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Foreword

This review of the Swiss health system was undertaken jointly by the OECD Secretariat and the World Health Organisation (WHO) at the request of the Swiss Federal Office of Public Health. It follows the OECD reviews of the health systems of Korea (2003), Mexico (2005) and Finland (2005).

The review assesses the institutional arrangements and the performance of the Swiss health system against key policy goals of effectiveness and quality, access and consumer satisfaction, efficiency and financial sustainability. It discusses the factors affecting performance and offers an assessment of the challenges the system faces for the future and the need for reform. In so doing, it aims at furthering the debate on health reforms in Switzerland through a review of the strengths and weaknesses of the current system and an evaluation of alternative paths of reform.

Within OECD, the main authors of this report were Francesca Colombo, Pascal Zurn (seconded from WHO) and Howard Oxley, assisted by Maria Luisa Gil Lapetra and Maartje Michelson. Contributions and comments were received by several members of the OECD Secretariat, including Elizabeth Docteur, Martine Durand, Claude Giorno, John Martin and Peter Scherer. WHO's input was provided by the Regional Office for Europe in Copenhagen in collaboration with WHO headquarters in Geneva, with contributions from Guy Carrin, David Evans, Christian Gericke, Joseph Kutzin, Valérie Nadrai and Elke Jakubowski.

The completion of this report would not have been possible without generous support from the Swiss authorities. The report benefited from the expertise of, and the material received from, many Swiss officials and health experts that the review team met during a mission to Switzerland in August 2005. These included officials from different federal offices and agencies, in particular the Federal Office of Public Health and the Federal Office of Statistics; authorities from the cantons of Jura, Neuchâtel, St. Gallen and Zurich; health insurers; hospitals, nursing homes and health professionals; consumer associations and non-governmental organisations; the pharmaceutical industry; and other health experts. The review team is especially thankful to the members of the International Affairs Division of the Swiss Federal Office of Public Health for their help in preparing the mission and co-ordinating the supply of data, in particular Delphine Sordat, Laurence Krattinger and Gaudenz Silberschmidt.

A draft report was presented to a seminar organised by the Swiss Federal Office of Public Health, the OECD and the WHO in April 2006 in Bern (Switzerland). The final report has benefited from comments by Swiss health experts and representatives from other OECD countries who participated in that seminar and provided valuable comments. The review team is particularly thankful to Kimmo Leppo from the Ministry of Social Affairs in Finland and to Mr. Roel Bekker, Mr. Frido Kraanen and Ms. Ingrid Linnemans from the Ministry of Health, Welfare and Sport of the Netherlands who attended the seminar as representatives of the OECD Group on Health and who kindly acted as discussants for the draft report.

Table of Contents

Executive Summary 11

Introduction 15

Chapter 1. **Organisation of the Swiss Health System** 17

1.1. Salient features of Switzerland 19
1.2. The economic size of the health sector 29
1.3. Governance of the Swiss health system 29
1.4. Health financing and insurance coverage 31
1.5. Health service delivery 39
1.6. Provider payments, reimbursement and contracting 54
Notes 59

Chapter 2. **The Performance of the Swiss Health System: Effectiveness and Quality** 63

2.1. Health levels and inequalities 64
2.2. Lifestyle and risk factors 70
2.3. Prevention of diseases and health promotion 74
2.4. Quality of care 80
Notes 85

Chapter 3. **The Performance of the Swiss Health System: Access to Care and Health-system Responsiveness** 89

3.1. Access to health care and coverage 90
3.2. Responsiveness of the Swiss health system 103
Notes 108

Chapter 4. **The Performance of the Swiss Health System: Efficiency and Financial Sustainability** 111

4.1. The financial sustainability of health spending 112
4.2. The efficiency of the Swiss health system 124
Notes 141

Chapter 5. **Recent and Proposed Reforms to the Swiss Health-insurance System** . . 145

5.1. The first revision of the LAMal 146
5.2. The second revision of the LAMal 147
5.3. Further reforms in the area of long-term care 151
Notes 151

Chapter 6. **Policy Challenges and Options for Reform** 153

6.1. Effectiveness and quality of the Swiss health system 156
6.2. Access to care and financial protection 159
6.3. Efficiency and financial sustainability 161
6.4. Systemic issues for the longer-term 171

List of Acronyms 175

Canton Abbreviations 177

References 179

List of boxes

1.1. The social health-insurance system under the LAMA 19
1.2. Main responsibilities for health at federal, cantonal and municipal levels . . 31
1.3. LAMal: key regulatory requirements relative to insurance coverage 35
1.4. Selected institutions involved in health-promotion and prevention activities in Switzerland 44
2.1. HIV/AIDS prevention activities. 77
2.2. The French Public Health Policy Act 79
2.3. Cost-effective interventions to combat leading risk factors in Switzerland 81
2.4. Quality management and improvement in Switzerland: selected initiatives . . . 84
3.1. Procedures for including or excluding goods and services in the LAMal benefit package. 94
3.2. Cross-cantonal differences in the management of premium subsidies 101
3.3. Mechanisms to address consumer protection in Switzerland 106
4.1. Long-term projections for health and long-term care (LTC) spending. 116
4.2. The freeze in the opening of new medical practices 119
4.3. Ageing of the Swiss workforce and other emerging trends 120
4.4. Number and size of LAMal insurers 135
4.5. Improving risk-equalisation mechanisms 136
4.6. Measures taken by insurers to influence care delivery and control cost 139
6.1. Policy recommendations for reforming the Swiss health system 173

List of tables

1.1. Basic demographic indicators in Switzerland, 2003 23
1.2. Per capita national income by canton, 2003. 24
1.3. Indicators of public-health risks in OECD countries, 2003 or latest available year 27
1.4. Regulatory oversight in the Swiss health-insurance market. 33
1.5. Special insurance contracts within the mandatory health-insurance system (LAMal) 34
1.6. Financing of health expenditure in Switzerland, 2003 37
1.7. Resources available in the Swiss health-delivery system and other OECD countries, 2003 or latest available year 41
1.8. Public and private hospitals in Switzerland, 2003. 46
1.9. Proportion of foreign-born doctors and nurses in Switzerland, 2001. 49
1.10. Registration of foreign-trained nurses and midwives in Switzerland, 2004 . . 50
1.11. Distribution of health expenditure by type in OECD countries, 2003. 52

1.12. Hospital payment systems in Swiss cantons, 2004 56
1.13. Reimbursement for medically-needed treatments in shared wards and private rooms 58
2.1. Share of the population reporting their health as "good" or better in OECD countries, 1992 and 2002 69
2.2. Proportion of men and women under medical treatment during the last 12 months, Switzerland, 2002 69
2.3. Mortality rates for breast cancer in Swiss cantons among women aged 55-74, 1995-2002 70
2.4. Ten leading risk factors and diseases or injuries for mortality, Switzerland, 2002 72
2.5. Ten leading risk factors and diseases or injuries for burden of disease, Switzerland, 2002 72
2.6. Taxation on cigarettes and still wine in selected OECD countries, 2005 80
3.1. Health expenditure on different types of care by financing agent, Switzerland, 2003 92
3.2. Financing of Swiss health expenditure by the government, social insurance and households, 2003 95
3.3. Coverage of health insurance and the share of out-of-pocket payments in OECD countries, 2003 96
3.4. Subsidies to low-income individuals for the purchase of health insurance 98
3.5. Importance of different mandatory health-insurance products, 1996-2003 101
3.6. Evolution of subsidies for low-income individuals and number of beneficiaries, 1996-2003 102
3.7. Health-care resources by canton 103
3.8. Cantonal health-system resources, LAMal spending and the economic capacity of cantons 104
3.9. Perceived adequacy of Swiss medical services and payers, 1992-2002 105
4.1. Expenditure on in-patient, out-patient and drugs in Switzerland, 1985-2003 . . . 117
4.2. Indicators of intensity of use of health-care resources in OECD countries, 2003 or latest available year 127
4.3. In-patient productivity and bed-operating ratios in OECD countries, 1993 and 2003 128
4.4. Parallel hospital financing in Switzerland, 2002 131
4.5. Administrative costs, loss ratios and reserves of LAMal-insurer, 1996-2003. . 141
5.1. Federal Council's proposals to Parliament for the latest revision of the Health-insurance Law (LAMal) 148

List of figures

1.1. The health system in Switzerland: financial flows, 2005 20
1.2. Map of Switzerland 21
1.3. GDP per capita in OECD countries, 2004 21
1.4. Increasing life expectancy in Switzerland, 1960-2003 24
1.5. Life expectancy at birth and at age 65 in OECD countries, 2003 or latest available year 25
1.6. The Swiss population by age group, 2005 and 2050 26
1.7. Share of the population considering their health to be good or very good in OECD countries, 2003 or latest available years 26

1.8. Mortality and fertility in selected OECD countries, 2003 or latest available year . . . 28
1.9. Share of selected causes of mortality, early 2000s . . . 28
1.10. Health expenditure in OECD countries as a percentage of GDP, 2003 . . . 30
1.11. Per capita health expenditure and per capita GDP in OECD countries, 2003 . . . 30
1.12. Financing of health expenditure in OECD countries, 2003. . . . 39
1.13. Evolution in the relative share of health-financing agents in Switzerland, 1990-2003. . . . 40
1.14. Expenditure on health promotion and prevention as a share of total health expenditure in OECD countries, 2003 . . . 42
1.15. Funding of health promotion and prevention activities in Switzerland, by financing agent, 2004 . . . 42
1.16. Main health promotion and prevention programmes of the Swiss Federal Office of Public Health by level of funding, 2004 . . . 43
1.17. Acute-care beds in Switzerland and in selected OECD countries, 1980-2003 . . . 45
1.18. Evolution of the density of doctors in Switzerland and in selected OECD countries, 1980-2002 . . . 48
1.19. Expenditure on pharmaceuticals per capita in OECD countries, 2003 . . . 51
1.20. Share of expenditure for out-patient pharmaceuticals paid by the government or social insurers in OECD countries, 2003. . . . 53
1.21. Country of origin of drugs sold in the Swiss domestic pharmaceuticals market . . . 53
2.1. Potential years of life lost per 100 000 population, Switzerland and OECD average, 1960-2002 . . . 64
2.2. Mortality rates for ischaemic heart and cerebro-vascular diseases, Switzerland and selected OECD countries, 2002 . . . 65
2.3. Mortality rates for all cancers, Switzerland and selected OECD countries, 2002 or latest available year . . . 66
2.4. Mortality rates for breast, prostate and lung cancer, Switzerland and OECD average, 1960-2002. . . . 67
2.5. Mortality rates for mental-health disorders, Switzerland and OECD average, 1995-2002. . . . 68
2.6. Selected indicators of health-care quality, Switzerland and OECD average . . . 71
2.7. Increasing overweight and obesity rates among the adult population, Switzerland and OECD average, 1992-2002. . . . 73
2.8. Fruits and vegetable consumption, Switzerland and OECD average, 1961-2002 . 73
2.9. Suicide rate per 100 000 population in selected OECD countries, early 2000s. . . . 77
2.10. Immunisation coverage for diphtheria, tetanus, pertussis and measles for young children, Switzerland and OECD countries, 2003 . . . 78
3.1. Health expenditure on different types of care by financing agent in selected OECD countries, early 2000s . . . 93
3.2. Out-of-pocket expenditure as a share of total household consumption, 2003 or latest available year . . . 97
3.3. LAMal premia as a share of disposable income, after the payments of premium-reduction subsidies . . . 99
3.4. Income per capita, premia, subsidies and number of beneficiaries: correlations . . . 100
3.5. Premium variation within and across cantons, 2005 . . . 107

4.1. Average annual real growth rate of per capita GDP and health spending in the OECD, 1996-2003 113
4.2. Change in health expenditure as a share of GDP between 1996 and 2003 . . . 113
4.3. Health expenditure under the LAMal, 2003 114
4.4. Growth in LAMal premia and in the consumer price index. 114
4.5. Physician density and average LAMal premia across Swiss cantons 118
4.6. Medical technologies in Switzerland and other OECD countries, 2003 122
4.7. Doctors' income in Switzerland and other OECD countries, latest available year 123
4.8. Life expectancy at birth and health spending per capita, 2003. 125
4.9. Average length-of-stay for acute care in OECD countries, 1990 and 2002 126
4.10. Cardio-vascular procedures, Switzerland and OECD countries, 2003 129
4.11. Health-care resources and utilisation across Swiss cantons. 130
4.12. Share of cataract and tonsillectomy surgeries carried out as day cases in OECD countries, 2003 132
4.13. Administrative expenditure as a share of total health spending in selected OECD countries, early 2000s 140

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Executive Summary

The Swiss health system meets a range of important goals set for it. Measures of health status compare well with other OECD countries. It has achieved universal health-insurance coverage, permitting access to a broad range of health-care services. Up-to-date medical services are widely available and patients are largely satisfied with the health services they receive. However, these successes come at a high financial cost. Spending on health as a share of GDP (or GNP) is among the highest in the OECD area, and continues to increase more rapidly than GDP. At the same time, other OECD countries perform equally well, or even better, at lower levels of health spending.

Responsibility for health policy is fragmented, reflecting the division of powers in the Swiss federal system. In practice, there are 26 health systems with little linkage between them, making difficult the development of consistent national policies and wider markets for health-care insurance and provision.

Finding a better balance between prevention and cure

Despite a range of prevention and health promotion programmes, fragmentation of responsibilities in the area of disease prevention and health promotion has favoured dispersed and largely un-coordinated activities. Policy co-ordination would benefit from a framework law governing policies in this area. In introducing specific prevention and health promotion programmes, the Swiss authorities should focus on areas that are of particular attention for public health (such as tobacco and alcohol consumption) or where inadequate attention has been paid in the past (such as mental health and obesity). Cost-effective prevention measures should be emphasised.

Greater transparency over quality and effectiveness of care is needed

Nation-wide indicators of quality of care are lacking and a national effort to collect data on care quality should be put in place. The existing reliance on professional self-regulation to ensure quality of care may not be sufficient to guarantee that best-practice standards of care are being met. Professional self-regulation can be improved by further development of best-practice guidelines, more information on medical errors and better links between performance and rewards and sanctions.

The system of premium subsidies could benefit from greater consistency across cantons

While financing of the Swiss health care is regressive, access to health care appears to be ensured by the existing premium subsidies and cost-sharing exemptions. However, there

remain large cross-canton differences in subsidy levels and eligibility conditions. Policy coherence would benefit from the establishment of minimum standards across cantons as regards income cut-off points for receipt of subsidies and minimal levels of subsidy.

There is scope for increasing the cost-effectiveness of the health-care system

Insurance and supply of care need to be organised on a multi-canton or national basis and redundant capacity cut back. Current financing and payment arrangements encourage high levels of provision and favour higher-cost hospital care. DRG-type payments for impatient care should promote greater efficiency in provision and shorter hospital stays, augmenting available supply. Primary care should shift towards payment systems with a larger prospective or capitation component and gatekeeper or family doctor arrangements should be encouraged. Cost pressures may also be eased by more careful examination of the services covered by the basic benefit package and by strengthening technology assessment, especially for new treatments.

Greater competition may help control costs but needs supporting reforms to make it work

Greater use of generics would reduce costs and more foreign competition in the market for non-patented drugs will place downward pressure on pharmaceutical drug prices. Price-setting for patented products should use a wider range of countries as benchmarks. Competition in insurance markets should be strengthened and aligned with incentives to increase quality and efficiency. Selective contracting should be allowed in the in-patient as well as the ambulatory sector, but insurers should purchase on the basis of quality and access to care as well as price. Cutbacks in supply should not be prevented by cantons "bailing out" loss-making providers. Better information needs to be made available on the performance of the health-care system and of individual providers and insurers.

Longer-term gains in performance require changing health-system governance

Fragmentation of responsibilities – as for prevention and health promotion – could be reduced through an overarching framework law for health, setting out national objectives, funding responsibilities and the tasks attributed to the various levels of government. Existing arrangements such as LAMal and a potential law on prevention could be embedded therein. Constitutional change would seem to be required to achieve this. But the recent referendum in the area of education shows that measures to improve policy coherence in the area of health are possible if there is sufficient policy consensus behind them.

Introduction

This study reviews the Swiss health system. It has two main objectives. First, it uses a comparative-analysis framework to assess system performance against key policy objectives of health-system effectiveness and responsiveness, access to care and equitable financing, efficiency of provision, and financial sustainability (see OECD, 2004b). Second, it focuses on system's weakness and discusses potential areas of reform to improve performance.

The Swiss health system exhibits many well-recognised achievements, for example in terms of good health outcomes and high responsiveness to patients' expectations thanks to a largely unconstrained choice of provider and access to care through full health-insurance cover. Nonetheless it also faces several challenges. New emerging public-health concerns, such as mental health and obesity, challenge the ability of current governance arrangements to address public-health issues satisfactorily. A major health-insurance reform was implemented in 1996, which secured population-wide access to a comprehensive range of modern health services by mandating the take up of health-insurance coverage offered by competing insurers. However, the health-insurance reform goals of containing the ongoing rise in health spending *via* increased insurance market competition have not been achieved and there has been little effort to encourage and measure quality of care. The associated high level of health spending has raised concerns about value for money. Several proposals for further reforms have been put forward and much discussion exists about alternative measures concerning, in particular, ways to improve efficiency.

In addressing those challenges, policy makers confront a difficult environment for reform arising, in large part, from the current institutional features of the Swiss governance system. An overarching federal framework for governance in the health system is absent, obstructing efforts to implement national policies in areas such as health prevention and promotion. Information systems are inadequate to inform evidence-based policy debate and decision making. The system is fragmented with a high degree of autonomy of Swiss cantons leading to 26 sub-systems of provision. At the same time there are multiple-insurance systems and competing health insurers pool risks over very small areas and populations. As a result, cantons often lack adequate size to organise health-supply efficiently and effective competition among insurers remains weak. Demand- and supply-side incentives do not appear to encourage cost-efficiency. The system allocates resources on the basis of a combination of planning by cantons and managed competition across insurers. This mixed structure often creates tension between stakeholders which are motivated by conflicting political and economic incentives. Not surprisingly then, very different views have developed concerning the appropriate direction for reform. Since any major reform of the health system will

require ratification in a popular referendum, building a national consensus for change is particularly important.

The report begins with a description of the key characteristics of the financing, provision and provider-payment mechanisms of the Swiss health system. This is followed in Chapter 2 by a discussion of the evidence on the performance of the health system in terms of health attainments, the balance between health prevention and cure, and quality of health-care services. Chapter 3 examines the strengths and weaknesses of the Swiss health system with regard to equitable coverage for and access to health care, as well as responsiveness to patient needs. Chapter 4 looks at factors underlying the rapid increase in health spending and potential areas of efficiency gains while Chapter 5 provides an overview of the current state of recent reforms and reform proposals. The final chapter provides an overall evaluation and makes recommendations for further reforms.

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Chapter 1

Organisation of the Swiss Health System

This chapter describes the key characteristics of the Swiss health system. It identifies the main actors operating within the system and highlights their roles and relationships. Section 1.1 provides some background on salient features of Switzerland, its administrative/political structure, the characteristics of the population, and the social environment. Section 1.2 provides a brief overview of the size of the health system, and its importance within the Swiss economy. Next, in Section 1.3, the chapter focuses on governance, and the sharing of responsibilities for health policy development, and for implementation and provision. Section 1.4 explains arrangements for the financing of the health system, as well as those for the insurance coverage of the population. This is followed, in Section 1.5, by a description of the organisation of health service delivery and the relationship between providers and patients. A final section explains payment and contractual arrangements between providers and third-party payers.

Since Switzerland adopted a federal constitution in 1848 which gave only limited responsibility to the federal state in the field of health, the high degree of autonomy of Swiss cantons has moulded the Swiss health system. From this time until today, there has been continuous discussion over the respective roles and responsibilities of the cantons and of the Swiss confederation leading, over the years, to a modest expansion in federal responsibilities.

As in many OECD countries, the development of the health-care system in Switzerland during the 20th century has been characterised by a strong emphasis on curative care and the key role of the medical profession, while health promotion and disease prevention policies gained greater attention only during the last 25 years.

While health-care provision has remained a cantonal responsibility, social insurance has been a federal responsibility since the beginning of the 20th century. Prior to the introduction of a federal law on health insurance in 1911, health coverage was provided by a large diversity of community insurers. Membership was mainly based on trade union affiliation, on employment activity, religious background, and geographical location. The number of community insurers was estimated to be 2 006 in 1903, covering only 14% of the population. Community insurers were small: half had less than 100 members and 50% were only present in one municipality. Moreover, lack of co-ordination between community insurers, arbitrary selection of members and unclear mechanisms to fix premia were not unusual (Mulheim, 2003).

To address problems of pooling fragmentation, the government first proposed a federal Health-insurance Law in 1889 which included compulsory coverage for all workers up to a certain income level, but the proposal was rejected in a referendum. The first federal law on sickness and accident insurance (LAMA)[1] was adopted in 1911. Its scope was less ambitious than the 1889 proposal. Initially, the law aimed simply at subsidising recognised health insurers and imposing minimal regulatory requirements (Box 1.1). Over the years, various revisions were introduced, including regulations to facilitate portability of insurance and better definition of benefits covered by the LAMA. In 1994, concerns about rising health-care costs, equity of coverage and provision of high-quality services led to the adoption of a new federal law on health insurance (LAMal).[2]

Today, the Swiss health system is financed to a significant extent (one-third) through compulsory health-insurance[3] premia that are defined by insurers operating under community risk pooling arrangements rather than on the basis of earnings or income. On 1 January 2004, nearly 7.4 million Swiss residents had mandatory insurance, of which 71% were adults, 21% were children, and 8% were young people in training (Office fédéral de la santé publique, 2004d). The number of insurees has remained fairly stable since 1996 and there are virtually no uninsured people. Figure 1.1 illustrates schematically the Swiss health system.

Box 1.1. **The social health-insurance system under the LAMA**

The 1911 Federal Law on Sickness and Accident Insurance (LAMA), a federal law inspired by a Bismarckian model of social insurance, covered health insurance in Switzerland until it was replaced by the LAMal in 1996. The 1911 Law established a basic benefit package, but affiliation remained predominantly voluntary and insurance conditions varied greatly across insurers (all of which were non-profit sickness funds). Individual premia were calculated on the basis of the age of entry into the fund and the sex of the person insured. Premia for women could be up to 10% higher than those for men, while age of entry into the fund led to large variations in premia**.** Nominal premia were unrelated to earnings. Bad risks could not move freely across insurers because sickness funds could refuse cover and charge premia irrespective of the premia charged under the contract with a previous sickness fund. Solidarity was difficult to achieve under such conditions. Competition across sickness funds was not fair either. Sickness funds received financial subsidies from the government that only imperfectly accounted for differences in risk structures across insurers (a problem that has continued even after the introduction of the risk-adjustment system under the LAMal). Funds with a higher percentage of bad risks were forced to charge higher average premia, which created incentives for younger and healthier people to leave the fund. Some sickness funds disappeared from the market or had to merge with others to avoid bankruptcy. Although the need to revise and modernise the LAMA emerged since the 1960s as a result of growing cost pressures and concerns over solidarity, voters rejected all attempts to correct its weaknesses until the new federal Health-insurance Law was ratified in 1994 and came into effect in 1996 (Gilliand, 1990).

Source: Adapted from Colombo (2001).

1.1. Salient features of Switzerland

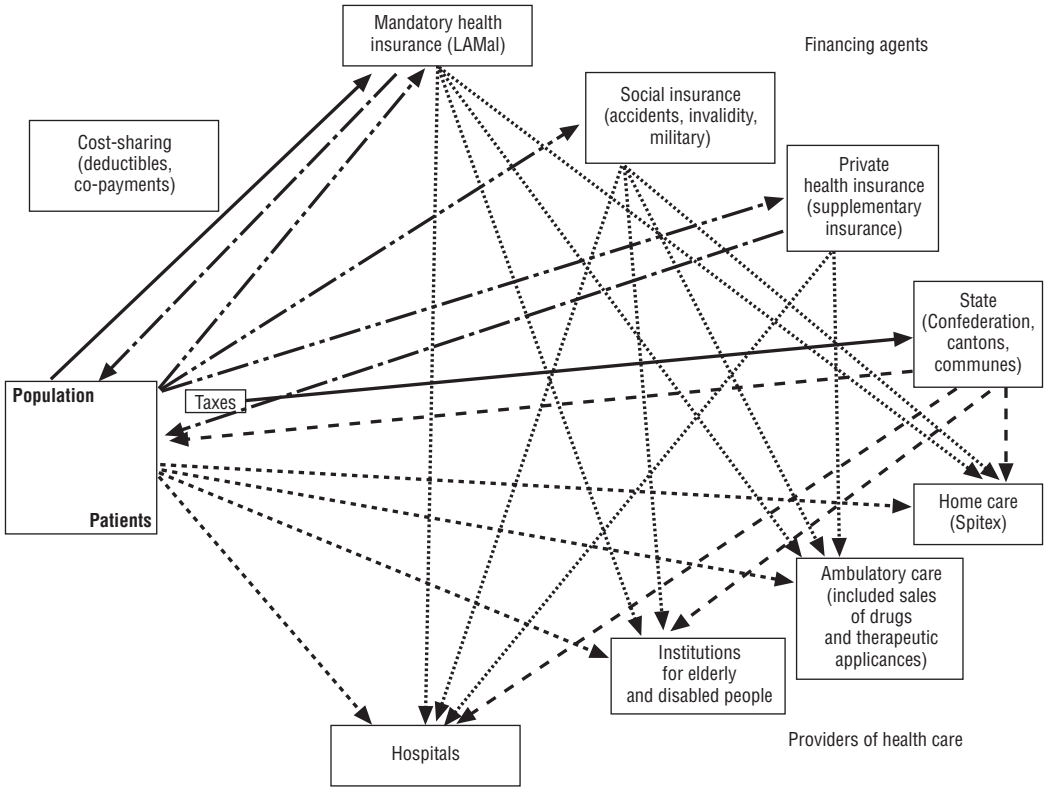
Switzerland is a small country[4] of 7.4 million inhabitants covering a territory of 41 285 km^2. It is a federal state, made up of 26 cantons (Figure 1.2). The native language of about 65% of the population is German, 20% is French, and 6.5% is Italian. A small fraction of the population speaks Romansh (0.5%) as their native tongue, while other non-official languages make up the remainder (Office fédéral de la statistique, 2005c).

1.1.1. Political and administrative structure

Government responsibilities in the Swiss federal structure are split between three different levels: the confederation; the cantons (26); and the municipalities (2 873 in 2004, but decreasing over time). There is considerable decentralisation of powers to lower levels of government. Each canton has its own constitution, parliament, government and courts and the cantons hold all powers not specifically delegated to the confederation. The confederation has varying degrees of responsibilities in areas such as foreign policy, national security, monetary policy, environment, health and transportation. Finally, the municipalities have authority in several domains, including education, social policy, and local planning, with varying levels of autonomy in decision making, as granted by each canton.

The Swiss confederation has been characterised by the stability and continuity of its political institutions. The legislative powers are exercised by a parliament with two chambers: the National Council, where individual cantons are represented in proportion to the number of their inhabitants, and the Council of States, where each canton is represented by two members.[5] Members of both chambers are elected directly by the

Figure 1.1. **The health system in Switzerland: financial flows, 2005**



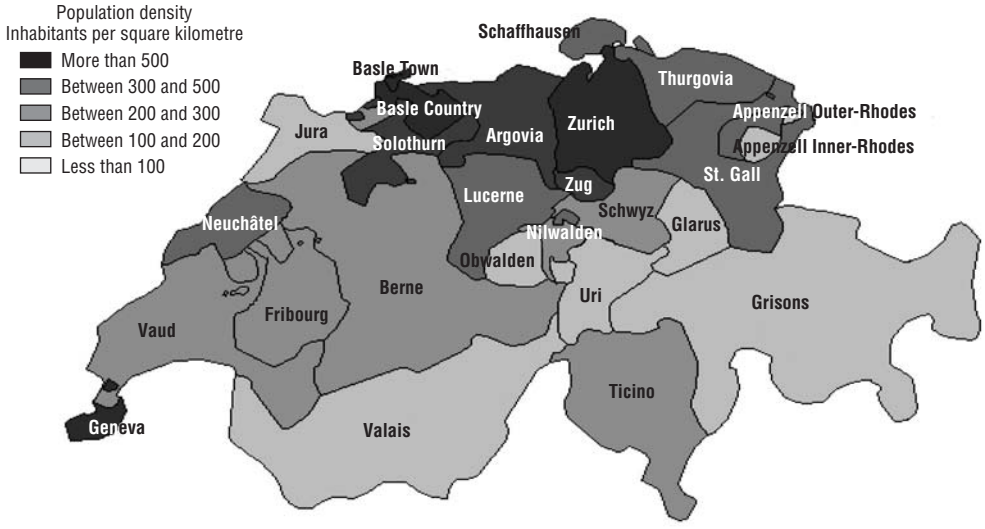
Source: OECD (2005), *OECD Health Data 2005*, Paris.

people.[6] The government consists of seven members of the Federal Council and is elected every four years by the assembly of both parliamentary chambers. Its presidency rotates among the seven ministers. The highest rulings are made by the Federal Supreme Court in Lausanne, the Federal Insurance Court in Lucerne, and – since 2004 – by the Federal Criminal Court in Bellinzona.[7]

One distinguishing feature of the Swiss political system is the right of initiative and referendum by the population. The right of initiative (made upon the request of at least 100 000 voters) concerns modifications to the federal constitution. A referendum can be initiated in relation to a new or an amended legislation and must be requested by at least 50 000 voters. In some cases, a referendum is mandatory according to the constitution, for example, for joining supra-national organisations.

Relations with the European Union, which accounts for 50% of Switzerland's trade, have been at the forefront of public debate for many years. Switzerland is not an EU member but has bilateral agreements with the European Union. Those agreements have greatly facilitated the free movement of persons between EU member states and Switzerland. As a result, a progressive opening of labour markets between the EU and

Figure 1.2. **Map of Switzerland**



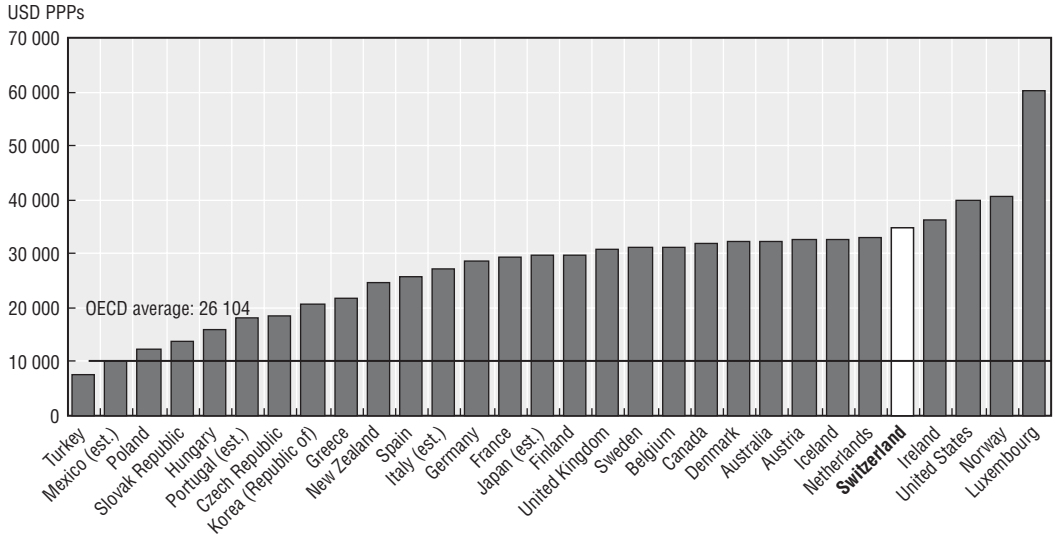
Source: OECD (2005), *Territorial Grids of OECD Member Countries*, Paris.

Switzerland is taking place. The mutual recognition of diplomas of medical doctors and nurses is one measure in the health sector illustrating this trend.[8]

1.1.2. Social and economic context

Switzerland is one of the richest OECD countries. Measured by GDP per capita, it ranks fifth after Luxembourg, Norway, the United States and Ireland (Figure 1.3). Its per capita GDP of nearly USD 35 000 PPPs in 2004 was a fourth higher than the OECD average of USD 26 000 PPPs. The Swiss main economic sectors include microtechnology,

Figure 1.3. **GDP per capita in OECD countries, 2004**



Source: OECD (2005), *System of National Accounts*, Paris.

biotechnology and pharmaceuticals, as well as banking and insurance. A key characteristic of the Swiss economy is its openness to international trade and investment (OECD, 2005d), although there are still strong barriers to imports and high subsidies to domestic producers.

