OECD Reviews of Health Systems
Switzerland 2011
© OECD/World Health Organization 2011

Chapter 2

Health Insurance

This chapter examines the health insurance system of Switzerland. Section 2.1 outlines the general trends in Switzerland's health insurance market, including the role of private supplementary health insurance. Section 2.2 discusses health financing equity issues and the financial burden faced by households by assessing premium level differences, the premium subsidy mechanism and out-of-pocket payments. In Section 2.3, the extent of competition in the health insurance market is discussed, with a focus on the risk equalisation mechanism and managed care plans. Finally, Section 2.4 reviews the current reform agenda and examines proposals on the surveillance of the insurance market and the development of integrated care networks.

In 1996, Switzerland implemented the Health Insurance Law (LAMal), which sought to achieve three main objectives: strengthening solidarity in the Swiss health system, containing health spending, and guaranteeing high-quality coverage. This chapter analyses the evolution of health insurance coverage and the health insurance market fifteen years after the introduction of LAMal.

2.1. General trends in the Swiss health insurance market

The Health Insurance Law (LAMal) was adopted in 1994 and sought to implement mandatory coverage by health insurance for all Swiss residents in 1996. The Swiss health insurance market relies on regulated competition based on a set of key principles: health insurers cannot make profits on contracts for mandatory health insurance,[1] consumers have free choice of insurer, and insurers are compelled to accept any applicant. The benefit basket covered by health insurance is defined at national level for all insurees and health insurers must offer the same premium to all enrolees with the same health insurance contract provided they are in the same age category (0-18; 19-25; 26 and above) and same region. Health insurers can propose optional health insurance contracts which provide lower premiums in exchange for higher deductibles ("franchise à option") or "managed care" contracts. Insurers can also offer "bonus" contracts, where insurees receive premium reductions if they do not claim any reimbursement from their insurance fund. Finally, governments provide subsidies to certain groups of people to help reduce the cost of health insurance premiums.

Swiss health insurance offers comprehensive coverage of health care

Switzerland's health insurance benefit basket includes a wide range of goods and services for curative and rehabilitative care. In principle, all medical treatments and diagnostics prescribed by doctors and dispensed by licensed professionals are covered, unless they are explicitly excluded from the benefit basket. In contrast, medicines and other medical goods must be included in a positive list to be eligible for reimbursement. Additional benefits have recently been added: medical psychotherapy has been reimbursed since 2009. Following a referendum in the same year, the Federal Council decided that five alternative medicines will be reimbursed (anthroposophic medicine, homeopathy, neural therapy, herbal medicine and Chinese traditional medicine) for a six year period from January 2012, provided that they are delivered by physicians. These alternative medicines will be evaluated over this period of time. Mandatory health insurance also covers the costs of medical care provided to patients receiving long-term care in institutions or at home.[2] Dental care and prosthesis have always been excluded from this benefit package, and vision products were excluded in January 2011. However, dental care and vision products are reimbursed when responding to specific medical needs (such as a chronic health condition).

Though all goods and services covered by LAMal are required to meet criteria of effectiveness, appropriateness and value-for-money (Art. 32 of LAMal), most services are not formally assessed. The exception to this is pharmaceuticals and some medical devices (Paris and Docteur, 2007). As such, many services are included in the benefit basket with potentially little scientifically proven value.

For most benefits covered by health insurance, tariffs are set at national level (for medical goods) or negotiated at cantonal level (for services). After paying a deductible (CHF 300 in contracts with an ordinary deductible), patients contribute to the cost of care through co-insurance rates – usually 10% of costs – up to an annual ceiling. Patients also pay additional co-payments for hospital stays (a flat daily rate, increased from CHF 10 to 15 in 2011). For medical goods other than medicines, market prices can often be higher than official tariffs, in which case patients pay the difference between the price and tariff in addition to co-payments. A selected list of preventive interventions is provided at no cost for patients; these include selected vaccines for children, mammography for women over 50, etc.[3]

Timing of reimbursements often varies depending on the type of medical services. In general, patients pay the cost of ambulatory health services (such as doctor's consultations) and are later reimbursed by health insurance funds. In contrast, hospital services are paid directly to providers by health insurance and patients' contribution to costs are paid to health insurers after receiving care.

By international standards, the benefit basket is comprehensive in terms of benefit covered, except for dental treatments and vision products (Paris *et al.,* 2010). "Rationing" has not been part of the political agenda. The level of user charges, however, is one the highest in the OECD (see Section 2.2 of this chapter).

Consumers can choose between different options for health insurance plans

Consumers cannot only choose their insurer but also between different types of health insurance plans. Ordinary contracts offer the highest level of financial protection against health care spending (*i.e.* they provide the lowest levels of deductible: CHF 300) but also have the highest level of premiums. Other forms of health insurance contracts offer lower premiums with either higher deductibles or restrictions in the choice of doctor or hospital (see Table 2.1).

Following the implementation of the Health Insurance Law in 1996, the majority of consumers (55%) opted for the ordinary health plans, 37.4% opted for plans with higher deductibles, while only 7.5% opted for plans with restrictions in providers' choice. Over the years, consumer choices have changed: the take-up of ordinary plans have been continuously declining, first to the benefit of high-deductible health plans, while the take up of plans with a restricted network of providers stagnated at 7-8%. However, since 2004, the popularity of plans with restricted choice of provider has increased dramatically, with the share of insurees choosing such plans (36.9%) now higher than ordinary plans (35.2%), high-deductible plans (27.9%) and bonus plans (0.1%) (See Figure 2.1 and OFSP, 2011a).

Consumer choice has increased at cantonal level, in spite of market concentration nationally

Increased market concentration has been observed at the national level since the implementation of LAMal: the number of insurers supplying mandatory health insurance

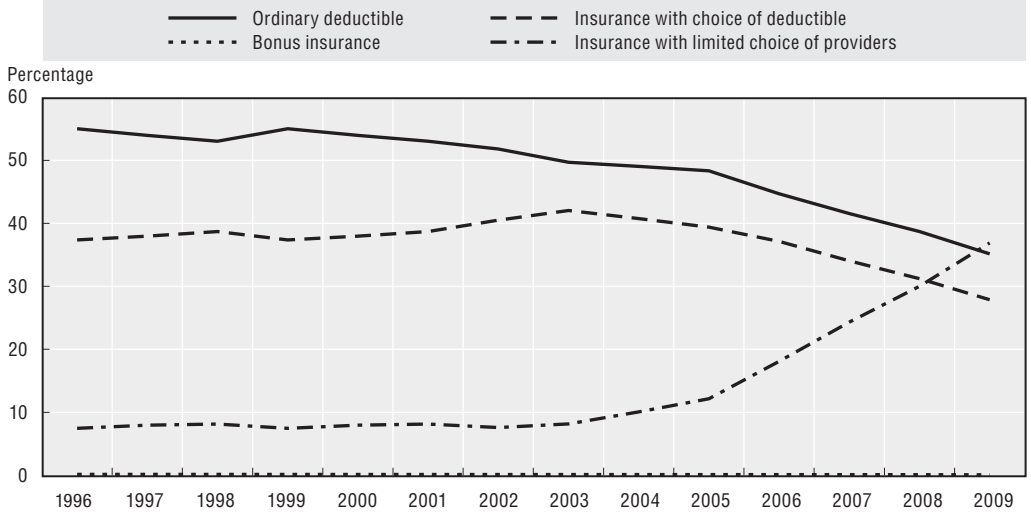
Table 2.1. **Types of insurance contracts within the mandatory health insurance (LAMal)**

	Ordinary basic health insurance	Insurance with choice of deductible	Bonus insurance	Insurance with limited choice of providers
Premium level	Ordinary premiums are set by individual insurers in each "region"[1] and three categories of population (0-18, 19-25, over 26 years).	Premium reductions can be granted up to 50% of the ordinary premium offered by the insurer but cannot exceed 70% of the difference between the deductible chosen and the ordinary deductible. *E.g.* if the deductible is 1 000, the premium reduction cannot exceed 0.70*(1 000 – 300) = CHF 490.	Annual premium reductions if no claim. The premium paid for the first year is 10% higher than ordinary insurance. Premiums can then decrease up to 45% of ordinary premium after five years.	Premiums reduced at insurers' discretion, by a maximum of 20% of the ordinary premium.
Cost-sharing[2]	Deductible: Children: No; Adults: CHF 300/year.	Menu of choices for deductibles: Children: CHF 100/200/300/400/500/600. Adults: CHF 500/1 000/1 500/2 000/2 500.	As in ordinary insurance.	As in ordinary insurance.
	Co-insurance: 10% of the costs of medical goods and services beyond deductible. 20% for brandname drugs when cheaper generics exist.	As in ordinary insurance.	As in ordinary insurance.	As in ordinary insurance, with possibility to further reduce or remove cost-sharing in plans.
	Co-payment: CHF 15 per day for hospital stays.	As in ordinary insurance.	As in ordinary insurance.	As in ordinary insurance.
	Ceiling: total amounts paid for co-insurance cannot exceed CHF 700 for an adult, CHF 350 for a child and CHF 1 000 for all children in a family.	As in ordinary insurance.	As in ordinary insurance.	As in ordinary insurance.
Choice of doctor/hospital	Free choice among doctors and hospitals agreed by health insurance, within the canton.	As in ordinary insurance.	As in ordinary insurance.	Restricted to providers participating to the network.

1. Cantons are divided in up to 3 regions for which insurers must define uniform premiums for a given plan.
2. Cost-sharing exemptions exist for pregnant women, social assistance beneficiaries and recipients of supplementary old-age and disability benefits, as well as for maternity-related care.

Source: OECD (2006); OFSP (2011a).

Figure 2.1. **Trends in the take-up of different types of health insurance plans among the insured population between 1996 and 2009**



Source: OFSP (2011a), *Statistiques de l'assurance maladie 2009*.

decreased from 145 in 1996 to 81 in 2009. Nonetheless, concentration in the Swiss health insurance market remains low by international standards: in 2008, the top 5 insurers accounted for 43% of market share, compared to 89% in Czech Republic or 94% in the Netherlands. Only Germany had a lower concentration, with the top 5 insurers accounting for 39% of market share (Paris *et al.*, 2009). However, while there was increased concentration in the number of funds, consumer choice has increased at cantonal level, with the average number of insurers operating in each canton rising from 38 in 1997 to 59 in 2011 (Franck and Lamiraud, 2009; OFSP, 2011a).

Private supplementary health insurance covers one third of the population

People can subscribe to contracts for supplementary health insurance beyond their mandatory health insurance. Under law, these contracts cannot cover benefits covered by mandatory health insurance, or cost-sharing for mandatory health insurance. Supplementary health insurers define the range of benefits covered by each contract as well as premiums. Contracts typically cover one or several of the following benefits: private rooms in hospitals, dental care, alternative medicines and cash benefits for sickness absence.

