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« Le système de santé tchèque par rapport à l'Europe – à la recherche de la stabilité financière »

Salle du Parlement de la République Tchèque
Prague

The Swiss Health System: A Summary Description

Health System Structure

- ***Objectives*** – Beginning in 1996, Switzerland's revised Health Insurance Law (known as "LAMal") replaced its previous fragmented, regionally-administered system with a *national mandatory health insurance system* that seeks to: 1) promote equal coverage regardless of risk, 2) contain rising health care costs, and 3) guarantee high-quality basic health services.
- ***Organization*** – The Swiss health care system is based on a *managed competition* structure with an *individual mandate* requiring Swiss residents to purchase private health insurance coverage offered by competing insurers. Those who do not purchase the "compulsory basic health insurance" are assigned to an insurer and face a surcharge. Public employees with military insurance and non-Swiss citizens with equivalent coverage are exempt.
- ***Governance*** – Responsibility for regulating the Swiss health system is divided between the federal government ("the Swiss Confederation"), 26 Swiss state governments ("cantons"). The cantons delegate some of their responsibilities to municipalities. The system is characterized by considerable decentralization of power, a high degree of autonomy at the local level, and slightly different health systems in each canton. *Federal responsibilities* include oversight of the health insurance system. *Cantonal responsibilities* include playing a key role in provision and financing of health services. The federal government and cantons share policy making, regulatory, and health system monitoring responsibilities.
- ***Participation*** – Insurers seeking to provide compulsory health insurance are required to register with the Swiss Federal Office of Public Health, which oversees the insurance system, and must meet certain requirements. In 2003, there were 93 registered insurers in Switzerland offering compulsory health insurance, which covered about 7.4 million people (71% adults, 21% children, and 8% students in training). Three-quarters of all residents are

covered by 15 large carriers, including one insurer that has 15% market share. The number of health insurers in each canton ranges from 39 to 65.

- ***Benefit Mandates*** – By law, insurers offering compulsory health insurance policies must offer a *uniform benefit package* to everyone regardless of risk (chronic conditions, sex, disability, age, etc.) The mandated package of compulsory health benefits has increased over time, and is fairly comprehensive – including coverage for inpatient hospital care in shared wards, ambulatory care, disease prevention and health promotion, accidents, maternity, pharmaceuticals, medical devices, long-term care, psychiatric services, and complementary medicine. Covered benefits must be effective, efficient, and appropriate.
- ***Plan Differentiation*** – The Swiss health insurance system allows for some differentiation among compulsory health plans to give consumers choice. *Ordinary insurance plans* feature a standard premium and mandated standard annual deductible, and free choice of provider. In the case of *insurance plans with choice of deductible*, insurers can vary the annual deductible between the standard deductible and a legislated upper limit. Insurers can also offer *insurance with limited choice of providers*, (restricted provider network HMO-type model, or general practitioner gatekeeper network model). Insurers can also offer five-year contracts for "*bonus insurance*" policies in which the initial premium paid in the first year is 10% higher than for ordinary compulsory basic health insurance, but annual premium reductions occur if no claim is made during the period.
- ***Premiums*** – By law, insurers are allowed to set different per capita premiums for each type of compulsory insurance policy they offer in each of the cantons where they operate (with lower premiums for children and college students). The premiums are *community-rated* (the same for everyone an insurer covers within a given canton or subregion of a canton, regardless of risk). Insurers compete based on differences in the premiums they set for the same benefits within a given canton. By law, insurers are not allowed to earn profits from the mandated benefits package, and the Swiss federal government has the power to require an insurer to reduce any proposed premiums that are too high. The average family of four pays $680 in premiums for basic coverage ($8,167 annually). The federal and cantonal governments subsidize compulsory health insurance for low-income individuals.
- ***Cost-Sharing –*** In addition to the deductible, there is 10% coinsurance on the price of all services covered by compulsory health insurance, up to a maximum upper limit per year, as well as copayments for certain services.
- ***Consumer Choice*** – Consumers are guaranteed free choice of any health insurer and type of compulsory health plan within their canton of residence, and can change their compulsory insurance company twice a year. Most patients (90%) are enrolled in compulsory health insurance plans that offer free choice of providers within their canton.
- ***Risk Adjustment*** – Post-enrollment risk adjustment based on age and sex is conducted to avoid penalizing insurers with high-risk enrollees. Under this system, which is administered by a joint organization that was established by the registered insurers, insurers with relatively costly risk pools are compensated by carriers with low-cost risk pools.
- ***Provider Reimbursement*** – The reimbursement system is characterized by *uniform prices*. Cantonal and intercantonal associations of health insurers negotiate reimbursement with provider associations annually. For example, the relative weights and points associated with the fee schedule that is used to pay for physician and outpatient hospital services is negotiated annually at the cantonal level. Conversely, there is considerable variation in