Cantons vary considerably with respect to their size (on average, 40 km^2), demography, and socio-economic situation (Table 1.1 and Table 1.2). The canton of Zurich, with a population of 1.2 million inhabitants, is the most populated, whereas the half-canton of Appenzel Inner Rhodes has a population of only 15 000 inhabitants. Population density varies by a factor of 190 between the most densely populated canton of Basel City and the more sparsely populated canton of Grisons (Office fédéral de la statistique, 2005c). Approximately 75% of the Swiss population lives in urban areas with large cross-cantonal differences, with 13% living in the largest cities[9] of Zurich, Geneva, Basel, Bern and Lausanne (Office fédéral de la statistique, 2004c). In terms of income and financial capacity, wide inequalities exist. The income per capita of the canton of Basel-Town, the highest in Switzerland, is more than twice that of the canton of Obwalden, the lowest (Office fédéral de la statistique, 2005c). A fiscal equalisation mechanism – financed by the confederation and by the wealthiest cantons – compensates, to a large extent, for differences in cantonal tax revenues. Despite a low unemployment rate (around 4% in 2004), the Swiss economy lacks dynamism and productivity gains are weak compared with other OECD countries (OECD, 2006a).

1.1.3. Demographics trends

Compared with other OECD countries, the Swiss population is relatively old. In 2003, the share of the population over 65 was 15.7%, while 22.5% were below the age of 19, compared with OECD averages of 14.1% and 25.4%, respectively (OECD, 2005a). Switzerland has experienced a progressive ageing trend as a result of falling fertility and lengthening lifetimes. Fertility rates have declined since the 1970s. Life expectancy at birth and at age 65 has been steadily increasing since the beginning of the century and this trend has continued since 1970 (Figure 1.4) – thanks to reductions in mortality rates which fell nearly by half during the period 1970-2001. With an estimated life expectancy at birth of 77.8 years for men and 83 years for women, Switzerland is 3 years and 2.3 years above the OECD average for men and women, respectively (Figure 1.5). Switzerland has the fourth highest life expectancy for men in the OECD area, behind Iceland, Japan and Sweden, and the third highest for women, behind Japan and Spain (OECD, 2005a). As a consequence, the number of over 64 years-old has more than doubled since 1950, while the number of over 80 years-old has quadrupled (Office fédéral de la statistique, 2004k).

The population has grown from 5.3 million inhabitants in 1960 to almost 7.4 million in 2004, rising at a yearly average rate of 0.7%, in line with the OECD average of 0.8% (OECD, 2005a). The share of the foreign-born population in the total is estimated at 22.4 %, which is – after Luxemburg and Australia – the highest among OECD countries (OECD, 2005f). Under assumptions of continued lengthening of lifetimes and stability in the fertility rate and immigration flows, the total population is expected to continue to grow until 2030, falling thereafter. It is projected to reach about the same levels as at the end of the 1990s in 2050 (United Nations, 2003). At the same time, the overall dependency ratio (ratio of the population over 65 to the population aged 19-64, in percent) is projected to increase from 48.5% of the population in 2005 to almost 80% in 2050. Conversely, the share of the

Table 1.1. **Basic demographic indicators in Switzerland, 2003**

		Population[1]	Share of the population living in cities[2]	Share of the population living in rural areas[2]	Population density[3]	Dependency ratio[4]	Old-age dependency ratio[5]
CH	Switzerland	7 364	73%	27%	178	0.61	0.25
AI	Appenzell Inner-Rhodes	15	0%	100%	87	0.78	0.28
AR	Appenzell Outer-Rhodes	53	53%	47%	218	0.69	0.28
AG	Aargau	561	65%	35%	399	0.59	0.22
BL	Basel-Country	264	92%	8%	511	0.61	0.27
BS	Basel-Town	187	100%	0%	5 045	0.61	0.33
BE	Bern	952	62%	38%	160	0.63	0.29
FR	Fribourg	247	55%	45%	148	0.63	0.21
GE	Geneva	424	99%	1%	1 501	0.58	0.23
GL	Glarus	39	0%	100%	56	0.68	0.28
GR	Grisons	187	49%	51%	26	0.62	0.26
JU	Jura	69	30%	70%	82	0.70	0.28
LU	Lucerne	353	51%	49%	236	0.65	0.25
NE	Neuchâtel	167	74%	26%	208	0.67	0.29
NW	Nidwalden	39	87%	13%	142	0.58	0.21
OW	Obwalden	33	0%	100%	68	0.66	0.23
SH	Schaffhausen	74	74%	26%	248	0.66	0.30
SZ	Schwyz	135	80%	20%	149	0.61	0.22
SO	Solothurn	247	77%	23%	312	0.63	0.27
SG	St. Gallen	457	67%	33%	226	0.65	0.24
TG	Thurgau	232	49%	51%	234	0.65	0.24
TI	Ticino	317	86%	14%	113	0.61	0.30
UR	Uri	35	0%	100%	33	0.67	0.27
VS	Valais	285	56%	44%	55	0.62	0.25
VD	Vaud	639	75%	25%	199	0.63	0.25
ZG	Zug	104	96%	4%	434	0.56	0.20
ZH	Zurich	1 250	95%	5%	723	0.56	0.24

1. Thousands of people at 31 December 2003.
2. As defined by the 2000 population census (Recensement fédéral de la population – RFP, 2000).
3. Inhabitants per squared km.
4. Defined as the population aged 0 to 19 and 65 and over divided by the population aged 20 to 64.
5. Defined as the population aged 65 and over divided by the population aged 20 to 64.

Source: Office fédéral de la statistique (2005), *Encyclopédie statistique de la Suisse*, Neuchâtel.

working-age population is projected to decrease from 62% in 2003 to 55% in 2050 (Figure 1.6) (United Nations, 2003).

1.1.4. *Epidemiological profile*

Swiss people generally perceive their health status as good. Around 86% of the population claims to be in good or very good health, compared with an OECD average of 68% (Figure 1.7) (OECD, 2005a). However, approximately 15% of the population report that they suffer from a chronic health problem affecting their daily life, and 13% of the population over 65 living in a private household report that they suffer from a severe handicap (visual problem, hearing impairment, mobility difficulties, etc.), or are limited in their daily activities (dressing, eating, etc.) (Office fédéral de la statistique, 2003c). While the share of the population that is overweight or obese is still below the OECD average (37% of the Swiss population is considered overweight compared with 48% OECD-wide), excess body mass is becoming an important public-health concern. Other indicators of public-

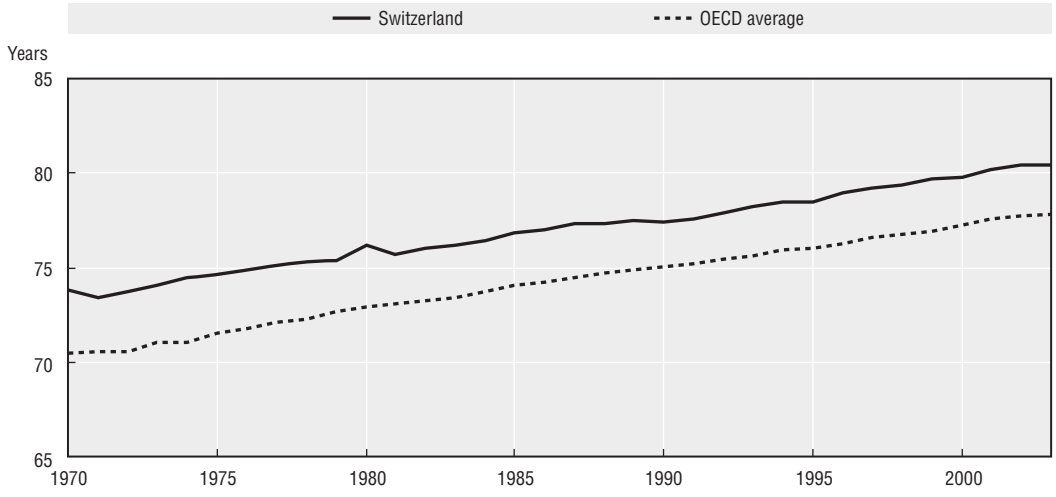
Table 1.2. **Per capita national income by canton, 2003**

By decreasing order

		CHF
BS	Basel-Town	99 865
ZG	Zug	86 499
ZH	Zurich	66 050
GL	Glarus	64 318
NW	Nidwalden	61 934
GE	Geneva	59 123
SH	Schaffhausen	52 781
BL	Basel-Country	51 849
VD	Vaud	51 332
CH	***Switzerland***	***51 230***
AG	Aargau	48 145
SZ	Schwyz	46 696
UR	Uri	45 630
GR	Grisons	45 565
NE	Neuchâtel	45 474
SO	Solothurn	43 902
SG	St. Gallen	43 388
TG	Thurgau	43 121
BE	Bern	43 066
AI	Appenzell Inner-Rhodes	42 633
AR	Appenzell Outer-Rhodes	42 232
LU	Lucerne	41 219
TI	Ticino	38 745
FR	Fribourg	38 342
VS	Valais	37 367
JU	Jura	36 901
OW	Obwalden	35 359

Note: CHF 1 = USD 0.740 and EUR 0.659 (2003).
Source: Office fédéral de la statistique (2005), *Comptes nationaux,* Neuchâtel; OECD (2005), *OECD Health Data 2005*, Paris.

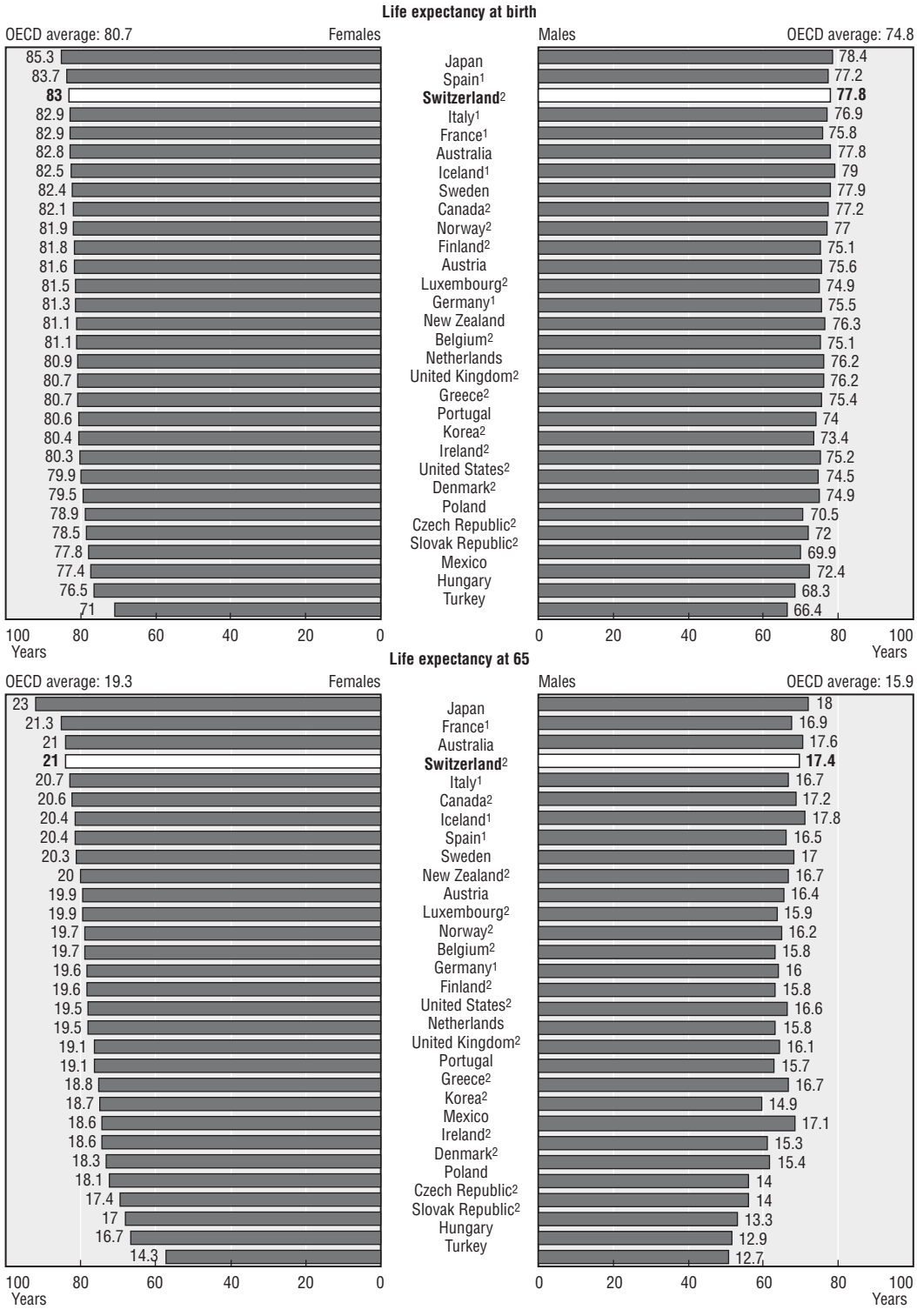
Figure 1.4. **Increasing life expectancy in Switzerland, 1960-2003**



Note: Up to the year 1985, the OECD average includes some countries with incomplete series. The OECD average excludes Korea.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 1.5. **Life expectancy at birth and at age 65 in OECD countries, 2003 or latest available year**

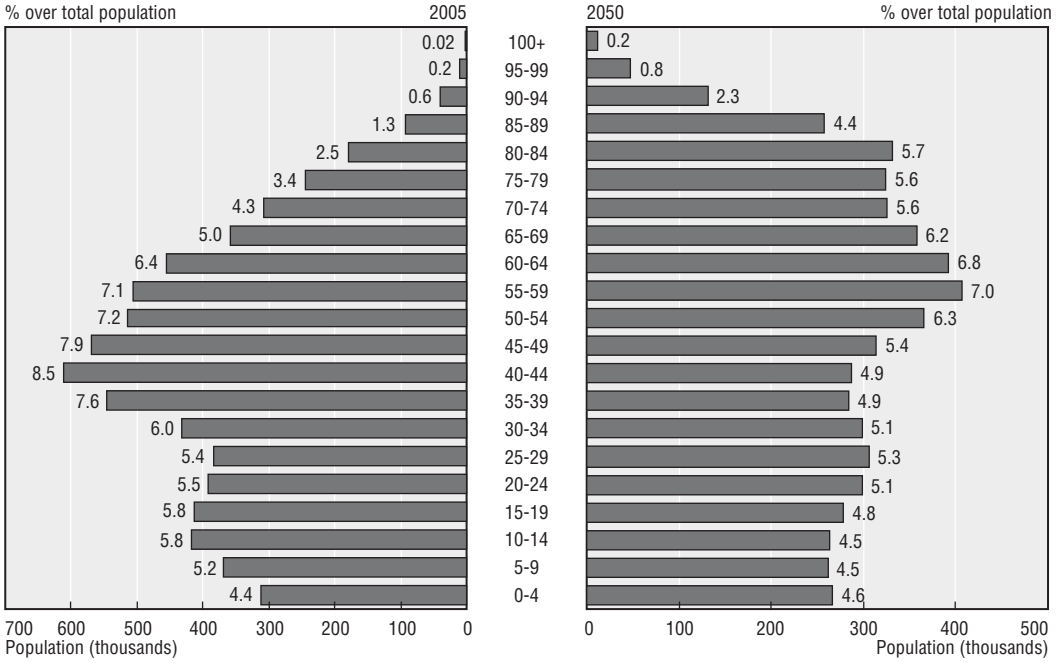


Note: Values ranked by decreasing order of female life expectancy at birth and at age 65 respectively.

1. 2001.
2. 2002.

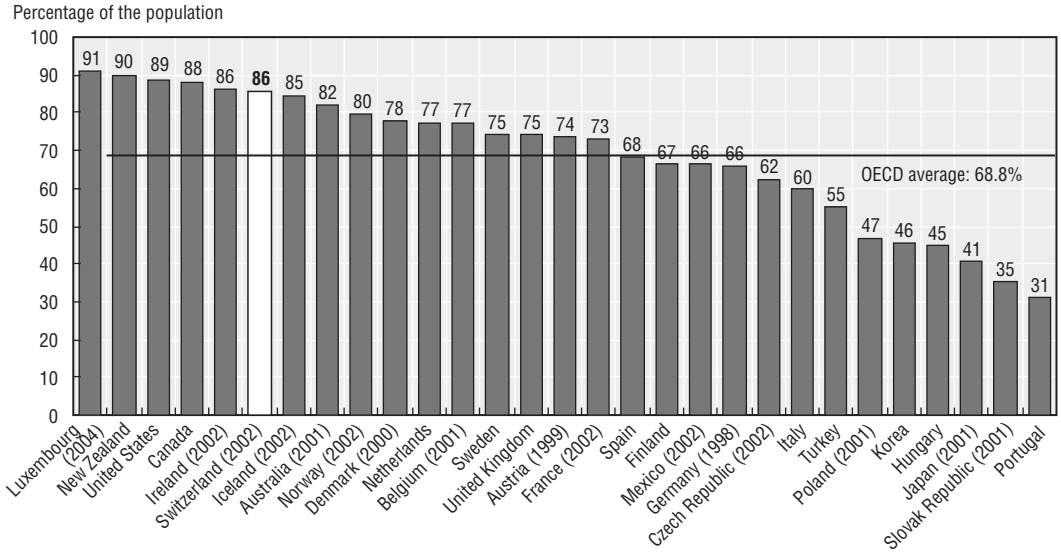
Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 1.6. **The Swiss population by age group, 2005 and 2050**



Source: United Nations (2003), *World Population Prospects 1950-2050 (The 2002 Revision)*, New York.

Figure 1.7. **Share of the population considering their health to be good or very good in OECD countries, 2003 or latest available years**



Source: OECD (2005), *OECD Health Data 2005*, Paris.

health risks show that tobacco and alcohol consumption are slightly over the OECD average (Table 1.3) (OECD, 2005a).

The overall age-standardised mortality rate in Switzerland is estimated at 550 deaths per 100 000 population, corresponding to the fourth lowest in OECD countries after Japan, Australia and Iceland (OECD, 2005a) (Figure 1.8). Non-communicable diseases, including

Table 1.3. **Indicators of public-health risks in OECD countries, 2003 or latest available year**

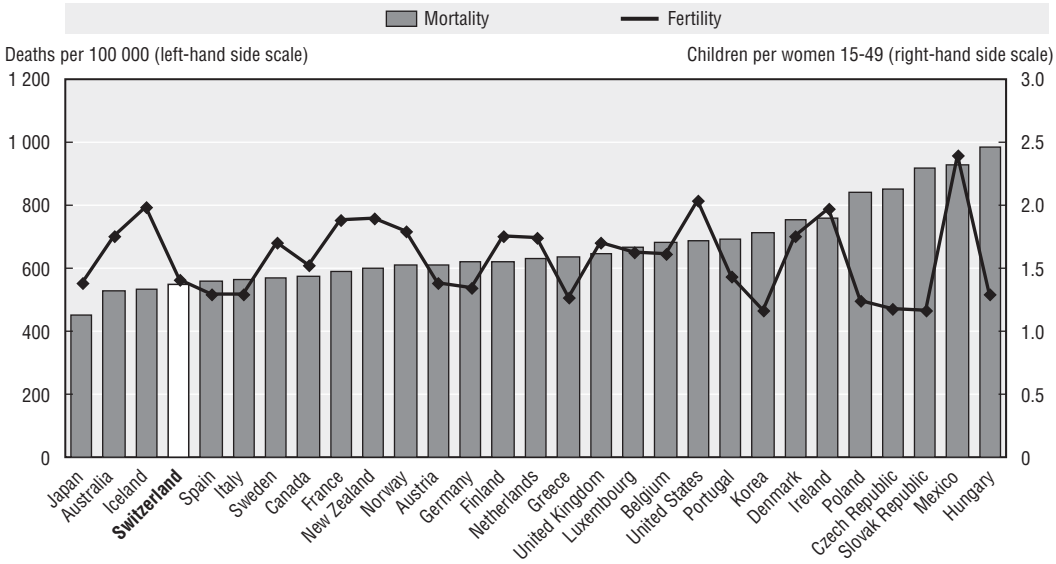
	Alcohol consumption (liters per capita for population over 15 years)	Tobacco consumption (% of daily smokers in the population)	Overweight and obese population[1] (% of the population with BMI > 25 kg/m^2)
Australia	9.8[2]	19.8[3]	58.4[4]
Austria	11.1	36.3[4]	46.1[4]
Belgium	10.7	27	44.4[3]
Canada	7.8[2]	17	46.5
Czech Republic	12.1	24.1[2]	51.1[2]
Denmark	11.5	28.0	41.7[5]
Finland	9.3	22.2	45.0
France	14.8[2]	27.0	37.5[2]
Germany	10.2	24.3	49.2
Greece	9.2[2]	35[5]	57.1
Hungary	13.4[2]	33.8	52.8
Iceland	6.5	22.4	48.8[2]
Ireland	13.5	27[2]	47[2]
Italy	8.0	24.2	42[2]
Japan	7.6	30.3	24.9
Korea	9.3	30.4	30.6[3]
Luxembourg	15.5	33[3]	52.8
Mexico	4.6	26.4[2]	62.3[5]
Netherlands	9.7	32.0	45[2]
New Zealand	8.9	25.0	56.2
Norway	6.0	26.0	42.7[2]
Poland	8.1	27.6[3]	n.a.
Portugal	11.4	20.5[4]	49.6[4]
Slovak Republic	7.6	24.3[2]	57.6[2]
Spain	11.7	28.1	48.4
Sweden	7.0	17.5	42.8
Switzerland	**10.8**	**26.8**[2]	**37.1**[2]
Turkey	1.5	32.1	43.4
United Kingdom	11.2	26.0	62.0
United States	8.3[2]	17.5	65.7[2]
OECD average	**9.6**	**26.4**	**47.9**

1. BMI stands for body mass index and it is defined as the mass in kg divided by the square of the height in meters. Estimates relate to the adult population (normally the population aged 15+ unless otherwise stated) and are based on national health interview surveys for most countries (self-reported data), except for Australia, New Zealand, the United Kingdom and the United States where estimates are based on the actual measurement of weight and height. This difference in survey methodologies limits data comparability, as estimates arising from the actual measurement of weight and height are significantly higher than those based on self-report data.
2. 2002.
3. 2001.
4. 1999.
5. 2000.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

age-related conditions, are the major cause of death in Switzerland, as in other OECD countries. Diseases of the circulatory system represented 40% of all deaths in 2000, followed by malignant neoplasm (cancers) with 25% of deaths and respiratory diseases with 6% of deaths (OECD, 2005a) (Figure 1.9). Over the past few years, the overall mortality rate has further decreased, due to fewer deaths from circulatory problems. However, mortality from mental health disorders, including Alzheimer's disease, and lung cancer among women is increasing (Office fédéral de la statistique, 2005e).

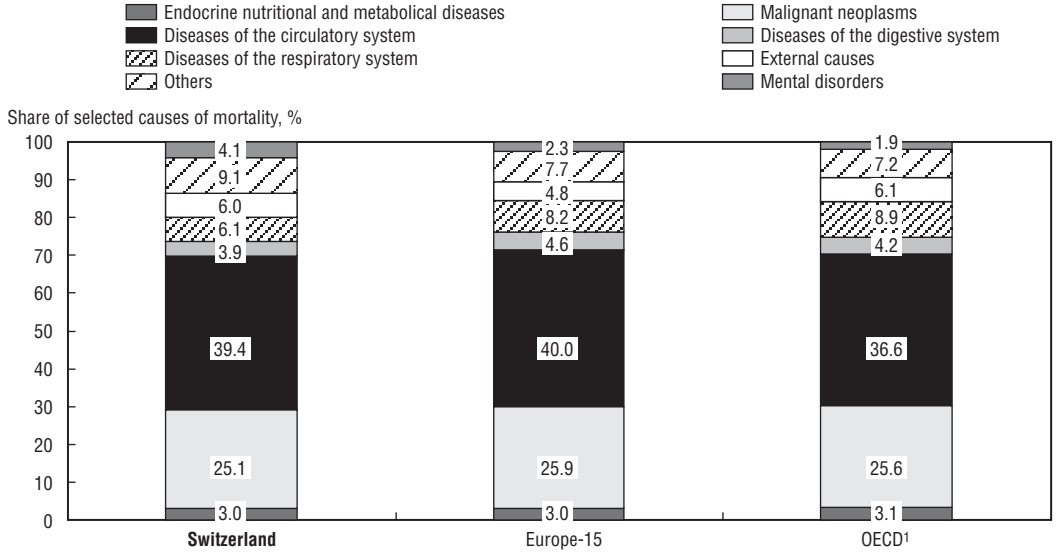
Figure 1.8. **Mortality and fertility in selected OECD countries, 2003 or latest available year**



Note:
Mortality:
Mexico: 1995. Belgium: 1997. Denmark and France: 1999. Canada, Ireland, Italy, New Zealand, Switzerland and the United States: 2000. Australia, Germany and Sweden: 2001. Greece, Iceland, Japan, Korea, Norway, Poland, the Slovak Republic, Spain and the United Kingdom: 2002.
Fertility:
Australia, Canada, Korea and Mexico: 2002.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 1.9. **Share of selected causes of mortality, early 2000s**

Switzerland and selected country groupings



Note:
Austria, the Czech Republic, Finland, Hungary, Luxembourg, and the Netherlands: 2003. Greece, Iceland, Japan, Korea, Norway, Poland, Portugal, the Slovak Republic, Spain and the United Kingdom: 2002. Australia, Canada, France, Germany, Ireland, Italy, Sweden, Switzerland and the United States: 2001.
Denmark and New Zealand: 2000.
1. The OECD average excludes Belgium, Mexico and Turkey.
Source: OECD (2006), *OECD Health Data 2005*, Paris.

1.2. The economic size of the health sector

As a share of GNP, Switzerland devotes more resources to health spending than any other OECD country apart from the United States and Germany. In 2003, Switzerland spent 10.7% of GNP on health, compared with 15% in the United States and 11.1% in Germany. Country comparisons are less favourable for Switzerland when data are normalised by GDP. In this case the share of spending is 11.5% of GDP and Switzerland ranks second after the United States (Figure 1.10).[10] In terms of per capita health expenditure, Switzerland has a similar ranking (Figure 1.11). Health expenditure as a share of GDP has been increasing steadily over time, rising by 2.4 percentage points between 1990 and 2003, above the OECD average increase of 1.5 percentage points. This increase is explained, to a certain extent, by the moderate growth in GDP in Switzerland over recent years. The share of total government spending devoted to health was 14% in 2003, of which nearly 13% was for cantonal subsidies to hospitals.[11]

With approximately half a million people working in the area of health (12% of total employment) this sector is one of the most important employers in Switzerland (Office fédéral de la statistique, 2003d). Employment growth over the past years has been significantly higher in the health sector than in the rest of the economy. Between 1985 and 2001, employment in the health sector increased by 70% compared with only 12% for the entire Swiss economy (Office fédéral de la statistique, 2003d).

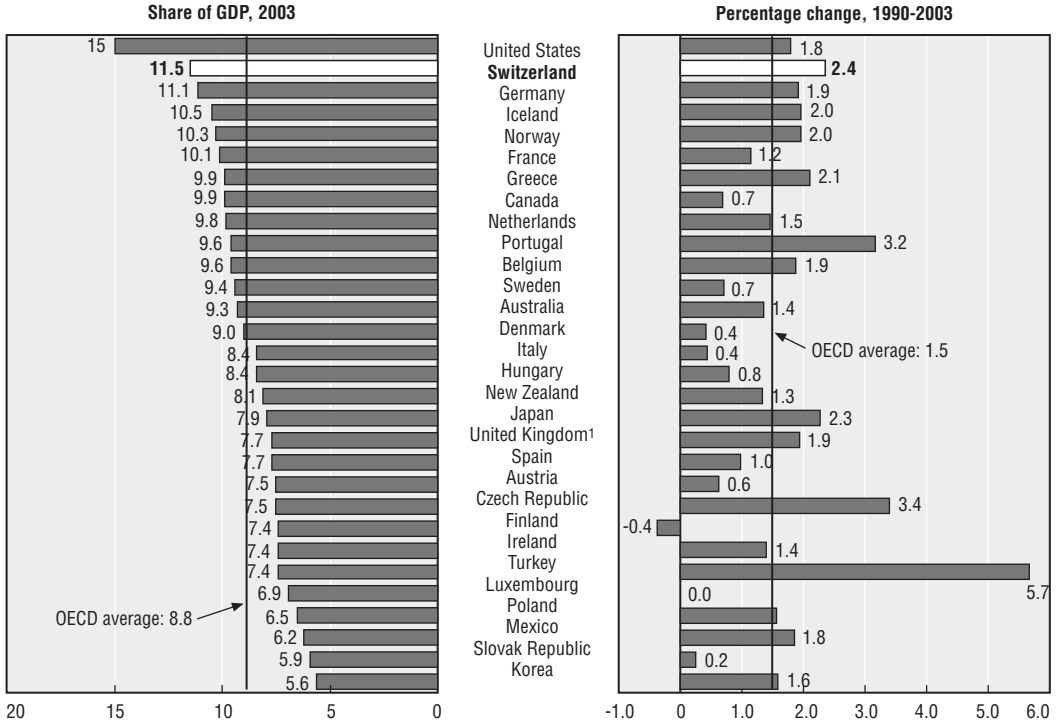
1.3. Governance of the Swiss health system

Responsibility for health-policy development and implementation falls to the cantons, unless specifically attributed to the confederation. Cantons play a key role in the provision and financing of health services, while both cantons and the confederation are involved in policy making, regulatory and monitoring of the health system. Box 1.2 summarises the main responsibilities for the confederation, cantons and municipalities. The large decentralisation of political power and the large degree of local autonomy in the organisation of health care has resulted in slightly different health systems in each of the 26 cantons. Perhaps because of this, the Swiss authorities have never defined explicitly the overall objectives of the health system or defined standards and measures to assess whether these goals are being achieved.

Over the past few years, the confederation has acquired new responsibilities, either through a transfer of power from cantons or through the revision of federal laws (in particular the Health-insurance Law) or the introduction of new federal laws. For example, the responsibility for registration and market-entry authorisation of pharmaceutical and medical devices fell to the confederation following the establishment of Swissmedic.[12] More recently, the confederation has been increasingly involved in highly specialised medicine, research and postgraduate education, but the constitutional basis for this increased role is sometimes not fully evident. While medical education has been under the responsibility of the confederation since 1877, responsibilities for paramedical education are now being transferred from the cantons to the confederation.