The share of the insured population holding at least one contract of supplementary health insurance was 75% in 2001, according to the Federal Office for private health insurance (quoted by Dormont *et al.*, 2009). New data suggest that 88% of enrolees held at least one supplementary insurance contract in 2007 (Lamiraud, 2011). However, private insurance for inpatient care in private or semi-private departments – allowing choice of physician and superior accommodation – makes the most significant contribution to health care financing. According to health surveys, 29.5% of people aged 15 and over held such contracts in 2007. In terms of financing, private health insurance plays a significant role in Switzerland, accounting for 8.8% of current health spending in 2009. Amongst countries in which private health insurance only acts as a secondary source of coverage (on top of a public or social insurance system), only France, Canada and Slovenia have higher levels of expenditure (respectively 13.6%, 13.4% and 13.3%).

About 1 000 different supplementary health insurance products existed in 2011. These products were offered by private insurance companies and health insurance funds, with private-for-profit health insurers holding three-quarters of the market share. All supplementary health insurance products are subject to surveillance, formerly conducted by the Federal Office of Private Insurances (OFAP) under the Law on Insurance Contracts. Following changes to legislation in 2008, the Swiss Financial Market Supervisory Authority (FINMA) is now responsible for the supervision of insurance companies, in addition to holding responsibilities for banks and other financial intermediaries (OFAP, 2008). In addition to requirements applying to all sectors supervised by FINMA (mainly related to solvency), supplementary health insurance is subject to regulations on a number of further areas. These include prior review and approval of premiums and terms and conditions of insurance and, limitations on tariff setting – tariffs should not be so low that they put solvency at risk, so high that they affect consumers and tariffs should not discriminate between policyholders beyond what is actuarially justifiable. Technical reserves are also required to avoid insolvency, and must be evaluated and taken into account in premium setting. Insurers should also be transparent in their accounting (FINMA, 2010).

Insurees often purchase social health insurance and supplementary health insurance from the same insurer (see Section 2.1). This situation is considered to work counter to transparency and fair competition in health insurance markets for social insurance. The fact that health insurance funds use the same infrastructures (offices, personal) for activities in both sectors does not favour transparency of administrative costs, and also raises issues in terms of confidentiality – for example, information on health status obtained through supplementary health insurance contracts (questionnaires, exams) can be used to manage social health insurance contracts and to select risks. On the other hand, opponents of further reforms argue that a streamlined process for claims is simpler for users and that separate claim processes would increase total administrative costs, especially the administrative costs for social health insurers (who are partly cross-subsidised by supplementary health insurance). A law is currently being proposed with the objective of more clearly separating the activities of social and supplementary health insurance.

2.2. The 1996 Health Insurance Law has strengthened solidarity, but health financing inequalities remain

Switzerland has reached universal coverage

Health insurance coverage has been mandatory for all residents in Switzerland since 1996. It is also mandatory for non-residents with a regular and income-generating activity in Switzerland and non-residents employed by a company whose headquarters are located in Switzerland. Cantons are responsible for the enforcement of mandatory health insurance and cantonal authorities are required to subscribe any resident who has not complied with this obligation to a health insurer.

Only few residents do not pay health insurance premiums and even fewer are not registered. In 2006, the Law on Health Insurance was amended in order to discourage negligent defaulters (*i.e.* those who forgot to pay). Since then, health insurers have been required to refuse payment for health care bills presented by negligent defaulters until they have fully recovered unpaid premiums and related interests. As a result of this, health professionals have sometimes denied treatment, though not in case of emergency. According to the OFSP (2011a), more than 366 000 insured people have been sued by health insurers for unpaid premiums in 2009 and health insurance payments have been withheld for 93 000 of them (OFSP, 2011a).

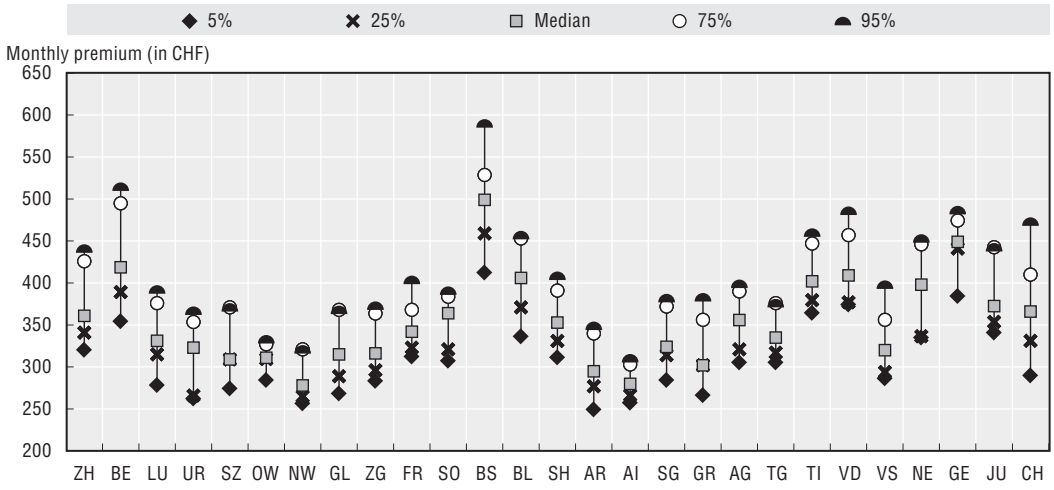
However, health professionals have recently expressed concerns about people seeking care without insurance coverage. In March 2010, the parliament revised the law with the objective of protecting people facing serious financial problems for paying premiums: from January 2012, cantons will pay 85% of unpaid premiums and other debts to health insurance (as identified by insurers) on behalf of beneficiaries and pay subsidies for the purchase of health insurance directly to insurers. Defaulters will be asked to refund insurers as soon as they can but should not renounce to health care services because of financial reasons. Insurers will then refund 50% of this sum to cantons.

Health insurance premiums vary widely across and within cantons

There are large differences in premium levels across cantons, insurers within cantons and even within sub-regions of cantons (see Figure 2.2). These intra-cantonal premium differences persist because of insurers' risk-selection activities (see below) and also because relatively few insurees switch insurers from year to year, although this number has been rising recently (see the following section).

Figure 2.2. **Distribution of health insurance premiums paid for adults over 25, by canton of affiliation, 2011**

Premiums estimates for plans with ordinary deductibles and insurance accident

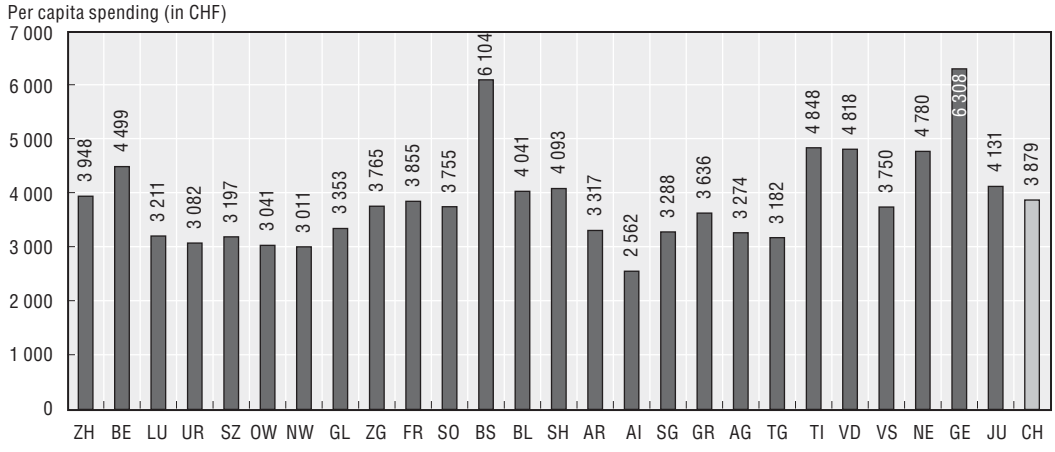


Lecture: In the canton of Zurich, 5% of adult insurees pay less than CHF 322 per month for health insurance, 50% of insurees pay less than CHF 361 and 5% pay more than CHF 441.

Note: These estimates are based on the most recent data on the distribution of insurees among insurers and plans (2009) and on premiums approved for 2011. They only apply for insurees over 25 with insurance accident choosing plans with ordinary deductible. In 2009, 31% of adults over 25 opted for plans with ordinary deductible, 60% of which had accident insurance.

Source: OFSP (2011a), *Statistiques de l'assurance maladie*.

Figure 2.3. **Sum of cantons' payments to providers, insurance premiums and cost-sharing on a per capita basis by canton, 2007**



Source: Adapted from Reich *et al.* (2011).

Cross-cantonal premium variations largely (though not entirely) reflect variations in health spending. Figure 2.3 illustrates the sum of cantons' payments to providers, insurance premiums and cost-sharing for insurance covered services for the year 2007. This ranged from CHF 2 562 per capita to CHF 6 308 per capita across the 26 cantons (Reich *et al.*, 2011). These variations are likely to reflect the significant geographical differences in factors that drive health costs in Switzerland. This includes provider remuneration levels, the density of health services supply (*e.g.*, number of physicians and number of hospital beds) and higher costs incurred by teaching hospitals in some cantons (Leu *et al.*, 2009, Reich *et al.*, 2011).

Public subsidies help some individuals and families pay health insurance premiums

By nature, non-income related premiums are very regressive. In 2008, premiums accounted for 11.8% of household income for the lowest income quartile and 3.4% for the highest income quartile (Household Survey Data, 2008). In order to lessen the burden on lower income households, the Health Insurance Law introduced public subsidies. While subsidies are co-financed by the confederation and cantons, the latter are responsible for their management within a general framework set by LAMal. Each canton establishes eligibility criteria, the amount of the individual subsidy, and processes for receiving subsidies. The LAMal requires premium reductions of at least 50% for children and young adults in training in low and middle income households, but lets cantonal authorities determine the thresholds used to define "low and middle income".

Subsidies are co-financed by the confederation through federal transfers earmarked for premium reductions. Initially, federal transfers were allocated to cantons according to the size of their population, their financial capacity and the level of premiums in the canton. The allocation formula was changed in 2001 to account for the level of subsidies actually paid by the canton instead of the level of premium. Cantons were required to pay at least one third of the federal transfers for premiums reductions. This system was changed again in 2008 to comply with a new scheme for inter-cantonal financial equalisation. Under the new system, the total amount of federal funds allocated for premium reductions is computed to cover 25% of social health insurance costs (including cost-sharing) for 30% of insurees (which makes 7.5% of gross costs). Federal funds are then allocated to cantons according to the size of their population and the number of enrolees entitled by LAMal to premium reductions (OFSP, 2010 and LAMal).