hospital reimbursement mechanisms across cantons, ranging from per diems to case-based payments. The negotiated fee schedules are reviewed and approved by the cantonal governments. Additionally, the federal government sets maximum prices for pharmaceuticals and medical devices through Swissmedic.

- ***Provider Networks*** – By law, insurers are required to reimburse services delivered by *any willing provider* authorized to practice within the context of LAMal; apart from doctors in managed care settings, insurers do not have freedom to contract separately. The cantons are responsible for licensing providers, as well as for developing lists limiting the number of hospitals and nursing homes that can be reimbursed under compulsory insurance (based on planning criteria).
- ***Supplemental Coverage*** – In addition to the basic insurance coverage, as described above, consumers have the option to purchase *supplementary insurance*. These plans are voluntary and can reimburse for services not covered by the compulsory health insurance, as well as for other amenities. About one in four residents have one of the major supplementary policies, which cover superior inpatient accommodations. Insurers are allowed to profit from the sale of supplementary benefits, provide risk-adjusted premiums, and refuse to enroll high-risk individuals.
- ***System Effectiveness*** – The Swiss population's health status is among the highest in Europe. There is generous benefit coverage, and consumer satisfaction and perceptions of quality of care are high. The country has achieved universal health insurance, and there are few inequities in access to care.
- ***System Limitations*** – The cost of the Swiss health system largely outstrips the country's sluggish GDP growth, leading to perceptions that the value for money invested in the health system is low. There is an imbalance between prevention and cure. Quality improvement initiatives are uncoordinated (relying largely on professional self-regulation) and there are few quality indicators. Additionally, there are horizontal inequities in health financing and premium growth will raise financing pressures.
- ***Current Reform Objectives –*** *Cost control* is a primary objective of various Swiss health system reforms that are currently under consideration. The Swiss population recently rejected a proposal to institute a single payer system for compulsory health insurance. An additional concern relates to *improving centralization and coordination of certain functions*, such as preventive care and development of quality measures. *Hospital financing reform* is of particular interest. An initiative is currently underway to establish a uniform national DRG system for hospital payment. Additionally a draft bill proposes to encourage competition by gradually removing cantonal boundaries that limit patient mobility.

Health Financing

- ***Health Expenditures*** – In 2004, total health expenditures in Switzerland were 11.5% of gross domestic product (GDP) – higher only than the U.S. (15.4%). Switzerland's per capita total health expenditure was $5,572 in 2004. Private spending accounted for 41.5% of Switzerland's total health expenditures in 2004.
- ***Funding Source*** – In 2003, about a third (32.7%) of Swiss health expenditures are financed through the *basic compulsory health insurance policies* that citizens purchase individually (not through an employer), and for which they pay a per capita premium to the insurer.

Another third (31.6%) is funded by *direct payments* made by individuals out of their own pockets. The remainder is paid by *government subsidies* (17.9%, including 12.9% in cantonal subsidies to institutional providers), *voluntary private health insurance* (9.0%), *disability and accident insurance* (7.8%), and *other private financing* (1.0%).