Various institutions have jurisdiction over health activities, at both federal and cantonal levels. The Federal Office of Public Health (Office fédéral de la santé publique, OFSP) and the Federal Office of Statistics (Office fédéral de la statistique, OFS) – both belonging to the Federal Department of Home Affairs – are central actors at federal level while, at cantonal level, public health departments play a major role. As the capacity of

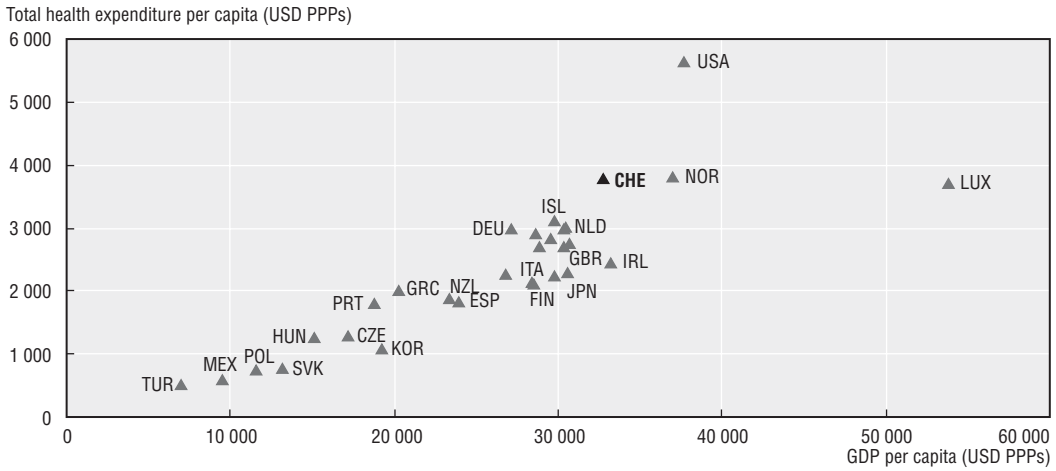
Figure 1.10. **Health expenditure in OECD countries as a percentage of GDP, 2003**



Note:
Health care spending in Switzerland as a share of GNP is 10.7 per cent. See main text for details.
The following series present breaks, years in brackets:
Finland (1993), Germany (1992), Hungary(1998), Japan (1995), Mexico (1999), the Netherlands (1998), Norway (1997), Portugal (1995), Spain (1991), Sweden (1993), Turkey (1999) and the United Kingdom (1997).
Data for the following countries are estimated: Canada, France, Hungary, Iceland, Japan, Norway, Switzerland and Turkey.
1. 2002.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 1.11. **Per capita health expenditure and per capita GDP in OECD countries, 2003**



Note: Data for 2003 have been estimated for: Canada, France, Hungary, Iceland, Japan, Norway, Switzerland and Turkey.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

Box 1.2. **Main responsibilities for health at federal, cantonal and municipal levels**[1]

Federal level

Legislative and supervisory role in the following areas

- Control and eradication of communicable diseases.
- Promotion of exercise and sport.
- Social insurance.
- Oversight of professional medical examinations and recognition of doctors' qualifications.
- Promotion of science, research and tertiary education.
- Genetic engineering, reproductive medicine, transplant medicine and medical research.
- Protection of the health and safety of the workforce.
- Protection of the environment.
- Quality and safety control of medicines and medical devices.
- Food safety.
- Substance abuse.
- Health profession training (non-university training).
- Provision of health statistics.

Cantonal level

- Provision of health care and partial finance of hospital costs.
- Authorisation to open a medical practice or pharmacy.
- Disease prevention and health education.
- Implementation of federal laws delegated by the federal government.

Municipal level

- Implementation of responsibilities delegated by cantons, for example the provision of nursing and home care.

1. This list is not exhaustive. See Kocher (2005) for additional areas of responsibilities at federal, cantonal and municipal level.

Source: European Observatory on Health Care Systems (2000); Kocher (2005).

individual cantons to undertake health activities can vary greatly, a political co-ordination body – the Swiss Conference of the Cantonal Ministers of Public Health (CDS) – was established in 1919 to promote co-operation among the 26 cantons and between cantons and the confederation. Through regular meetings, the CDS facilitates the development of common policies between them and the confederation. However, this process does not result in binding decisions on all the parties, rather it facilitates consensus-building. Only when cantons agree to make a formal agreement, does a decision taken through the CDS become legally binding on all parties.

1.4. Health financing and insurance coverage

The federal Health-insurance Law requires each individual residing in Switzerland to purchase basic health insurance from one of a number of competing health funds. Such mandatory health insurance pays for a third of total health spending, while a further near-

third is funded by individuals out of their own pockets (Office fédéral de la statistique, 2005i). The rest is financed by the government, by other social insurance schemes, and by voluntary health insurance.

1.4.1. *Mandatory insurance schemes*

The 1994 Health-insurance Law (LAMal)[13]

The LAMal extensively regulates the system of mandatory health insurance so as to achieve three main objectives:[14] *i)* strengthening solidarity (compared with the previous LAMA legal framework) by promoting equal coverage conditions for individuals with different health risks; *ii)* containing health expenditures; and *iii)* guaranteeing high-quality basic health services. While most features of the law are directly related to financing and coverage – analysed in this section – this comprehensive legal framework deals with several other aspects of the health system, such as health providers and health-service tariffs (see Sections 1.5 and 1.6 below).

The main regulatory provisions related to mandatory health insurance are:

- *Mandatory affiliation*. All residents in Switzerland must purchase basic health insurance. Insurance is purchased on an *individual* basis – *i.e.* the insurance policy does not cover dependents – and is not sponsored by employers.
- *Non-profit requirement and separation of basic health insurance from other insurance activities*. Mandatory health insurance is provided by multiple and competing insurers that are authorised to offer such cover. Insurers must provide this cover separately from other activities (*e.g.*, voluntary health insurance), cannot make profits on this branch of their operations, and are subject to regulatory and surveillance requirements (Table 1.4).
- *Standardised benefit package*. The benefits covered by mandatory health insurance are defined by the LAMal and related rulings. They include health services and medical goods needed to diagnose and treat sickness. According to the LAMal, benefits covered must be effective, appropriate, and efficient (see also Box 3.1, p. 94).
- *Cantonal scope of insurance coverage*. Individuals have to take up insurance within their canton of residence. Insurers fix different premia in each of the cantons where they operate. Insurees have free choice of provider within the canton where they are insured, and can obtain reimbursement of treatment outside the canton in the case of an emergency or when a medically necessary treatment is not available in their canton.[15]
- *Open enrolment and free choice of insurer*. LAMal insurers are compelled to accept all individuals residing in the canton without reserve. Individuals have the freedom to choose and switch insurers in their canton, subject to some timing rules.
- *Community rating of premia*. Each insurer fixes competitively the premium charged and premia are the same for all its insurees (*i.e.* insurers cannot adjust premia to the perceived risk of individual insurees). Premia are not earnings-related, *i.e.* the poor pay the same premia as the rich.
- *Risk equalisation*. A risk-equalisation system attempts to compensate insurers for differences in costs arising from variation in their risk structures; the compensation formula includes adjustors for age and sex.
- *Cost-sharing*. All individuals (expect for those eligible for exemption) share in the cost of health services through a deductible, co-insurance and co-payments.[16] The cost-sharing

Table 1.4. **Regulatory oversight in the Swiss health-insurance market**

	Authorities responsible for the surveillance of insurance activities and participants				
	Federal Council	Federal Department for Home Affairs	Canton	Federal Office of Public Health	Federal Private Insurance Office
Surveillance of insurers				Sickness funds.	Private life and non-life insurers.
Surveillance of activities					
Basic mandatory health insurance (LAMal)	Has overall responsibility for the execution of the LAMal.	Provides authorisation for insurers to offer LAMal coverage.	Is responsible for checking individual affiliation.	Implements measures and has responsibility for the surveillance of the LAMal (*e.g.*, premium approval).	–
Daily cash-benefit insurance				Has responsibility for the surveillance of this insurance type when it is offered within the framework of the LAMal.	Has responsibility for the surveillance of this insurance type, when it is offered under the LCA regime.
Voluntary health insurance					Has responsibility for the surveillance of voluntary health insurance.

Note:
LAMal: Loi fédérale sur l'assurance-maladie (Federal Health Insurance).
LCA: Loi sur le contrat d'assurance (Insurance Contract Law).
Source: OECD based on data from national authorities.

requirements differ between ordinary health insurance and special forms of insurance (Table 1.5).

- *Special forms of insurance*. Individuals can choose special forms of health insurance offered by their LAMal insurer. These insurance products enable individuals to benefit from premia reductions in exchange for restrictions on the conditions of ordinary cover. Two of these special insurance types (insurance with higher deductibles and bonus insurance – see Box 1.3) entail a higher financial risk for insurees. A third type of special insurance involves the insuree accepting a limited choice of providers (*e.g.*, Health Maintenance Organisation, gatekeeping insurance) (Table 1.5).
- *Subsidies to low-income individuals and families*. Cantons pay means-tested subsidies to eligible low-income individuals and families in an attempt to mitigate the regressive effects of non-income-related premia. These subsidies are co-financed by the confederation.

More details on the legal framework of mandatory health insurance and the way it is organised are provided in Box 1.3, Table 1.4 and Table 1.5. The evolution of the market is analysed in Chapter 4, while recent proposals for reforming certain elements of the LAMal are discussed in Chapters 4 and 5 below.

Other social-insurance schemes paying for health costs

In addition to the LAMal, the Swiss health system has three other social-insurance schemes covering health risks: coverage against accidents, invalidity insurance, and care for the armed forces.

Table 1.5. **Special insurance contracts within the mandatory health-insurance system (LAMal)**

	Ordinary basic health insurance	Insurance with choice of deductible	Bonus Insurance	Insurance with limited choice of providers (HMO, "réseau de santé")
Premium level	Ordinary premia are set competitively by each LAMal insurer for each canton; within each canton, insurers can apply a maximum of three premium scales in different geographical areas of each canton.	Premia must be at least 50% of the premium for ordinary insurance. Premia are reduced in relation to the deductible level, up to a maximum reduction of: – Adults: 160; 560; 960; 1 360; 1 760 CHF. – Children (< 18 years): 80; 160; 240; 320; 400; 480.	Annual premium reductions if no claim is made during the period. The initial premium paid in the first year is 10% higher than ordinary insurance. Then premia can be decreased up to 45% from ordinary premia after five years.	Premium reductions on the ordinary premia are fixed by the fund, but cannot exceed a 20% reduction.
Cost-sharing[1]	*Deductible:* CHF 300 per year. *Co-insurance:* 10% of the cost of health goods and services beyond the value of the deductible. *Co-payments*: for each patient stay in hospital, 10 CHF per day. *Ceiling:* the 10% co-insurance cannot exceed an annual cumulated individual amount of 700 CHF for adults and 350 CHF for children.	*Deductibles:* Insurers can offer insurance products with five possible levels of deductibles: – Adults: 500; 1 000; 1 500; 2 000; 2 500 CHF. – Children: 100; 200; 300; 400; 500; 600. *Co-insurance, co-payments and ceilings*: as in ordinary insurance.	As in ordinary insurance.	As in ordinary insurance. The insurers can offer policies with limited choice of providers that are totally or partly exempted from cost sharing.
Choice of doctor/hospital	Free, among all doctors and hospitals entitled to be reimbursed by mandatory health insurance.	As in ordinary insurance.	As in ordinary insurance.	Restricted to providers participating in the network.

1. Cost-sharing exemptions are available for large families, women during maternity, social-assistance beneficiaries and recipients of supplementary old-age and disability benefits. The deductible levels and relative premium reductions are those approved for 2005.

Source: Revised from Colombo, F. (2001), "Towards More Choice in Social Protection? Individual Choice of Insurer in Basic Mandatory Health Insurance in Switzerland", Labour Market and Social Policy-Occasional Paper, No. 53, OECD, Paris; Office fédéral de la santé publique (2005), *Primes de l'assurance de base 2005*, Bern.

According to the Federal Law on Accident Insurance (LAA),[17] all workers employed in Switzerland are compulsorily insured for the risk of accident and professional illness (Ludwig and Morger, 2005). Insurance is taken up by employers or enterprises.[18] Premia are set as a function of salaries, and vary depending on the sector of activity. Benefits provided are both cash and in-kind. The former covers loss of income, as well as invalidity and survival pensions as a result of an accident or professional illness. The latter includes direct payments by the insurer for the cost of health goods and services received by an insuree. Accident insurance amounted to 3% of total health expenditure in 2003 (Office fédéral de la statistique, 2004i) (Table 1.6). Insurees have freedom of choice of provider and, unlike the LAMal, they are not required to pay deductibles or co-payments on care received. Mandatory accident insurance is provided by several insurers, which cover different sectors of economic activity, as designated by the law. The Swiss national accident insurer (SUVA) covers 53% of all workers, primarily operating in the secondary sector (industry, artisans, industrial commerce, etc.). Other carriers include private insurers, sickness funds, and public accident-insurance funds (Ludwig and Morger, 2005). The SUVA has adopted a case-management approach whereby case managers engage actively in measures to steer the way care is delivered to insurees, particularly in the case of complex and multiple needs. This approach is aimed at minimising the time needed for

Box 1.3. **LAMal: key regulatory requirements relative to insurance coverage**

Surveillance

The Federal Council has overarching responsibility for the implementation of the LAMal. Insurers willing to offer mandatory health insurance (92 in 2004) need to seek authorisation from the Federal Department of Home Affairs and must meet certain requirements pertaining to the adequacy of the financial and organisational structure. Insurers can have different juridical status, but must practice mandatory insurance according to the principle of "mutuality". While both commercial health insurers and sickness funds can become LAMal-insurers, so far there have been no cases of commercial health insurers asking for authorisation to provide basic cover. Cantons are responsible for checking individual affiliation to basic health insurance and can insure automatically all individuals who have not done so by themselves (automatic enrolment is carried out by the cantonal authority). In this case, the insuree will not have choice over the insurer and s/he will be liable for paying the basic health-insurance premia. Cantons are also responsible for the organisation of the system of subsidies for low-income persons. The Federal Office of Public Health (FOPH) is responsible for overseeing the implementation of the law. LAMal insurers have to submit annual reports, their budgets and financial reports to the FOPH, and communicate the list of premia for the following year for approval. The FOPH is also responsible for monitoring the financial viability of LAMal insurers.

Benefit package

The package of services covered is specified by a legal ruling (Ordonnance sur les prestations dans l'assurance obligatoire des soins en cas de maladie – OPAS). Risks covered include illness, maternity and accident.* For medical services, mandatory coverage is based on a non-exclusive catalogue of diagnostic services and treatments. Hospital services are covered only for the equivalent cost of treatment received in a shared ward. The law also specifies some exclusions. Pharmaceuticals, complementary medicine, and non-medical services more generally (*e.g.*, physiotherapy) are covered on the basis of a positive list. Some prevention and screening measures, such as pap smears, HIV tests, colonoscopies, and vaccinations, including for influenza, are also covered. Dental care is covered where it concerns a serious illness.

Free choice of insurer

Mandatory health insurance is fully portable across LAMal-insurers. Individuals can switch LAMal-insurer at the end of June and December in any given year, within their canton of residence. Individuals have to communicate their decision to change insurer at least three months before or, in the case of a change in the premium, one month before these dates. LAMal-insurers have to give written communication to all insurees of the premium levels applicable for the following year at least two months in advance of the change. The insurer can oppose an individual's switching decision only if the individual's premium has not been paid. Insurers are also required to send to the previous insurer an attestation certifying that cover has been taken with a different insurer. People holding a special LAMal insurance contract can only decide to switch insurer on 31 December, and those with bonus insurance must contract for a period of five years.

Community rating of premia

Despite community rating, premia vary across insurers and, for each insurer, across cantons. The law allows additional premium differentiations. First, individuals who already benefit from mandatory accident-insurance can ask for a reduction in the basic insurance premium. Second, insurers can apply a maximum of three premium echelons in

Box 1.3. **LAMal: key regulatory requirements relative to insurance coverage** *(cont.)*

each canton, reflecting variations in health costs across regions within the canton. Third, insurer set three age-related categories of (progressively higher) premia: children (0-18 years), young people (19-25) and adults. Fourth, individuals choosing special health-insurance forms (see below) obtain premium reductions.

Risk equalisation

The risk-equalisation mechanism was established in 1993 in order to reduce incentives to compete on the basis of risk selection. Insurers with a more favourable risk structure (as measured by age and gender) than the average must pay money to a common pool ("Institution commune") to compensate insurers with a less favourable risk structure. There are 30 risk groups: 15 age cohorts, each divided by gender. The "Institution Commune" provides transfers on a canton-by-canton basis, hence reflecting cost differences across cantons. According to the LAMal, the mechanism was to be discontinued after the law had been in effect for ten years, on the assumption that the risk structures of insurers would by then have equalised, making the compensation system superfluous. As this hypothesis was not borne out, the federal parliament approved the extension of the system for five years in October 2004, without changing its structure.

Special forms of insurance *(see* Table 1.5)

Ordinary basic health insurance allows individuals free choice of providers and requires them to pay standard premia and an annual deductible fixed by law ("franchise légale"). Insurance with a choice of deductible ("franchise à option") offers a reduction on the ordinary premia where individuals choose a higher deductible. Bonus insurance ("assurance avec bonus") requires individuals not to make any claim during a year in order to obtain a premium reduction from one year to the next. Insurance with limited choice of providers allows individuals to obtain premium reductions on their basic health-insurance policy if they agree to use only certain designated providers in manage-care-type arrangements. All LAMal-insurers provide ordinary insurance and insurance with choice of deductible. On average, about one insurer in ten provides HMO-type insurance (one type of insurance with reduced provider choice – see Section 1.5.2), and about one in seven provides bonus insurance in any canton.

Premium reductions for low-income people

The confederation makes a certain amount of subsidies available annually to cantons, earmarked for premia reductions. In order to receive federal subsidies, cantons must themselves pay a minimum amount. The Swiss Parliament fixes both the overall annual subsidy allocated by the federation and the minimum amount to be matched by each canton every four years (this of course leaves cantons free to pay more). The overall federal subsidy is distributed across cantons on the basis of the resident population and the economic capacity of the canton. The law allows cantons to reduce the budgeted amount they are supposed to pay by a maximum of 50%; in this case, the federal subsidy is reduced. At the very minimum, cantons must pay at least a third of the federal subsidy. Each canton establishes the amount of the individual subsidy, eligibility criteria, and procedures. According to a new revision of the LAMal approved in spring 2005, cantons will also be required to reduce, by at least 50%, the insurance premia for children and young people in training living in families with low or middle income. In 2004, 40% of Swiss households received subsidies and these households represented one-third of all individuals (see Chapter 3).

* Accident insurance under LAMal only covers those individuals who are not covered by statutory accident insurance scheme for employed people.

Source: Chancellerie fédérale (2004b); Britt *et al.* (2005); Gilliand and Rossini (1997); Colombo (2001).

the reintegration of insurees into the labour market following accident or work-related illness. Individuals who hold an accident insurance under the LAA are entitled to a percentage reduction on the ordinary LAMal premia established by the insurer.

Table 1.6. **Financing of health expenditure in Switzerland, 2003**

Financing agent	Millions CHF	Percentage of total
TOTAL	**49 881**	**100**
General government	**8 949**	**17.9**
Confederation	*156*	*0.3*
– Subsidies to institutional providers (hospitals and nursing homes)	1	0.0
– Prevention	66	0.1
– Administration	88	0.2
Cantons	*7 404*	*14.8*
– Subsidies to institutional providers (hospitals and nursing homes)	6 418	12.9
– Home care	224	0.4
– Prevention	251	0.5
– Administration	183	0.4
– Disability	307	0.6
– Ancillary services	21	0.0
Municipalities	*1 390*	*2.8*
– Subsidies to institutional providers (hospitals and nursing homes)	759	1.5
– Home care	176	0.4
– Prevention	125	0.3
– Administration	61	0.1
– Disability	65	0.1
– Ancillary services	203	0.4
Social insurance schemes	**20 226**	**40.5**
Mandatory health insurance (LAMal)	16 304	32.7
Accidents insurance (LAA)	1 512	3.0
Disability insurance (AVS-AI)	2 361	4.7
Military insurance (AM)	48	0.1
Voluntary insurance (LCA)	**4 478**	**9.0**
LAMal insurers	1 645	3.3
Commercial insurers	2 833	5.7
Private households	**15 743**	**31.6**
Cost-sharing (social insurance)	2 589	5.2
Cost-sharing (voluntary insurance)	39	0.1
Out-of-pocket (other than cost-sharing)	13 116	26.3
Other private financing	**485**	**1.0**

LAMal: Loi fédérale sur l'assurance-maladie (Federal Health Insurance).
LCA: Loi sur le contrat d'assurance (Insurance Contract Law).
Source: Office fédéral de la statistique (2004), *Coût et financement du système de santé en 2003*, Neuchâtel.

Disability insurance is provided under the legal framework of the Law on Disability Insurance (LAI).[19] It is organised in a decentralised manner with offices in each canton jointly administering old-age and disability benefits (AVS-AI) (Lauenberger and Demund, 2005). Half of disability expenditure is financed by the government (confederation and

cantons), with the remainder through salary-based contributions. Disability is defined as damage to health resulting in permanent or long-term incapacity to work (European Observatory on Health Care Systems, 2000). Benefits cover spending for rehabilitation (including the cost of medical, nursing and other rehabilitation services), disability pensions (59% of overall expenditure), and disability allowances. Supplementary benefits are also available. Health-related expenditures under the AVS-AI represented 4.7% of total health expenditure in 2003 (Office fédéral de la statistique, 2005i) (Table 1.6).

Military insurance (Assurance militaire, AM), established in 1852, covers all individuals employed in the field of defence and maintenance of security (Gebel, 2005). Benefits provided range from loss of income to invalidity pensions, accident and sickness, and old-age. Health-related expenditures under the military insurance scheme accounted for 0.1% of total health expenditure in 2003 (Office fédéral de la statistique, 2005i) (Table 1.6).

1.4.2. Voluntary health insurance

Two main types of voluntary health insurance exist in Switzerland: *i)* daily cash-benefit insurance; and *ii)* supplementary health insurance.

Daily cash-benefit insurance is often sponsored by employers on behalf of their employees and covers the obligations they have to continue paying wages in the event of illness or hospitalisation (loss of income). Insurers may offer daily cash-benefit insurance under the legal regimes of the LAMal or the Insurance Contract Law (LCA).[20]

LAMal insurers[21] and other life or non-life insurers can offer *supplementary health insurance* under the legal framework of the LCA. In this context, insurers can adjust premia to risk, refuse bad risks, and terminate contracts should the individual fail to disclose all health and medical conditions affecting his or her risk status. Supplementary health insurance is usually purchased individually and insurees can obtain tax deductions for insurance premia up to a threshold. Insurance can cover special hotel services in the event of hospitalisation (such as accommodation in private or semi-private rooms), as well as goods and services that are not reimbursed by the LAMal (such as dental care). Since 1 January 2001,[22] supplementary insurance has been prohibited from covering cost-sharing requirements on mandatory health insurance.

The size of the supplementary health-insurance market has been falling since the introduction of mandatory health insurance (see Section 3.1.1). The market has also evolved from being dominated by LAMal insurers to being predominantly offered by commercial insurers. LAMal insurers had three quarter of the market in 1996 (Colombo, 2001). In 2003, 64% of overall premia were earned by the 66 commercial insurers operating on this market, compared with 36% of premia earned by 56 LAMal insurers (Office fédéral de la santé publique, 2004d; Britt *et al.*, 2005).

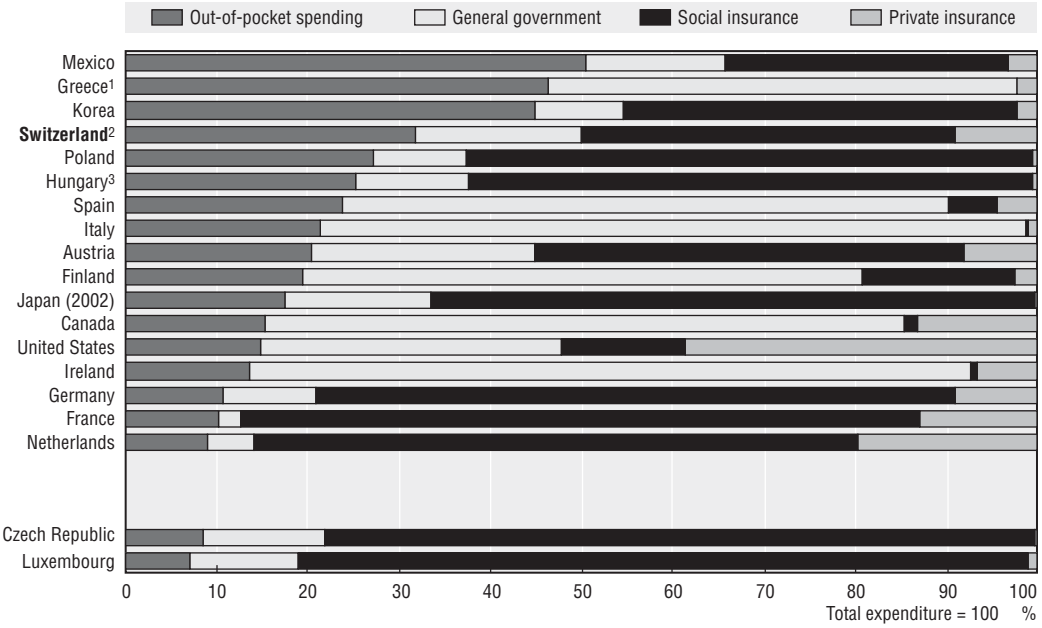
The Federal Private Insurance Office (Office fédéral des assurances privées, OFAP) is responsible for the institutional surveillance of commercial life and non-life insurers, and for the supervision of voluntary health-insurance schemes within the context of the LCA, even when they are provided by LAMal insurers (Table 1.4).

1.4.3. Financing of health expenditure

Mandatory payments through government and social insurance accounted for 58% of total Swiss health expenditure in 2003 (Table 1.6) (Office fédéral de la statistique, 2005i). Government-financed health expenditure was 18% in 2003, shared between the cantons

(15%), the municipalities (3%) and the federal government (0.3%). These funds are spent on subsidies to institutional providers (hospitals, long-term care institutions, home care), as well as prevention, public health and administration charges.[23] Out-of-pocket spending, at 32%, is the fourth-highest percentage of overall health expenditure in the OECD area after Mexico (51%), Greece (46%), and Korea (45%) (Figure 1.12). Finally, 10% of total health spending is channelled through voluntary private health insurance, one of the most significant shares of total spending in the OECD area after the United States, the Netherlands, France and Canada.

Figure 1.12. **Financing of health expenditure in OECD countries, 2003**



Note: Countries are ranked by decreasing share of out-of-pocket expenditure.

1. Data for Greece for general government include data both for general government and for social insurance.
2. In the case of Switzerland social insurance refers to mandatory health insurance (LAMal) and other obligatory social insurance schemes making payments for health care (military, accident and disability insurance).
3. Data for Hungary are estimated.

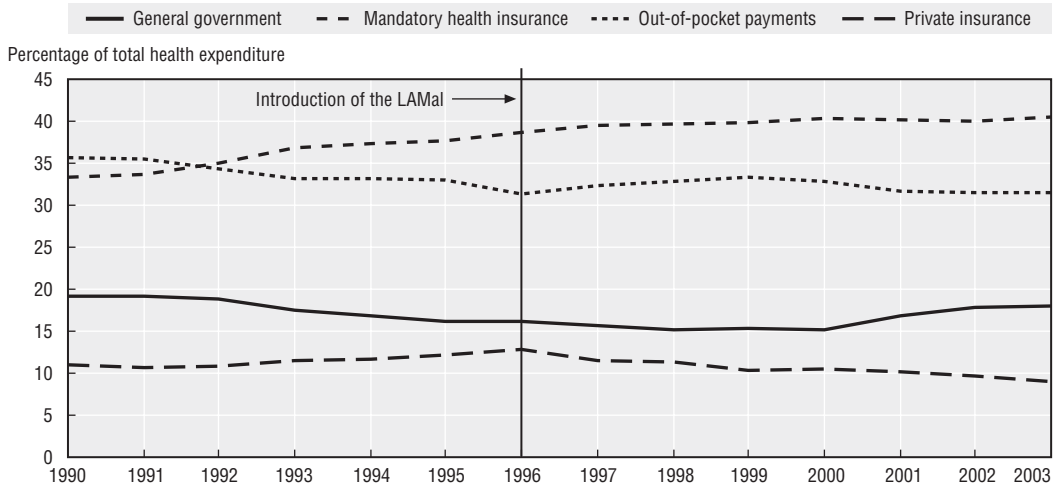
Source: OECD (2005), *OECD Health Data 2005*, Paris.

The relative share of different financing agents has evolved since 1990 (Figure 1.13). Government spending has remained fairly constant as share of total health spending over the period 1990-2003. Increased funding of total health expenditure from basic health insurance (under the LAMA prior to 1996 and under the LAMal thereafter) explains the reduction in the share of out-of-pocket spending and voluntary health insurance.

1.5. Health service delivery

Administration of the health-delivery system is highly decentralised. Cantons are responsible for providing health service needed by the population, and financing of health services under the LAMal is also organised at cantonal level. Apart from doctors employed by hospitals, ambulatory-care doctors are self-employed and work in independent practices. Most hospitals are owned by cantons and municipalities although specialised hospitals are often privately owned. Responsibility for public-health initiatives, disease-

Figure 1.13. **Evolution in the relative share of health-financing agents in Switzerland, 1990-2003**



Note: Mandatory health insurance refers to health expenditure financed by basic health insurance (LAMal), accident insurance (AA), military insurance (MI) and disability insurance (AI).

Source: OECD (2005), *OECD Health Data 2005*, Paris.

prevention and health-promotion programmes lie with the cantons and, to a limited extent, with the confederation.

Resources allocated to the delivery of health-care services are generally higher in Switzerland than on average in the OECD. This is especially the case for health-care employment, practising physicians and nurses, long-term care beds and some technology devices such as MRIs (Table 1.7).

1.5.1. Public health programmes

Similarly to other OECD countries, total spending for promotion and prevention is significantly lower than for curative care. In Switzerland, 2.2% of health expenditures – around CHF 1 billion – is devoted to disease prevention and health promotion, compared with an average of 2.7% for all OECD countries (Figure 1.14) (OECD, 2005a).[24] This amount is financed by cantonal, municipal and federal contributions, as well as private organisations (Figure 1.15). Most programmes of the Federal Office of Public Health are oriented towards primary prevention activities in the field of HIV/AIDS, tobacco and substance abuse (Figure 1.16).

Public health issues are not limited to the health sector. Policies in other sectors – such as education, housing, transportation, environment and taxation – can also affect health conditions and outcomes (Allin *et al.*, 2004).