There is a large variation in the way cantons manage their subsidy system. Spending capacity – measured by the difference between available budgets and funds actually paid – varies across cantons. More than half of cantons make use of the LAMal clause that allows them to limit the amount spent on subsidies (see Chapter 1), leading to a corresponding reductions in the federal allocation. Differences also exist in eligibility thresholds and in assets-testing. Moreover, cantons have their own fiscal laws, and therefore do not follow similar methods for calculating taxable income. As a result, a household may benefit from premium subsidies in one canton but not in another, at equal income levels. Finally, the process for applying for subsidies varies across cantons. Timing and deadlines are not uniform. In some cantons, households are automatically informed whether they are entitled to subsidies and automatically receive their premium subsidies. In others, individuals have to apply for the subsidy. Some cantons transfer subsidies directly to the insurer, others to the insuree, and a few of them deduct from taxation (OECD and WHO, 2006; CDS, 2011; OFSP, 2008). A recent revision of the LAMal[4] requires cantons to pay subsidies directly to the insurer in the future.

In 2001, the Council of States recommended a social goal of premiums as a share of taxable household income not exceeding 8% (*i.e.* about 6% of taxed household income), however the parliament decided to leave it to cantons to fix premium limits. In addition to different eligibility thresholds, cantons have thus different models of determining premium subsidy levels (*cf.* CDS, 2011; OFSP; 2008). Sixteen cantons fix a maximum percentage of households' income to be spent on premiums and subsidise any additional amounts. While this limits the households' effective burden, premium payments remain regressive. Furthermore, families in these cantons have no incentive to choose an insurer

with a lower premium or to switch to a managed care contract – premium competition by insurers is of no relevance to them. Another eight cantons grant subsidies of a fixed amount according to income categories. For those families, there remain some incentives to select an insurer with a lower premium. Two cantons apply a combination of these two models.

In 2009, about 29% of insured people received subsidies for premium reduction in Switzerland. This varied significantly across cantons: from 21.9% in Vaud and Basel-Land to 45.6% in Nidwalden. The average premium subsidy was of CHF 1 571 nation-wide, but also varied significantly, from CHF 666 in Appenzell Inner-Rhodes to CHF 2 543 in Basel-City (see Figure 2.4). The share and number of beneficiaries has remained stable over the past ten years, but the cantons' share in total premium subsidies has significantly increased. The total amount of subsidies and the subsidy per household have also increased over the period.

Figure 2.4. **Share of population receiving premium subsidies and average level of premium subsidy per beneficiary by canton, 2009**

Source: OFSP (2011a), *Statistiques de l'assurance-maladie 2009*.

Table 2.2. **Trend in premium subsidies since 1999**

Year	Subsidies for mandatory health insurance premia (CHF million)	Of which: share of cantonal subsidies (%)	Number of individual beneficiaries	Share of beneficiaries in insured residents (%)	Annual average subsidy per individual (CHF)	Number of households beneficiaries	Annual average subsidy per household (CHF)
1999	2 689.7	33.1	2 334 267	32.1	1 152	1 230 090	2 187
2000	2 545.3	32.5	2 337 717	32.2	1 089	1 242 695	2 048
2001	2 657.2	32.3	2 376 421	32.5	1 118	1 268 943	2 094
2002	2 892.0	33.5	2 433 822	33.1	1 188	1 289 405	2 243
2003	3 065.5	35.0	2 427 518	32.9	1 263	1 287 365	2 381
2004	3 169.8	35.2	2 361 377	32.0	1 342	1 245 875	2 544
2005	3 201.8	35.6	2 262 160	30.4	1 415	1 215 989	2 633
2006	3 308.7	35.4	2 178 397	29.1	1 519	1 182 675	2 798
2007	3 420.5	35.1	2 271 950	30.1	1 506	1 225 436	2 791
2008	3 398.3	47.6	2 249 481	29.5	1 511	1 211 670	2 805
2009	**3 542.4**	**48.8**	**2 254 890**	**29.3**	**1 571**	**1 229 418**	**2 881**

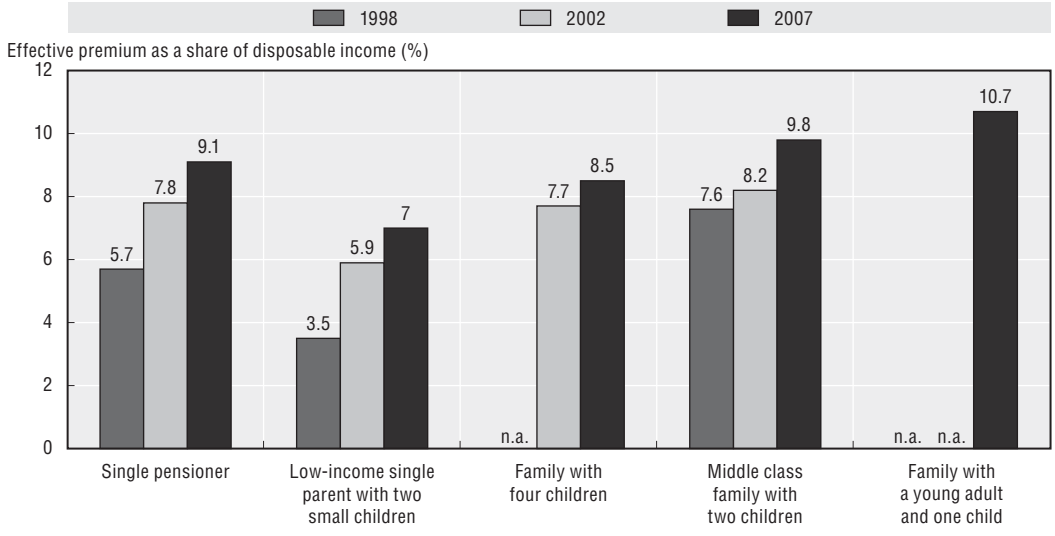
Source: OFSP (2011a), *Statistiques de l'assurance maladie en 2009*.

Overall, subsidising premiums is an effective way of lessening the regressive nature of health insurance premiums that all adults (employed or unemployed) as well as children face. However, because of differences in eligibility thresholds and premium subsidy amounts, inter-cantonal differences in effective premium burden[5] persist between households with similar income levels (see Figure 2.5 and OFSP, 2008). Yet, these differences cannot be interpreted independently from variations in taxation and in premiums levels. Furthermore, differences in the effective premium burden remain between households within the same canton. It is worth noting that achieving horizontal equity in health financing is not an explicit policy goal in providing premium subsidies in Switzerland. Furthermore, subsidies do not address health financing inequities resulting from out-of-pocket expenditure, such as copayments and deductibles which are independent of household incomes.

With premiums rising faster than income or subsidies over the past years, the premium burden has increased. However, this went down slightly in 2007, according to information provided by Swiss authorities. For four standardised household examples (single pensioner, low-income single parent with two small children, family with four children and a middle class family with two children), the effective premium burden has increased to 7.4% in 2002 from 5.6% in 1998, and today accounts for 8.9% of disposable household income in 2007 (see Figure 2.5 and also OFAS, 2003; OFSP, 2008).

Differences in premiums and premium subsidies imply a considerable degree of inequity in health financing both within and across cantons. According to various stakeholders, inter-cantonal inequities are considered an acceptable consequence of a federal system. However, there is a lack of analysis providing evidence on the level of inequity in health financing. Specifically, current household survey data does not include detailed information on the level of premium subsidies to households, making analysis of effective premium burden by income category difficult. Therefore, it is recommended that

Figure 2.5. **Average LAMal premium burden after the payment of premium-reduction subsidies, as a share of disposable income, for five types of households, in 1998, 2002 and 2007**



Source: OFSP (2008), *Monitoring 2007*.

Swiss authorities gather further evidence on this financial impact to households. A move to income-based premiums would not only ensure better health financing equity, but also save administrative costs spent on administering the premium subsidisation system.

Swiss patients face relatively high out-of-pocket payments for health care

In Switzerland, cost-sharing for services reimbursed by health insurance takes several forms. Firstly, people pay the full costs of health care goods and services until they have reached the amount of the deductible specified in their insurance contract (CHF 300 in ordinary contracts for adults). Beyond this, people pay 10% of health care costs up to an annual cap of CHF 350 for children and CHF 700 per adult. They also pay a fixed copayment of CHF 15 per day for inpatient care.

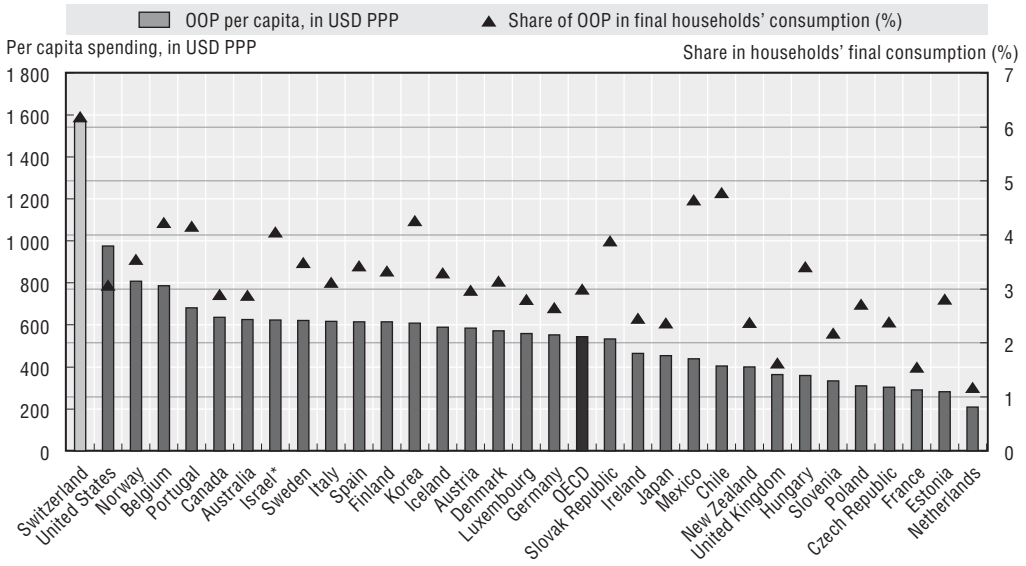
Several population groups are exempted from all or part of cost-sharing. For ordinary insurance contracts, there is no deductible for children. In addition, the sum of cost-sharing paid by families for the health costs of their multiple children must not exceed the cap set for an adult for the deductible and cost-sharing (*i.e.* CHE 1 000). Moreover, there is no cost-sharing for maternity related care. Expenditure ceilings and exemptions from cost-sharing are important mechanisms to limit out-of-pocket expenditure. However, they are unrelated to household income, which may leave lower-income households without financial protection from high out-of-pocket expenditures, even when below the set ceilings.

