Det schweiziska hälso- och sjukvårdssystemet (på svenska)

Källa: http://international.commonwealthfund.org/countries/switzerland/

Ansvaret för det schweiziska hälso- och sjukvårdssystemet är uppdelat mellan federal, kantonal och kommunal nivå.

De 26 kantonerna har en hög grav av självbestämmande inom ramen för konstitutionen. Systemet betecknas därför som decentraliserat. Kantonen ansvarar för att licensiera utförarna och koordinerar sjukhusens verksamheter. Kantonerna ansvarar också för subventionering av institutioner och individuella premier.

Den federala regeringen ansvarar för att reglera finansieringen av systemet, vilket sker genom en obligatorisk sjukförsäkring (MHI) och annan socialförsäkring. Den federala regeringen säkerställer också kvalitet och säkerhet för läkemedel och medicintekniska produkter samt samordnar folkhälsoinitiativ och främjar forskning och utbildning.

Kommunerna är främst ansvariga för omsorg och social verksamhet.

Den offentligt finansierade delen av hälso- och sjukvården och omsorgen (ca. 67% år 2014) finansieras via skatteintäkter (varav den största delen går till kantonerna för subventionering av akutvård och slutenvård), de obligatoriska sjukförsäkringarna och olika socialförsäkringsavgifter.

Den obligatoriska sjukförsäkringen MHI erbjuds av konkurrerande försäkringsbolag. Det federala folkhälsoinstitutet (FOPH) utövar tillsynen och sätter nivån för premier baserat på tidigare, nuvarande och beräknade framtida kostnader för försäkrade personer i en viss region.
MHI täcker det mesta från allmänläkare och specialistläkare till hemsjukvårdstjänster, fysioterapi, utvalda läkemedel och vissa förebyggande åtgärder. Sjukhustjänster omfattas också av MHI, men är till stor del subventionerade av kantonerna. Vård av psykisk sjukdom är täckt om den tillhandahålls av certifierade läkare. MHI täcker endast "medicinskt nödvändiga" tjänster i långtidsvård. Tandvård är i stor utsträckning utesluten från MHI, liksom glasögon och kontaktlinser för vuxna.

Den privatfinansierade delen av hälso- och sjukvården utgör en hög andel jämfört med andra OECD länder, ca. 32% år 2014. Det finns också möjlighet att komplettera den obligatoriska sjukförsäkringen med en frivillig försäkring (7,2% av de totala utgifterna) som ger möjlighet att t.ex. välja sjukhusläkare eller erhålla ett bättre rum under sjukhusvistelse. Andra intäkter kommer från självrisker och ”out-of-pocket” betalningar för tjänster som inte omfattas av försäkringen t.ex. tandvård eller långtidsvård.

The Swiss Health Care System (in English)

Source: http://international.commonwealthfund.org/countries/switzerland/

Duties and responsibilities in the Swiss health care system are divided among the federal, cantonal, and municipal levels of government. The system can be considered highly decentralized, as the cantons play a critical role.

Each of the 26 cantons has its own constitution and is responsible for licensing providers, coordinating hospital services, and subsidizing institutions and individual premiums.

The federal government plays an important role in regulating the financing of the system, which is effected through mandatory health insurance (MHI) and other social insurance; ensuring the quality and safety of pharmaceuticals and medical devices; overseeing public health initiatives; and promoting research and training.

The municipalities, in turn, are responsible mainly for long-term care (nursing homes and home care services) and other social support services for vulnerable groups.

Public funding
There are three streams of public funding:

1. Direct financing for health care providers through tax-financed budgets for the Swiss Confederation, cantons, and municipalities. The largest portion of this spending is given as cantonal subsidies to hospitals providing inpatient acute care.

2. Mandatory health insurance (MHI) premiums, which are universal.

3. Social insurance contributions from health-related coverage of accident insurance, old-age insurance, disability insurance, and military insurance.

All government expenditures on health are financed by general taxation. In 2014, direct spending by government accounted for 20.1 percent of total health expenditures, while income-based MHI subsidies accounted for an additional 5.6 percent. Including MHI premiums (31.0% of total health expenditure, excluding statutory subsidies), other social insurance schemes (6.3%), and old-age and disability benefits (4.4%), publicly financed health care accounted for 67.4 percent of all spending.

MHI is offered by competing nonprofit insurers supervised by the Federal Office of Public Health (FOPH), which sets floors for premiums calculated to cover past, current, and estimated future costs for insured individuals in a given region.