The confederation plays a public-health role in specific areas defined by the constitution and by other federal laws. These range from surveillance of communicable diseases to food safety, radiation protection and control of chemical products, taxation on addictive substances (alcohol, tobacco), promotion of sport activities, and health promotion and prevention related to the LAMal and accident insurance (European Observatory on Health Care Systems, 2000; Office fédéral de la santé publique, 2005d). Over the past few years, the confederation has endeavoured to strengthen its role in health promotion and prevention by establishing national policies in areas where it previously had no or limited responsibilities. For example, new and revised national programmes concerning, HIV/AIDS prevention, tobacco use and substance abuse have been introduced. However, the confederation is facing

Table 1.7. **Resources available in the Swiss health-delivery system and other OECD countries, 2003 or latest available year**

	Total health-care employment (per 1 000 population)	Practising physicians (per 1 000 population)	Practising nurses (per 1 000 population)	Acute-care beds (per 1 000 population)	Long term-care beds[1] (per 1 000 population)	Computed tomography scanners (per million population)	Magnetic resonance imaging units (per million population)
Australia	34.6	2.5[2]	10.2	3.6[2]	3.6[2]	n.a.	3.7
Austria	n.a.	3.4	9.4	6.0	1.7	27.2	13.5
Belgium	n.a.	3.9[2]	5.8	4[2]	2.9[2]	28.8[2]	6.6[2]
Canada	39.6	2.1	9.8	3.2[2]	13[3]	10.3	4.5
Czech Republic	25.0	3.5	9.4	6.5	0.7	12.6	2.4
Denmark	28.1	2.9[2]	10.3[2]	3.4[3]	5.1	14.5	9.1
Finland	31.2[2]	2.6	9.3	2.3	7.1	14.0	12.8
France	32.8	3.4	7.3	3.8	1.3	8.4	2.8
Germany	46.2	3.4	9.7	6.6	8.2[3]	14.7	6.2
Greece	14.8[4]	4.4[3]	3.9[4]	n.a.	n.a.	17.1[2]	2.3[2]
Hungary	n.a.	3.2	5.1	5.9	1.9	6.9	2.6
Iceland	43.3	3.6	13.7	n.a.	8.5[2]	20.7	17.3
Ireland	31.2	2.6	14.8	3.0	6.9[2]	n.a.	n.a.
Italy	19.9	4.1	5.4	3.9[2]	2.9	24.0	11.6
Japan	n.a.	2[2]	7.8[2]	8.5	5.0	92.6[2]	35.3[2]
Korea	n.a.	1.6	1.7	5.9	0.2	31.9	9.0
Luxembourg	13.1[5]	2.7	10.6[2]	5.7	5.9	26.7	11.1
Mexico	6.7	1.5	2.1	1.0	n.a.	1.5	0.2
Netherlands	31.1	3.1	12.8[3]	3.2[2]	3.7[3]	n.a.	n.a.
New Zealand	27.3	2.2	9.1	n.a.	n.a.	11.5	3.7
Norway	52.1	3.1	10.4[3]	3.1	9.1	n.a.	n.a.
Poland	n.a.	2.5	4.9	5.1	4.0	6.3	1.0
Portugal	13.8	3.3	4.2	3.1	n.a.	12.8	3.9
Slovak Republic	19.7	3.1	6.5	5.9	1.3	8.7	2.0
Spain	18.3	3.2	7.5	3.1	0.3	13.0	7.3
Sweden	n.a.	3.3[2]	10.2[2]	2.4[4]	n.a.	14.2[5]	7.9[5]
Switzerland	**59.3**[3]	**3.6**[2]	**10.7**[4]	**3.9**	**11.7**	**18.0**	**14.2**
Turkey	n.a.	1.4	1.7	2.3	n.a.	7.3	3.0
United Kingdom	33.1	2.2	9.1	3.7	3.5	5.8[3] (est.)	5.2 (est.)
United States	37.6	2.3[2]	7.9[2]	2.8	6.1[2]	13.1[2, 6]	8.6[6]
OECD average	**29.9**	**2.9**	**8.0**	**4.1**	**–**	**17.8**	**7.7**
OECD median	**31.2**	**3.1**	**9.1**	**3.7**	**–**	**13.6**	**6.2**

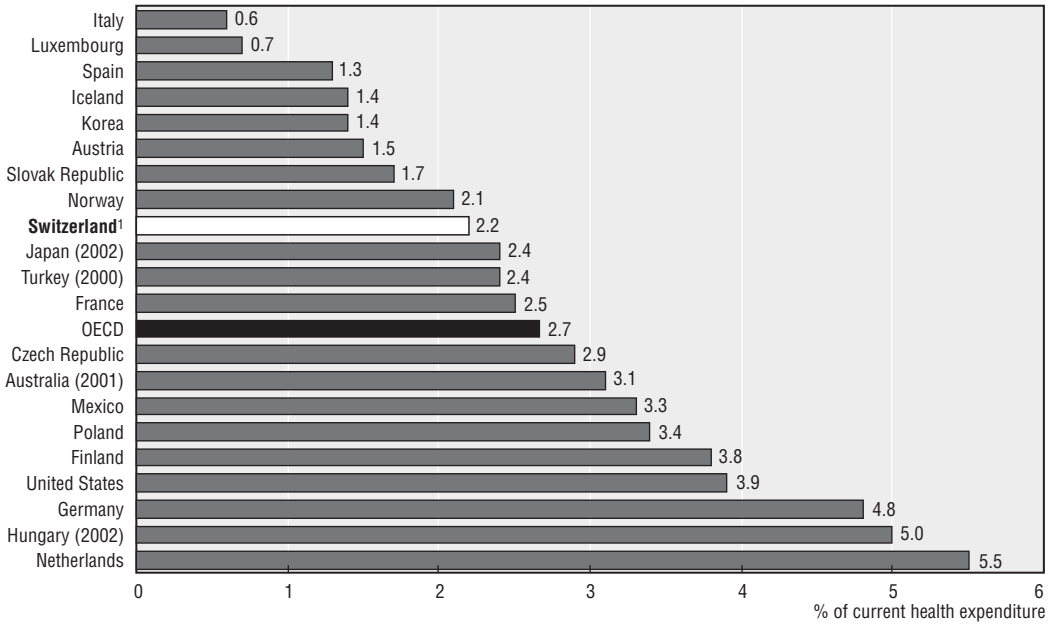
n.a.: not available.
est.: estimate.

1. Beds for people who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence in activities of daily living. These beds can be provided in different institutional settings, including hospitals, nursing homes and the like. Some countries report only beds in nursing homes while others also include beds in non-acute care hospitals (or hospital wards). This seriously limits the cross-country comparability of data on long-term care beds, no average and median have therefore been calculated for this indicator.
2. 2002.
3. 2001.
4. 2000.
5. 1999.
6. The figures for the United States considerably underestimate the real number of devices in that country, because they refer to the number of hospitals reporting to have at least one of these equipment rather than the total number of equipment in hospitals and in other locations (*e.g.*, specialised clinics). in other locations (*e.g.*, specialised clinics).

Source: OECD (2005), *OECD Health Data 2005*, Paris.

difficulties in finding a comprehensive legal support for the development of its public-health activities within the current legal framework. As a result, a discussion paper on a possible

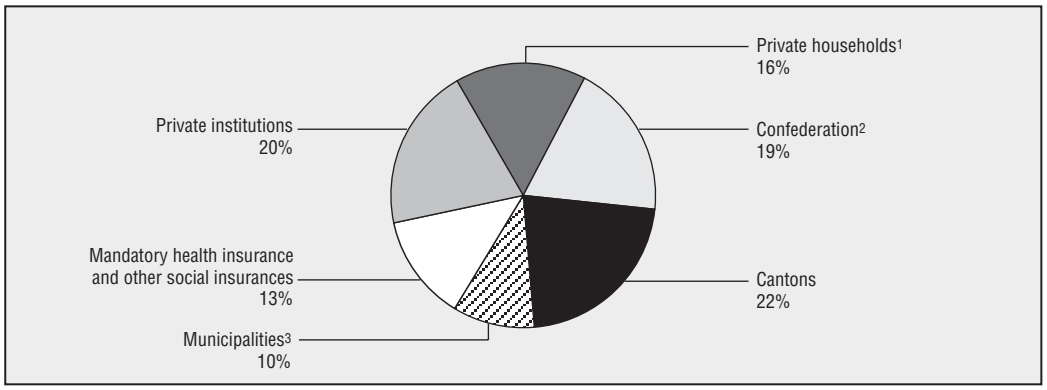
Figure 1.14. **Expenditure on health promotion and prevention as a share of total health expenditure in OECD countries, 2003**



1. Switzerland includes some spending for maternal and child-health programmes under out-patient care rather than under prevention and public health.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 1.15. **Funding of health promotion and prevention activities in Switzerland, by financing agent, 2004**



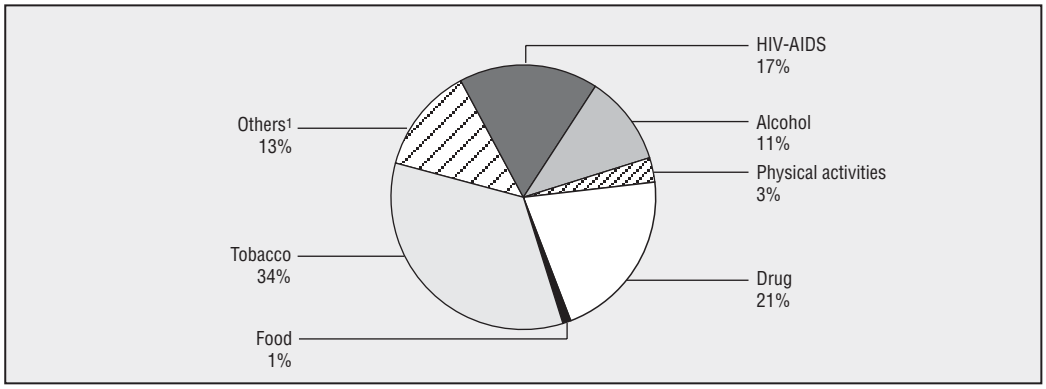
Note: Data refer to 2002 for Cantons, Municipalities, Mandatory health insurance and other social insurances, Private institutions and Private households.

1. It includes out-of-pockets payments, such as prophylactic dental care.
2. It includes the Federal Office of Public Health, SUVA, the Swiss health promotion and the Fund for road safety among other institutions.
3. School programmes mainly.

Source: Office fédéral de la santé publique (2005), *Prévention et promotion de la santé en Suisse – Bases à l'attention de la Commission spécialisée " Prévention + Promotion de la santé "*, Version November 2005, Bern.

new regulatory framework for health promotion and disease prevention has been recently presented (Special Commission on Prevention and Health Promotion – Commission spécialisée prévention plus promotion de la santé, PPS2010).

Figure 1.16. **Main health promotion and prevention programmes of the Swiss Federal Office of Public Health by level of funding, 2004**



1. Includes surveillance of infectious diseases, excluding HIV-AIDS.

Source: Office fédéral de la santé publique (2005), *Prévention et promotion de la santé en Suisse – Bases à l'attention de la Commission spécialisée " Prévention + Promotion de la santé "*, Version November 2005, Bern.

Cantons are responsible for primary prevention activities, such as the implementation of immunisation programmes and vaccination-coverage surveys.[25] Both secondary and tertiary prevention fall under cantons' responsibilities. For instance, national screening programmes do not exist in Switzerland and each canton is responsible for setting up its own programmes.[26] Cantons also have responsibilities for implementing disease-control intervention as decided and co-ordinated by the federal authorities.

To a significant degree, the implementation of health-promotion programmes, where they exist, is left to numerous not-for-profit associations and foundations. Important programmes include the "Health Promotion Switzerland", "Radix" and the Swiss Association of Cantonal Chiefs for Health Promotion[27] (see Box 1.4).

1.5.2. Organisation of ambulatory care

The ambulatory sector provides general medical care, diagnostic services, obstetric care, perinatal care, care for children, family planning, minor surgery, rehabilitation, dental care and home-based care. Ambulatory services are largely provided by physicians in independent/single-person practices (WHO Regional Office for Europe, 2001). In addition to independent practices, ambulatory services are also provided by out-patient departments of public and private hospitals and by managed-care-style organisations.

In the ambulatory sector, there is full freedom of choice of health-care physicians and unlimited access to either general practitioners or specialists. Although there is no gatekeeping system in place, most individuals seem to have a regular or family doctor. An exception concerns patients holding special insurance policies (see above) limiting the choice of providers. These individuals agree to use only certain designated providers from a Health Maintenance Organisations (HMOs), a family-doctor gatekeeping scheme, Independent Practice Associations (IPAs), Preferred Provider Organisations (PPOs) or similar managed-care arrangements in exchange for premium reductions on their basic health-insurance policy. Usually doctors participating in such managed-care arrangements act as gatekeepers, in the sense of directing the patient's health care. So far, only about 10% of all insured individuals have enlisted in insurance schemes with limited choice of

Box 1.4. **Selected institutions involved in health-promotion and prevention activities in Switzerland**

Health Promotion Switzerland

A foundation – Health Promotion Switzerland – was created in 1989 by the cantons and insurers. In 1998, the LAMaL provided the legal basis for it to take on a leading role in health promotion under the supervision of the federal government. The primary objectives of the foundation are: *i)* to efficiently implement good ideas for promotion in effective projects; *ii)* to achieve a high level of professionalism in health promotion in Switzerland in comparison with other countries; and, *iii)* to make health promotion more clearly visible in the Swiss political agenda.

The four main priority programmes are:

1. *Physical activity, Nutrition, Relaxation*: The objective of this programme is to stimulate people to take the initiative in promoting their health in these areas.
2. *Health and work*. The principal areas of attention of this programme are workplace safety, accident prevention and the prevention of occupational diseases.
3. *Adolescents and young adults*. The aim of this programme is to strengthen young people's sense of individual worth.
4. *Mental health*. In light of the growing importance of mental health problems, greater attention is being paid to prevention, particularly those related to stress. In addition, measures are also being considered to help individuals to organise and control their lives better.

Health Promotion Switzerland also supports projects that are planned and implemented in co-operation with the cantons and municipalities.

Activities of the Foundation are financed by an annual contribution – set at CHF 2.40 per year at the time of writing – from all persons insured with a statutory health-insurance fund. This contribution yields a total budget of around CHF 17 million per year. Contributions are collected by LAMal insurers *via* the insurance premium.

The Swiss Association of Cantonal Chiefs for Health Promotion

The aim of this association is to improve the co-ordination of health-promotion measures taken by cantons, and to improve the co-ordination between the federal government and the cantonal projects in the field of health promotion. The association includes four regional groups: Latin Switzerland, North-West Switzerland, Eastern Switzerland, and Central Switzerland, which, in turn, pursue co-ordinated health-promotion activities at the regional level.

Radix

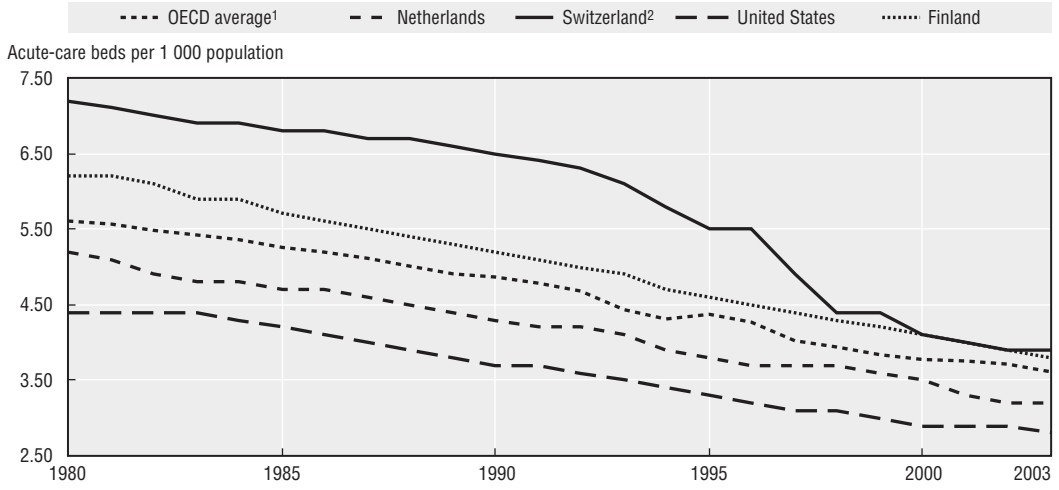
Radix is a foundation specialised in health-promotion activities for municipalities, schools and companies. It aims at encouraging municipalities and cantons to consider health promotion as an important issue. It provides services to municipalities, schools, and companies and has an annual budget of approximately CHF 3.5 million which is largely financed by federal or cantonal grants and donations.

providers, a figure which has been increased only slightly over recent years. This figure would probably be higher if insurers proposed such arrangements (HMOs) in all cantons, regions and cities.

1.5.3. Organisation of hospital supply

Hospital supply of acute-care beds in Switzerland, at 3.9 per 1 000 population, is slightly above the OECD median of 3.7 beds (Table 1.7). Bed supply per capita has undergone a trend reduction over the past two decades in line with other OECD countries (Figure 1.17). This trend can be explained by the hospital rationalisation which has occurred in certain cantons, as well as reductions in the average length of stay (see Chapter 4).

Figure 1.17. **Acute-care beds in Switzerland and in selected OECD countries, 1980-2003**



Note:
The United States is a federal system as in Switzerland, while in Finland the health system is highly decentralised. The Netherlands has a health insurance system with several of the features of the Swiss system.

1. OECD unweighted average. It includes the following countries: Australia, Belgium, the Czech Republic, Denmark, Finland, France, Hungary, Italy, the Netherlands, Norway, Portugal, Sweden, Switzerland, Turkey and the United States.
2. There is a break in the time series for Switzerland in 1997.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Hospitals vary on both their ownership and their legal status. Public hospitals are owned and, in many cases, run by cantons, municipalities or foundations, while private hospitals can be either for-profit or not-for-profit (European Observatory on Health Care Systems, 2000). In terms of functional role, general hospitals operate alongside specialised hospitals for rehabilitation and psychiatric care. High-tech and highly specialised medical treatments are supplied by several – often un-co-ordinated – facilities, including five university hospitals (Zurich, Bern, Basel, Lausanne and Geneva), and some large cantonal hospitals. Most emergency services are delivered by public hospitals (Undritz, 2005). Private facilities, representing about one fifth of overall hospital beds, generally provide simple surgical treatments, day-care and elective surgery. However, a few centres also offer highly specialised care.

Under the LAMal, cantons have been made explicitly responsible for hospital planning. Such plans are supposed to organise the capacity and structure of hospital supply on the basis of population needs and cost-control targets. There is large variation in the way cantonal plans are established, as the law does not establish specific criteria or methods. All public hospitals and a share of private hospitals[28] have been included in the

planning process. These hospitals are included in a cantonal list that gives them the right to claim insurance reimbursement for services covered by mandatory insurance. However, there are no specific criteria or methods for inclusion in the lists, although cantons have agreed on a set of common recommendations (*e.g.*, adequacy of medical personnel, equipment and service) (Conférence suisse des Directrices et Directeurs cantonaux de la santé, 2002 and 2005b). Cantonal subsidies cover the cost of investment, training and research, and a share of the running costs for LAMal-covered treatments delivered in shared rooms (or an equivalent if the service is delivered in private rooms, see Section 1.6 below). About three in five hospitals (81% of overall beds) receive cantonal subsidies (Table 1.8) (Office fédéral de la statistique, 2005a). The obligation to set up hospital plans does not extend to cross-cantonal agreements to co-ordinate supply.

Table 1.8. **Public and private hospitals in Switzerland, 2003**

Canton	Private				Public or subsidised				Total			
	Hospital beds		Hospitals		Hospital beds		Hospitals		Hospital beds		Hospitals	
	Number	Rate[1]	Number	Rate[2]	Number	Rate[1]	Number	Rate[2]	Number	Rate[1]	Number	Rate[2]
Switzerland	8 145	1.1	134	1.8	34 597	4.7	220	3.0	42 742	5.8	354	4.8
Appenzell Inner-Rhodes	17	1.1	1	6.7	97	6.5	1	6.7	114	7.6	2	13.3
Appenzell Outer-Rhodes	288	5.4	5	9.4	286	5.4	3	5.7	574	10.8	8	15.1
Aargau	920	1.6	11	2.0	2 519	4.5	11	2.0	3 439	6.1	22	3.9
Basel-Country	181	0.7	7	2.7	1 182	4.5	6	2.3	1 363	5.2	13	4.9
Basel-Town	133	0.7	3	1.6	2 229	11.9	11	5.9	2 362	12.7	14	7.5
Bern	1 141	1.2	14	1.5	4 214	4.4	22	2.3	5 355	5.6	36	3.8
Fribourg	138	0.6	3	1.2	779	3.2	5	2.0	917	3.7	8	3.3
Geneva	495	1.2	10	2.4	2 378	5.6	6	1.4	2 873	6.8	16	3.8
Glarus					128	3.3	1	2.6	128	3.3	1	2.6
Grisons	482	2.6	8	4.3	990	5.3	16	8.6	1 472	7.9	24	12.9
Jura	80	1.2	1	1.4	365	5.3	2	2.9	445	6.4	3	4.3
Lucerne	287	0.8	3	0.9	1 210	3.4	6	1.7	1 497	4.2	9	2.6
Neuchâtel	21	0.1	2	1.2	875	5.2	11	6.6	896	5.4	13	7.8
Nidwalden					98	2.5	1	2.6	98	2.5	1	2.6
Obwalden					81	2.4	1	3.0	81	2.4	1	3.0
Schaffhausen	30	0.4	1	1.4	442	6.0	3	4.1	472	6.4	4	5.4
Schwyz	32	0.2	1	0.7	263	1.9	3	2.2	295	2.2	4	3.0
Solothurn	47	0.2	2	0.8	881	3.6	7	2.8	928	3.8	9	3.7
St. Gall	237	0.5	4	0.9	2 063	4.5	15	3.3	2 300	5.0	19	4.2
Thurgau	633	2.7	10	4.3	779	3.4	4	1.7	1 412	6.1	14	6.1
Ticino	950	3.0	16	5.1	1 148	3.6	8	2.5	2 098	6.6	24	7.6
Uri					143	4.1	1	2.8	143	4.1	1	2.8
Valais	169	0.6	2	0.7	1 433	5.0	15	5.3	1 602	5.6	17	6.0
Vaud	758	1.2	12	1.9	3 120	4.9	23	3.6	3 878	6.1	35	5.5
Zug	127	1.2	2	1.9	357	3.4	3	2.9	484	4.7	5	4.9
Zurich	979	0.8	16	1.3	6 537	5.2	35	2.8	7 516	6.0	51	4.1

1. Acute-care beds per 1 000 population. Includes all beds in Swiss hospitals. The number differs from the figure presented in Table 1.7 because it includes acute care, psychiatric care, acute geriatric care and all other specialised care.
2. Hospitals per 100 000 population.

Source: Office fédéral de la statistique (2005), *Statistiques des hôpitaux et des établissements de santé non hospitaliers 2003*, Neuchâtel.

1.5.4. Long-term care (LTC)

Municipalities and, to a lesser extent, cantons, have responsibilities for the organisation and provision of care for the aged. Formal care is provided in old-age or disability homes, in medical nursing homes and at the homes of the care beneficiaries (so-called Spitex). Informal carers also play an important, albeit not quantified, role. The proportion of over 65s in need of long-term care services has been estimated between just under 10 and 11.5%, corresponding to 109 000 to 126 000 elderly (Mosle, 2005; Hoepflinger and Hugentobler, 2003).

The cantons generally subsidise the construction and running costs of public and certain private nursing and old-age homes. These institutions are subject to the same system of cantonal planning as hospitals. Two-thirds of nursing homes and other providers of institutional care are public institutions or non-profit organisations, while the remaining third is private for-profit (OECD, 2005b). Total bed capacity is around 85 200, with occupancy rates of 95-97% (Office fédéral de la statistique, 2005a; Mosle, 2005). While supply has been shifting away from long-stay wards in general hospitals (OECD, 2000), some elderly people requiring nursing care are admitted to hospitals due to waiting lists for entry to nursing homes. The majority of nursing-home residents are aged 80 and over. There are no standardised criteria across Switzerland for assessing the severity of cases. Institutions use three different systems (Plaisir, Rai/Rug and Besa) to evaluate the need for medical care.

Home-based care activities are significantly less important. However, growing concern about population ageing and their specific health needs have raised the policy profile of these issues and more attention is now being paid to the role of home-based care. Increased coverage of home-based services resulting from the introduction of the LAMal (which covers medical care for the elderly in these institutional environments), has been a contributing factor.

Spitex is the Swiss-German acronym for domestic aid and day-care services provided to the disabled and frail elderly outside hospitals (OECD, 2000). Home care is organised on a local or canton basis, predominantly (93%) by non-profit, private organisations. Spitex offers fairly comprehensive and wide-ranging services: 44% are considered long-term care, and 56% represent household and social-support services. About half of the cost is met through public sources. According to the most recent statistics, the volume and finance of home-care services remained flat between 1997 and 2000 (OECD, 2005b).

The Swiss system of institutional care for the frail elderly is financed about one-third through a complex system of public support, insurance and assistance and two-thirds by individuals (OECD, 2000). Unlike Germany, the Netherlands and Japan, there is no mandatory long-term care social insurance for the elderly. The LAMal covers the health-care component of care at home and in nursing and old-age homes. LAMal insurers do not, however, pay 100% of the LTC cost. Funding can come from other social-insurance schemes,[29] out-of-pocket payments and, if this is not sufficient, from the social-assistance system of cantons and municipalities (European Observatory on Health Care Systems, 2000). Access to social assistance is means-tested and available once an individual has exhausted his/her personal resources, including assets (OECD, 1999).

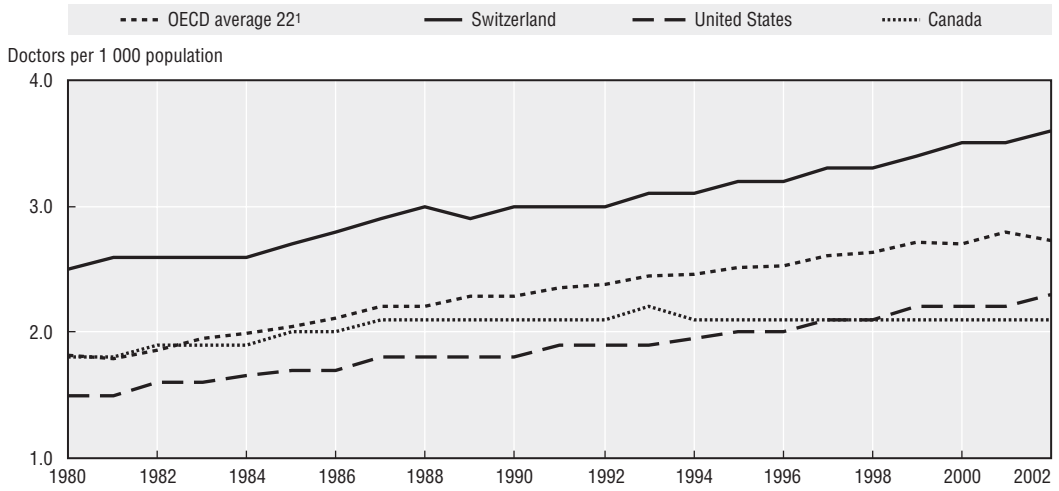
The overall (public and private) cost of long-term care (both medical and non-medical) for the frail elderly is estimated at around 1.3% of GDP for institutional care, and 0.2% for care services at home, placing Switzerland above the average for OECD countries. This

appears related to the higher share of those over 80 in the total population when compared with other OECD countries (OECD, 2005b).

1.5.5. *Human resources*

The majority of individuals employed in the health sector are in the institutional-care sector (approximately 56%), followed by the ambulatory, the industry and the business sectors. Employment in the health sector has increased significantly over the past years. For example, practising doctors rose from 2.4 to 3.6 per 1 000 population between 1980 and 2002 (Figure 1.18).

Figure 1.18. **Evolution of the density of doctors in Switzerland and in selected OECD countries, 1980-2002**



Note: The United States and Canada are federal systems as Switzerland.

1. The OECD average excludes the following countries for which data are not available across the 23-year period: Finland, Germany, Ireland, Italy, Mexico, the Slovak Republic and Spain.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

With ratios (per 1 000 population) of 3.6 doctors, 10.7 nurses, 0.5 dentists, and 0.5 pharmacists, Switzerland has a supply of health workers superior to most OECD countries (Table 1.7). However, the number of general practitioners in Switzerland (0.4 per 1 000 population) is lower than the OECD average of 0.8 per 1 000 population (OECD, 2005a).

The proportion of foreign doctors is estimated at 16% (Office fédéral des migrations, 2001) (Table 1.9). This is below comparable shares for the United States, the United Kingdom, Canada and Australia, which lie between 23% and 28% (Mullan, 2005), but above France and Germany, where foreign doctors represent less than 10% of all doctors (Couffinhal and Mousquès, 2001; Bundesaertzkammer, 2003). In Switzerland, the majority of foreign doctors are from developed countries, in particular Germany, which accounts for 60% of all foreign doctors (Office fédéral des migrations, 2001).

The supply of doctors and prospects for a significant rise in the number of EU-trained doctors coming to Switzerland following the mutual recognition of medical diplomas in 2002, raised concern about oversupply of doctors and related cost implications. This led to a more stringent policy regarding admissions to medical schools with the introduction of a *numerus clausus* policy at the universities of Bern, Zurich, Basel and Fribourg. In addition, a

Table 1.9. **Proportion of foreign-born doctors and nurses in Switzerland, 2001**

Country of origin	Doctors (2001)	Country of origin	Nurses (2001)
Germany	59.8%	Germany	26.6%
France	6.1%	France	12.2%
Italy	5.6%	Serbia-Montenegro	9.4%
Austria	3.9%	Italy	7.2%
Spain	1.4%	Croatia	5.4%
Belgium	1.4%	Netherlands	4.4%
Netherlands	1.1%	Austria	4.4%
Greece	0.7%	Bosnia-Herzegovina	3.4%
United Kingdom	0.6%	Spain	2.7%
Sweden	0.5%	India	2.6%
Luxembourg	0.2%	Portugal	2.5%
Portugal	0.1%	Belgium	2.2%
Finland	0.1%	Canada	2.2%
Denmark	0.1%	Philippines	2.0%
Norway	0.05%	Macedonia	1.5%
Iceland	0.02%	Turkey	1.4%
Ireland	0.02%		
Other countries	18.4%	Other countries	9.9%
Total	100.0%	**Total**	**100%**
Total foreign doctors	4 148	Total foreign nurses	19 095
As percentage of total doctors in Switzerland	16%	As percentage of total nurses in Switzerland	25%

Source: Office fédéral des migrations (2001), *Erwerbstätige ausländische Ärzte aus Staaten de EU und EFTA,* Stand: End August, Bern and personal communication; OECD (2005), *OECD Health Data 2005*, Paris.

freeze in the opening of new medical practices for practitioners working under the LAMal was adopted in 2002 for a period of three years (Chancellerie fédérale, 2002), and subsequently extended until the end of 2008. This measure applies to doctors in independent practices, which is the main type of practice for doctors in Switzerland, both for Swiss and for foreign-trained doctors. Doctors that are not authorised to set up a new private medical practice can look for employment in hospitals or practise outside the LAMal.

Nurses represent the largest professional health-worker category in Switzerland followed by physiotherapists. There are approximately 78 000 (professional) nurses (Office fédéral des assurances sociales, 2003a), mostly working in hospitals. Nursing homes and home care represent a small fraction of nursing employment. In hospitals, work overload, stress, and high turnover are quite common (Dumont and Longchamp, 1999; Künzi *et al.*, 2002). These factors have contributed to making this profession less attractive which, in turn, may explain the 20% decrease in the number of students in training between 1991 and 2001 and increased recruitment difficulties (Weyermann and Brechbuhler, 2005). The recruitment of foreign trained-nurses is playing an important role in balancing supply with demand in this segment of the labour market. The number of authorisations to practise given to foreign-trained nurses has increased over the years. While foreign-trained nurses represented 34% of the 4 600 yearly authorisations to practise issued for nurses in 2004 (Table 1.10) (Croix-Rouge suisse, 2005), foreign-born nurses represent 25% of the total number of nurses in Switzerland (Table 1.9) (Office fédéral des migrations, 2001). The latest estimate for New-Zealand is 17%, 8% for the United Kingdom, and 4% for the United States (Simoens *et al.*, 2005).[30]

Table 1.10. **Registration of foreign-trained nurses and midwives in Switzerland, 2004**

Country of training	Total (nurses and midwives)
Austria	18
Belgium	26
Denmark	1
Finland	6
France	442
Germany	468
Greece	0
Iceland	0
Ireland	2
Italy	143
Luxembourg	0
Netherlands	12
Norway	2
Portugal	1
Spain	8
Sweden	3
Switzerland[1]	24
United Kingdom	4
Other countries	390
Total foreign trained	**1 550**

1. Swiss women and men trained outside Switzerland.
Source: Croix-Rouge suisse (2005), *Reconnaissance des titres professionnels étrangers*, Bern.

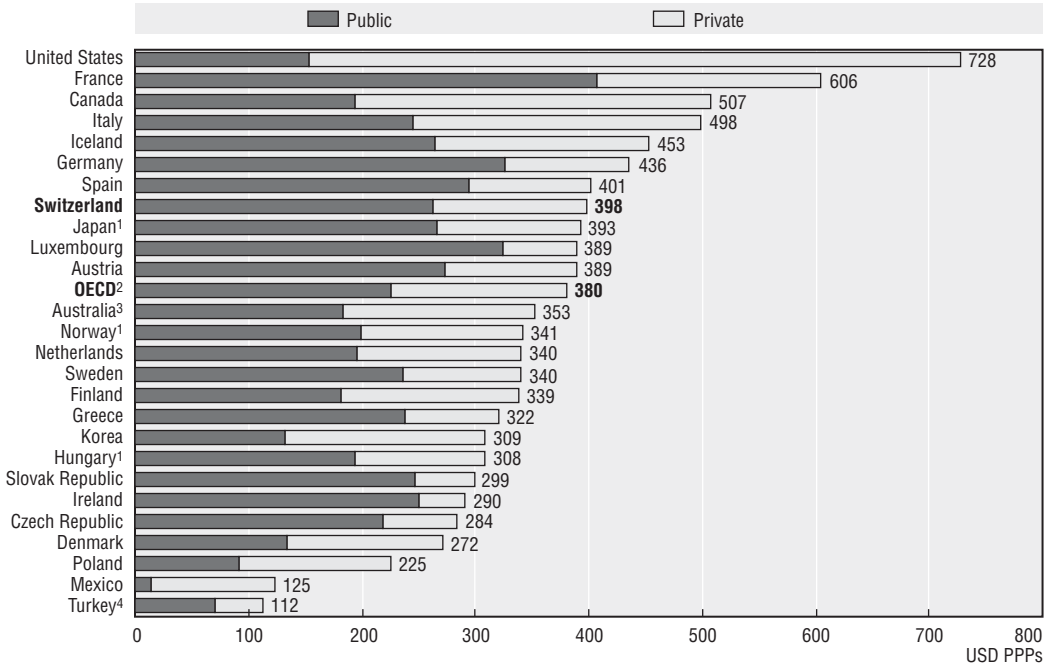
With the introduction of the LAMal, new opportunities have opened up for nurses to work as independent practitioners who can bill nursing services to the LAMal. The number of nurses having chosen this option was estimated at 900 in 2002 (Weyermann and Brechbuhler, 2005). Changes are also taking place in the training of nurses. The confederation has increased its responsibilities regarding non-medical professions with the creation of "Hautes Ecoles Spécialisées"[31] for health professions. The intention is to move the education level for nursing from secondary to tertiary level, as in many OECD countries.