By international standards, out of pocket health care costs in Switzerland are high. With 30% of health care costs paid by households, Switzerland ranked fifth among OECD countries in 2009, after Chile, Mexico, Greece and Korea (OECD, 2011). Per capita out-of-pocket payments in Switzerland are significantly higher than in all other OECD countries: they are 60% higher than the United States and almost three times as high as the OECD average. They represent 6% of households' final consumption, which is the highest level in the OECD. This is four times higher than in countries with the lowest shares, *i.e.* France and the Netherlands (see Figure 2.6). However, this data ought to be interpreted with caution. Households' contributions to the cost of long-term care (which accounts for one third of out of pocket payments in Switzerland) is known to be underestimated by several countries in the System of Health Accounts (SHA). Swiss recipients of long-term care also often receive cash benefits to help them face their costs, which are not, by definition, captured in SHA data, but obviously alleviate the financial burden of households (see Chapter 1, Section 1.5).

Households' contributions to health care costs include different types of payments: user charges for mandatory health insurance and supplementary health insurance, and in some OECD countries, informal payments (Hungary, the Czech Republic and Poland) or costs paid by non-insured people (the United States, Mexico and Turkey). In Switzerland, in 2009, households' direct payments for health care were mainly expenditures for health care and services not covered by health insurance (85% of OOP payments). Long-term care accounted for 35.5% of households' direct payments in 2009, basic medical and diagnostic services for 20% (more than half of which as cost-sharing), and dental care for another 18% (*OECD Health Data 2011*).

Out-of-pocket payments are usually regressive and thus the least equitable means to finance health care. In wealthy countries, consumers are more likely to spend money for "non-essential care", such as private rooms in hospitals or multiple vision products, and

Figure 2.6. **Households' direct payments for health care in OECD countries, 2009**



Note: Data for Australia and Japan refer to 2008. Data on OOP per capita refer to 2008 for Portugal, 2007 for Turkey and Austria, and to 2006 for the Netherlands. Data on the share of OOP in final households' consumption refer to 2008 for Austria and to 2007 for Portugal.
OOP: Out-of-pocket.
* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.
Source: OECD Health Data 2011.

such household spending decisions do not raise any equity concerns. In Switzerland, however, households' spending seems to encompass payments for important services (especially long term and dental care). In addition, the fact that an increasing number of consumers are opting for high-deductible plans is very likely to increase user charges for "essential care" and weaken the solidarity of the health insurance system. Therefore, Swiss authorities should monitor the nature of user payments in the Swiss health system and their impact on low-income groups. Households' survey data should be designed to better capture out of pocket payments that are net of health insurers' reimbursements[6], and measure out of pocket payments by income category.

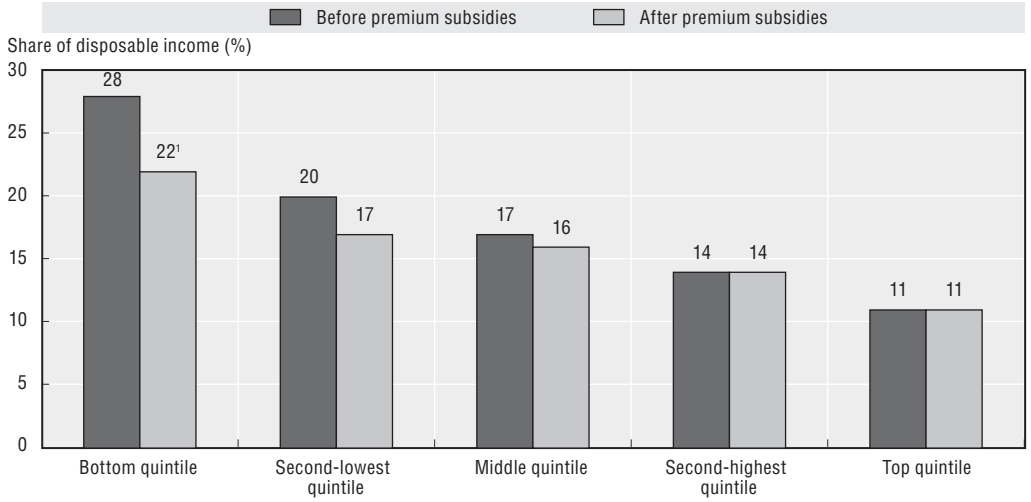
Contributions to the financing of health spending are inequitable

There are inequities in payments for health across income quintiles – both for premiums and out-of-pocket payments. Even when premium subsidies are included, the bottom income quintile's health payments as a share of disposable household income is much higher (22%) than that of the other income quintiles (17% and less), as shown in Figure 2.7 (Iten *et al.*, 2010).

Financing health care is a high burden for low-income families

There is some indication that people forego health services due to high out-of-pocket expenditure, and that this is related to socio-economic status. According to the 2004-05 Survey of Health, Ageing and Retirement in Europe, 3.7% of the Swiss population over 50 declared they had to forgo health care services in the last 12 months. In comparison with other countries surveyed, this rate was rather low: only Denmark and the Netherlands had much lower rates (1.6% and 2.5% respectively) while Germany and France

Figure 2.7. **Health care expenditures in 2007 by income quintile (before and after adjustment for premium studies)**



1. This figure is probably too high because welfare recipients are under-represented in the household budget survey and their premium subsidies are thus not included in the cost burden. The levelling effect of premium subsidies is therefore likely to have been underestimated in the bottom income bracket.

Source: Iten *et al.* (2010).

both had rates of 6% (Litwin and Sapir, 2009). However, the study suggests that individuals with low income are more likely to forego care for financial reasons in Switzerland.

In another population-based cross-sectional survey in Switzerland, 14.5% of respondents indicated that they renounced health care for economic reasons, primarily for dental care, but also for others (Wolff *et al.*, 2011). The 2010 Commonwealth Fund international health policy random sample survey reveals that 9% of the below average income sample group indicated that they had serious problems paying or were unable to pay medical bills, compared to 2% of the above average income level sample group. Likewise, only 67% of the below income level sample group were actually confident or very confident that they would be able to afford needed care (Schoen *et al.*, 2010). Self report surveys are known to be influenced by expectations that are influenced by many social and cultural factors, and can thus only provide some part of the picture of the financial burden. Yet this result is in line with the above data from the household budget survey and confirms that attention to the most vulnerable parts of the population is needed.

2.3. Competition in health insurance markets does not deliver all its promises

In the Swiss health insurance market, where the insured benefit package is uniform and there are no restrictions to accessing providers, consumers would be expected to choose their insurer on two main criteria: the premium and the quality of services provided (*e.g.* delay for reimbursement, responsiveness, etc). Without information on the quality of insurance services, consumers are expected to focus on price, and premiums should converge. However, switching rates are still rather low and there is no sign of premium convergence.

Switching rates are still low, though increasing in the recent period

Users can choose a health insurer in their canton of residence or work. On average, consumers face a large choice, with 59 insurers each offering several plans. Consumers are allowed to switch their plan and/or insurer every six month in June and December, with three months advance notice to the insurer. If an insurer announces a change in the premium for next year (increase or decrease), the advance notice is reduced to one month.

Consumers can search for information on dedicated websites, which display the full menu of choices (in terms of insurers, and option plans) and related premiums, for a given set of characteristics (commune of residence, composition of household, and deductible levels for each member of the family), as well as a "satisfaction note" based on a non-exhaustive survey.

Switching rates are not perfectly known because people that switch are not registered as such. Each insurer knows the number of new enrolees and "lost enrolees", but does not distinguish switchers from other new enrolees (newborns, new residents in the canton) or other departures (deaths, people who moved). In 2009, insurers admitted 961 884 new enrolees, including new residents and newborns, which represent 12.5% of the total number of insurees (OFSP, 2011a). According to available estimates, switching rates have fluctuated around 3 to 5% per year between 1997 and 2008, but seem to have increased recently due to the rise in premiums (based on interviews). Switching rates are often surprisingly low in countries with competing health insurers. In 2008, only 3.5% of insured people changed insurers in the Netherlands and 3% the Czech Republic (Paris *et al*., 2010).

Frank and Lamiraud (2009) examined factors explaining switching behaviour in Switzerland between 2000 and 2004. They found that, all other things being equal, consumers were more likely to switch insurers when the number of choices they faced was lower and when potential gains from switching were higher (the relative price they were paying compared with alternative choices). On the contrary, consumers were less likely to switch if their enrolment in current plan was longer. The characteristic of "intend to switch", as declared in a household survey, was generally associated with dissatisfaction with their current plan. The impact of having supplementary insurance was less clear, though it appeared to add to the complexity of choice and reduce the probability of switching. Another study (Dormont *et al*., 2009) showed that holding a supplementary health insurance substantially decreased the probability of switching, except when the policy holder assesses his/her own health as "very good". The authors conclude that "bad risks" probably fear to see their application for supplementary coverage be rejected by a new insurer. Such a result offers a convincing explanation for low switching rates in Switzerland. Since 2007, amongst the 88% of people holding at least one supplementary health insurance contract, only 9% have subscribed for a contract with a different insurer than their LAMal insurer (Lamiraud, 2011).

Fragmentation increases administrative costs and premiums

As Swiss health insurance is provided within cantons, the pooling function via the insurance system is limited to the cantonal level. With 26 cantons for 7.7 million people, the system is very fragmented. Moreover, insurance policies are offered in a wide variety of contracts such as ordinary insurance, managed care contracts, primary care provider contracts, bonus contracts and higher deductible options (as outlined above). Furthermore, insurers can differentiate premiums for up to three regions within a canton, For example, in the canton of Aargau with a population of 600 000, there are 63 insurers and more than

1 300 different policies/premium levels for the group of adults above 25 years alone (OFS, 2010). Usually, fragmented pools do not achieve complete cross-subsidisation between the healthy and the sick, since most risk equalisation mechanisms do not fully impede risk selection.

Multiple fund systems, especially with small pools, often coincide with relatively higher administrative costs (Carrin and James, 2005), as the potential for economies of scale is not fully exploited in light of structural duplication. Moreover, a risk equalisation mechanism also creates additional administrative costs. Thus, like other multiple insurance fund systems, such as Germany, Luxembourg and France, Switzerland has relatively higher administrative costs for both social and private health insurance. Those accounted for respectively 5.9% and 17.0% of total health insurance costs, above the average of high-income OECD countries of 3.8% and 12.7% over the years of 2000-07 (Mathauer and Nicolle, 2011). Further measures to optimise administrative efficiency could thus also focus on lowering costs among Swiss health insurers. Moreover, smaller pools make it harder to equalise risks, which affect premium levels.