- ***Government Subsidies to Individuals*** – Low income families receive a means-tested government subsidy toward their insurance premiums. For people with very low incomes, the entire premium is paid directly by the municipal or cantonal authorities. These subsidies paid for through tax-financed allocations from the federal and cantonal governments. There have traditionally been large cross-canton differences in subsidy levels and eligibility, but a recent law passed in 2005 requires cantons to reduce premiums for children and students in low-income families by at least 50%.
- ***Government Subsidies to Institutions*** –Cantonal subsidies to hospitals cover the costs of investment, training and research, and a share of the costs for LAMal-covered treatments. Additionally, cantons and municipalities provide subsidies to nursing homes, in part to finance the costs of nursing care that cannot be covered by individual patients or supplementary benefits.
- ***Financing of Capital Improvements*** – The capital investment costs for public hospitals that are owned by cantons or municipalities, and publicly-subsidized hospitals are usually fully financed by cantonal tax revenues.

Health Care Delivery

- ***Ambulatory Health Care Delivery*** – Ambulatory health care is mainly delivered by general practitioners and specialists in private practice. The federal government has no planning authority for outpatient care. There is considerable variation in the density of doctors per inhabitant between urban and rural cantons.
- ***Secondary and Tertiary Health Care Delivery*** – Most Swiss hospitals are either publicly owned by cantons and municipalities or publicly-subsidized. Private hospitals that do not receive any financial government subsidies accounted for one-fifth of the country's hospital beds in 2003. Up-to-date services are widely available.
- ***Resource Capacity*** – The number of physicians per 1,000 population is 3.6. The number of nurses per 1,000 population is 10.8. There are 57 hospital beds per 10,000 population. There are 14.4 MRI units and 18.2 CT scanners per 1,000,000 population.
- ***Waiting Times*** – In 1990, a survey of general practitioners found that 16.1 percent of patients waited more than 12 weeks between a specialist visit and a surgical intervention. A recent OECD paper indicated that waiting times are not viewed as a policy concern in Switzerland.

Sources: OECD Reviews of Health Systems: Switzerland, Paris, France, October, 2006. Health Care Systems in Transition: Switzerland, 2000,European Observatory on Health Care Systems. Swiss Federal Office of Public Health web site (http://www.bag.admin.ch/themen/krankenversicherung/index.html?lang=en), accessed September 2007. Explaining Waiting Times Variations for Elective Surgery across OECD Countries, Siciliani and Hurst, OECD Health Working Paper, 2003

Health Spending, Resources, and Utilization by Country - Comparison

Switzerland

Indicator	Value (year)
Total Health Expenditures as a Percentage of Gross Domestic Product	11.5% (2004)
Per Capita Total Health Expenditures at Average Exchange Rate (U.S.$)	$5,572 (2004)
Private Health Expenditures as a Percentage of Total Health Expenditures	41.5% (2004)
Physicians (density per 1 000 population)	3.61 (2002)
Nurses (density per 1 000 population)	10.75 (2000)
Hospital beds (per 10 000 population)	57.0 (2004)
Magnetic Resonance Imaging (MRI) Units (density per 1,000,000 population)	14.4 (2005)
Computed Tomography (CT) Scanners (density per 1,000,000 population)	18.2 (2005)
Cerebrovascular Disease Discharges (per 100,000 population)	207 (2005)
Diabetes Mellitus Discharges (per 100,000 population)	68 (2005)
Respiratory System Disease Discharges (per 100,000 population)	856 (2005)

United States of America

Indicator	Value (year)
Total Health Expenditures as a Percentage of Gross Domestic Product	15.4% (2004)
Per Capita Total Health Expenditures at Average Exchange Rate (U.S.$)	$6,096 (2004)
Private Health Expenditures as a Percentage of Total Health Expenditures	55.3% (2004)
Physicians (density per 1 000 population)	2.56 (2000)
Nurses (density per 1 000 population)	9.37 (2000)
Hospital beds (per 10 000 population)	33.0 (2003)
Magnetic Resonance Imaging (MRI) Units (density per 1,000,000 population)	26.6 (2004)
Computed Tomography (CT) Scanners (density per 1,000,000 population)	32.2 (2005)
Cerebrovascular Disease Discharges (per 100,000 population)	235 (2005)
Diabetes Mellitus Discharges (per 100,000 population)	204 (2004)
Respiratory System Disease Discharges (per 100,000 population)	1,213 (2004)

Sources: World Health Organization Statistical Information System, June 22, 2007; OECD Health Data 2007 - Version: July 07