1.5.6. Pharmaceuticals

The Swiss population spends USD 398 PPP per capita on pharmaceuticals, above the OECD average of USD 380 PPP but only about half of expenditure in the United States (Figure 1.19). Drugs dispensed to *out-patients* accounted for 10.5% of total health expenditure in 2003, a share which was significantly below the OECD average of over 18% (Table 1.11). Two-third of this spending is paid by mandatory health insurance or other social insurers, a slightly higher share than the OECD average of 60% (OECD, 2005a) (Figure 1.20).

Swissmedic, the Swiss Agency for Therapeutic Products – established on 1 January 2002 – is responsible for registration and market-entry authorisation for pharmaceuticals and medical devices. The agency replaced the previous Intercantonal Office for the Control of Medicines. Swissmedic assesses and certifies that drugs and medical devices put on the Swiss market are high-quality, safe and effective. Product reviews require on average six to eight months, and a fast-track procedure (three to five months) exists for treatments against life-threatening conditions, those for which no satisfactory therapy is available,

Figure 1.19. **Expenditure on pharmaceuticals per capita in OECD countries, 2003**



Note:
Public refers to expenditure financed by the government or by social and mandatory health insurance.
Private refers to expenditure financed by private health insurance or by individuals (out-of-pocket).
1. 2002.
2. The OECD average excludes Poland and Turkey.
3. 2001.
4. 2000.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

and drugs having high therapeutic value. Reviews are repeated five years after the date of entry into the Swiss market. Following granting of market authorisation, the manufacturer can apply for inclusion of the drug in the list of reimbursed products to the Federal Office of Public Health which decides whether a drug is eligible for reimbursement, as well as the maximum reimbursement price (see Section 1.6).

The large majority of pharmaceuticals sold in Switzerland are branded products, and most of these are subject to prescriptions. In 2002, four-fifths of the overall turnover of the domestic pharmaceutical market consisted of drugs requiring a medical prescription (Cueni, 2005a). The sales of generics tripled between 2000 and 2005, when it accounted for 8% of the market. There has been a further increase in the early months of 2006 to 12% (Zubler, 2006).[32] This rapid increase appears to be linked to the introduction of differentiated co-payments for generics.

About 55% of the drugs consumed in Switzerland (in terms of value at manufacturer prices) are sold through pharmacies. Dispensing doctors are the second most important channel (23% of the market), followed by hospitals (19%) and drugstores (less than 3%) (Interpharma, 2005). Only independent physicians with a special license accorded by cantons are allowed to dispense medication, in principle doctors operating in rural areas or in cantons with a relatively low number of pharmacies. This practice exists in 13 cantons. Dispensing doctors account for approximately one quarter of all independent practitioners (Hänggeli *et al.*, 2005). Over time, the share of pharmacies and consumer-good stores in

Table 1.11. **Distribution of health expenditure by type in OECD countries, 2003**

Percentage of total health expenditure	In-patient	Out-patient	Home care	Ancillary services	Total dispensed to out-patient	*Of which:* pharmaceutical and other medical non-durables
Australia (2001)	39.7	24.9	0.1	5.3	18.1	14.0
Austria	36.1	29.8	n.a.	n.a.	22.5	16.9
Canada	31.7	25.2	1.8	6.3	19.2	16.9
Czech Republic	33.9	28.3	0.3	1.0	25.5	21.9
Denmark	50.7	28.5	3.6	n.a.	12.1	9.8
Finland	39.5	30.0	n.a.	1.4	18.9	16.0
France	41.2	22.9	0.4	4.0	24.7	20.9
Germany	34.7	20.9	5.2	6.3	19.9	14.6
Hungary (2002)	29.0	22.6	0.1	5.4	31.8	27.6
Iceland	56.5	21.8	n.a.	0.3	16.8	11.8
Italy	41.5	30.2	n.a.	n.a.	22.1	22.1
Japan (2002)	40.0	32.4	0.5	0.8	19.3	18.4
Korea	22.4	35.9	n.a.	n.a.	31.2	28.8
Luxembourg	37.8	23.6	6.1	6.2	13.0	10.5
Mexico	38.0	30.0	0.3	0.2	21.4	21.4
Netherlands	39.6	21.8	3.8	2.4	16.7	11.4
Norway	45.3	17.7	7.7	5.6	13.6	9.4
Poland	29.5	22.1	4.1	3.0	32.4	30.3
Slovak Republic	30.4	15.4	0.1	4.0	43.6	38.5
Spain	27.2	39.6	n.a.	0.9	25.1	21.8
Sweden	32.0	47.7	n.a.	n.a.	14.8	12.6
Switzerland[1]	**47.9**	**27.3**	**2.1**	**3.1**	**12.7**	**10.5**
United States	27.1	43.7	2.4	n.a.	13.2	12.9
OECD average[2]	**37.0**	**27.9**	**2.4**	**3.3**	**21.2**	**18.2**

n.a.: not available.

The following countries: Belgium, Greece, Ireland, New Zealand, Portugal, Turkey and the United Kingdom have not been included in the table as data are only available until the mid-1990s.

1. Switzerland may overestimate expenditure for long-term care, an important component of in-patient health spending. Data on in-patient expenditure also include capital investment, which other OECD countries account for separately (capital spending represents 5.7% of in-patient expenditure and 2.7% of overall health spending). These factors may push up the overall share of in-patient health spending compared to other OECD countries.
2. The OECD average excludes Austria, Finland, Iceland, Italy, Korea and Spain for Home care; Austria, Denmark, Italy, Korea and the United States for ancillary services.

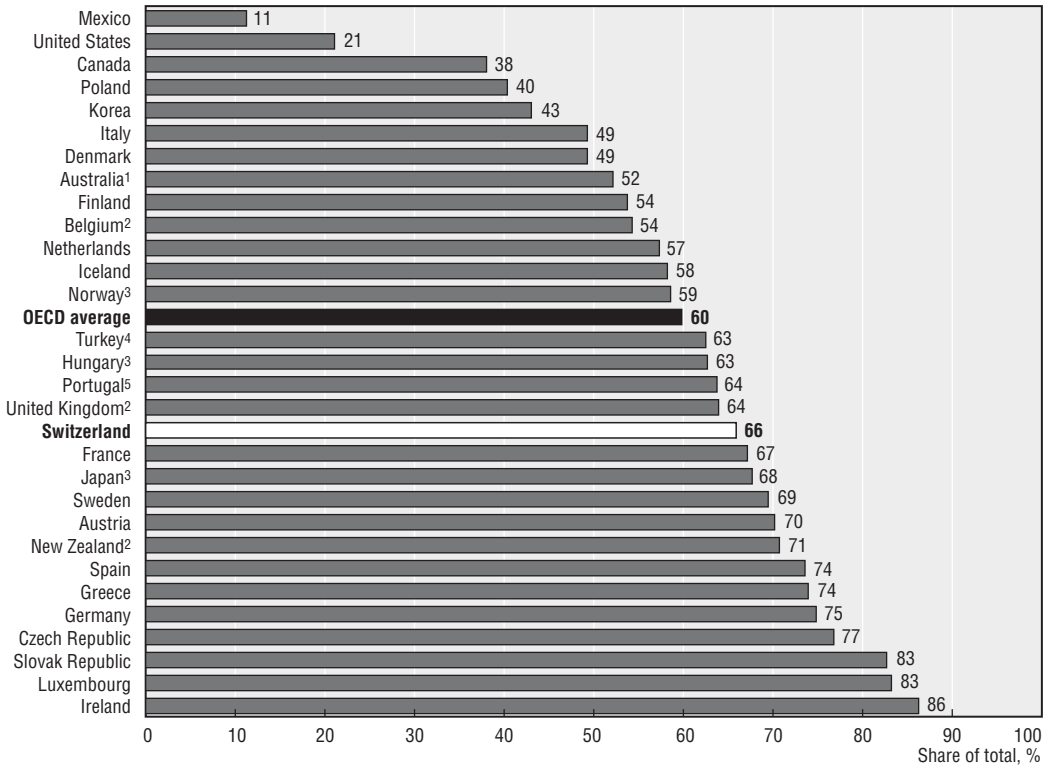
Source: OECD (2005), *OECD Health Data 2005*, Paris.

total drug sales has been diminishing, while that of hospitals and dispensing doctors has grown (Cueni, 2005a).

A quarter of the pharmaceuticals sold in Switzerland (CHF 4 066 million in 2004 at producer prices) are produced by domestic firms (Figure 1.21), of which Novartis, Roche and Serono, the largest companies, represent 61% (Interpharma, 2005). The remaining three quarters consist of drugs manufactured by foreign firms, a small share of which is also produced in Switzerland.

Over 90% of the pharmaceuticals manufactured in Switzerland are for export (Cueni, 2005b). Drug exports (CHF 40 billion in 2005) represent almost a quarter of overall Swiss exports, and exceed imports by 50% (Interpharm, 2005). Swiss producers also represented 8% of the world pharmaceutical markets. The main destination markets fall within Europe. Domestic firms mainly invest in the development of new drugs. In 2004, a fifth of the overall revenues of the six largest Swiss drug companies[33] was spent on R&D.

Figure 1.20. **Share of expenditure for out-patient pharmaceuticals paid by the government or social insurers in OECD countries, 2003**

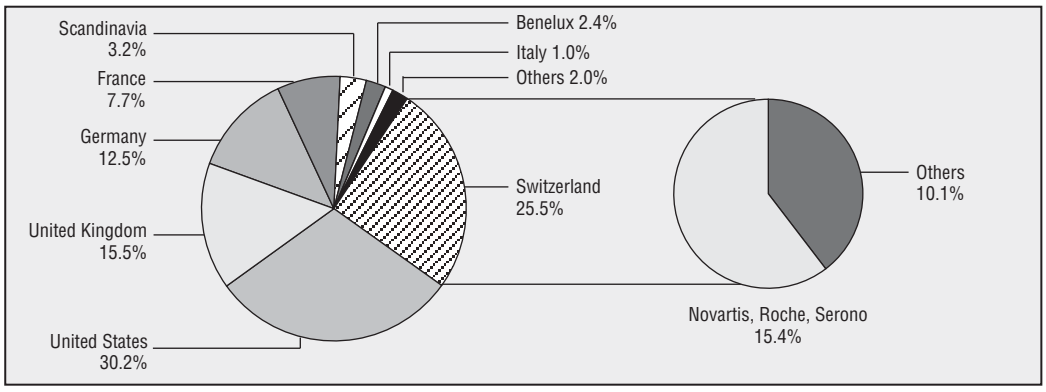


Note: Expenditure refers to pharmaceuticals and other medical non-durables.

1. 2001.
2. 1997.
3. 2002.
4. 2000.
5. 1998.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 1.21. **Country of origin of drugs sold in the Swiss domestic pharmaceuticals market**



Source: Interpharma (2005), *Le marché du médicament en Suisse*, Basel.

1.5.7. Expenditure by type of health services

Switzerland spent 48% of its total health expenditure in 2003 on in-patient care, 27% on out-patient care and 10.5% on pharmaceuticals dispensed to out-patients. The share of in-patient care is much higher, and that of drugs is lower than the OECD average (Table 1.11). The relative share of expenditure by type of care has remained stable over time.

1.6. Provider payments, reimbursement and contracting

Swiss providers receive payments from third-party insurers, from canton governments, or directly from patients. Subsidies to hospitals from cantonal and municipal authorities were 13% of total health expenditure in 2003, or 44% of total in-patient cost.[34] At present, ambulatory-care services are mostly paid on a fee-for-service basis, while hospital payment arrangements are more varied.

The law establishes that providers' bills should be based on tariffs agreed by convention between insurers and providers, or fixed by the authorities.[35] For LAMal-covered services, insurers are required to reimburse services delivered by all providers authorised to practise within the context of the LAMal (so-called "obligation to contract"). LAMal and other social insurers (LAA, AI, AM) have separate negotiations with providers. Payments for services not reimbursed by social insurers are based on market prices.

1.6.1. Payment mechanisms, price and tariff levels

Ambulatory-care sector

GPs and specialist doctors working in ambulatory-care settings, and those with admitting rights to hospitals,[36] are paid on a fee-for-service basis. This is also the primary means of remuneration for other self-employed health professionals (such as nurses, dentists, midwives, physiotherapists). Since 2001, payments for the majority of pharmacists have been based on fee-for-service (RBP, "Rémunération Basée sur les Prestations") rather than the preceding system of retail price margins on dispensed drugs.[37] Individuals usually pay providers directly and are later reimbursed by insurers. However, for drugs, patients pay the pharmacists' fee and the required cost-sharing, with the remainder reimbursed directly by the insurer.

Doctors treating patients who have chosen a LAMal-policy with limited choice of provider are paid differently depending on the specific managed-care model. In the case of HMOs, doctors are paid by capitation and can contract with different insurers. In the case of group practices with budgetary responsibility (IPA-type managed care), such as MediX Zurich and Bubenberg Bern, individual doctors are paid on a fee-for-service basis. A global budget – which is calculated on the basis of the prospective cost per group of insurees[38] – is agreed between the IPA and their insurance partners. These budgets can include associated hospital costs for patients. When the actual cost of treating insured patients is less than the budget, the surplus is shared among participating doctors. Similarly, doctors participating in "gatekeeping" arrangements, which represent two-thirds of managed-care models in Switzerland, are paid fee-for-service and may receive a share of the benefits gained by the network (Baur, 2004).

Finally, most hospital doctors and other health professionals employed by the hospital or nursing homes are paid by salary. Generally these doctors work only in hospitals and do not have the right to private practice.

Within social-insurance schemes, all medical and medical-related professions have a nationally agreed tariff structure that sets the relative weight of the different services provided. These relative weights have been negotiated between the relevant professional associations[39] and insurers (health, accident, military and disability) and a certain number of points are attributed to each service (European Observatory on Health Care Systems, 2000). For example, medical fees have been based on such a unified relative tariff system (TARMED) since 1 January 2004. The TARMED specifies the resource-based points for each type of medical treatment. It is also used as the basis for setting tariffs for out-patient services delivered by hospitals. For accident, military and disability insurance, the actual value attached to each point is also set nationally. For LAMal-insurers, national agreements over the value of the "point" exist for dentists and dieticians. However, in the case of medical fees, the value of the "point" is collectively negotiated between the cantonal associations of insurers and providers, and thus the value of the "point" can reflect the differences in salaries and prices across cantons. Similar canton-based agreements exist for chiropractors, ergotherapists, nurses and physiotherapists.

Outside of the LAMal, providers set their prices freely, although usually on the basis of the nationally agreed point structure. These refer to services not covered by the LAMal, doctors who have explicitly refused to participate in the LAMal system (and therefore have no right to reimbursement by LAMal insurers), or those who cannot charge LAMal-insurers in the context of the freeze on the opening of new office-based practices.

Hospitals and nursing homes

The predominant payment mechanism for hospitals is per diem or bed day. However, since the introduction of the LAMal, and particularly in the context of proposals for revising the system of hospital financing,[40] there has been a trend towards new remuneration mechanisms based on services, such as case-based payments per department, service or specialty, or DRGs (primarily using the all-patients diagnosis-related group classification, AP-DRG). Payment mechanisms vary significantly across cantons, and sometimes by social insurer and individual hospital (Table 1.12). A new project (called Swiss DRG) to establish a uniform national DRG system is underway.[41] For services covered by insurance, hospitals usually receive payments directly from insurers.

Like ambulatory services, in-patient hospital tariffs (whether per diem or other mode of payment) for services covered by social-insurance schemes are negotiated between hospital associations and insurers. The costs of drugs used in in-patient settings are included in the tariff, as well as the cost of diagnostic and therapeutic services, unless otherwise negotiated. The tariff can differ across social-insurance schemes. For example, tariffs paid by the accident insurer are higher than those agreed with LAMal insurers because they reflect both investment and running costs, and not just operating costs.

Hospital financing is not solely reliant on payments by insurers. Cantons fully finance the capital investment, research and education costs of public and selected private hospitals included in cantonal lists. They also finance a share of the recurrent costs of hospital treatments reimbursed under the LAMal. This share is fixed by law at 50% at least for individuals cared for in public wards, and it varies by canton depending on the level of reimbursement negotiated between insurers and hospitals.[42] According to the LAMal, cantons can set global budgets for hospital subsidies, established on the basis of historical or prospective costs.[43] Some cantons set service contracts with hospitals which specify the amount of the transferred subsidy and the services to be provided. Despite such contracts,

Table 1.12. **Hospital payment systems in Swiss cantons, 2004**

Canton		Acute care	Psychiatry	Remarks
Appenzell Inner-Rhodes	AI	Per diem		
Appenzell Outer-Rhodes	AR	Case/service-based payments and per diem	Per diem	
Aargau	AG	MIPP fixed payment, fixed payment/service or per diem	Per diem	The MIPP is a remuneration system practised at Aarau cantonal hospital which is based on phase of treatment of patients
Basel-Country	BL	Full case-based per diem	Full case-based per diem	
Basel-Town	BS	Per diem	Per diem	Specific procedures counted as extras
Bern	BE	Specific case-based payment for IIe hospital; case/service-based payement for all other public hospitals	Per diem	AP-DRG since 1/1/2004 for AA/AI/AM
Fribourg	FR	Case/service-based payments and per diem	Per diem	
Geneva	GE	Per diem	Per diem	Specific procedures counted as extras
Glarus	GL	Case/service-based payments and per diem		Supplement paid for intensive-care units
Grisons	GR	Case/service-based payments and per diem	Per diem	Supplement paid for intensive-care units
Jura	JU	Case/service-based payments and per diem	Per diem	Supplement paid for intensive-care units
Lucerne	LU	Per diem	Per diem	Case-based payments for heart surgical interventions
Neuchâtel	NE	Case/service-based payments and per diem		Supplement paid for intensive-care units, breakdown by AP-DRG from 2005 to be applied to AA/AI/AM, from 2006 to LAMal
Nidwalden	NW	Case-based payments for the canton's residents and partial per diem for outsiders		
Obvalden	OW	Case-based payments for canton's residents and partial per diem for outsiders	Per diem	
Schaffhausen	SH	Case-based payments and per diem	Per diem	Grafts are counted as extras
Schwyz	SZ	AP-DRG applied since 1.1.2004 both to AA/AI/AM and LAMal sectors		
Solothurn	SO	Per diem		
St. Gallen	SG	Case/service-based payments and per diem	Per diem	Grafts are counted as extras
Thurgau	TG	Case/service-based payments and per diem	Per diem	
Ticino	TI	AP-DRG applied to AA/AI/AM and to Helsana covered population under the LAMal	Per diem	Helsana's AP-DRG are currently under development and have not yet been approved by the cantonal government
Uri	UR	Case-based payments for the canton's residents and partial per diem for outsiders (including a supplement for grafts)		
Valais	VS	AP-DRG applied since 1.1.2004 to AA/AI/AM and to LAMal since 2005; before case/service-based payments and per diem	Per diem	
Vaud	VD	AP-DRG applied since 2002 both to AA/AI/AM and LAMal sectors	Per diem	
Zug	ZG	AP-DRG applied since 1.1.2004 both to AA/AI/AM and LAMal sectors	Per diem	
Zurich	ZH	Specific case-based payments and per diem at USZ; case/service-based payments and per diem for all other public hospitals	Per diem	Including a supplement for grafts

AA: Accident insurance; AI: Disability insurance; AM: Military insurance; AP-DRG: All-patients diagnosis-related-groups; LAMal: Mandatory health insurance.
Source: Adapted from: *www.gdk-cds.ch/fileadmin/pdf/Gesundheitsoekonomie/Spitalfinanzierung/Spitaltarife_Kantone/Stuktur_Spitaltaxen-f.pdf.*

most cantons cover deficits incurred by public hospitals, although some are starting to apply some penalties for hospitals exceeding the budget. Services not covered by social insurers, including the additional costs of superior accommodation and comfort services, are paid directly by the individual or by supplementary health insurance.

The LAMal reimburses the medical costs of stays in nursing homes (but not other cost elements such as accommodation and entertainment). Insurers can agree payments on the basis of cases with nursing homes. As for hospitals, cantons provide subsidies to public and certain private nursing homes and can set global budgets.

Pharmaceuticals

Since 1 January 2004, the Swiss Federal Office of Public Health has been responsible for pharmaceuticals' reimbursement and pricing under the LAMal. Only pharmaceuticals included in a positive drug list by the Federal Office of Public Health (the so-called "specialty list", SL) are reimbursable by mandatory health insurance. The list shows two different prices for each pharmaceutical: a retail public price, corresponding to the level reimbursed by the LAMal (before cost-sharing deductions) and inclusive of a 2.4% VAT; and a manufacturer's selling price. In 2004, the SL included about 2 500 drugs.[44] Non-reimbursed drugs are not subject to price controls, although the Price Surveillance Authority is responsible for ensuring "reasonable" prices.

The Federal Office of Public Health considers whether a drug can be reimbursed and its maximum reimbursement price, following advice from the Federal Drug Committee (Cueni, 2005a). The Federal Drug Committee reviews the efficacy, adequacy and cost-effectiveness of the drug before advising the Federal Office of Public Health. The body comprises representatives from health-insurance companies, the pharmaceutical industry, health professionals, the Price Surveillance Authority, Swissmedic, and representatives of the insurees. Decisions are guided by price comparisons with other therapeutically-equivalent drugs as well as the manufacturers' selling prices in reference countries (Germany, Denmark, the Netherlands, and the United Kingdom). If available, the drug prices of France, Italy and Austria can also be considered as "supplementary" evidence to inform decisions, particularly when large price differences for the same product exist in the four reference countries or when the drug is only sold in the supplementary countries (Cueni, 2005a). When the drug is not yet sold in reference-price countries – Switzerland is often the first launch market – the decision on the reimbursement price is guided by the price comparison with other therapeutically-equivalent drugs. An innovation bonus, reflecting the degree of innovation, can be added to cover R&D costs.

Prices set by the Federal Office of Public Health are reviewed periodically. Examinations take place at four different points in time: upon the drug's listing on the SL; two years after market entry (since July 2002); seven years after market entry (from July 2006),[45] and, finally, upon expiration of the patent or after 15 years of listing in the reimbursement catalogue. On this occasion, the price of the drug is aligned to the average price in the reference countries. From July 2006, prices of generics are required to be at least 30% lower than those for innovative drugs at market entry. After 24 months, generics' prices should also undergo another 15% price reduction compared with the original products.

Once a drug has been included in the SL, insurers reimburse the price of the drug, less the required patient cost-sharing (deductibles and co-insurance). Since the beginning of 2006, there have been differentiated co-payments for branded drugs where there are generic substitutes.

Margins in the distribution of drugs are shared between wholesalers and retailers. While the breakdown of margins used to be fixed by Sanphar, an association of companies

distributing drugs in Switzerland, the Swiss competition authority (Comco) has prohibited such agreements since 2000 in view of their negative impact on competition (OECD, 2003).

1.6.2. Contracting

The law allows providers flexibility regarding joining a given tariff agreement. A provider (*e.g.*, doctors, pharmacist, nurse) can decide to join in an agreement, even if s/he is not a member of a professional association. Moreover, members are not obliged to adhere to a tariff agreement stipulated with insurers (Britt *et al.*, 2005). Those who decide not to join – only a few at present[46] – must negotiate a separate tariff with insurers.

Conversely, insurers have a *de facto* obligation to conclude contracts with all providers authorised to practise within the context of the law. These include all hospitals which satisfy certain infrastructure and service requirement and are included in the cantonal hospital planning, and all doctors who operate in independent practice.[47] Apart from doctors in managed-care settings, insurers do not have freedom to contract selectively.

Table 1.13. **Reimbursement for medically-needed treatments in shared wards and private rooms**

Financing agent	Individuals in shared wards		Individuals in private or semi-private rooms	
	Intracantonal	Outside the canton	Intracantonal	Outside the canton
Canton/municipality	• Public hospitals or private hospitals on the cantonal list: at least 50% of the running costs applicable to shared wards, as well as investment costs. • No cantonal support for cost in other private hospitals.	• Public hospitals or private hospitals on the cantonal list: Hospital bill (based on fees for out-of-canton patients) minus the part covered by LAMal insurers. • No cantonal support for cost in other private hospitals.	• Public hospitals or private hospitals on the cantonal list: cantons contribute an amount equivalent to treatments delivered in shared wards. • No cantonal support for cost in other private hospitals.	• Public hospitals or private hospitals on the cantonal list: cantons contribute an amount equivalent to treatments delivered in shared wards. • No cantonal support for cost in other private hospitals.
Mandatory insurance	• Public hospitals or private hospitals on the cantonal list: at most 50% of the running costs applicable to shared wards. • Other private hospitals: running and investment costs (the percentage of costs covered is not set by law).	• All hospitals: coverage up to the tariffs charged by the hospital to cantonal residents treated in shared wards.	• Public hospitals or private hospitals on the cantonal list: at most 50% of the running costs applicable to shared wards. • Other private hospitals: running and investment costs (the percentage of costs covered is not set by law).	• Coverage up to the tariffs charged by the hospital to cantonal residents treated in shared wards.
Supplementary insurance			• Extra costs for treatment in private or semiprivate rooms (superior accommodation, special meals, etc.) and residual costs.	
Out-of-pocket expenditure	Cost-sharing: 1) Deductibles: between 300 and 2 500 CHF for adult persons; 2) Co-insurance: 10 % of the cost of medical services above the deductible but cannot exceed 700 CHF per year per adults and 350 CHF per child; 3) Co-payment: fixed sum of 10 CHF per day per hospitalisation for persons living alone.		• Extra costs for being treated in private or semi-private rooms (better accommodation, special meals, etc.) and residual costs, if they are not reimbursed by the supplementary insurance.	

Source: Adapted from "Tribunal fédéral des assurances", ruling of 30 November 2001.

In the ambulatory sector, cantonal tariffs apply to all treatments delivered by the providers of the respective canton. In the inpatient sector, providers can set higher fees for patients coming from a different canton. If the individual receives a treatment outside of the canton of residence, his or her insurer will reimburse up to the tariff the provider would charge to residents in cases of emergency or when a service is unavailable in the insuree's canton-of-origin. In those circumstances, the canton of origin covers any difference between the actual bill charged to the patient and the tariff reimbursed by the insurer (Table 1.13). Such a system of tariff protection and reimbursement does not apply when an individual chooses to receive medical treatment outside the canton of origin without a valid medical reason or approval by the canton of origin. In these cases, patients are liable to pay any difference between the bill charged by the provider (corresponding to fees for out-of-canton patients) and the tariff applicable (and thus reimbursed) in her/his canton of origin. Cantons can stipulate agreements concerning coverage of costs for treatments delivered outside the canton.[48]

Notes

1. Loi fédérale sur l'assurance-maladie et l'assurance-accident, 13 June 1911.
2. Loi fédérale sur l'assurance-maladie, 18 March 1994. The law came into effect on 1 January 1996.
3. This is referred to as "social health insurance", "mandatory health insurance" or "basic health insurance" in the LAMal and related rulings.
4. This size corresponds to the 9th and 3rd smallest OECD country, respectively. Population data refer to the permanent resident population at the end of 2004.
5. One member in the case of half-cantons, such as Basel-Town and Basel-Country.
6. The National Council has 200 members and the Council of States has 46 members. At the time of writing, the Swiss parliament has a right-of-centre majority.
7. From 2007, the Federal Supreme and the Federal Insurance Courts will be merged.
8. Switzerland and the EU have over the years increased interest in health as a common policy field.
9. Excluding suburban areas of these cities.
10. In the case of Switzerland, GNP was 8% higher than GDP in 2003, reflecting large positive income flows from abroad. Where a national accounts aggregate is used as an indicator of the capacity to finance the health-care system, GNP is probably a better measure than GDP, which has been typically used for these types of assessments. Few other OECD countries have significant differences between GNP and GDP.
11. These figures exclude subsidies to low-income individuals which are not recorded as federal health spending in Swiss Government statistics.
12. Swissmedic is the Swiss Agency for Therapeutic Products. It ensures that only high-quality, safe and effective medicines and medical devices are placed on the market in Switzerland.
13. This section draws heavily on previous work on the mandatory health-insurance system by Colombo (2001).
14. These objectives were contained in the message concerning the revision of the 1911 Sickness and Accident Law (LAMA), 6 November 1991, pp. 3-5.
15. Individuals who seek care outside the canton without a medical reason or for personal considerations can be charged the difference in costs between the home canton and the costs charged by the canton providing the care. However, the costs charged by the canton providing care cannot exceed its own "external tariff". The patient can, however, cover his additional costs through complementary insurance.
16. Deductibles are lump sums that insurees have to pay out-of-pocket until insurance coverage kicks in. Co-insurance consists of cost-sharing requirements whereby individuals pay a share of the cost

of the medical service (*e.g.*, 10%). Co-payments are fixed sums (*e.g.*, CHF 10) paid for per day for each episode of hospital care (*e.g.*, a night in hospital).

17. Loi fédérale sur l'assurance-accident, 20 March 1981.

18. In 2005, this included 400 000 enterprises, representing 3.5 million of insurees (Ludwig and Morger, 2005).

19. Loi fédérale sur l'assurance-invalidité, 19 June 1959.

20. Loi fédérale sur le contrat d'assurance, 2 April 1908.

21. Art. 12 of the LAMal authorises insurers providing mandatory coverage to offer voluntary health-insurance products in parallel. Usually, insurers create separate companies for the management of mandatory and voluntary health insurance.

22. Date of enactment of a LAMal revision of 24 March 2000.

23. Subsidies to low-income individuals and families for the purchase of health insurance, whose cost is shared by the federal and cantonal governments, do not appear here as they are part of health spending for insurance premia. The breakdown of health spending by financing agents, which is the way *OECD Health Data* are reported, shows health expenditure according to who pays for health goods and services, rather than who bears the financing burden. The overall share of health-related expenditure funded through federal and cantonal government tax revenues was 24% in 2003, if subsidies are included (Office fédéral de la statistique, 2005i) (see Table 3.2). Except for those subsidies, the confederation does not make earmarked allocations to cantons for financing health costs. Each canton receives a "fair" share of federal tax revenues based on a system of revenue-sharing transfers, but is free to choose how to use such funds. Cantons also raise their own revenues via taxes and other charges.

24. Swiss data on spending on health prevention and promotion are likely to be slightly underestimated because: *i)* the cost of some maternal and child-health programmes is included under out-patient care; *ii)* total health expenditure includes an overestimate of long-term care spending. Spending on health prevention and promotion as a share of GDP is therefore likely to be close to the OECD average.

25. The Swiss Federal Office of Public Health publishes recommendations with regard to immunisation policy. However, there is neither a national immunisation policy nor legal requirement at federal level for immunisation.

26. This is illustrated by screening for breast cancer. In most cantons, screening activities are conducted at the initiative of patients, who voluntarily visit a general or specialised practitioner (so-called "opportunistic screening"). By 2005, only five cantons had developed a systematic quality-assured breast-screening programme (Vaud, Geneva, Valais, Jura and Fribourg). The programme targets women aged between 50-69. In these cantons, the mandatory health insurance only covers screening taking place in a programme and not the opportunistic screening.

27. There are a number of other initiatives including: the Swiss Council for Accident Prevention, the Swiss National Accident Insurance Fund, the Conference of Cantonal Liaison Officers for Substance Abuse, the Swiss Cancer League and the Swiss Lung League, the Swiss Council for Accident and Prevention.

28. While the hospitals on cantonal lists are normally public or private non-profit institutions, private-for-profit hospitals can also be included when they receive a specific mandate for care by the cantonal authorities.

29. Non-medical costs are paid by a combination of accident insurance, the first and second-pillar pension income or disability benefits, and complementary benefits to AVS-AI. If a person needs assistance in four activities of daily living, old-age insurance pays a disability allowance. Living costs (at home or in an institution) have to be paid by the patient. Complementary AVS-AI benefits are available to the elderly with inadequate resources to help cover the difference between the actual cost and what is available through old-age and disability pensions. These benefits are regulated by the confederation and paid by cantons, and consist of monthly allowances and subsidies for medical and disability expenses. However, many eligible elderly do not apply for such benefits, considering it a form of social assistance (OECD, 2000).