Health insurers mainly compete on risk-selection

In Switzerland, the health insurance benefit basket is uniform, copayments are defined at central level (including available "special options") and insurers are obliged to contract with all providers. At the same time, there is almost no information on quality of providers' services, and even if such information was available, health insurers could not really benefit from it under current arrangements. Prices of health care services are most often negotiated at cantonal level for all insurers and all providers, with some exceptions.[7] All these characteristics do not leave many options to health insurers other than risk-selection and the reduction of administration costs to compete on premiums or on the quality of health care services.

Van de Ven *et al*. (2007) listed possible strategies for insurers to select good risks despite their obligation to accept any applicant. This list includes:

- Marketing through targeted advertisements aimed at the healthier.
- Selective contracting with providers (*e.g.*, in managed care contracts) likely to attract the healthier who are more willing to accept limited provider choice.
- Designing complementary insurance benefits packages and setting premiums such that low-risk individuals are attracted.
- Exclusively offering contracts with high deductibles, which will offset higher risk individuals.
- Establishing insurance conglomerates to channel new enrolees to specific contracts depending on their health risks; this strategy most often works due to the huge number of different contracts on offer, limiting the consumer's ability to be fully informed.
- Identifying high risks via a health status declaration for those seeking complementary insurance.
- Delaying reimbursements for chronically ill persons in order to make them leave the insurance.
- Terminating insurance activity in areas with many high-cost patients.

Many of these strategies are indeed manageable options for Swiss health insurers. The extent to which they really use them is not easy to determine.

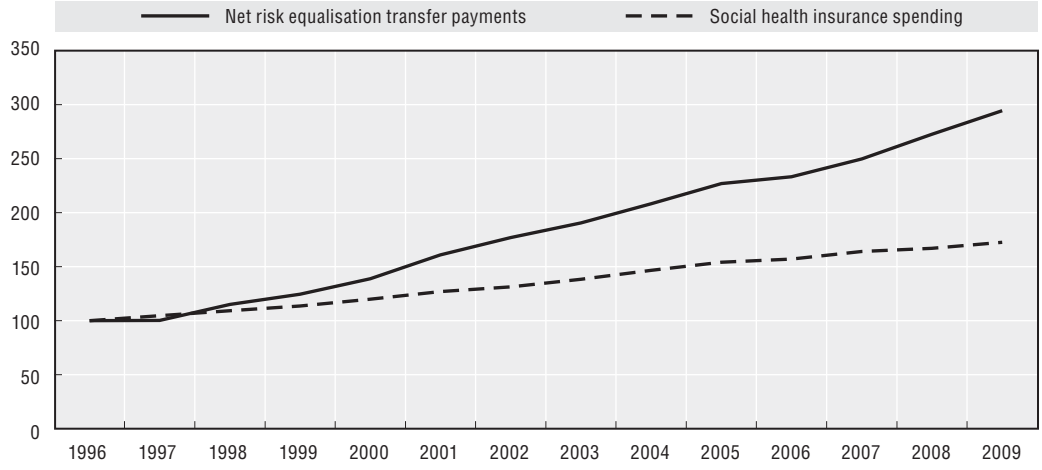
The inclusion of another risk factor into the risk-equalisation formula is a good step but may not be enough

Risk equalisation is considered necessary to remove incentives for insurers to select good risks, especially given community-rating requirements and large differences in insurers' risk structures in each canton. Initially, the risk equalisation mechanism was based on two simple risk factors only: age and gender. Various studies have shown that these two factors only explain a very small percentage (6%) of expenditure variation (Holly *et al.*, 2004, Beck 2004). The 30 existing risk classes (15 age categories, 2 gender categories) are very heterogeneous and thus reduce incentives for risk selection to only a limited degree. In contrast, it is worthwhile for insurers to risk select (Beck *et al.*, 2010). The problems posed by the existing system based on two risk factors have been pointed out in several studies (for an overview, see OECD and WHO, 2006; Beck *et al.*, 2010; Leu *et al.*, 2009). In particular, large insurance conglomerates with subsidiary companies are able to offer different insurance policies at varying premium levels and they can attempt to channel new applicants to insurance contracts adapted to their expected level of health risks (Hammer *et al.*, 2008).

The extent of risk selection is also demonstrated by large and persisting intra-cantonal differences in premiums across insurers (see Section 2.1 of this chapter). Moreover, risk structures seem to get increasingly more and more unequally distributed – Figure 2.8 below reveals that the risk equalisation transfer volume has increased faster than social health insurance expenditure.

A new and third risk factor – hospitalisation beyond three days in the previous year – has been included in the risk equalisation formula and will be applied from January 2012 onwards. The newly introduced risk factor of prior hospitalisation is assumed to reduce risk selection behaviour, as simulation studies have shown (Beck *et al.*, 2010), however it is more limited than what pharmaceutical cost groups (PCGs) would have achieved. While this new factor will not fully avoid risk selection, it will now also be profitable for insurers to invest in product innovation, *i.e.* further develop managed care contracts (Hammer *et al.*, 2008).

Figure 2.8. **Comparison of trends in net risk equalisation volume and SHI expenditure over 1996-2009**



Source: OECD Health Data 2011; Sutter and Wunderlin (2009).

Box 2.1. **Risk equalisation in Germany and the Netherlands**

Germany's morbidity-based risk equalisation mechanism and initial experiences

In 2009, a central Health Fund was established to pool financial resources for the mandatory social health insurance system. The risk equalisation mechanism was reformed in 2009 by taking morbidities into account for the calculation of risk equalisation payments/transfers and switching to a prospective system. In addition to 20 age, two gender categories and six levels of invalidity benefit payments, the disease burden related to 80 diseases is considered. Due to different severity levels, this results in 106 "hierarchical morbidity groups". Selection criteria for these were cost-intensive chronic diseases or diseases with difficult progress causing above average costs. Doctors and not insurers undertake the morbidity coding. Importantly, patient data with morbidity codes is de-identified before being sent to the Health Fund, from where risk-adjusted payments are made to the insurers.

An initial assessment of the impact of this new risk equalisation mechanism is positive overall: incentives for risk selection could be reduced, with the transfer volume across sickness funds changing tremendously. The newly calculated transfer payments for the sick substantially reduced the financial gap in relation to the full costs. As a result, the sick are no longer only "bad risks", but investment in care programmes are now worthwhile. However, the healthy are still the best risks as transfers for them (standardised expenditure) are still above their costs. Preventive health care activities pay off, as an insurance fund gains if a member is healthier than the year before.

Very importantly, remuneration of providers is equally based on morbidity. Diagnosis-related groups (DRGs) have been used since 2004 for inpatient care and standard service volumes are now used to pay outpatient physicians' services, in order to channel financial resources in a more patient centered way.

However, there has also been some criticism. Insurers find financial planning and budgeting difficult. The Federal Association of Statutory Health Insurance Physicians warns of manipulation through alliances between insurers and providers, which result in up-coding. Insurers, in contrast, point to the need for "right coding". Furthermore, no systematic evaluation of this new mechanism is planned or envisaged.

Netherlands' risk equalisation system based on multiple risk factors and experiences

The Dutch risk equalisation system is based on the following risk factors: age, gender, types of income (five categories), ten regions (based on degree of urbanity, share of immigrants, average income level, share of singles, standardised mortality probabilities, access to hospitals and outpatient care, number of long-term care beds), 20 pharmaceutical cost groups (PCGs), and ten diagnosis cost groups (DCGs). The latter two risk adjusters were added in 2002 and 2004 respectively, and are important new features in the risk equalisation mechanism. PCG is an indicator for outpatient morbidity based on prior use of prescribed drugs, whereas DCGs estimate future inpatient expenditures based on hospital diagnoses. These two risk adjusters can explain more than 20% of the overall variation in annual spending among individuals.

In a five-country study by Van de Ven *et al*. (2007), however, the profits from risk selection are still considered as "fair/high" in the Netherlands. In fact, despite a comprehensive set of risk factors, Dutch insurers still have a number of tools for risk selection, and more than prior to the 2006 reforms. This includes the possibility for organising managed care, some flexibility in determining the precise benefit package, complementary insurance to be sold together with basic mandatory insurance, and the option of offering premium rebates for group contracts up to 10%. The Dutch experience thus shows that in addition to a solid risk equalisation scheme, other insurance design issues are of critical importance.

Source: AOK Federal Association (2011); Schang (2009); Ministry of Health, Welfare and Sports (2008); Van de Ven *et al.* (2007).

On the other hand, it is unlikely that this new factor leads to increased length of stay. With DRGs, hospital providers will have a stronger incentive to keep average lengths of stay low, and it is questionable whether insurers can exert pressure on providers. However, this may occur in managed care contracts, where insurers could influence providers to keep

certain (low-cost) patient cases beyond three days in order to receive higher risk equalisation payments. Another concern around the current risk equalisation mechanism is that the current provider payment mechanism of fee for service in ambulatory care leaves the insurer with the full expenditure uncertainty. This provides again another incentive to insurers to practice risk selection.

Simulations by the Common Institution under the LAMal revealed that the amount being redistributed among insurers will only increase by 2-3% in total, from its current level of 25%, even though payments/transfers will change dramatically for some insurers. This new risk factor is thus an interim step only, and has been agreed on as compromise solution. The long-term aim should therefore be morbidity-based risk factors, as used in other countries. Indeed, discussions on morbidity-based risk factors are under way, and Swiss stakeholders are seeking the inclusion of more effective risk factors in the near future. Clearly, some level of risk selection will continue, since insurers will be able to select non-complicated hospital stays from complicated ones, even via their bills.

It is clear, however, that risk selection is not only practiced by insurers; insurees equally engage in selection of contracts and insurers depending on their own health risk profile (and expected health care expenditure). This can be seen in healthy, young and higher educated people switching more often, generally in order to obtain lower premium levels. At the same time, this group is also more likely to choose a managed care contract (Leu *et al.*, 2009). As in Germany and other countries, free choice of insurer has not led to a new (and more balanced) distribution of risks among insurers. Most consumers choose to remain with their insurer, especially those with higher health risks.

Risk-equalisation is retrospectively based on actual spending, weakening the incentives for efficiency and cost-containment. It is thus advisable to switch to a prospectively risk equalisation calculation mechanism. Not only will it facilitate premium calculation; it will ultimately encourage insurers to be more focused on efficiency.

