offer different packages; therefore, there is no basic standard of coverage for outpatient and inpatient services, medications and preventive measures. In general, private insurers pay higher rates to providers than rates paid under public programmes, leading to wide variations in payment rates among payment sources [16].

Psychiatric outpatient treatment

In Switzerland, a mix of public and private facilities provide outpatient psychiatric treatment [17]. Patients are responsible for a 10% copayment for outpatient services, 10% copayment for generic prescriptions and 20% copayment for brand name medications. Almost all Swiss residents are insured with the basic insurance and have equal access to outpatient treatment within their canton. Outpatient psychiatric service fees are calculated using the TARMED tariff system, which determines the rates for different procedures [18]. Physicians are reimbursed for services rendered at similar rates and therefore there is hardly any preferential treatment of patients based on their insurance [19]. Unlike the U.S., even continuous psychotherapy is covered if indicated.

In the U.S., outpatient mental health care is provided by both public and private facilities. Copayments, medications, access to outpatient treatment and access to specific providers vary greatly depending on the health insurance plan [20]. Individuals without insurance usually do not have access to outpatient treatment unless they pay out-of-pocket for the clinician visit and medications, which many uninsured patients are unable to do. Physicians and clinics often only treat patients who have certain insurances with preestablished contracts. This can lead to preferential treatment of patients who have insurance policies with higher payment rates for services rendered [16]. There is often a limit on the number of outpatient visits allowed per year or a decreased payment rate after a determined number of visits. Lack of access to outpatient care due to lack of insurance could lead to increased rates of inpatient hospitalisation. In 1996, the Mental Health Parity Act (MHPA) was signed into law in an attempt to prohibit insurers or health care plans from discriminating between coverage offered for mental illness and physical disorders and diseases. In 2008, the implemented Mental Health Parity and Addiction Equity Act (MHPAEA) tried to fill the loopholes and include substance abuse treatment [21].

Psychiatric inpatient hospitalisation

In Switzerland, most acute and chronic inpatient hospitalisations occur at psychiatric hospitals. Length of stay in 2005 was over 30 days for an average psychiatric inpatient hospitalisation [22]. Inpatient hospitalisation fees are mostly paid for by the canton and the basic health insurance plans. The percentage paid by the canton varies by canton. The rest is covered by the basic insurance plans and the patient pays a small percentage until the maximum deductible is reached. Inpatient hospitalisations are covered by the SII as long as medically indicated [19]. The cost of inpatient psychiatric hospitalisation is calculated in the form of per diem rates [23, 24].

Psychiatric hospitalisations in Switzerland have a strong emphasis on the comprehensive treatment of the patient as a whole and not just their psychiatric illness. This emphasis is promoted by rehabilitation and reintroduction back into the community [17]. There are many complementary forms of therapy offered such as individual psychotherapy, group therapy, exercise therapy, art and music therapy. Patients are encouraged to maintain their autonomy. There is a trend towards more open units at the psychiatric hospitals, meaning that the patients are able to leave the unit at any time [25].

In the U.S., acute psychiatric hospitalisations usually occur at regular hospitals that have designated psychiatric units. Length of stay varies between 4–10 days on most general psychiatry inpatient units [26, 27]. The rates for acute inpatient hospitalisation are either in the form of per
who have insurance or certain types of insurance with pre-existing contracts. The payment rates are negotiated between the hospital and insurance companies. If a patient does not have insurance, the cost of the hospitalisation is absorbed by the hospital. The patient will be sent a hospital bill, but most patients without insurance are not able to pay the high costs of inpatient hospitalisation. Patients who do not have health insurance, but qualify for Medicaid, can apply for Medicaid and have the hospitalisation stay retroactively paid [30–32].

Although patients without insurance cannot be refused treatment, there can be preferential admission of patients who have insurance or certain types of insurance with pre-existing hospital contracts. State psychiatric hospitals have both acute and chronic psychiatric units. Most patients who are in the state psychiatric hospitals for chronic hospitalisation have Medicaid, because most insurance policies do not cover hospitalisation for extended lengths of time [33]. Resources are limited at the state psychiatric institutions, leading to fewer rehabilitative and therapeutic services being available. Most psychiatric units are locked, meaning that patients are not able to leave the unit without permission [34, 35].

**Day treatment programmes**

In Switzerland, day clinics and treatment programmes include many therapeutic groups such as art therapy, cognitive training, psychotherapy, movement therapy, cooking, nutrition, outdoors sports and home skills groups [36]. The group sizes are small and the staff consists of trained professionals, often nurses, who provide intense individual treatment. Some programmes also include specific groups for the elderly and rehabilitation groups for dementia [37]. Day treatment programmes are paid for by the basic health insurance and/or the canton, as long as psychiatrically indicated. If a person needs treatment in a day treatment programme, there are openings available and there are very few barriers to treatment.

In the U.S., there are decreased day treatment programmes and openings available owing to decreased funding from the states. Day treatment programmes provide rehabilitative services and groups run by trained staff. The groups are often focused on skills training, group psychotherapy, art therapy and exercise therapy. Treatment is limited by availability of programmes, openings and insurance coverage [38, 39].

**Residential treatment centre**

In Switzerland, residential treatment centres (RTCs) are mainly funded by the canton, individual insurance and disability insurance. There is a strong emphasis on rehabilitation and work. Most patients chose to work at various jobs available at the centres such as gardening, agriculture, landscaping, creating stationary, jewelry making, sewing, woodworking, stonemasonry and production of small electronics. The jobs are allocated on the basis of the level of functioning of each patient and of patient interest. Many of the products are sold in the community or to companies, and the profits go back to the RTC. These jobs help re-integrate the patients into the community. There are also group therapy and skills training groups available. Patients usually have their own rooms and the general accommodations are equal to the standard of living in the community. There are limited places available in the residential treatment centres [40].