30. For the United States and New-Zealand, the data reflect foreign-trained nurses.

31. Hautes Écoles Spécialisées are at the level of Swiss universities, but syllabuses are more application- and achievement-oriented.

32. According to data from Interpharma (2005), generics represented CHF 180 million in 2004, while the whole domestic market was CHF 4 066 million.

33. Novartis, Roche, Serono, Actelion, Vifor et Cileg.

34. These percentages were calculated from data on the implementation of a System of Health Account for Switzerland, available on the OECD website at *www.oecd.org/health*.

35. According to the LAMal, tariffs can be based on time worked (*e.g.*, for nurses providing Spitex services), services (*e.g.*, for doctors in independent practice), or set-prices, *i.e*, forfaits (per patient, per diagnostic group, per group of patient, as well as prospective global budgets for a group of insurees). When professional associations and insurers do not manage to agree on a uniform national fee structure, the Federal Council fixes it.

36. Doctors with admitting rights to a public or private hospital have, in some cases, to pay to the hospitals part of the income received from patients. These are a small fraction of total doctors.

37. The main principle behind the RBP is to remunerate pharmacists on the basis of the service rendered in terms of specialised counselling to the patient, as well as for the capital and logistics cost of their activity (Cueni, 2005a). Pharmacists receive a fee for handling the prescription and advising the patient, and a fee for keeping patients' records (Jordan and Enderle, 2005).

38. The capitated cost per group of insurees is calculated on the basis of the age, sex and other characteristics of that group. MediX uses over 700 capitation groups. These contracts often have complex risk-sharing arrangements to allow for unforeseen events and high-cost patients.

39. Doctors' associations (FMH), hospitals' association (H+), pharmacists' association (Société suisse des pharmaciens), etc.

40. "Message concernant la révision partielle de la Loi fédérale sur l'assurance-maladie (financement hospitalier)" of 15 September 2004.

41. The strategic committee for Swiss AP-DRG projects has decided not to include the investment costs in the DRG for the time being, but recommended its inclusion in a later stage (Comité stratégique, 2005).

42. This refers to public hospitals or hospitals subsidised by the cantons. In contrast, private hospitals can be covered by the insurers up to as much as 100% depending on negotiations between private hospitals and the insurers.

43. Hospital budgets are currently operated in Vaud, Schwyz, Zurich, Valais, Bern and a few other cantons.

44. The list is available on the Internet at *www.bag.admin.ch/themen/krankenversicherung/00263/00264/00265/index.html?lang=de*.

45. But only if the use of the drug has not been extended to the treatment of other medical conditions.

46. For example, only 8 out of 95 insurers have not adhered to the convention for RBP remuneration of pharmacists, and about 70 pharmacies out of 1 680.

47. However, doctors who have refused to participate in the LAMal system or cannot charge LAMal insurers are excluded.

48. At present, only treatments furnished by providers practising in Switzerland are covered by the LAMal. The Federal Department of Home Affairs has put forward a proposal to allow reimbursement for treatments received abroad, with a view to stimulate price competition. A pilot initiative has been launched in the cantons of Basel-Town and Basel-Country in co-operation with the German county of Lörrach.

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Chapter 2

The Performance of the Swiss Health System: Effectiveness and Quality

This chapter examines how the Swiss health system performs in terms of health achievements, prevention, and quality of health services. While the Swiss health system is relatively expensive, it delivers high health outcomes and inequalities in health are less pronounced than in most other OECD countries. However, in the field of health promotion and disease prevention, outcomes are mixed and opportunities to improve health are not currently being taken. A lack of clear designation of responsibilities in the Swiss system and incentives to invest in prevention activities are key reasons for this. Finally, while quality is recognised as an important issue, mechanisms for monitoring and managing health-care quality seem weak and make it difficult to have an overall view of the quality of the Swiss health-care system.

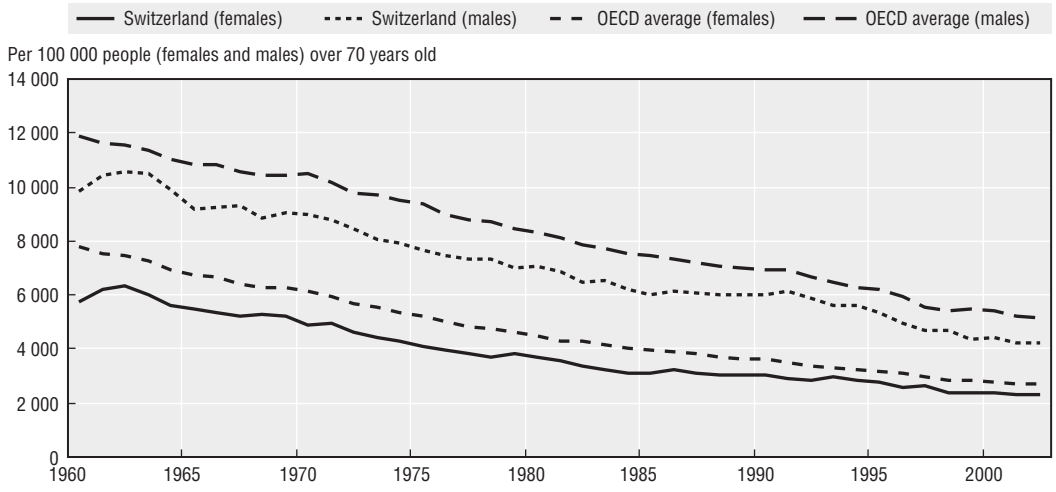
2.1. Health levels and inequalities

Assessing impact of the health-system on health status is difficult as the level of health is affected by many factors other than health care, such as gender, lifestyle, education, socio-economic factors and the origin of the foreign-born population. However, changes in health status are likely to provide some indication about the impact of the heath system on health.

2.1.1. Health status

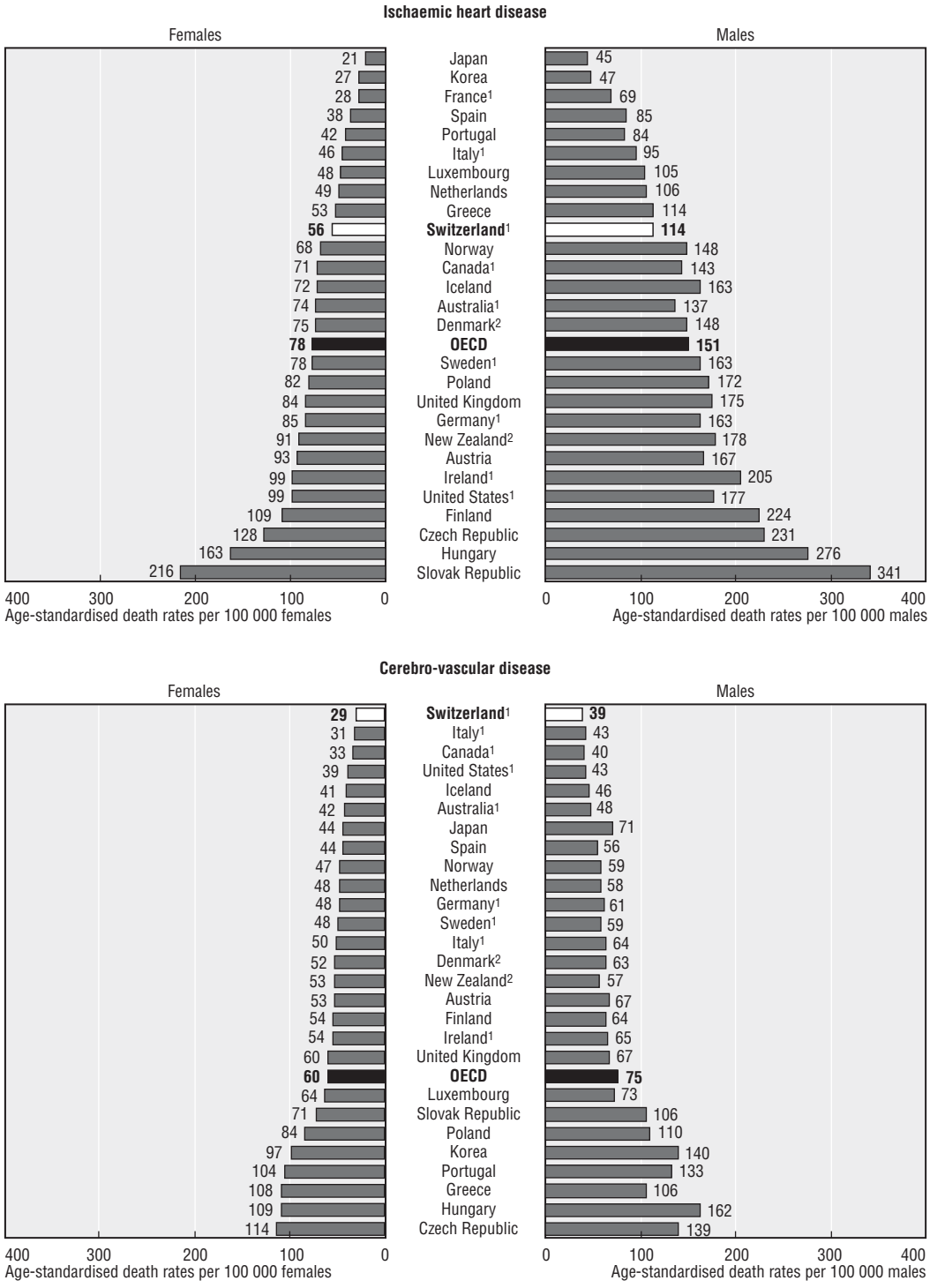
Between 1960 and 2002, the health of the Swiss population, which was already high by OECD standards, continued to improve. Life expectancy increased from 70.1 years, the sixth highest in OECD countries, to 80.2 years, the fourth highest (OECD, 2005a). This improvement has been accompanied by a large reduction of potential years of life lost (PYLL) – a "premature mortality" indicator measuring years of life lost by people who died below 70 years of age, per 100 000 population. The reduction for the Swiss population as a whole (57%) was roughly in line with the average of the OECD countries. However, for women the fall in Switzerland (65%) was above the OECD average decline of 59% (Figure 2.1), while for men the improvement in Switzerland was not as great as the OECD average.[1] Switzerland has also one of the lowest mortality rates from cardio-vascular diseases, the main cause of death in Switzerland and OECD countries (Figure 2.2),[2] whereas for cancers – the second main cause of death – the situation is more contrasted, with some forms of cancer higher than the OECD average and others lower (Figures 2.3 and 2.4).

Figure 2.1. **Potential years of life lost per 100 000 population, Switzerland and OECD average, 1960-2002**



Note: The OECD average excludes Turkey, the Slovak Republic, Mexico, Korea and the Czech Republic.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 2.2. **Mortality rates for ischaemic heart and cerebro-vascular diseases, Switzerland and selected OECD countries, 2002**

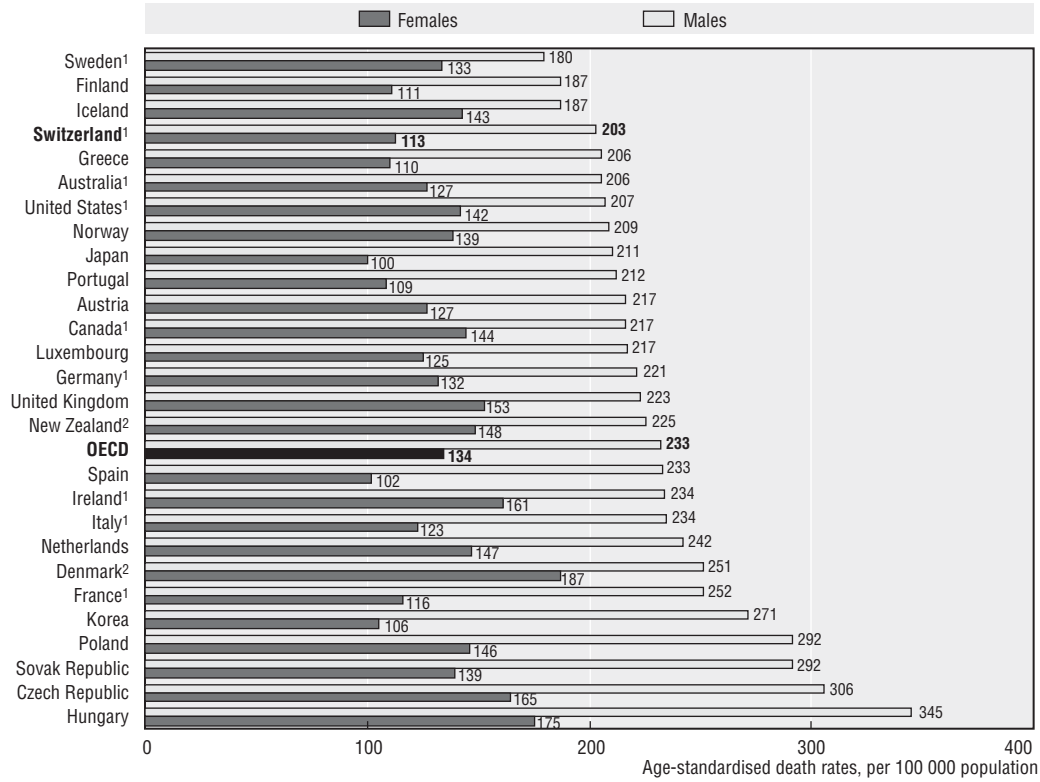


Note: Raw mortality data are extracted from the WHO mortality database (March 2005), and are age-standardised to the 1980 OECD population.

1. 2001.
2. 2000.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 2.3. **Mortality rates for all cancers, Switzerland and selected OECD countries, 2002 or latest available year**



Note: Raw mortality data are extracted from the WHO mortality database (March 2005), and are age-standardised to the 1980 OECD population.

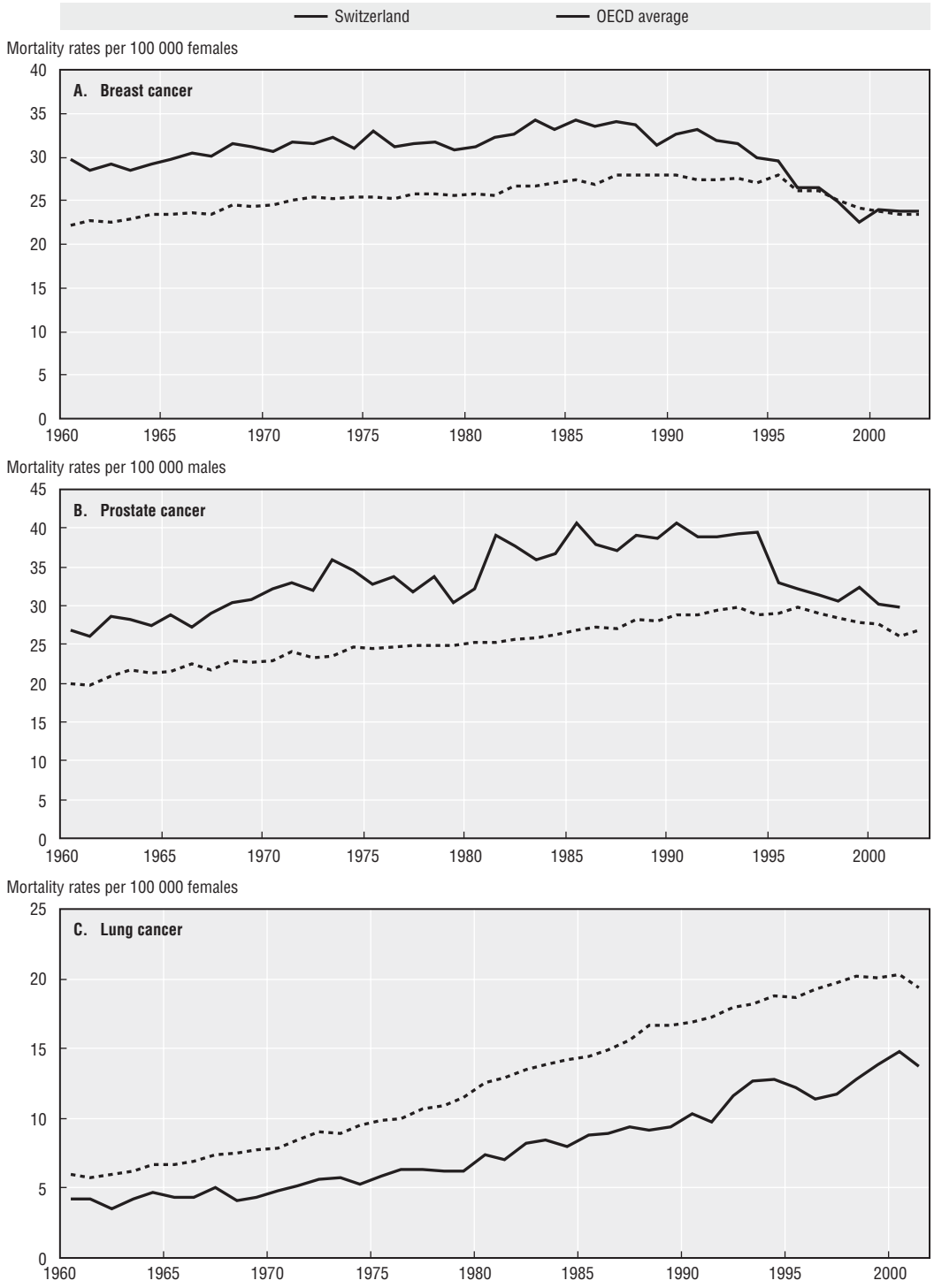
1. 2001.
2. 2000.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Despite a general improvement in the health status of the Swiss people, morbidity and mortality have increased for some health conditions. Mortality from mental health disorders, especially dementia, has risen in Switzerland and in other OECD countries, an evolution largely explained by population ageing. Despite a decrease over the past years in mental-health disorder mortality in Switzerland, this is still above the OECD average (Figure 2.5) (OECD, 2005a). Another concern is the large increase in lung-cancers mortality rates among women from 4 to 14 deaths per 100 000 between 1960 and 2002 (Figure 2.4), which is mainly associated with the rise of female smokers over the last decades. Lung-cancer mortality rates among men have not increased to such an extent, even though mortality rates are approximately three times higher than for women (OECD, 2005a).[3] Even though lung cancer mortality rates in Switzerland remain below the OECD average for both man and women, most of these deaths are preventable.

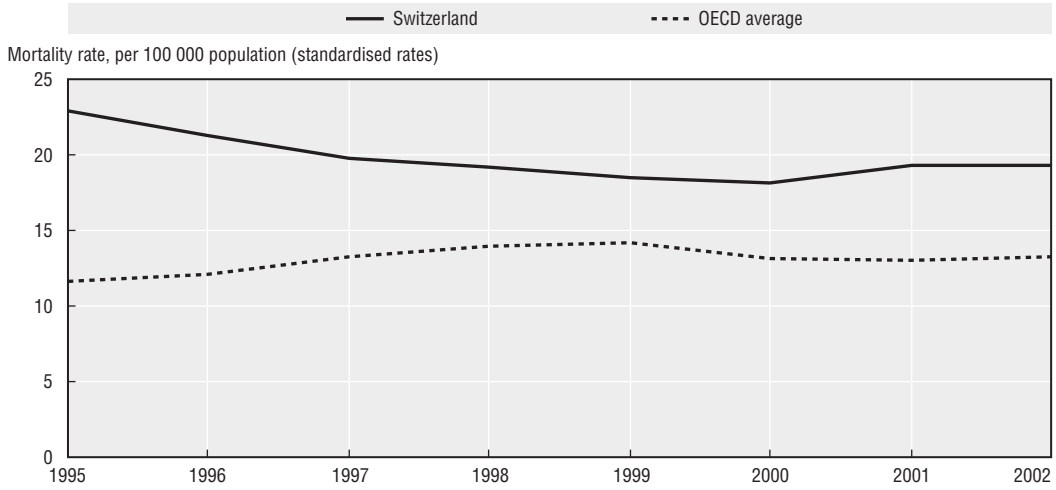
Not only does Switzerland have relatively good health indicators, but a large majority of the Swiss population also rate their health as good or very good. This has remained stable over the past ten years with ratings between 85% and 86%, well above the OECD average of around 70% (Table 2.1). While a large majority of Swiss people have a positive view of their health, back pain, headaches, and arthritic problems are reported as the most common problems. The likelihood of people reporting those problems tends to increase with age and is higher in

Figure 2.4. **Mortality rates for breast, prostate and lung cancer, Switzerland and OECD average, 1960-2002**



Note: The OECD average excludes the Czech Republic, Greece, Korea, Luxembourg, Mexico, the Slovak Republic and Turkey.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 2.5. **Mortality rates for mental-health disorders, Switzerland and OECD average, 1995-2002**



Note: The OECD average excludes the Czech Republic, Greece, Korea, Luxembourg, Mexico, the Slovak Republic and Turkey.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

women. The most frequent diseases for which people report they are receiving medical treatment are hypertension, rheumatic diseases – the latter affecting more women than men – and hay fever and other allergies (Table 2.2) (Office fédéral de la statistique, 2005d).

2.1.2. Health inequalities

Health inequalities are still present among the Swiss population but to a lower extent that other OECD countries. Inequalities in health levels between people with higher and lower educational levels have been found in all European countries (Mackenbach, 2005; Van Doorslaer *et al*., 1997). Inequalities in mortality rates – on the basis of age and sex and country of origin – can also be found for many specific causes of death including cardiovascular diseases, many cancers and injuries. For cardiovascular diseases mortality rates are higher among people in lower socio-economic classifications, especially for mortality from strokes (Mackenbach, 2005). Morbidity rates also tend to be higher among those with lower education levels, occupational class or income. While these types of inequalities are also present in Switzerland, they tend to be lower than in most other developed countries (Holly and Benkassmi, 2003; Leu, 2005). For instance, in a study involving nine European countries, Switzerland was found to have smaller-than-average inequalities in terms of mortality and morbidity (Mackenbach *et al.*, 1997). Variations in health are the greatest among people of different income levels, followed by inequalities according to educational achievement and to the type of economic activity, in particular retirement (Leu, *ibid*.). Additional factors appear to be gender and country of origin of migrant workers (Holly and Benkassmi, 2003).

Cross-canton differences in total mortality rates can reach 10%[4] (Office fédéral de la statistique, 2005e). This variation is attributed to age structures, migration, gender and differences in socio-economic status among the population, and does not seem to be determined by differences in the availability of health services between cantons (Office fédéral de la statistique, 2005e). Indeed, it also appears that the performance of cantons regarding some preventable causes of deaths[5] is independent of the level of supply of health services

Table 2.1. **Share of the population reporting their health as "good" or better in OECD countries, 1992 and 2002**

	1992	2002
Australia (1989-2001)	79.2	81.9
Austria (1991-1999)	71.2	73.5
Belgium (2001)	n.a.	77.2
Canada (1994-2001)	89.2	87.6
Czech Republic (1993-2002)	42.4	62.2
Denmark (1991-2000)	80.4	77.9
Finland	68.4	68.7
France	n.a.	72.9
Germany (1998)	66.1	n.a.
Hungary (2000)	n.a.	43.2
Iceland (1998-2002)	81.8	84.6
Ireland (1998-2002)	85.7	86.0
Italy (1994-2002)	59.7	59.6
Japan (1992-2001)	47.8	40.6
Korea (1992-2001)	46.4	45.6
Mexico	n.a.	66.2
Netherlands	79.3	77.5
Norway (1998-2002)	79.6	79.9
Poland (2001)	n.a.	46.8
Portugal (1999)	31.3	n.a.
Slovak Republic (1993-2002)	35.3	35.2
Spain (2001)	n.a.	69.8
Sweden	73.3	73.8
Switzerland	**84.6**	**85.8**
United Kingdom	77.2	74.4
United States	89.1	88.8
OECD average[1]	**68.4**	**69.2**

n.a.: not available. Canada's data present a break in their series.
1. The OECD average has been constructed based on the available data at each point.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

Table 2.2. **Proportion of men and women under medical treatment during the last 12 months, Switzerland, 2002**

Diagnostic	Men	Women	Total
Hypertension	13.6	14.3	14.0
Hay fever/other allergies	9.8	10.2	10.0
Rhumatisms	6.0	11.0	8.6
Nervous depression	4.2	5.9	5.1
Chronic bronchitis/emphysema	3.4	3.4	3.4
Cancer/tumours	2.2	3.2	2.7
Diseases of the kidneys/kidney stones	2.5	1.9	2.2
AMI	3.2	1.2	2.2
Stroke	1.2	0.7	1.0

Note: AMI: Acute myocardial Infarction.
Source: Office fédéral de la statistique (2003), *Enquête suisse de la santé 2002*, Neuchâtel.

(Crivelli and Domenighetti, 2003). One exception is breast cancer mortality among women aged 55-74, where rates are lower in cantons with much higher rates of mammography.[6] (Table 2.3). As a general rule, the rates of mammography examination are significantly lower in Switzerland than in the average of OECD countries (Mattke *et al.*, 2006) (Figure 2.6).

Table 2.3. **Mortality rates for breast cancer in Swiss cantons among women aged 55-74, 1995-2002**

Canton	1995 mortality rate	2002 mortality rate	% change in mortality rate 1995-2002	Is there a screening programme?
Geneva	95	58	–49	Yes
Vaud	77	54	–35	Yes
Valais	98	60	–49	Yes
Zurich	93	81	–14	No
Bern	83	67	–21	No
French-speaking Switzerland[1]	88	60	–35	Yes[1]
German-speaking Switzerland	89	76	–14	No
All Switzerland	**87**	**72**	**–21**	No

Note: Mortality rates are defined as the number of deaths per 100 000 females aged 55-74 years.

1. In French-speaking part of Switzerland, only the following cantons have a screening programme: Geneva, Fribourg, Valais, Vaud and Jura.

Source: Office fédéral de la statistique (2005), *Encyclopédie statistique de la Suisse*, Neuchâtel (*www.bfs.admin.ch*).

Although no specific national programme to reduce health inequalities exists in Switzerland, some programmes target specific groups, for example for the health of migrants. More generally, socio-economic differences are addressed through social-welfare programmes providing financial and material support to people in need.

2.2. Lifestyle and risk factors

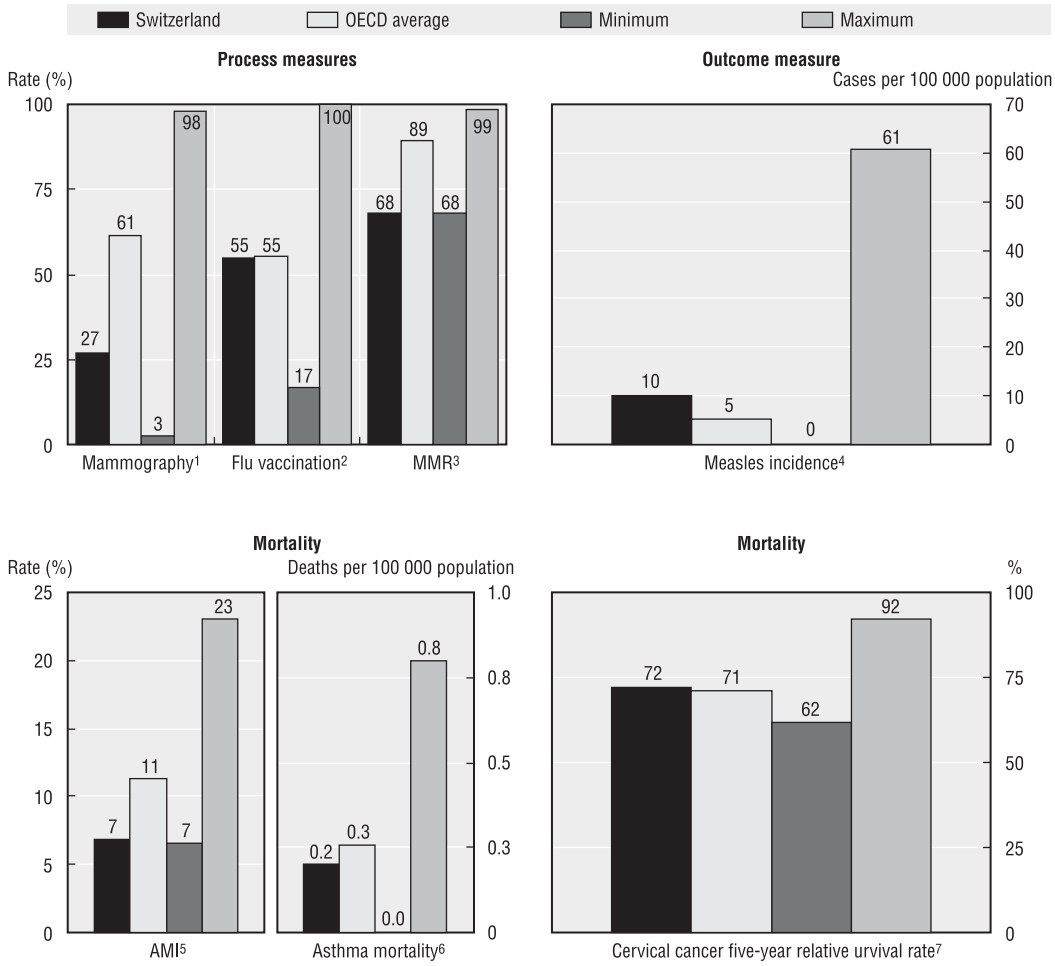
Disease, disability and death can be attributed to a selected number of risks to human health. In Switzerland, as in other OECD countries, at least one-third of the overall disease burden is caused by tobacco, alcohol, blood pressure, cholesterol and obesity (WHO, 2002).

WHO estimates show that about 65% of mortality in Switzerland is attributable to ten leading risk factors (Table 2.4). Considering both morbidity and mortality, 45% of the overall disease burden (DALYs)[7] in Switzerland is attributable to ten leading risk factors, which largely, but not entirely, overlap with the risk factors for mortality (Table 2.5). Risk factors such as high blood pressure, high cholesterol, and high body-mass-index (BMI) are all partially caused by over-consumption of certain foods and food components, and by a lack of physical activity.

Tobacco use is estimated to be directly or indirectly responsible for the yearly deaths of about 8 300 individuals each year in Switzerland (ISPA, 2004; Frei, 1998) – 15% of the total number of deaths – making smoking the leading preventable cause of death. The prevalence of tobacco consumption (26.8%) has remained stable over the past ten years but is slightly above the OECD average (25.1%). More worrisome is the fact that the number of young smokers (15-24 years) has increased from 31 to 37% over the past ten years (Office fédéral de la statistique, 2005d). In addition, it appears that young people tend to start smoking earlier, around the age of 16 (Office fédéral de la santé publique, 2005b).

Growing numbers of overweight and obese individuals[8] represent a more recent public-health concern. Poor dietary habits, combined with reduced physical activity, have led to strong increases in rates of those overweight or obese in most OECD countries (Figure 2.7). Although the proportion of obese and overweight individuals is lower in Switzerland (37%) than the OECD average (47%) (OECD, 2005a), recent findings suggest that

Figure 2.6. **Selected indicators of health-care quality, Switzerland and OECD average**



1. Screening rate is defined as the number of women aged 52-69 reporting having received a bilateral mammography during the past year over the number of women aged 52-69 answering survey questions on mammography or eligible for screening program (%).
2. Influenza vaccination is defined as the number of people offered an annual influenza vaccination over the number of adults aged 65 and over (%).
3. MMR stands for measles, mumps and rubella and is administered (generally) to children under two years of age (%).
4. Measles incidence is defined as the number of reported cases per 100 000 population.
5. AMI stands for Acute Myocardial Infarction and is defined as the number of deaths in-hospital that occurred within 30-days of hospital admission over the number of people hospitalized with AMI diagnosis (%).
6. Asthma mortality rate is defined as the number of people dying from asthma, as primary cause, per 100 000 population, aged 5-39.
7. Cervical cancer five-year relative survival rate is defined as the observed rate of women diagnosed with cervical cancer surviving five years after diagnosis over the expected survival rate of a comparable group from the general population (%).