The risk equalisation mechanism is linked to and organised by canton. It thus does not serve to address differences in social health insurance expenditure per capita across cantons. The cantonal organisation of the risk equalisation scheme is reflected in very different risk equalisation standard expenditures across cantons. For example, for the risk group of women aged 19-24, the 2009 risk equalisation standard expenditures (payments) range from CHF 93 to CHF 211 (2009 data from Common Institution under LAMal).

The high levels of fragmentation in a country with a small population raises questions about a single health insurer. In theory, a single insurer could pool risks more effectively. In light of risk equalisation mechanisms that are imperfect as long as there remain incentives for risk selection, a single insurer might in principle better ensure health financing equity across the population and strong purchasing, in addition to a tendency for lower administrative costs. Moreover, it provides incentives to focus more on prevention. A single insurer system thus has some important advantages. However, it has also its drawbacks, since it eliminates consumer choice, may inhibit innovation in insurance products or risk under-provision and rationing care when negotiated prices are too low (OECD and WHO 2006).

Shifting from a multiple insurer system to a single insurer system is with no doubt a tremendous challenge, although Korea demonstrated that a step-wise merging into a single fund is possible (Mathauer *et al.*, 2009). However, this is likely to be particularly difficult for Switzerland, which has a very long history of multiple insurers for over

100 years, a strong preference for choice, and as a reflection of its federalism, an attachment to cantonal organisation. Moreover, there are considerable transaction costs to consider, not least the question about where to place all staff from the current health insurers. Any such reform option thus needs to be critically assessed as to its overall financial implications, its practical implementation as well as political feasibility (Mathauer and Carrin, 2011). In fact, the option of a single insurer in Switzerland has already been rejected several times so far by the population, although a new initiative was launched in 2011.

Managed care plans have taken off since 2006 but insurers only modestly "manage care"

Since 1996, insurers have had the ability to propose alternative forms of health insurance contracts. Among these alternative forms, "managed care plans" prescribe that insurees follow specific health care pathways and/or to seek care with a restricted network of providers in exchange for lower health insurance premiums.

Managed care takes several forms in Switzerland, with or without formal contracts between insurers and providers (see Box 2.2). Until 2004, only a small proportion of insurees (below 10%) chose such health insurance plans. Since then, the share of the population opting for managed care plans has increased to reach 36.9% in 2009. A reform bill aims to promote one specific form of managed care – integrated care networks,[8] which are currently more prevalent in German-speaking cantons and in Geneva than in other French or Italian-speaking parts of Switzerland.

Generally, integrated care networks impose some form of gate-keeping, mainly provided by generalist doctors. Patients must obtain referral to access specialists or hospitals (except paediatricians, ophthalmologists and gynaecologists and emergency services).

The extent to which current managed care networks increase quality and efficiency in health care delivery is not well known. By nature, the impact of managed care is difficult to assess and disentangle from risk-selection, since these specific forms of contracts are known to attract people with good health risk profiles (Conklin and Nolte, 2010). Thus, age-and-gender adjusted comparisons of health care spending of managed care policy holders and other insurees are not sufficient to estimate savings achieved through managed care.

According to Beck *et al.* (2009), only two studies have estimated cost-savings achieved by managed care on Swiss data with an appropriate methodology. Lehmann and Zweifel (2004) estimated that cost differences between managed care policy holders and other insurees ranged from 34% (for independent practice associations) to 62% for HMOs in 1997-2000. In the case of HMOs, efficiency gains explained two-third of the cost difference and risk-selection explained the remaining third. For independent practice associations (IPAs) and preferred providers organisations (PPOs), cost differences were lower (respectively 34% and 39%) and risk-selection explained a greater share of them (two-third for IPAs and one-third for PPOs). Beck *et al.* (2009) estimated the cost-difference between managed care policy holders and other insurees of a given fund in 2007. They found that risk-selection explained half of the cost differential and estimated genuine efficiency gains at 8.7% across the 18 managed care plans offered by this insurer.

Evidence on the impact of managed care on quality of care is sparse and focuses on care processes rather than on health outcomes. One study, based on a survey of physicians, suggested that physician networks' practices tend to be more compliant with components

Box 2.2. **Managed care and integrated care networks in Switzerland in 2011**

In Switzerland, managed care plans take several forms:

- In "contract models", health insurers contract with physicians' networks, health maintenance organisations (HMO) or call centres.
  - There are two types of HMOs: staff models, with physicians employed by the health insurer who owns the HMO (the most common form) and group models, in which physicians own the HMO. In HMOs, health professionals, generally paid on salaries, provide different types of care in health centres. In terms of patient choice, HMOs are in general a little more restrictive than a physicians' network since patients can choose the centre but not their own physician.
  - In a physicians' network, doctors (mainly generalists) commit to providing continuing medical education to their members, to engage in quality management processes (most often in quality circles) and in management control. Physicians' networks often share financial risks with insurers through bonus/malus or capitation payments. Physicians receive payments from insurers for their participation to continuing medical education and other quality initiatives. Networks can be Integrated Medical Groups or Individual practice Associations (IPA), or a mixture of both.

  In 2010, there were 86 physicians' networks and HMOs in Switzerland, 84% of which share financial responsibility with health insurers. In such contracts, groups of physicians and health insurers agree on an objective for health care costs incurred for a group of patients and share gains and losses when actual costs are below or above the agreed objective. The contracts stipulate the objective as well as modalities for financial risk-sharing. In 2007, capitation rates ranged from less than CHF 50 for children that were not hospitalised in the previous year to CHF 1 200 for 90-year old persons who were hospitalised in the previous year. Insurers pay for outliers (*e.g.* over CHF 20 000). Gains and losses are capped (*e.g.* CHF 3 000 or CHF 10 000 per year per physician).

  Virtually all networks have implemented some elements of quality management: quality circles (96%), critical incident reporting (53%), use of guidelines (41%), disclosure of quality and/or cost data to health insurers (55%). Physicians' networks often contract with other providers for external services (hospitals, emergency services or call centres for 43%) and 51% refer their patients to "preferred providers".
  - Call centres are generally independent organisations, employing health professionals and contracting with health insurers to provide a "triage function" of demand for health care.
- In other models (without contracts between insurers and providers), insurers select a list of providers, on their own criteria and insurees have a limited access to this network. Providers do not commit to anything special and may even ignore that they are on insurers' lists.

According to Santésuisse, in 2010, 11.2% of insurees had managed care health insurance with General Practitioners' financial co-responsibility and 32.4% had managed care plans without financial responsibility for GPs. Residents of the north-eastern parts of Switzerland opt for managed care gate-keeping more often that than their counterparts of other regions.

Source: Baumberger (2007); Berchtold and Peytremann-Bridevaux (2011).

of the Chronic Care Model when treating patients with chronic illnesses than group or single handed practices (Steuer-Stey *et al.*, 2010, quoted by Berchtold and Peytremann-Bridevaux, 2011). Information sharing is undoubtedly a positive aspect of managed care networks given the potential of information and communication technologies in terms of efficiency and quality of care (OECD, 2010). According to the organisation Forum Managed Care, 60% of physician networks exchange electronic information with other providers and 30% organise co-operation with hospitals and emergency departments.

A reform proposal, that has been in gestation since 2002, aims to further improve the co-ordination of care through integrated care networks. This proposal is discussed below, together with the reform project on health insurance surveillance.

2.4. The reform agenda

Reform proposal to develop integrated care networks

In 2002, the Federal Council assessed the impact of LAMal and concluded that initial objectives were generally met, with the exception of cost-containment. In its analysis, managed care emerged as a part of the solution to contain costs. The Federal Department of Interior constituted a working group that was placed in charge of making propositions to foster the development of managed care along with experts and stakeholders (representatives of health professionals, provider institutions and insurers). The working group recommended that: the term "restricted network" be replaced by "integrated care"; incentives should be created for the development of such networks; better contracts should define the financial co-responsibility of providers' groups and insurers; the minimal duration of integrated care plans should be removed; end-of-year *ex post* premium reductions should be allowed, along with greater flexibility in premium setting for managed care plans; selective contracting with providers should also be allowed; financing of inpatient care should switch to single-payer; and the risk-equalisation formula should be refined. The initial objective of this set of proposals was clearly cost-containment.

Since then, a reform project was presented to the parliament (in 2004) and has been commented on by stakeholders. New propositions have been made, such as creating an obligation for insurers to propose option plans, lower cost-sharing for patients opting for such plans (and parallel increase of cost-sharing for patients not opting for such plans). A consensus seems to have emerged from a group of key stakeholders (the FMH, Santésuisse, CDS, H+ and the Swiss Federation of patients), who all agree on the following proposals:

- Consumers should keep the freedom of choice between managed care plans or other plans;
- In managed care plans, contracting between providers and health insurers should be mandatory. This would put an end to the "lists of preferred providers", made up by health insurers without transparent criteria for selection nor any commitment from selected providers;
- Managed care plans should not exclude patient with chronic disease and multiple morbidities;
- Insurers should create financial incentives for patients and providers;
- Patients should be allowed to select a specialist as gate-keeper, and access to psychiatrists should be direct.

In recent years, several OECD countries have implemented policies and programmes with the aim of improving the efficiency and quality of care, notably through better co-ordination of care (OECD, 2010a). For instance, Germany developed disease management programmes (DMP) and the Netherlands introduced new payment schemes to promote integrated care (see Box 2.3). A number of lessons can be drawn from these experiences. The first lesson is that these programmes all focus on chronic disease management and patients with complex needs, *i.e.* on conditions with the highest burden on morbidity and health care costs. The second lesson is that, when appropriately designed, these

programmes can improve the co-ordination of care as well as the quality of care in terms of processes, though impact on health outcomes are more difficult to assess and virtually unknown. Another conclusion is that co-ordination of care does not always save money. Improvements in the quality of care often come at a cost, which does not systematically offset savings achieved through better co-ordination. But it certainly improves value for money in health system (OECD, 2010a).

Strategies adopted in Germany and the Netherlands – two countries that are relatively similar to Switzerland in several respects – have common features: standards of care (or at least minimum requirements) have been defined at the national level by stakeholders based on the latest evidence available. Both systems include some form of monitoring of performance: in the Netherlands, care groups have to report on a large set of performance indicators, which are defined at the national level. In Germany, the law requires systematic assessment of DMP programme, which is a condition of the renewal of accreditation. Such requirements impose a reliance on well structured information systems. In both countries, patient education and self-management of disease is emphasised. Switzerland would certainly benefit from more in depth consideration of foreign experiences (good and bad outcomes) to design appropriate incentives for better co-ordination of care.