In the U.S., federal and/or state funding, government insurance, social security disability or private organisations usually fund residential treatment centres. Although each facility varies, many facilities offer therapeutic groups and rehabilitative services, which often have a specific focus such as substance abuse, a specific disorder or age category [41, 42]. Patients have access to social workers, who can help guide them on obtaining employment or further education [43]. The standard of living in each RTC varies significantly. There are limited places available in the residential treatment centres.

**Substance abuse treatment**

Because of universal health insurance, patients with substance abuse disorders in Switzerland have access to treatment with all the above forms of psychiatric treatment. Inpatient detoxification and inpatient rehabilitation are covered by the basic health insurance policies as long as psychiatrically indicated [44]. In addition to methadone maintenance treatment programmes and buprenorphine, Heroin-assisted treatment (HAT) is available. In HAT, patients are prescribed injectable heroin, which must be injected at the treatment facility [45–48].

Although many forms of treatment for substance abuse disorders are available in the U.S., access to treatment is limited by insurance and ability to pay for inpatient rehabilitation. In 2008, the implemented Mental Health Parity and Addiction Equity Act (MHPAEA) tried to improve the coverage for substance abuse treatment [21]. Health insurance policies vary on the degree of coverage for substance abuse treatment, and some policies will only cover certain substances, such as alcohol but not illicit drugs. Many substance abusers are unemployed because of their substance abuse and therefore many are uninsured or are insured by Medicaid. Patients who do not have insurance, do not have access to substance abuse treatment, inpatient rehabilitation or medications such a methadone and buprenorphine [49, 50]. There are no Heroin-assisted treatment programmes in the U.S. Patients who are in acute withdrawal will be treated if they go to an emergency department and are admitted to a hospital. If the patient is uninsured, the cost of treatment is absorbed by the hospital or the patient can apply for Medicaid if eligible [32].
Involuntary commitment

In Switzerland, the prevailing legal norms regarding involuntary commitment have been revised and the new laws have been in effect since January 2013 [51]. In order to initiate such a procedure, debility (mental illness, mental retardation or neglect of basic human needs) has to be determined. The patient has to be in need of protection, which can only be achieved by placement in an appropriate facility, including psychiatric clinics, hospitals or residential facilities. The implementation of federal legislation falls to the cantons, which designate qualified physicians who are entitled to pronounce such commitment. A duration of an involuntary commitment is limited to as long as the patient’s condition requires further treatment in an involuntary inpatient setting, not exceeding six weeks [52].

In the U.S., the state laws determine the way involuntary commitment is implemented. Procedures vary from state to state, but have to adhere to the civil rights laws under the Fourteenth Amendment of the U.S. constitution [53]. The U.S. Supreme Court case O’Connor v. Donaldson was a landmark in mental health law because it limited involuntary treatment and hospitalisation by requiring a court order for long-term commitment [54]. In order to be involuntarily hospitalised, a patient has to exhibit behaviours that are a danger to himself or others. Initiation of an involuntary examination is usually done by a health care professional, but procedures vary depending on different state laws [55].

Discussion

The U.S. and Switzerland are among the world’s wealthiest countries, with high health care spending per capita and a high percentage of the GDP spent on health care. Neither country has socialised medicine, but instead has independent health insurance companies that are allowed to compete on price and services covered. As described in this review, the actual treatment of psychiatric patients is similar in that both countries have comparable approaches using various modalities to help people with mental health issues. The largest difference between the two countries is that Switzerland has mandatory universal health insurance and more regulation over the health insurance companies, and negotiated costs of treatment.

The differences in health insurance policies and large number of uninsured or underinsured lead to significant health disparities within the U.S. Patients with mental health disorders are at higher risk of experiencing these disparities because many patients with chronic mental illnesses are unable to maintain employment and therefore are uninsured or are insured with Medicaid or Medicare. Uninsured patients cause a strain on the health care system because the treatment costs of these patients are often absorbed by the hospitals and subsidised by the state or federal government. These patients often do not have access to outpatient services or medications and therefore seek treatment when they are decompensated or more ill, requiring more high-cost acute inpatient treatment. It remains to be seen if the implemented Patient Protection and Affordable Care Act will have the impact to address these disparities [56].

Switzerland is about to implement a major change in the reimbursement policies for psychiatric inpatient treatment. Based on the 2007 revision of the law regarding hospital financing, Switzerland will be changing to a performance-oriented reimbursement method [57]. The organisation Swiss Diagnosis Related Groups (SwissDRG) has a task force working on a new tariff system called TARPSY, which will be based on psychiatric cost groups (PCGs) [58]. It remains to be seen what impact this change in policy will have on mental health care in Switzerland.

Conclusion

We think that the U.S. will benefit from implementing Patient Protection and Affordable Care Act to ensure that all individuals have access to health services. Although this would increase an individual’s general access to treatment, it would not be enough to solve the problem of differential treatment of patients based on insurance and general health disparities. As in the Swiss health care system, there should be more regulation of the privatised health insurance policies, requiring that certain basic services are covered. There should also be more regulation of the negotiated costs of treatment and regulation of the costs of pharmaceutical medications. The system in the U.S. accommodated for differences in psychiatric care by establishing a varied reimbursement system. It remains to be seen if Switzerland will make similar choices, which could lead to a split between general medical and mental health care. Both medical and mental health policy makers in Switzerland should remember the history of the U.S. as they build more efficient mental health systems [20]. Changes in the health care system of both countries are important for all individuals, but more so for the chronically mentally ill, who are among of the most vulnerable individuals in society.

References