Source: Mattke, S. *et al.* (2006), "Health Care Quality Indicators Project Initial Indicators", OECD Health Working Papers No. 22, OECD, Paris.

the situation has been deteriorating over recent years. The proportion of overweight individuals in the 25-74 age group increased from 33% to 41% between 1992 and 2002 (Office fédéral de statistique, 2003c). A comparison with similar studies carried out 20 and 40 years ago shows that the number of overweight children has tripled in 20 years, and comparable figures for obesity show a six-fold increase. Obesity now affects 20% of

Table 2.4. **Ten leading risk factors and diseases or injuries for mortality, Switzerland, 2002**

Rank	Risk factor	*% total deaths*	Rank	Disease or injury	*% total deaths*
1	High blood pressure	19.2	1	Ischaemic heart disease	17.6
2	Tobacco	15.3	2	Cerebrovascular disease	7.4
3	High cholesterol	12.0	3	Trachea, bronchus and lung cancers	4.7
4	High BMI[1]	8.6	4	Alzheimer and other dementias	4.7
5	Physical inactivity	4.5	5	Lower respiratory infections	4.1
6	Low fruit and vegetable intake	3.1	6	Chronic obstructive pulmonary disease	3.2
7	Illicit drugs	0.7	7	Diabetes mellitus	3.0
8	Alcohol	0.6	8	Colon and rectum cancers	3.0
9	Occupational airborne particulates[2]	0.5	9	Prostate cancer	2.5
10	Urban outdoor air pollution	0.5	10	Hypertensive heart disease	2.3
% of total deaths		*65.0*	*% of total deaths*		*52.6*

1. BMI stands for body mass index and it is defined as the mass in kg divided by the square of the height in meters.
2. Occupational airborne particulates refer to non-malignant respiratory diseases that arise from occupational exposure to airborne particulates (mainly dust). The main respiratory diseases are asthma, chronic obstructive pulmonary disease (COPD), and the three main pneumoconioses: asbestosis, silicosis and coal workers' pneumoconiosis.

Source: Estimated from the WHO database on "Burden of disease".

Table 2.5. **Ten leading risk factors and diseases or injuries for burden of disease, Switzerland, 2002**

Rank	Risk factor	*% total DALYs*	Rank	Disease or injury	*% total DALYs*
1	Tobacco	11.2	1	Unipolar depressive disorders	10.3
2	High blood pressure	7.3	2	Ischaemic heart disease	6.2
3	Alcohol	7.2	3	Alzheimer and other dementias	4.7
4	High BMI	6.0	4	Alcohol use disorders	4.6
5	High cholesterol	5.1	5	Hearing loss, adult onset	4.2
6	Illicit drugs	2.7	6	Cerebrovascular disease	3.3
7	Physical inactivity	2.4	7	Trachea, bronchus and lung cancers	3.1
8	Low fruit and vegetable intake	1.6	8	Chronic obstructive pulmonary disease	2.8
9	Unsafe sex	0.7	9	Self-inflicted injuries	2.8
10	Childhood sexual abuse	0.6	10	Osteoarthritis	2.7
% of total DALYs		*44.8*	*% of total DALYs*		*44.6*

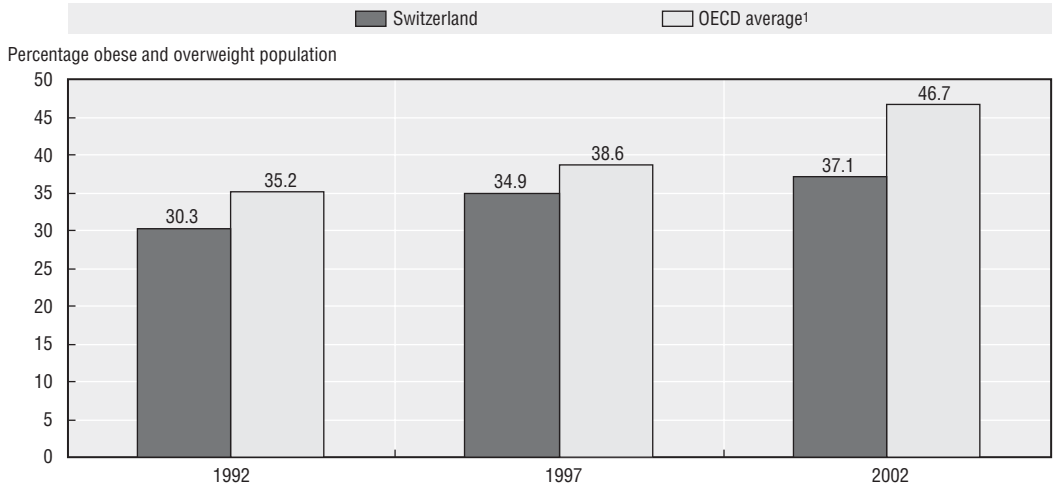
Note: DALYs stands for disability adjusted-life years and it is defined as the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.
Source: Estimated from the WHO database on "Burden of disease".

teenagers (15 years old), and 4% of children between 6 and 12 years (Zimmerman *et al.*, forthcoming).

While epidemiological studies have indicated that fruit and vegetables offer protection from numerous degenerative disorders such as cardiovascular diseases, consumption of fruits and vegetables is currently below the OECD average (Figure 2.8). This has also decreased over time, unlike the OECD average which has risen over the past four decades (OECD, 2005a). Moreover, only 45% of the 15-24 age group consume fruit and vegetables on a daily basis compared with 59% for the entire Swiss population (Office fédéral de la statistique, 2005d).

Alcohol consumption also represents an important share of the burden of disease in Switzerland. In addition to the deaths caused by gastrointestinal diseases due to alcohol, about 30% of the 509 deaths due to traffic accidents in 2004 were attributed to alcohol

Figure 2.7. **Increasing overweight and obesity rates among the adult population, Switzerland and OECD average, 1992-2002**

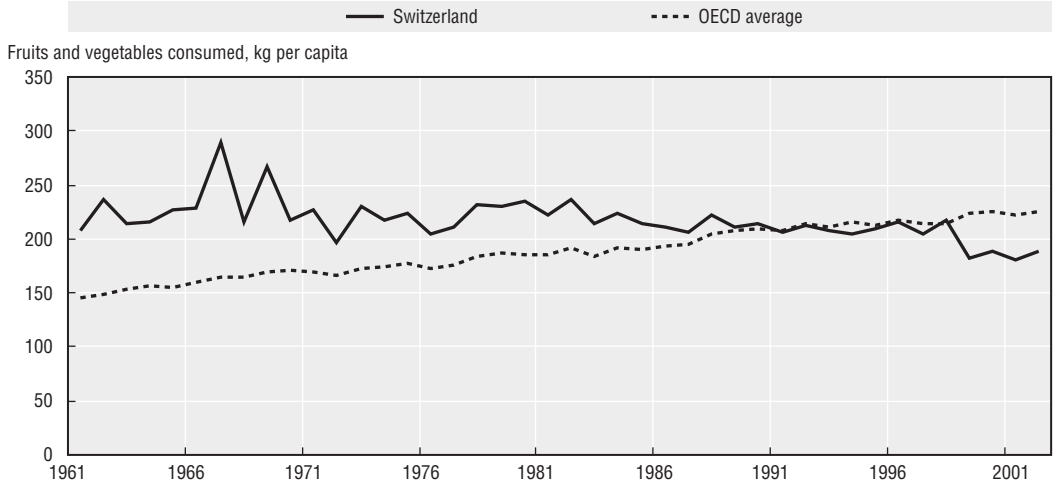


Note: For Australia, New Zealand, the United Kingdom and the United States, figures are based on health examination surveys rather than health interview surveys. Estimates from health examinations are generally higher and more reliable than those coming from health interviews.

1. The OECD average is a 15-country average which excludes Australia, Austria, Belgium, Canada, Denmark, Germany, Greece, Hungary, Korea, Mexico, New Zealand, Poland, Portugal, Spain and Turkey due to lack of data.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Figure 2.8. **Fruits and vegetable consumption, Switzerland and OECD average, 1961-2002**



Note: The OECD average excludes the Czech Republic, Luxembourg and the Slovak Republic.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

consumption (Bureau suisse de prévention des accidents, 2005). Yearly consumption of alcohol in Switzerland (10.8 litre per capita) is above the OECD average (9.6 litre per capita) (OECD, 2005a). This tends to vary across Swiss cantons. In the Italian- and French-speaking parts of Switzerland, the share of the population for which alcohol consumption represents a moderate or a high risk[9] for health is higher than in the German-speaking part (Office fédéral de la statistique, 2005d).

2.3. Prevention of diseases and health promotion

Implementing prevention activities in Switzerland is rendered more difficult because of a fragmented legislative framework for public-health policy. There is no overarching legislative framework for disease-prevention and health-promotion activities and a lack of clear delegation of responsibilities to the various levels of government. Prevention and health-promotion activities have traditionally tended to take place at the canton level, but comprehensive information is often lacking. Over the past several decades, a number of federal programmes have been put in place to respond to selected needs. While some of these appear to perform well, others have been less successful.

The level of expenditures on health promotion and disease prevention has been a major issue of debate. As noted above, just over 2% of total health spending goes in these activities. The lack of an overarching policy framework, broader disincentives to prevention, lack of knowledge about effective strategies and the absence of sound evaluation of existing policies have possibly led to an under-investment in prevention. These factors may also explain the mixed performance of existing prevention activities and strategies. In this context, the potential for cost-effective interventions does not appear to have been fully exploited, with some cost-effective measures underutilised or not utilised at all.

2.3.1. Selected public-health concerns and government policies for health promotion and disease prevention

Cantonal programmes

As noted, health promotion and disease prevention exist at both the federal and canton levels, although lack of comprehensive information across cantons makes overall evaluation difficult. Cantons have acted independently in this area, even though there is some co-ordination *via* the CDS (see Chapter 1). For example, in the field of tobacco prevention, Vaud is the only canton to have a law banning the sale of cigarettes to minors, while Ticino is the first one to have adopted a law forbidding smoking in buildings open to the public including bars and restaurants. Given their responsibilities for education, cantonal policies are often focused on the school system and immunisation programmes at this level are common. A more limited number of cantons are also active in secondary prevention, for example screening programmes for breast cancer. Non-profit organisations, such as associations combating cancer are very active in the field of health promotion as well. A few cantons (*e.g.* St. Gallen) have introduced a global approach to prevention that is integrated with curative care.

Federal programmes

At the federal level, a series of programmes have been introduced, although cantons are also active in the same fields in a number of cases.

Tobacco consumption. Efforts to reduce tobacco consumption have not been very successful to date, in particular with respect to young smokers (Bolliger-Salzman *et al.*, 2000). This situation has prompted the adoption of new measures in the 2001-2005 "Global National Tobacco Programme" aimed at strengthening prevention activities in this area. These include the delegation of projects by the Swiss Federal Office of Public Health to non-profit organisations, the strengthening of the co-ordinating role of the Federal Office, the implementation of new regulations and the increase of financial and human resources

devoted to tobacco prevention (Office fédéral de la santé publique, 2005b). A key policy measure was the creation in 2004 of a prevention fund financed by a tax of 2.6 centimes per cigarette, corresponding to approximately 18 million Swiss francs per year (Chancellerie fédérale, 2004i). At the international level, Switzerland has not yet ratified the international treaty for tobacco control.[10]

The Swiss authorities seem to have difficulties in developing a common and coherent policy towards tobacco consumption. Tobacco taxation is essentially for fiscal and not for prevention purposes (van der Linde, 2005). For example, in 2004, CHF 2 billion of the tax on tobacco was transferred to the old-age insurance system, with only CHF 18 million spent for prevention. There is likely to be little direct conflict between fiscal and public-health objectives as price elasticities for tobacco consumption are generally considered to be less than one such that an increase in tobacco taxes should also lead to an increase in tobacco-tax revenues (Townsend *et al.*, 1994). There is, however, an apparent contradiction between the will to reduce tobacco consumption and the existence of subsidies to local tobacco producers, despite the fact that domestic production represents only a small fraction of total tobacco consumption in Switzerland. More generally, the Swiss authorities have to deal with the presence of a strong and well-organized tobacco industry in Switzerland. Indeed, the tobacco industry is an important employer in some Swiss cantons and generates substantial income for the confederation on profits made by tobacco companies, in addition to the taxation of sales of cigarettes.[11]

Overweight and obese individuals. The Health Promotion Switzerland Foundation (see Chapter 1) is particularly involved with campaigns such as "*Suisse Balance*", whose aim is to promote healthy body weight through physical activity and the attainment of a well-balanced diet in terms of caloric intake and other nutrients. Despite these efforts, it appears that the scope for preventing excess body mass has not been fully exploited, even though there is an urgent need for action in this area (Suter, 2005). While the link between excess weight and heart disease, diabetes and other chronic conditions is well established, there is almost no common and comprehensive public-health approach at the national level aimed at reducing this risk factor. The activities by Health Promotion Switzerland stand as the unique exception.

Alcohol consumption. Alcohol prevention has traditionally been undertaken by the cantons and by private non-profit institutions. There are marked differences across cantons in both the type and scope of activities (Sager and Vatter, 2000). The direct involvement of the Swiss Federal Office of Public Health in alcohol prevention is relatively recent and was initiated only in 1999 with the first national global alcohol programme. This programme aims at reducing risky behaviour that is related to alcohol consumption among the Swiss population (Peters *et al.*, 2002). Approaches to alcohol prevention tend to differ from those for tobacco. In contrast to tobacco, the law forbids the sale of alcohol to minors.[12] However, alcohol taxation is not as systematic or as heavy as for tobacco products. In fact, there is no taxation on wine – with the exception of a value-added tax and import taxes – and taxation on spirits was reduced significantly in 1999, following the GATT/WTO agreement.

Only in the case of sweet alcoholic drinks targeting young people, so-called "alcopops", has a special taxation (four times above the standard taxation rate) been introduced (February 2004). This has led to a significant decrease of "alcopop"

consumption among young individuals.[13] Another positive development relates to the recent measures to reduce traffic accidents due to alcohol. Since January 2005, various measures have been introduced, including a decrease in the authorised blood alcohol content from 0.8 to 0.5 mg/mL, a level similar to that in most western European countries. Initial results are encouraging as the number of deaths related to alcohol in traffic accidents has decreased by approximately 26% during the first six months of 2005 (Office fédéral de la statistique, 2005h).

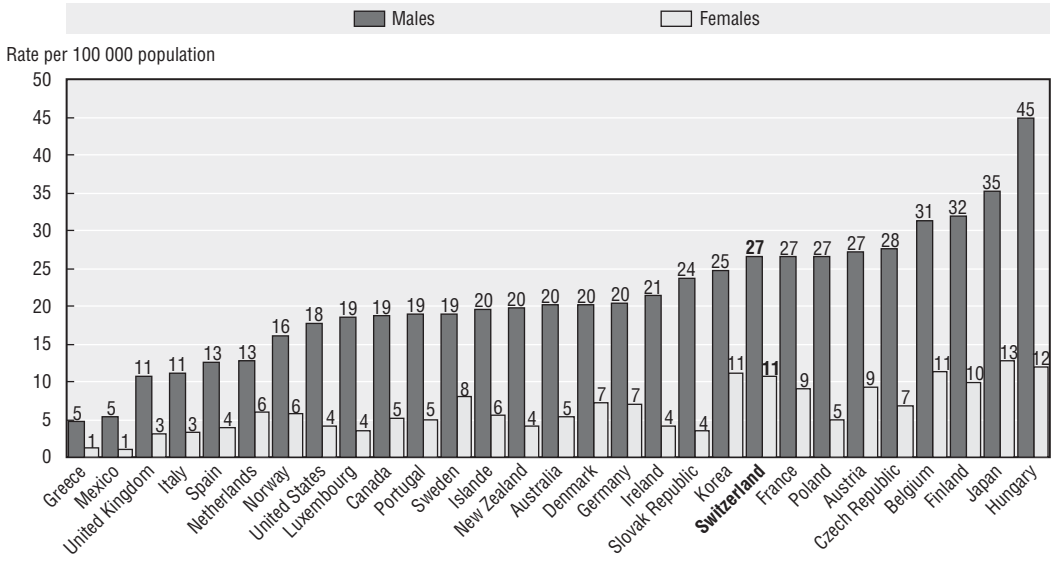
At the same time, subsidies allocated to local wine producers contrast, to a certain extent, with attempts to curtail the consumption of alcohol in Switzerland. Like tobacco, the alcohol industry is an important source of economic activity in various cantons in Switzerland.

Mental health. Mental health has become the most important single burden of disease in Switzerland in line with many developed countries (Table 2.5). It includes acute and chronic mental health disorders among the young and the adult population,[14] as well as conditions associated with elderly people such as Alzheimer's disease. However, in spite of increased visibility and public discussion of mental-health problems, it remains an area where prevention appears to be neglected or coherent programmes lacking. Although the suicide rate in Switzerland is among the highest in the OECD (Figure 2.9), there are no suicide-prevention programmes at the national level (Lehmann *et al.*, 2004). Depression – the number one disease burden in Switzerland – is another area lacking systematic and large-scale intervention. There is currently no national policy, and only few cantons are active in this field.[15] Prevention related to mental-health problems of elderly people is another area that has not received a lot of attention. Nonetheless, to address the different problems related to mental health, the Swiss Federal Office of Public Health and the cantons initiated, in 2000, a project for the development of a mental-health policy in Switzerland, which has resulted in the adoption of a national reference framework in 2005 (Lehmann *et al.*, *ibid.*).[16]

HIV/AIDS. More activities have been developed in the field of infectious diseases. The confederation developed successful prevention programmes against HIV/AIDS (Box 2.1) which are thought to have contributed to a significant initial decline of newly diagnosed HIV infections in Switzerland (Office fédéral de la santé publique, 2006). The number of newly diagnosed HIV cases has again increased in 2002 but has slightly declined in the following years. In particular, it has risen among homosexuals, underlining the difficulties in sustaining prevention gains in the long term.

Immunisation. The performance of Switzerland regarding immunisation against other infectious diseases is mixed. While for diphtheria, tetanus, pertussis, and flu, immunisation rates are broadly equal to the OECD average, the measles immunisation rate is estimated at 82% compared with 91% on average for the OECD (Figure 2.10). Not surprisingly, measles incidence in Switzerland is significantly higher than the OECD average (Figure 2.6). It seems as if there is a certain degree of resistance towards immunisation against measles, mumps and rubella. This scepticism is especially strong among mothers with high educational levels (Lang *et al.*, 2005) and immunisation is not mandatory for children entering schools.

Figure 2.9. **Suicide rate per 100 000 population in selected OECD countries, early 2000s**



Note: Countries are ranked by increasing level of male rate of suicide.

Source: World Health Organisation (2005), *Mental Health, Suicide Prevention and Special Programmes*, Geneva.

Box 2.1. **HIV/AIDS prevention activities**

These take various forms and cover a wide range of activities:

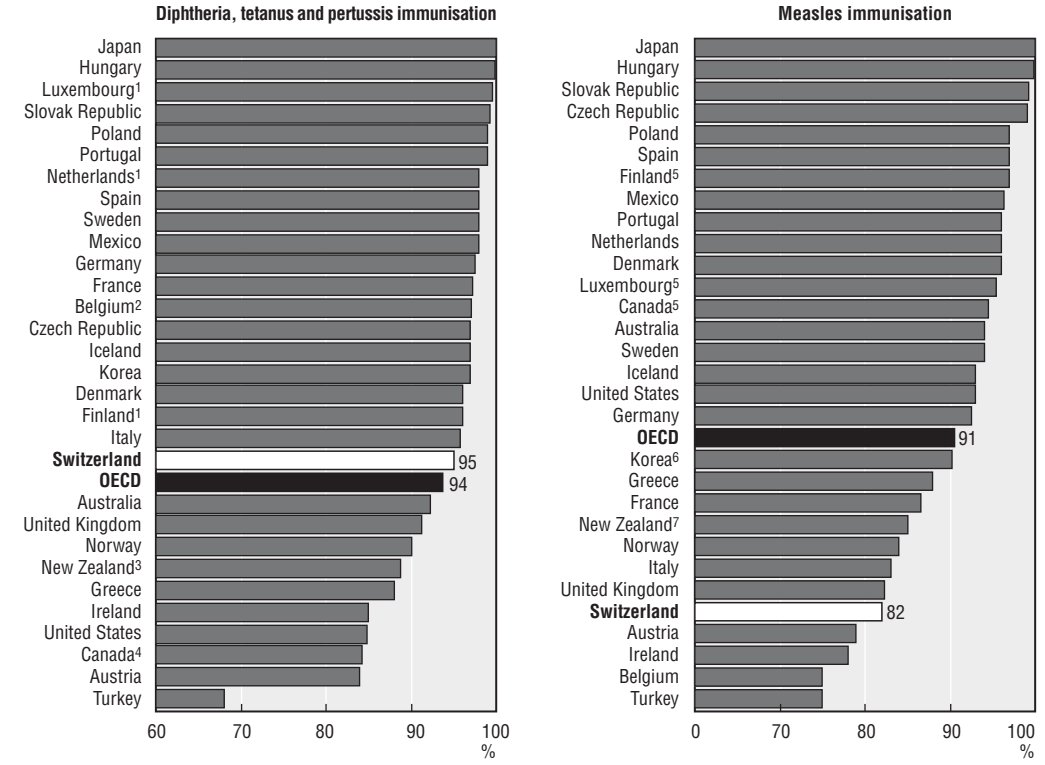
- general information to the public such as the "Stop Aids" campaigns;
- programmes targeted at specific groups such as homosexuals, intra-venous drug users, prisoners, foreign workers, schoolchildren, etc.;
- condom promotion;
- syringe exchange programme;
- HIV screening;
- post-exposure prophylactic treatment;
- prophylactic treatment against opportunistic infections.

The federal government, through the Swiss Federal Office of Public Health, allocates most of its financial resources for HIV prevention to information campaigns and to the Swiss Aids Federation, which is the parent organisation of cantonal and regional AIDS associations. Swiss cantons and cities also have separate programmes for HIV prevention. A large share of their budget is attributed to associations active in the field.

2.3.2. Barriers to investment in prevention

Currently, disease prevention and health promotion are addressed by various federal and cantonal laws without an overall coherent policy. This has resulted in some confusion between the roles and responsibilities of actors (*e.g.* between the confederation and the cantons), adversely affecting the performance of overall prevention activities. For example, a recent analysis of alcohol prevention policies found considerable differences in cantonal outcomes. Co-operative implementation strategies between cantons, and between the cantons and the confederation, were considered weak (Sager, 2003). This situation was

Figure 2.10. **Immunisation coverage for diphtheria, tetanus, pertussis and measles for young children, Switzerland and OECD countries, 2003**



1. 2002.
2. 1999.
3. 2000.
4. 1998.
5. 2002.
6. 2000.
7. 1999.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

largely explained by the lack of resources at the cantonal level, a lack of collaboration between cantons, and a relatively passive attitude on the part of the confederation that neither encourages co-operation between cantons, nor favours vertical co-operation between cantonal and federal authorities. In contrast to Switzerland, some countries have successfully introduced a specific law on public health (Box 2.2).

Weak incentives to invest in prevention

Weak incentives to engage in prevention also contribute to the absence of effective policies in this area. In the current system of insurance, individuals are not encouraged to adopt healthy lifestyles (Kenkel, 2000). In this context, adequate information on the adverse consequences of unhealthy lifestyles is often lacking. For example, empirical studies show that consumption of fats, saturated fats and cholesterol fell rapidly between 1985 and 1990 in the United States, following health-information dissemination, often by food producers (Ippolito and Mathios, 1996). Insurers in competitive markets also have little incentives to invest in prevention: for example, the insured person might change insurer before the insurer can capture the potential benefits of its investment in prevention in the form of lower lifetime health cost. Providers have little incentive to encourage

Box 2.2. **The French Public Health Policy Act**

The Act, adopted on 9 August 2004, sets out the roles and responsibilities of the public authorities in public health policy. The new law:

- Defines the scope, the process of policy development and specifies the instruments available to achieve public health policy goals, both at the national and regional level.
- Requires that Parliament votes the objectives of the public health policy proposed by the government every five years.
- Provides for regional public health plans based on national objectives and creates a new regional institution to implement them.
- Supports research and training in public health through the creation of a new school of public health. And
- Introduces a yearly monitoring with regard to the implementation of the law as well as an evaluation after five years.

Source: Paris and Polton (2006).

prevention, particularly in systems – such as Switzerland – with a predominately fee-for-service payment structure for providers.

More generally, there is a lack of education programmes for professionals in the area of prevention. In addition, the limited number of public-health institutions – either in the private sector or the public administration – has meant that there has been only weak institutional support for such policies, in particular at the canton level, which may have contributed to the current focus on curative services. In this context, even current prevention activities are often biased towards secondary and tertiary rather than primary prevention.

2.3.3. Cost-effective interventions are underutilised

There are certainly opportunities to improve population health through primary and secondary prevention in Switzerland. These appear to be being restricted by the current fragmented legislative framework for health promotion and disease-prevention activities, as well as weak incentives to invest in prevention. A number of preventive strategies with proven effectiveness are underutilised or not utilised at all. For example, taxes on alcohol and tobacco consumption do not have prevention as their main objective and increasing them would result in substantial health benefits. In Switzerland, taxes on cigarettes represent approximately 60% of the retail selling price, which is lower than in most OECD countries. Unlike tobacco, there is no taxation on wine in many OECD countries, including Switzerland[17] (Table 2.6). Other interventions of proven cost-effectiveness in the area of primary prevention that do not seem to be implemented satisfactorily include efforts to reduce salt consumption, promotion of physical activity, in particular for children and adolescents, certain types of screening, measures to increase the low fruit and vegetable intake, and efforts to increase coverage of childhood immunisation.[18] Box 2.3 summarises the cost-effectiveness of key interventions to combat risk factors for cardio and cerebro-vascular diseases, cancers, chronic obstructive pulmonary disease (COPD), and diabetes mellitus which together cause about 38% of overall mortality in Switzerland.

Table 2.6. **Taxation on cigarettes and still wine in selected OECD countries, 2005**

	Cigarettes	Still wine	
	Total tax, including VAT as a % of retail selling price of a pack of cigarette	VAT (%)	Excise duty per hectolitre in euros
Belgium	75	21	47
Czech Republic	67	19	0
Denmark	75	25	82
France	80	19.6	3
Finland	75	22	212
Germany	76	16	0
Greece	73	19	0
Ireland	78	21	273
Italy	75	20	0
Luxembourg	70	12	0
Hungary	75	20	0
Netherlands	73	19	59
Austria	75	20	0
Poland	75	22	35
Portugal	78	12	0
Slovak Republic	70	19	0
Spain	78	16	0
Sweden	69	25	237
Switzerland	60	7.6	0
United Kingdom	77	17.5	247

Source: European Commission (2006b), "Excise Duty Table: Part III – Manufactured tobacco", Brussels.

2.4. Quality of care

There are no national policies setting standards of care quality, monitoring of outcomes systematically or country-wide programmes to ensure improvements in this area. Responsibilities have traditionally been left to professional self-regulation and local-level initiatives, with limited disclosure and few mechanisms for accountability for quality of care. There is only limited evidence concerning technical quality. Recent involvement by the Swiss federal government in this area has enabled the collection of selected quality-of-care data. These suggest that the performance of the Swiss health system in terms of quality is mixed, as in most other OECD countries. New federal initiatives have also emerged in the area of monitoring and improving patient safety. Such efforts are welcome steps towards establishing uniform standards of care and facilitating greater empowerment of consumers to select providers on the basis of quality of care.

2.4.1. The dominant role of professional self-regulation

Professional self-regulation is the prevailing approach to ensuring technical quality of care in Switzerland. The Swiss Medical Association (FMH) has adapted and implemented codes of conduct and ethics currently used in other OECD countries, as well as professional rules regarding post-graduate training and life-long continuing education. Assurance of the quality of human resources is based on education standards and regulatory requirements on admission to practise medicine, including licensing and registration.[19] Doctors wishing to practise medicine must hold a federal diploma issued by the Department of Home Affairs and must have at least two years of postgraduate education as well as one of the federal post-graduate degrees mentioned in the LEPM.[20] At present,

Box 2.3. **Cost-effective interventions to combat leading risk factors in Switzerland**

The WHO-CHOICE database (*www.who.int/choice*) has estimated the cost-effectiveness of a large number of preventive and health promotion measures for the group of Western European countries to which Switzerland belongs (called EUR-A countries). These are countries with very low child and very low adult mortality rates. It reports results in terms of the number of disability-adjusted life years (DALYs) averted for each dollar spent on a programme (Evans *et al.*, 2005; Evans *et al.*, 2006; Tan-Torres *et al.*, 2003).

Costs include the expenses of implementing and running the programmes, such as those necessary to develop, pass and enforce legislation for tobacco taxes. DALYs capture the impact of these measures on both mortality and morbidity. They can be considered as the number of healthy years of life gained by each dollar spent on prevention and promotion, the terminology used below.

Because of uncertainty around the exact levels of costs and effects in different settings, interventions are divided into three broad groups on the basis of their cost-effectiveness. Those that gain each DALY at a cost less than GDP per capita are defined as very cost-effective. Those gaining each DALY at a cost greater than three times GPD per capita are not cost-effective, while remaining interventions are defined as cost-effective. While the exact magnitude of the estimated costs per DALY will be slightly different for Switzerland, their classification into these broad bands is unlikely to be affected. All of the interventions discussed here fall into the very cost-effective band.

Tobacco

Price increases have consistently been shown to reduce cigarette consumption in a variety of high-income settings. Typically a relative price increase of 10% leads to a fall of 3 to 5% in consumption (Chaloupka and Warner, 2000). Consumption among teenagers falls more than among adults. Raising tobacco taxes is, therefore, a very effective means of reducing mortality and morbidity. It would be very cost-effective to increase the current tax rate for tobacco applied in Switzerland, where total tax represents 60% of the retail selling price of a pack of cigarettes, to the highest rate observed in the region (France, 80%). This action would gain an additional 32 500 years of healthy life for the population in Switzerland – equivalent to saving the lives of over 1 600 50-year old people each year. Increasing taxes even further would, obviously, prevent even more deaths.

Other very cost-effective preventive actions targeting tobacco are a comprehensive ban on tobacco advertising and the development and enforcement of clean indoor air laws – the latter is something that countries such as Sweden, Italy and Ireland have already put in place. Each would gain another 5 000 years of healthy life at very low cost.

A common argument is that a significant increase in tobacco taxation can increase the risk of smuggled tobacco products. In this context, smuggling tobacco products into Switzerland is currently not a penal offence.

High blood pressure, overweight, physical inactivity, high cholesterol, low fruit and vegetable intake

Reducing salt intake can significantly reduce blood pressure and the mortality and morbidity associated with cardiovascular disease. In many Western countries, dietary patterns are changing and people are relying more on pre-packaged and processed foods, often with high salt content. Legislation to reduce the salt content in processed food is likely to be very cost-effective, while voluntary agreements with industry are likely to be cost-effective. The former option could lead to a gain around 22 200 years of healthy life in

Box 2.3. **Cost-effective interventions to combat leading risk factors in Switzerland** *(cont.)*

Switzerland per year. Voluntary agreements might have approximately half the impact, although this depends on the extent to which any agreement with the industry is respected.

In some settings, mass media messages to encourage people to exercise more and reduce cholesterol levels have proven very cost effective. There have also been recent experiments to encourage people to increase their intake of fruit and vegetables, which have been promising. Their overall impact on population health is likely to be somewhat lower than for the above interventions.

Recent evidence suggests that treating people with a combination of risk factors that increase their risk of a cardiovascular event in the next ten years (*e.g.* diabetes, high cholesterol and blood pressure, smoking) with a combination of medicines aimed at blood pressure, cholesterol and blood viscosity would be very cost-effective. The yearly gains in healthy life would be in the order of 150 000 years – equivalent to saving the lives of approximately 7 500 50-year olds. Focusing on individual risk factors rather than the combined risk of a cardiovascular event reduces only slightly the cost-effectiveness of this form of secondary prevention. Although the impact on the overall health budget is greater than for primary preventive actions, the health benefits are substantially more. Moreover, the cost-effectiveness of these activities is still very attractive compared with many types of routine curative care – in fact, they prevent the need for many types of high-cost curative care in future years (Murray *et al.*, 2003).