MHI covers most general practitioner (GP) and specialist services, as well as an extensive list of pharmaceuticals and medical devices; home care services (called Spitex); physiotherapy (if prescribed); and some preventive measures, including the costs of selected vaccinations, selected general health examinations, and screenings for early detection of disease among certain risk groups (e.g., one mammogram per year for women with a family history of breast cancer).
Hospital services are also covered by MHI, but are highly subsidized by the cantons. Care for mental illness is covered if provided by certified physicians. The services of nonphysician professionals (e.g., psychotherapy by psychologists) are covered only if prescribed by a qualified medical doctor and provided in his or her practice. MHI covers only “medically necessary” services in long-term care. Dental care is largely excluded from MHI, as are glasses and contact lenses for adults (unless medically necessary), but these are covered for children up to age 18.

Private funding
Private expenditure accounted for 32.6 percent of total health expenditure in 2014, which is high by comparison with other OECD countries. There is complementary voluntary health insurance (VHI, 7.2% of total expenditure) for services not covered in the basic basket of MHI and supplementary coverage for free choice of hospital doctor or for a higher level of hospital accommodation.

Cost-sharing and out-of-pocket spending
Under MHI, insurers are required to offer a minimum annual deductible of CHF300 (USD235) for adults and a zero deductible for children up to the age of 18, although insured persons may opt for a higher deductible and a lower premium.

Out-of-pocket payments for services not covered by insurance (and in addition to cost-sharing) accounted for 18.6 percent of total health expenditure. Most of these direct out-of-pocket payments were spent on dentistry and long-term care. Providers under MHI are not allowed to charge above the fee schedule.

Safety net
Maternity care and some preventive services are fully covered and thus exempt from deductibles, coinsurance, and copayments. Children or young adults in school (up to the age of 25) do not pay copayments for inpatient care. Federal government and the cantons provide income-based subsidies to individuals or households to cover MHI premiums. Premiums for health insurance are not supposed to exceed 8 to 10% of household income. Overall, 26.9 percent of residents in 2014 benefited from individual premium subsidies. Municipalities or cantons cover the health insurance expenses of social assistance beneficiaries and recipients of supplementary old age and disability benefits.

How is the delivery system organized and financed?

Primary care
As registering with a GP is not required, people not enrolled in managed care plans generally have free choice among self-employed GPs. In 2015, 38.2 percent of doctors in the outpatient sector were classified as GPs. There are no specific financial incentives for GPs to take care of chronically ill patients, and no concrete reforming efforts are under way to engage GPs in “bundled payments” for chronic patients (e.g., diabetics). Primary (and specialist) care tends to be physician-centered, with nurses and other health professionals playing a relatively small role. In 2015, 56.1 percent of physicians were in solo practice.

Apart from some managed care plans in which physician groups are paid through capitation, ambulatory physicians (including GPs and specialists) are paid according to a national fee-for-service scale (TARMED). Billing above the fee schedule is not permitted.

Outpatient specialist care
In the outpatient sector, 61.8 percent of doctors were classified as specialists in 2015. Residents have free access (without referral) to specialists unless enrolled in a gatekeeping managed care plan. Specialist practices tend to be concentrated in urban areas and within proximity of acute-care hospitals. The public health system allows specialists to see MHI patients as well as private patients.

After-hours care
Cantons are responsible for after-hours care. They delegate those services (fees set by TARMED) to cantonal doctors’ associations, which organize care networks in collaboration with their affiliated

doctors. The networks can include ambulance and rescue services, hospital emergency services, and walk-in clinics and telephone advice lines run or contracted by insurers. There is no institutionalized exchange of information between these services and GPs' offices (as people are not required to register).

Hospital care

Hospital care represented one-third (36.4%) of total health expenditures in 2014. For services covered by MHI and billed through a national diagnosis-related group (DRG) payment system, hospitals receive around half (45%–55%) of their funding from insurers.The other half is covered by cantons and municipalities, or, in case of additional services, by private health insurance. The cantons are responsible for hospital planning and funding and are legally bound to coordinate plans with other cantons. In 2012, in parallel to the introduction of the DRG system, free movement of patients between cantons was allowed, reducing cantonal fragmentation.

Mental health care

Psychiatric practices are generally private, and psychiatric clinics and hospital departments are a mix of public, private with state subsidies, and fully private. There is also a wide range of socio-psychiatric facilities and daycare institutions that are mainly state-run and state-funded.

Long-term care and social supports

Services are provided for inpatient care in nursing homes and institutions for disabled and chronically ill persons and for outpatient care through Spitex.

Inpatient long-term somatic and mental services are covered by MHI but are highly subsidized by the cantons. For services in nursing homes and institutions for disabled and chronically ill persons, MHI pays a fixed contribution to cover care-related inpatient long-term care costs; the patient pays at most 20 percent of care-related costs that are not covered, and the remaining care-related costs are financed by the canton or the municipality.

Almost half of the total Spitex expenditure of, as of 2014, is financed by government subsidies. MHI and the other social insurances covering the cost of medically necessary health care at home made up roughly one-third. The rest (18.0%), devoted mainly to support and household services, was paid out-of-pocket, by old age and disability benefits, by VHI, or by other private funds.