Switzerland: health care indicators

Group 1: Germany, Netherlands, Slovak Republic, Switzerland

A. Efficiency and quality

B. Amenable mortality by group of causes

Data not available

C. Prices and physical resources

D. Activity and consumption

E. Financing and spending mix

F. Policy and institutions

Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country).

In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).

In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.

In Panel F, data shown are simple deviations from the OECD average.

**SWITZERLAND**

**GROUP 1:** Extensive reliance on market mechanisms in regulating both basic and “over-the-basic” insurance coverage and abundant private provision of health care.

<table>
<thead>
<tr>
<th>Efficiency and quality</th>
<th>Prices and physical resources</th>
<th>Activity and consumption</th>
<th>Financing and spending mix</th>
<th>Policies and institutions</th>
<th>Weaknesses and policy inconsistencies emerging from the set of indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>High DEA score and low inequalities in health status</td>
<td>High health care spending per capita and as a share of GDP</td>
<td>Large share of out-of-pocket payments</td>
<td>Less levers for competition for insurers offering basic insurance cover as they are not allowed to contract selectively with providers</td>
<td></td>
<td>Assess the potential merits of selective contracting clauses</td>
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<tr>
<td>Mixed scores on output/hospital efficiency</td>
<td>More high-tech equipment and less acute care beds</td>
<td>Higher in-patient share</td>
<td>Less information for users on the quality and prices of services</td>
<td></td>
<td>More information on the quality and prices of services could raise competition and contain health care prices</td>
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<tr>
<td>High quality of out-patient and preventive care</td>
<td>More doctors and nurses per capita</td>
<td>Less doctor consultations per capita</td>
<td>Low drug share</td>
<td>Less gate-keeping and more out-of-pocket payments</td>
<td>The balance between gate-keeping and out-of-pocket payments, as mechanisms to avoid excessive demand, could be examined</td>
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<tr>
<td>Administrative costs are broadly in line with the group average</td>
<td>High health care prices</td>
<td></td>
<td>More decentralisation but less consistency in responsibility assignment across levels of governments</td>
<td></td>
<td>Improved consistency in the allocation of responsibilities across levels of government could help exploiting efficiency gains</td>
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