Box 2.3. **Disease and case management programmes in Germany and the Netherlands**

Disease management programmes in Germany

The Social Health Insurance Reform Act in 2000 reinforced provisions to improve co-operation between physicians practicing in ambulatory care and hospitals through selective contracting. This was targeted at patients with chronic diseases in the social health insurance scheme covering about 88% of the German population. Consequently, disease management programmes (DMP) were introduced in 2002 initially for type II diabetes, breast cancer, coronary heart disease, and chronic obstructive lung disease. They were later extended to type I diabetes, asthma and heart failure. Sickness funds were allowed to contract providers selectively for the integrated management of diseases in line with a protocol of minimum requirements on treatment guidelines and referrals to specialists, quality assurance, documentation, training and information of provider and patients, and evaluation three years following accreditation. DMP contracts were conducted selectively between sickness funds and general practitioners, and in order to enroll into DMP, patients had to sign up for a specific provider. Treatment guidelines are established at the national level by the Federal Joint Committee (G-BA), a decision body gathering associations of physicians, dentists, hospitals and health insurance funds.

Until 2008, sickness funds received a higher share from the risk structure compensation scheme for patients enrolled in the DMP. This provided strong incentives for insurers to introduce DMP. For instance, Schreyögg and Busse report that sickness funds received higher compensation of 2600 Euros for a breast cancer patient enrolled in a DMP in 2003 (Schreyögg and Busse, 2005). Following some initial resistance from physicians in fear of bureaucratisation, skepticism over sickness funds' capacities to review claim data and plan programmes, and in favor of more outcome oriented requirements, the DMP eventually experienced better acceptance amongst providers and patients. As of November 2010, 5.9 million patients – around 7% of the members of the social health insurance scheme – were enrolled in DMP and more than 60 000 providers participated (Website of the Association of Ambulatory Care Physicians KBV, *www.kbv.de/themen/23272.html*).

Box 2.3. **Disease and case management programmes in Germany and the Netherlands** *(cont.)*

Evaluation of the DMP is required by law and there have been a number of evaluations on individual conditions in academic and institutional settings, mostly by sickness funds themselves. Initial findings on patients with cardiovascular diseases enrolled in DMP by the AOK – one of Germany's largest statutory social health insurers with 24 million insured members – suggested reductions of systolic blood pressure and smoking cessation by about one third of patients; a reduction in chest pain of about 15%, and a notable reduction of acute coronary incidents and ischemic infarction during the first two years of enrollment (AOK, 2009). The comparative longitudinal ELSID study on a diabetes type II DMP showed better rates of patients' involvement in their care, and better support in setting goals for diet and physical activity compared to the control group. Another study found significantly better behavioral counseling for those patients enrolled in DMP (Szecsenyi *et al*., 2008). ELSID and selective evaluations of individual sickness funds have shown some minor cost reductions in DMP patients as opposed to those not enrolled. A more recent study (Stock *et al*., 2010) assessed the impact of DMP programmes for diabetes after four years. Although authors of the study acknowledge potential bias due to the selection of the control group, the results are striking: programmes reduce by half the risk of mortality (within four years) and the risk of chronic renal insufficiency, by one fourth the risk of myocardial infarction, by 20% the risk of stroke and by 40% the risk of lower leg amputation. Last but not least, the cost of care was 25% lower for patients included in DMP.

Overall, substantial difficulties in defining the requirements of a systematic evaluation of the German DMP remain to date so that comprehensive conclusions about the effectiveness of DMP in Germany cannot yet be drawn (Schaufler, 2006).

Integrated care and bundled payments In the Netherlands

In 2010, the Dutch Ministry of Health introduced a new scheme in order to overcome financial barriers to integrated care for patients with chronic diseases. The new system consists in a prospective payment for people with chronic conditions to multidisciplinary teams of caregivers. The payment stands for all health care services but provisionally excludes drugs, diagnostics and medical devices. Aimed to be implemented for four chronic conditions, the programme was initially launched for two of them: diabetes and cardiovascular risk factors and then extended to chronic obstructive pulmonary disease and heart failure.

Under this scheme, care is co-ordinated by groups of providers ("care groups"). Health insurers contract with care groups on the basis of a negotiated price per patient and per year, taking into account the expected case mix of patients with a chronic disease. Then, care groups can either deliver care themselves or purchase outpatient health care services (consultations only) to GP group practices, specialists or nurses based in hospitals or individual providers (*e.g*. dieticians and physiotherapists). Negotiations on the content of heath care to be provided are based on "care standards", developed by provider and patient associations and public health authorities in compliance with existing guidelines. All programmes of integrated care include general modules primarily based on support for self-management and the promotion of healthy life styles, as well as several disease-specific modules which are separated in four phases: early diagnosis and detection, diagnosis, individual care plan and treatment, and co-ordination, rehabilitation, participation and secondary prevention. Performance indicators attached to different modules are available in a minimum data set. For instance, 35 performance indicators exist for integrated care of diabetic patients. These indicators can be used in price negotiations between insurers and care groups. Care provided under bundled payments is free of charge for patients (Tsiachristas, 2010).

Bundled payments were experimented for diabetes in 2007 with an ongoing evaluation based on ten care groups. The evaluation showed wide variations in the level of bundled payments for diabetic patients, persisting over the years, and which reflect both the impact of negotiations and different conceptions of standards of care for diabetic patients across care groups. The experiment showed improvements in co-ordination of care, compliance with protocols, and use of electronic records, as well as an increase in

Box 2.3. **Disease and case management programmes in Germany and the Netherlands** *(cont.)*

transparency. However, it is too early to measure the impact on quality of care. On the other hand, the adverse effects of implementing bundled payments was reduced choice of providers for users and the apparent conflict of interests for GPs in care groups which are both commissioning and providing care. Another concern is the large – maybe too large – market power of care groups over subcontracted caregivers (Struijs and Baan, 2011).

Source: Busse *et al.* (2010); Schreyögg and Busse (2005); AOK (2009); Tsiachristas (2010); Struijs and Baan (2011); Szecsenyi *et al,* (2008); Schaufler (2006).

Reform project to improve functioning of health insurance markets

A new law on surveillance, rather than a revision of the existing LAMal, has been prepared and consultations of the draft law are taking place in the first part of 2011. The political rationale of this law is to guarantee the key principles of the social health insurance in the future and to protect insurees. It aims at providing a basis for an effective surveillance and at promoting transparency to strengthen regulated market competition. In the medium-term, a separate surveillance agency would be established, which will be able to operate at three levels: 1) request information and issue directives; 2) take preventive measures; and 3) intervene.

According to the proposed draft law, the OFSP (or optionally, a surveillance agency) would have a key role in approving premium levels (*i.e.* increases and decreases). This would take account of new regulations to determine proper risk-based reserve levels, which would ultimately slightly increase, as intended by the OFSP to avoid insurer bankruptcy. In the case of non-approval, the surveillance agency would have the right to set appropriate premium levels. This serves to ensure that premiums cover expected costs, whilst avoiding the accumulation of abundant reserves and accruals. In particular, this would make cross-subsidies from other insurance branches unnecessary, but also imply that insurers can no longer keep premiums artificially low. Premiums at too low a level would have to be absorbed by reserve funds. When premiums are set at too high a level, insurers would need to pay back premium payments if the insurer is solvent among other conditions. Above all, this would contribute to assuring a steady increase in premiums.

A number of other important provisions are also included. The regulatory provisions relating to reinsurance will be improved and complemented in order to protect insurees and insurers from insolvencies. In order to avoid regulation, insurers have found a consensus for self-regulating brokers' activities and commissions for selling insurance contracts. The aim is to limit administrative costs, but also to hamper risk selection activities.

In sum, the amendments with respect to LAMal surveillance point in the right direction overall – towards strengthening fair competition among insurers. However, insurers consider these amendments to be very burdensome. It will be important to closely monitor the effects of these reforms on the insurance market and insurer behaviour. These measures are expected to re-establish trust and to contribute to administrative efficiency. Finally, the agency will have more effective enforcement instruments, including increasing penalties to level significant enough that are material to insurers.

For some (especially small) insurers, this law might create an additional administrative burden. The proposed law may thus also contribute usefully to the trend of insurance mergers. Likewise, while competencies as to premium setting are clearly with the federal level and later the surveillance agency, cantons may continue playing an important role in this process. It remains to be seen whether this facilitates and smoothens the premium setting process, or whether, from a systems perspective, this functional duplication turns out to be inefficient. Furthermore, it is critical the OFSP and later the surveillance agency will have the necessary resources and capacity to effectively undertake its functions. The projection of cost trends of all insurers will be a tremendous task. Finally, the stronger regulation of insurers will have to be matched with regulatory provisions and measures that strengthen competition on the provider side, foremost the possibility for selective contracting.

Notes

1. Both "sickness funds" and commercial insurance companies can offer mandatory health insurance contracts, provided this part of their activity is run not for profit. Until now, private companies have not shown great interest in social health insurance and only sickness funds provide social health insurance coverage.
2. For more details on the financing of long-term care, see *www.oecd.org/dataoecd/61/28/47878092.pdf*.
3. Following services of preventive care are fully reimbursed: neo-natal screening for six conditions; echography (Graf technique) for hip dysplasia in newborns before six weeks; rickets prophylaxis for children under one year; up to eight preventive visits for children before school age; vaccines for children: diphtheria, tetanus, whooping cough, poliomyelitis, measles, mumps and rubella before 16; and haemophilus influenzae before age 5, hepatitis B (in priority for new-borns of infected mothers and children between 11 and 15); vaccines for adults: diphtheria and tetanus every ten years (or after injury for the latest), flu vaccine for people over 65 or with serious disease; and hepatitis B; HIV tests for newborns of HIV-infected mothers and for other high-risk population; gynaecologic examination every three years; mammography every two year over 50 and every year for high-risk women; coloscopy when familial antecedents of cancer; and skin examination for people with high risk of melanoma.
4. Loi Fédérale sur l'Assurance-Maladie (LAMal), Modification du 19 mars 2010.
5. The effective premium burden refers to the share of premiums – net of subsidies – in a household's income.
6. Household survey data currently captures all household spending on health care, including spending for health services for which they are later reimbursed by the health insurance (Rossel, 2009).
7. In some occasions, individual health insurances have decided to step out from collective price negotiation to directly negotiate with providers.
8. "*Réseaux de soins integer*" in French. The term "integrated care" is used in very different ways, depending on countries and systems (Nolte and McKee, 2008). In the United States, integrated care refers to situations in which accountable organisations integrate both health insurance and health care provision functions. In a European context, it rather refers to the co-ordination of "cure and care" functions or to the co-ordination of different types of health care services. In Switzerland, integrated care – though not precisely defined – rather refer to the latest.

References

AOK (2009). *Sonderauswertung zum DMP KHK mit Differenzierung nach Geschlechtern und zum Diabetes mellitus Typ 2*, June 2009, available at *www.aok-gesundheitspartner.de/bund/dmp/evaluation/gesetzlich/bund/index.html*.

Balthasar, A. (2003), *Die Sozialpolitische Wirksamkeit der Prämienverbilligung in den Kantonen. Monitoring 2002*, Daniel Wiedmer (ed.), Beiträge zur sozialen sicherheit, Forschungsbericht Nr. 20/03, BBL Vertrieb Publikationen, Bern.

Balthasar, A., O. Bieri and B. Gysin (2008), "Monitoring 2007. Die Sozialpolitische Wirksamkeit der Prämienverbilligung in den Kantonen", *Schweizerische Eidgenossenschaft*, Lucerne, February.

Baumberger, J. (2007), "Managed Care", in G. Kocher and W. Oggier (eds.), *Système de santé suisse*, Hans Huber, Bern, pp. 219-228.

Beck, K. (ed.) (2004), *Enlisement de la réforme de la compensation des risques? Expériences internationals et solutions concrètes pour la Suisse*, Risk Adjustment Network, Lucerne.

Beck, K., M. Trotmann and P. Zweifel (2010), "Risk Adjustment in Health Insurance and its Long-term Effectiveness", *Journal of Health Economics*, Vol. 29, pp. 489-498.

Berchtold, P. and I. Peytremann-Bridevaux (2011), "Integrated Care Organisations in Switzerland", *International Journal of Integrated Care*, Vol. 11.

CDS – Conférence Suisse des Directrices et Directeurs Cantonaux de la Santé (2011), *Assurance-Maladie: Réduction de Primes, Tableau Synoptique*, CDS, Bern.

Conklin, A. and E. Nolte (2010), *Disease Management Evaluation – A Comprehensive Review of the Current State of Art*, Rand Europe, Cambridge.

Dormont, B., P.Y. Geoffard and K. Lamiraud (2009), "The Influence of Supplementary Health Insurance on Switching Behavior: Evidence from Swiss Data", *Health Economics*, Vol. 18, pp. 1339-1356.

FINMA – Autorité Fédérale de Surveillance des Marchés Financiers (2010), "FINMA Defines Supervisory Requirements on Supplementary Health Insurances", Press Release, 27 April 2010.

Forum Managed Care (2010), "La coresponsabilité budgétaire dans les soins integers", Forum Managed Care.

Frank, R.G. and K. Lamiraud (2009), "Choice, Price Competition and Complexity in Markets for Health Insurance", *Journal of Economic Behavior and Organization*, Vol. 71, pp. 550-562.

Hammer, S., M. Peter and J. Trageser (2008), "Wettbewerb im Gesundheitswesen: Auslegeordnung", Final report, research protocolle Obsan, Obsan, Neuchâtel.

Holly, A., L. Gardiol and Y. Eggli (2004), "Health-based Risk Adjustment in Switzerland: An Exploration Using Medical Information from Prior Hospitalisation", Institut d'Economie et de Management de la Santé, University of Lausanne, Lausanne.

Iten, R. *et al.* (2010), *Economic Impact of Rising Healthcare Expenditures*, Infras, Zurich.

Lamiraud, K. (2011), "Le rôle des consommateurs dans la concurrence des systèmes d'assurance santé : L'exemple de la Suisse", Présentation, Paris, March 2011.

Letter to Herr Strupler, Bundesamt für Gesundheit, Kranken- und Unfallversicherung, Bern, 28 March 2011.

Leu, R.E. *et al.* (2009), "The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets", The Commonwealth Fund, No. 1220.

Litwin, H. and E.V. Sapir (2009), "Forgone Health Care Due to Cost Among Older Adults in European Countries and in Israel", *European Journal of Ageing*, pp. 167-179.

Mathauer, I. and G. Carrin (2011), "The Role of Institutional Design and Organizational Practice for Health Financing Performance and Universal Coverage", *Health Policy*, Vol. 99, pp. 183-192.

Mathauer, I. and E. Nicolle (in press), "A Global Overview of Health Insurance Administrative Costs: What Are the Reasons for Variations Found?", *Health Policy*, doi: *http://10.1016/j.healthpol.2011.07.009*.

Mathauer, I., K. Xu, G. Carrin and D. Evans (2009), *An Analysis of the Health Financing System of the Republic of Korea and Options to Strengthen Health Financing Performance*', Department of Health Systems Financing; WHO, Geneva.

Ministerium für Gesundheit (2008), "Beschreibung der Risikostrukturaugleichssystematik des niederländischen Krankenversicherungsgesetzes", Gemeinwohl und Sport.

OECD (2010a), *Value for Money in Health Systems*, OECD Publishing, Paris.

OECD (2010b), *Health Care Systems Efficiency and Policy Setting,* OECD Publishing, Paris.

OECD (2010c), "Health Care Systems: Getting More Value for Money", Economics Department Policy Note No. 2, OECD Publishing, Paris.

OECD (2010d), *Improving Health Sector Efficiency: The Role of Information and Communication Technology*, OECD Publishing, Paris.

OECD and WHO (2006), *OECD Reviews of Health Systems: Switzerland*, OECD Publishing, Paris.

OFAP (2008), *Rapport annuel 2007*, Office Fédéral des Assurances Privées, Bern.

OFAS – Office Fédéral des Assurances Sociales (2003), "Die sozialpolitische Wirksamkeit der Prämienverbilligung in den Kantonen. Monitoring 2002", *Forschungsbericht,* No. 20/03, Bern.

OFSP – Office Fédéral de la Santé Publique (2008), *Monitoring 2007: Die sozialpolitische Wirksamkeit der Prämienverbilligung in den Kantonen. Experten-/Forschungsberichte zur Kranken- und Unfallversicherung*, Bundesamt für Gesundheit, Luzern.

OFSP – Office Fédéral de la Santé Publique (2010), *Statistiques de l'assurance maladie obligatoire 2008*, Office Fédéral de la Santé Publique, Bern.

OFSP – Office Fédéral de la Santé Publique (2011a), *Statistiques de l'assurance maladie 2009*, Office Fédéral de la Santé Publique, Bern.

OFSP – Office Fédéral de la Santé Publique (2011b), *Aperçu des primes*, Office fédéral de la santé publique, Bern.

Paris, V., M. Devaux and L. Wei (2010), "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries", *Health Working Paper No. 50*, OECD Publishing, Paris.

Rossel, R. (2009), "Private Health Expenditure – Data Sources and Estimation Methods, Country Case Study: Switzerland", Room document presented at the Workshop on Improving the Comparability and Availability of Private Health Expenditures under the System of Health Accounts Framework, 12 June 2009, OECD Conference Centre, Paris, France.

Schang, L. (2009), "Morbidity-based Risk Structure Compensation", *Health PolicyMonitor*.

Schaufler, T (2006), "Anforderungen an die Evaluation von Disease Management Programmen: Defizite und ihre Ursachen", *Recht und Politik im Gesundheitswesen*, Vol. 12, No. 2, pp. 50-54.

Schoen, C., R. Osborn, D. Squires, M.M. Doty, R. Pierson and S. Applebaum (2010), "How Health Insurance Design Affects Access to Care and Costs, by Income, in Eleven Countries", *Health Affairs*, Vol. 29, No. 12, pp. 2323-2334.

Schreyögg, J. and R. Busse (2005), "Disease Management in Germany", *Euro Observer*, Vol. 7; No. 2, pp. 3-4.

Struijs, J.N. and C.A. Baan (2011), "Integrating Care Through Bundled Payments – Lessons from the Netherlands", *New England Journal of Medicine*, Vol. 364, No. 11, pp. 990-991.

Sutter, R. and U. Wunderlin (2009), "Bericht über die Durchführung des Risikoausgleichs im Jahr 2009", Institution commune LAMal, Solothurn.

Swiss Confederation (2011), "Bundesgesetz betreffend die Aufsicht über die soziale Krankenversicherung (Krankenversicherungs-Aufsichtsgesetz, KVAG)", January.

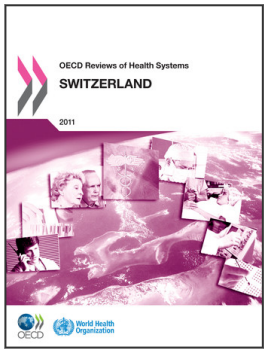
Szecsenyi, J, T. Rosemann, S. Joos, F. Peters-Klimm and A. Miksch (2008). "German Diabetes Disease Management Programs Are Appropriate for Restructuring Care According to the Chronic Care Model. An evaluation with the Patient Assessment of Chronic Illness Care Instrument", *Diabetes Care*, Vol. 31, No. 6, pp. 1150-1154, June.

Tsiachristas, A. (2010), "Towards Integrated Care for Chronic Conditions: Dutch Policy Developments to Overcome the (Financial) Barriers", *Health Policy*, Vol. 101, pp. 122-132.

van de Ven, W.P.M.M., K. Beck, C. Van de Voorde, J. Wasem and I. Zmora (2007), "Risk Adjustment and Risk Selection in Europe: 6 Years Later", *Health Policy*, Vol. 83, pp. 162-179.

van Kleef, R.C., K. Beck, W.P.M.M. van de Ven, R.C.J.A. van Vliet (2008), "Risk Equalization and Voluntary Deductibles: A Complex Interaction", *Journal of Health Economics*, Vol. 27, pp. 427-443.

Wolff, H., J.-M. Gaspoz and I. Guessous (2011), "Health Care Renunciation for Economic Reasons in Switzerland", *Swiss Medical Weekly,* Vol. 141, Article No. w13165.



From:
OECD Reviews of Health Systems: Switzerland 2011

Access the complete publication at:
https://doi.org/10.1787/9789264120914-en

Please cite this chapter as:

OECD/World Health Organization (2011), "Health Insurance", in *OECD Reviews of Health Systems: Switzerland 2011*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/9789264120914-5-en

This work is published under the responsibility of the Secretary-General of the OECD. The opinions expressed and arguments employed herein do not necessarily reflect the official views of OECD member countries.

This document and any map included herein are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

You can copy, download or print OECD content for your own use, and you can include excerpts from OECD publications, databases and multimedia products in your own documents, presentations, blogs, websites and teaching materials, provided that suitable acknowledgment of OECD as source and copyright owner is given. All requests for public or commercial use and translation rights should be submitted to rights@oecd.org. Requests for permission to photocopy portions of this material for public or commercial use shall be addressed directly to the Copyright Clearance Center (CCC) at info@copyright.com or the Centre français d'exploitation du droit de copie (CFC) at contact@cfcopies.com.