Alcohol

In order to reduce hazardous alcohol consumption, a number of cost-effective interventions are currently underutilised in Switzerland. As with tobacco, increasing taxes is a very cost-effective measure to reduce demand and consumption (Chisholm *et al.*, 2004). The absence of taxes on wine has already been mentioned above. Beer is taxed using an *ad valorem* tax of CHF 0.2475 per litre, corresponding to less than 5% of the retail price. An increase by 20% of the current alcohol tax rate would gain about 11 000 healthy years of life, while a 50% increase would gain over 12 000 annually. A nearly complete advertising ban on alcohol products would also be very cost-effective but would result in a smaller health improvement – at approximately 3 200 healthy years of life annually. Other measures of proven effectiveness such as random breath testing and brief advice in the context of a medical consultation on the need for a lowering in alcohol intake have less favourable cost-effectiveness ratios, though they still fall into the very cost-effective band of interventions. Thus, hey could have large effects on population health. Brief advice, for example, could gain over 13 000 years of healthy life annually in Switzerland.

Screening for cancer

Strictly speaking, screening for cancer is not a preventive intervention. However, early detection of cancers, particularly in their asymptomatic stages with appropriate treatment, does prevent or attenuate morbidity and mortality. To be successful, screening programmes need to be able to ensure considerable compliance with the screening recommendations. Breast cancer screening with mammography every two years for women aged 40 to 60 is very cost-effective and could save an additional 39 400 years of healthy life if fully applied. Other screening programmes like one-time colonoscopy screening at age 50 or colonoscopy every ten years or sigmoidoscopy every five years coupled with annual faecal occult blood testing also appear to be very cost-effective ways of improving population health (Groot *et al.*, in press; Ginsberg *et al.*, 2004) though they are rarely fully applied.

medical schools are accredited on a voluntary basis. In 2005, in accordance with the LEPM, all post-graduate curricula leading to general practice or other specialisations were accredited by federal Department of Home Affairs. The federal law does not require other formal procedures for admitting doctors to practise within the context of the LAMal. Cantons may, nonetheless, link the authorisation to practise to certain conditions, such as collaboration in the provision of emergency services.

Only timid moves have been made towards more modern forms of self-regulation, such as formalised mechanisms,[21] practice audit or external supervision,[22] suggesting that introducing a comprehensive, state-of-the-art approach to quality assurance and improvement should be a high priority. The medical bodies and professional societies – both in Switzerland and elsewhere – have developed clinical pathways and medical guidelines but no consensus has been reached regarding which one to select and to apply throughout Switzerland. In addition, there has also been resistance by practitioners to use standardised criteria of medical practice and a lack of incentives to encourage their use. As a result, clinical pathways and medical guidelines are not systematically used. There appears to be – as in most other OECD countries – variation in the practice of medicine[23] and a need for more systematic use of evidence-based medicine. Cantons may, in theory, intervene and cancel the authorisation to practise if health professionals neglect their professional duties, but in practice they do not play an active role in this context.

2.4.2. A large number provider-led, quality-management initiatives has emerged at the local level

A large number of isolated initiatives for quality measurement and management have emerged at local and, in some cases, cantonal or cross-cantonal level (Box 2.4). Usually, these developments have been initiated by single providers, sometimes with little support and finance from the care institutions. However, they are not built upon an underlying national performance framework. The programmes are heterogeneous, rely on different methodologies and are neither systematically applied nor co-ordinated. They may therefore lack the scale and the institutional backing for scaling-up into a coherent nation-wide programme. Furthermore, data collected within the context of such activities are often not publicly accessible and may not be fully comparable, thereby making the dissemination of good practices extremely difficult.

2.4.3. The need for greater federal involvement

The LAMal empowers the federal government to guarantee the quality and adequacy of services reimbursed under it. However, the authorities have not used this power and, until recently, had delegated this task entirely to insurers and providers. Since early 2005, however, the Swiss authorities have acknowledged the need for more federal involvement in quality improvement and patient safety, partly because of inadequate progress by the professional associations and insurers, and partly because growing health-care expenditure has called for increased attention to be paid to quality and value-for-money issues. There is now discussion at federal level about the need for a systematic framework for quality measurement and reporting, as well as the establishment of minimum national standards. Efforts in this direction are still embryonic.

For example, new patient safety requirements are being discussed[24] and the Swiss Federal Office of Public Health is examining measures to improve patient safety. These range from the introduction of a minimal case-load requirement for some complex

Box 2.4. **Quality management and improvement in Switzerland: selected initiatives**

Several provider or canton-led quality initiatives are underway in Switzerland.

Four cantons – Zurich, Bern, Solothurn and Aargau – participate in the "*Verein Outcome*" initiative. This initiative has measured outcomes in all public and private hospitals in the participating cantons since 2003. Data reporting is based on a standardised framework, thus enabling inter-cantonal benchmarking. However, data are not published.

The *Swiss Noso* initiative is a voluntary system for reporting and controlling hospital-acquired infection data, that was started in 1994 with input from the Swiss Federal Office of Public Health. It is based on a group of hospital epidemiologists providing advice and elaborating guidelines regarding prevention and treatment of nosocomial infections. The group publishes quarterly bulletins on issues ranging from bioterrorism, guidelines for treating patient with hemorrhagic fever and other topics of interest, drawing from domestic and international scientific evidence. It carries out regular surveys on the prevalence of hospital-acquired infections and, in 2004, 49 hospitals were evaluated. The group also organises courses for nurses and other medical practitioners on prevention and control of nosocomial infections, based on the promotion of evidence-based practices.

The Swiss hospital pharmacist's association is actively involved in measures to reduce medication errors. Since 2004, a reference system for quality assurance in hospital pharmacists has been established. Based on this, three hospitals have been already certified (and five asked for certification). The association is also working on a guide for hospital pharmacy risk-management and holds open discussion on quality issues on the Web site.

The canton of St. Gallen runs a quality-management programme resulting in hospital certification. The University hospital of Bern runs a quality-management programme in cardiovascular care, based on health-care certification, quality-management circles and the use of gold-standards. The programme has helped improve patient care and satisfaction. The nursing staff has also set up a strategy for developing clinical practice and research, which looks at monitoring and enhancing the quality-of-care outcomes. In collaboration with the "Outcome" initiative, the canton of Bern has been running a project on "quality of acute care" since 2000, aimed at introducing, in all hospitals, systems of outcome measurement in the canton. A contract between providers, insurers and patients' associations was signed in 2002, covering issues such as choice of pilots, content and use of data, common procedures, and project financing.

In addition, quality management programmes are also applied by several professional organisations: for example private and public laboratories (*e.g.*, the Swiss commission for quality insurance in medical laboratories – QuaLab). The hospital association and the LAMal insurance association have also established a co-ordination programme (KIQ).

Despite all these activities, many hospitals do not have an overall quality-of-care policy, but address problems as they arise. Some hospitals have set up commissions on nosocomial infections following the occurrence of adverse events. Others have established critical incidence reporting systems or implemented mechanisms of risk management. There are also no standardised mechanisms of quality control such as accreditation procedures for hospitals. Some accreditation systems (*e.g.*, Sanacert/VQG) have been operating, but they are neither widespread nor encouraged by the Swiss Government.

interventions to requirements for hospitals to adopt critical-event reporting systems, whose data would be compiled in a national database. Hospitals will also be required to evaluate regularly the way staff is handling critical events. Anonymous surveys of patient's

experience and satisfaction with safety, including the use of open-disclosure policies, are expected to be delivered. The success of these initiatives will depend, in part, on the use of a standardised methodology to report findings into a national monitoring system.

Quality indicators reveal mixed outcomes for Switzerland

The short supply of indicators of medical outcomes has led the Swiss Government to commence work on developing a set of quality-of-care indicators that could be used for benchmarking performance at national and sub-national level. At present, Switzerland does not have a national information system to generate such indicators. Nonetheless, a number of ad-hoc studies or surveys were developed at different points in time. Evidence collected from these sources enables some light to be shed on how Switzerland performs in a number of key areas of the care process, compared with other OECD countries.[25] Overall, Switzerland appears to be doing well in certain key areas, such as asthma mortality and acute myocardial infarction. However, outcomes are not uniformly high, *e.g.*, performance is poor in mammography (Figure 2.6).

The move towards more standardised monitoring and reporting procedures for health-care quality is a slow and challenging process. Not all stakeholders appear to be ready to embrace a quality and value culture. For example, patients and consumers have much resisted the proposal to introduce a patient card on grounds of privacy concerns, a measure that has helped some other OECD countries to facilitate better care co-ordination among providers. Several providers regard the use of standardised principles of professional practice and external oversight of professional quality with suspicion. Insurers have thus far focussed exclusively on prices in their negotiations with providers. Payment systems are not aligned to reward quality improvements, nor are there incentives for competition to take place on such grounds. In fact, policy debates appear to be still dominated by cost-reduction concerns, suggesting that efforts still need to be made to instil a quality and value approach.

Notes

1. Healthy life expectancy, which is a measure based on life expectancy at birth that also includes an adjustment for time spent in poor health, is also high compared with other OECD countries. The expected number of years in full health in Switzerland is estimated at 73.2 years against an OECD average of 70.2 years.
2. This is especially the case for cerebro-vascular disease, and to some lower extent for ischemic hearth disease.
3. In fact, recent data for men suggest a decrease in lung cancer mortality (Office fédéral de la statistique, 2005k).
4. The mortality rate is higher in cantons Appenzell Rhodes-Interior, Fribourg, Jura, Glaris, Basel-Town, Neuchâtel and the Valais, whereas it is lower in the cantons Basel-Country, Geneva, Nidwalden, Ticino.
5. Pneumonia, uterine cancer, tuberculosis, Hodgkin's disease, appendicitis, hypertension, rheumatic chronic disease of the heart, chronic liver disease and cirrhosis.
6. Systemic screening programmes have only been introduced from 1999 in the cantons of the Vaud, Geneva, Fribourg, the Valais and the Jura and are unlikely to have affected outcomes.
7. The burden of disease is expressed in Disability Adjusted Life Years (DALYs). This health-outcome summary measure combines mortality and morbidity outcomes and adjusts life years for the effects of disease on disability. For details on how DALYs are constructed, see Murray (1994).

8. A Body Mass Index (BMI) of over 25 (kg/square of the height in meters) is defined as overweight, and a BMI of over 30.
9. Moderate risk: 20 to 40 g (women) or 40 to 60 g (men); high risk > 40 g (women) or > 60 g (men).
10. The "WHO framework for tobacco control" requires countries to impose restrictions on tobacco advertising, sponsorship and promotion, establish new packaging and labelling of tobacco products, establish clean indoor air controls, and strengthen legislation to clamp down on tobacco smuggling (WHO, 2003).
11. Some major international tobacco companies have their international headquarters in Switzerland.
12. The sale of strong alcohol to minors below 18 is illegal, as is the sale of beer and wine to those below 16 years.
13. While "alcopop" consumption rose from 2 to 40 million bottles between 2000 and 2002, it decreased to 16 million bottles after the introduction of the special tax in 2004 (Département fédéral des finances, 2005).
14. Mental diseases in Switzerland currently account for four out of ten new disability benefit awards. In addition, the share of inflow because of mental health problems is much higher for the younger age groups (OECD, 2006b).
15. The cantons of Zug and Bern have established a programme called the Alliance Against Depression which is also under consideration in other cantons. The four axes of this programme are: *i)* improving the training of general practitioners to allow earlier detection of depression; *ii)* broaden the supply of care; *iii)* reinforce collaboration between actors; and *iv)* sensitise the public with information campaigns. Other programmes are currently under consideration by the Swiss Federal Office of Public Health.
16. Mental health has been recently set as a top priority by Health Promotion Switzerland.
17. With the exception of value-added tax.
18. In the area of secondary prevention, nationally-co-ordinated programmes are notably lacking in the areas of: breast, cervical and colon cancer screening programmes and monitoring of individual-based treatment; and in education for the control of high blood pressure and for the care of diabetic patients.
19. These follow the regulations laid out in the federal law concerning the professional practice of doctors, pharmacists and veterinarians (LEPM). The LEPM was revised in 2002 and will be replaced by the law on university-based medical professions (LPMed) in 2007.
20. In the case of foreign-trained doctors, dentists, nurses, midwifes, physiotherapists and about ten other professions, the Bilateral Agreement between EU member states and the European Union guarantees open access to the labour market as employed personnel if they posses an equivalent diploma issued/or recognised by a national health authority (according to the SLIM-Directive of the EU). Mutual recognition of diplomas is a formal procedure for EU citizens. In order to set up independently, doctors and dentists immigrating from a EU member state require a post-graduate qualification that is recognised by a national health authority. Health professionals originating from non EU member may only work as employed professionals.
21. Formalised mechanisms of self-regulation include tools that institutionalise collegial exchanges and build in an evaluation element, such as peer review and medical audit, practice audit, recertification, confidential use of quality indicators and benchmarking and confidential reviews of incidents. See Mattke (2004) for an analysis of instruments to monitor and improve quality of care.
22. As a consequence of the requirement for accreditation of post-graduate education in 2005, the FMH has had to review its methods for evaluating education and training, revalidation and re-licensing. The FMH is also reviewing the desirability of introducing individual performance reviews. The association is promoting audit and appraisal of medical errors, local complaints and the creation of incidence reporting systems, as well as benchmarking of prescribing patterns. In the process of the revision of the LEPM and the development of the LPMed, continuing medical education was made compulsory from 2002 onwards for all doctors practicing in Switzerland (Hesse *et al.*, 2005).
23. See, as one example, Seematter-Bagnoud *et al.* (1999) for a discussion of under-use and over-use of diagnostic upper gastrointestinal endoscopy in various clinical settings in Switzerland. Evidence on practice variation in OECD countries has been studied, among others, by Capocaccia *et al.* (2003); Mehta *et al.* (2002); Lindsay *et al.* (2005) and Nordly *et al.* (2003).

24. A Swiss Federal Patient Safety Initiative was announced in 2000 and a National Patient Safety Foundation was launched in 2003.

25. These data were furnished by the Swiss authorities to the OECD as part of the OECD Health Care Quality Indicators Project. The purpose of the 23 country project (including Switzerland) was to develop a set of indicators based on comparable data that could be used to raise questions about differences in quality across countries.

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Chapter 3

The Performance of the Swiss Health System: Access to Care and Health-system Responsiveness

This chapter examines the strengths and weaknesses of the Swiss health system with regard to two main objectives of health-system performance: achieving equitable coverage for and access to health care; and ensuring responsiveness to patient needs. The chapter outlines the key challenges and achievements, examining possible reasons underlying current performance. It also discusses some of the key policies that the authorities have implemented to improve performance.

The Swiss health system has achieved considerable success in securing equitable coverage for, and access to, health services, as well as responsiveness to patient needs. Health coverage is available for all the resident population, and the scope of such coverage is comprehensive. The health system appears to provide a wide array of services that are geographically accessible. And responsiveness to patients' demands in terms of choice and timeliness is high. However, while the system does not ration access to health services because of supply constraints, it does use price as a rationing instrument on the demand side, and the relatively high degree of out-of-pocket payments may pose some challenges to equitable access for middle-income and large families, even despite mechanisms to protect vulnerable groups.

3.1. Access to health care and coverage

3.1.1. Comprehensiveness of coverage

Access to health-insurance coverage in Switzerland is fully adequate in two key dimensions.

First, since the implementation of the LAMal in 1996, the purchase of health cover is *mandatory* for the entire resident population. Cantons affiliate, *ex-officio*, any residents who have failed to buy insurance and the enforcement of this obligation does not appear to pose any special difficulties. The federal authorities do not report the existence of any uninsured individuals or groups.[1]

Second, the *scope of covered health services* is broad compared with other OECD countries (Polikowski and Santos-Eggimann, 2002). All curative treatments and diagnoses needed in the events of illness, accident and maternity are covered – with minor yearly modifications – apart from a few services that are explicitly excluded because they are not considered effective. Pharmaceuticals and non-medical treatments registered in a positive list are also reimbursed. As in several other OECD countries, coverage for dental care is restricted to those treatments associated with serious illnesses.

An indirect indicator of the adequacy of the mandatory-coverage package is that the voluntary health-insurance market is shrinking. Between 1996 and 2003, health financing paid by voluntary health insurance (expressed in constant prices using the 2000 GDP deflator) declined by about 12% from CHF 4 947 million to CHF 4 337 million (OECD, 2005a). According to the 2002 Swiss Health Survey,[2] the share of the population enjoying private or semiprivate hospital accommodation went from 52% in 1992 to 38% in 1997 and 32% in 2002 (Office fédéral de la statistique, 2004g). Among the possible factors underlying this trend are the limited additional benefits that supplementary insurance can provide (given the comprehensive cover under the mandatory system), and their affordability in the face of high and increasing mandatory insurance premia.

Despite this broad coverage, some concerns about the content of the benefit package and the depth of coverage for different types of services have been raised. For example, psychotherapy is only partially included in the benefit package, while other mental-health

treatments – an area where the burden of disease has become progressively more important in Switzerland as elsewhere (Rüesch and Manzoni, 2003) – are not included at all. Second, while the catalogue of covered benefits for curative services is unrestricted, prevention activities reimbursed by the LAMal must be cited in a "positive" list. This list is currently limited to vaccination, tobacco substitutes, and other "medicalised" prevention. Furthermore, the share of expenditure borne through collective sources varies by type of care. Over three-quarters of the cost of in-patient care (including day-care treatments) are paid by a combination of government and social insurance (LAMal, AA, AI, AM) (Table 3.1). This percentage drops to 48% for out-patient curative and rehabilitative services, and to 41% for long-term care. The share of social and government expenditure is generally smaller than in other OECD countries for which data are available for all types of services, with the exception of pharmaceuticals (Figure 3.1), for which the share of mandatory payments (63%) is comparatively large. Considering the breakdown of total private households' payments by type of care, about a third is spent on long-term nursing care, nearly a fifth on dental services, and only one eighth on pharmaceuticals (Rossel and Gerber, 2004).

Decisions over what services should be included in the LAMal benefit package have obvious budgetary implications and further expansion of an already comprehensive benefit package may not necessarily be desirable. In fact, there might even be a case for some exclusions. In theory, all products and services reimbursed by the LAMal are required to meet criteria of effectiveness, appropriateness and efficiency. In practice, most medical services or procedures have not been formally evaluated, as evaluation is only undertaken in case of a disagreement over reimbursement (Box 3.1). The health profession is left with considerable discretional authority. New technologies are often covered simply because they are prescribed by doctors and furnished by providers who are authorised to practise in the context of the LAMal. Moreover, procedures and criteria for determining reimbursement in the case of controversy lack transparency and explicit prioritisation (Sprumont *et al.*, 2005; Gress *et al.*, 2005). This raises questions over the cost-effectiveness of services already covered by the LAMal, as well as over the adequacy of procedures for including new benefits, although it is fair to say that other OECD countries do not apply consistently cost-effectiveness analyses either when making such decisions.

3.1.2. Equitable financing of health expenditure

Health coverage in Switzerland is both universal and comprehensive. Its regressive health-financing structure is to a certain extent mitigated by social-protection mechanisms built into the system, although these may not be as effective across all cantons and population groups.

Social-protection mechanisms reduce the impact of regressive health financing…

Overall, nearly two-thirds of health spending is made up of flat payments by individuals, either as insurance premia or as out-of-pocket spending (Table 3.2). The government channels funds for another 24% of total health spending, of which three quarters are subsidy payments to providers and funds for prevention and public health, while the remaining quarter is for subsidies to the purchase of insurance for low-income individuals.[3]

The high proportion of out-of-pocket payments is atypical for OECD countries with high shares of health spending in GDP.[4] Two other high-spending countries – the United

Table 3.1. **Health expenditure on different types of care by financing agent, Switzerland, 2003**

Percentage

	General government and mandatory insurances	General government (excl. mandatory health insurance)	Mandatory health insurance, other social insurance schemes[1]	*Private sector*	Private health insurance	Out-of-pocket payments	Non-profit institutions	*Total health expenditure*
Services of curative-rehabilitative care	***63***	**23**	**40**	***37***	**11**	**25**		***100***
In-patient care	*77*	45	32	*23*	16	7		*100*
Ambulatory and out-patient care	*48*		48	*52*	6	45		*100*
Services of long-term care	***41***	**14**	**27**	***59***		**57**	**2**	***100***
In-patient care	*36*	11	25	*64*		62	2	*100*
Home care	*82*	37	45	*18*	4	11	4	*100*
Ancillary services to health care	***56***	**15**	**41**	***44***	**8**	**34**	**2**	***100***
Clinical laboratory	*67*		67	*33*		33		*100*
Diagnostic imaging	*64*		64	*36*		36		*100*
Patient transport and emergency rescue	*44*	30	14	*56*	17	34	5	*100*
Medical goods dispensed to out-patients	***63***		**63**	***37***	**5**	**32**		***100***
Pharmaceuticals and med. non-durables	*66*		66	*34*	3	31		*100*
Therap. appl. and med. durables	*50*		50	*50*	17	33		*100*
Personal medical services and goods	***58***	**18**	**40**	***42***	**8**	**33**	**1**	***100***
Prevention and public health services	*64*	39	26	*36*		16	20	*100*
Health admin. and insurance	*63*	13	50	*37*	31	5		*100*
Total current expenditure on health	***59***	**18**	**40**	***41***	**9**	**32**	**1**	***100***

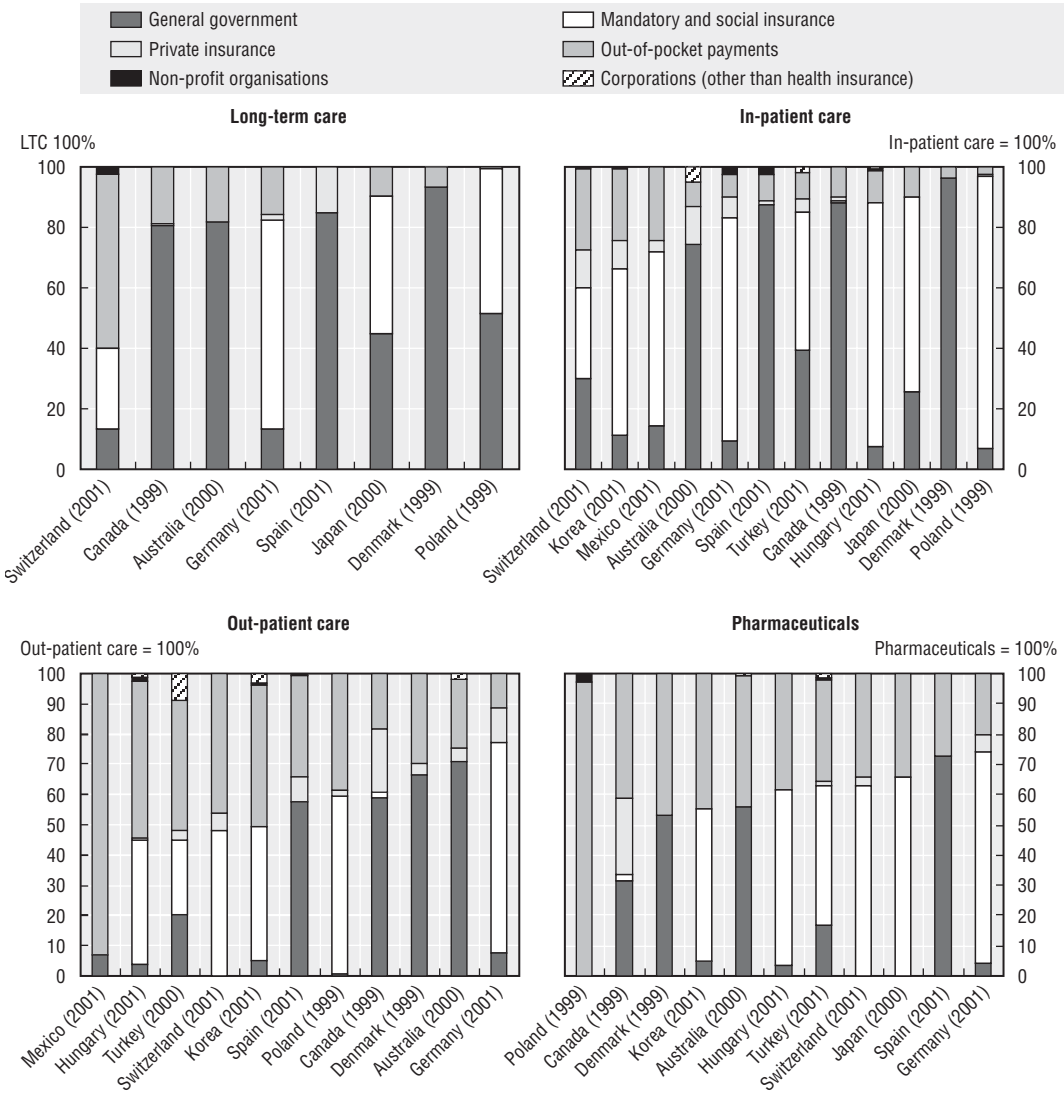
Note: Data are provisional.

1. Mandatory health insurance (LAMal), accident insurance (AA), disability insurance (AVS-AI) and military insurance (AM).

Source: Orosz, E. and D. Morgan (2004), "SHA-Based National Health Accounts in Thirteen OECD Countries: A Comparative Analysis", OECD Health Working Papers No. 16, OECD, Paris.

Figure 3.1. **Health expenditure on different types of care by financing agent in selected OECD countries, early 2000s**

Percentage share



Note: Spain's figure for general government includes social security funds.
Countries are ranked by increasing share of general government and mandatory social insurance.

Source: Orosz, E. and D. Morgan (2004), "SHA-Based National Health Accounts in Thirteen OECD Countries: A Comparative Analysis", OECD Health Working Papers No. 16, OECD, Paris.

States and Germany – appear at the bottom of the country distribution when ranked in terms of the share of total spending paid for through out-of-pocket payments, while Switzerland ranks near the top along with Mexico, Greece and Korea (Figure 1.12). This high share is also atypical of the majority of countries that have attained universal or near-universal coverage, apart from Korea and Greece (Table 3.3). Out-of-pocket payments account for 6.2% of total household consumption, the second highest proportion in OECD countries after Greece (Figure 3.2).

The purchase of insurance on the basis of premia that are not income-related and the large share of out-of-pocket payments have meant that the financing of health spending is, in principle, regressive,[5] raising concerns about the equitable sharing of the financing burden. To

Box 3.1. **Procedures for including or excluding goods and services in the LAMal benefit package**

Procedures for the inclusion of a medical good and service in the LAMal benefit package differ between curative goods and services, on the one hand, and drugs and preventive medical treatments, on the other.

Most curative services or procedures are covered unless specifically excluded. Health-care providers, sickness funds, health authorities, or patients' organisations can, if they have doubts about the effectiveness, appropriateness, or efficiency of a covered service, demand that the Swiss Federal Office of Public Health initiate an evaluation procedure (Sprumont *et al.,* 2005). The evaluation is conducted by the Commission on General Health Insurance Benefits, which takes decisions based on a review of evidence presented by the parties, but does not carry out its own evaluation. A list of the products or services that have been contested, and related decisions, is included in the OPAS (Ordonnance sur les prestations de l'assurance des soins).

Evaluations are undertaken systematically for preventive care, drugs and laboratory analysis, leading to the establishment of a positive list. It is the body applying for reimbursement under the LAMal (*e.g.*, the pharmaceutical company) that has to furnish evidence of effectiveness, efficiency and safety of the product.

Information on costs is often missing or incomplete in evaluations reviewed by the Commission on General Health Insurance Benefits, thus making it difficult to undertake sound cost-effectiveness analyses. There are some differences in the way the evaluation procedures are carried out compared with other OECD countries. Unlike in the United States, the United Kingdom, the Netherlands, Spain, France and Germany, no national Health Technology Assessment (HTA) agency or HTA programme has been established in Switzerland. In those OECD countries, the review of a service is directly commissioned by the institution responsible for the benefits decision. In Switzerland, conversely, it is the applicant (medical industry, medical societies) who is responsible for submitting an assessment report to the Commission (Gress *et al.*, 2005). Only occasionally, HTA or HTA-like reports are commissioned (Sprumont *et al.,* 2005).

Overall, there is no consistent application of cost-effectiveness analyses in Switzerland. Implementing a systematic evaluation for new procedures could represent a major challenge in the present context, as the federal authorities defining services to be covered by the LAMal have only limited resources at their disposal to conduct their own review and complete the information provided by the applicants.

reduce the equity implications of this health-financing structure, the Swiss authorities have established social-protection mechanisms targeted to poorer population groups.

For a start, subsidies for the purchase of health insurance help improve vertical equity (Chancellerie fédérale, 2004e; Balthasar, 1998, 2001 and 2003; Balthasar *et al.,* 2005; Office fédéral des assurances sociales, 2001). In 2003, subsidies were paid to a third of the Swiss population (or 41% of households), and to over 40% of the residents in five cantons (Table 3.4), most of which (58%) were single-person households (Office fédéral de la santé publique, 2004d). The subsidies almost halved the level of the premium among the households receiving them. The 2005 revisions to LAMal has introduced, from 2006/07, a minimum premium reduction by cantons of 50% for children and young people in training living in lower- and middle-income families (Table 3.4).

Table 3.2. **Financing of Swiss health expenditure by the government, social insurance and households, 2003**

Financing agent	Percentage of total cost
Total	**100**
Government	***23.9***
Subsidies to health care providers[1]	*16.4*
Cantons	14.0
Municipalities	2.4
Public health, administration and prevention	*1.6*
Confederation	0.3
Cantons	0.9
Municipalities	0.4
Reduction of LAMal premia	*5.9*
Confederation	4.0
Cantons	1.9
Social insurance	***7.9***
LAA: Accident insurance	3.0
AVS-AI: Old-age and survival insurance/Disability insurance	4.7
Military insurance	0.1
Other social protection schemes	***2.6***
Supplementary old-age and disability benefits (AVS-AI)	0.8
Social old-age	0.7
Allocations for disabled	1.1
Private Households	***64.7***
Health insurance premia[2]	*35.7*
Mandatory health insurance (LAMal)	26.8
Voluntary insurance (LCA), (LAMal-insurers)	3.3
Voluntary insurance (LCA), (Commercial insurers)	5.7
Cost-sharing	*5.3*
Mandatory health insurance (LAMal)	5.2
Voluntary insurance (LCA)	0.1
Direct payments	*23.7*
Other private funds	***1.0***

Note: LCA: Insurance Contract Law.
The sum of expenditure under social insurers (LAA, AVS-AI, Military), mandatory health insurance premia, and government subsidies to reduce LAMal premia correspond to data on total expenditure by social insurance schemes shown in Table 1.6 (40.5% of total health spending).
1. Subsidies to hospitals, nursing homes and home-care services.
2. Net of subsidies to low-income individuals.
Source: Adapted from Office fédéral de la statistique (2004), *Coût et financement du système de santé en 2003*, Neuchâtel.

Mechanisms are also in place to reduce the impact of high out-of-pocket payments. Cost-sharing exemptions are available for large families, women during maternity, social-assistance beneficiaries and recipients of supplementary old-age and disability benefits. There is an annual cap on deductibles and co-insurance payments establishing limits on the maximum out-of-pocket liability for covered services.

Cantonal subsidies for low-income individuals may not be equally effective for all types of households. According to criteria suggested by the Federal Council (Message of 6 November 1991), premium payments borne by households net of subsidies received should not exceed 8% of *taxable* income, roughly equivalent to 6% of *disposable* income (Balthasar *et al.*, 2005). This is not, however, a national mandatory standard. Despite a

Table 3.3. **Coverage of health insurance and the share of out-of-pocket payments in OECD countries, 2003**

	Coverage by government or social health insurance[1]	Share of out-of-pocket payments in total health spending
Australia	100[2]	21
Austria	98.0	19.2
Belgium	99.0	
Canada	100	14.9
Czech Republic	100	8.4
Denmark	100	15.8
Finland	100	19
France	99.9	10
Germany	90.1	10.4
Greece	100	46.5
Hungary	100	24.6 (est.)
Iceland	100	16.5
Ireland	100	13.4
Italy	100[3]	20.7
Japan	100[4]	17.3[4]
Korea	100	41.9
Luxembourg	99.0	7
Mexico	51[4]	50.5
Netherlands	76.4	7.8
New Zealand	100	15.7
Norway	100	15.5 (est.)
Poland		26.4
Portugal	100	
Slovak Republic	96.9	11.7
Spain	98.9	23.7
Sweden	100	
Switzerland	**100**	**31.5**
Turkey	64.0	20.4 (est.)
United Kingdom	100	11[5]
United States	26.6	14.1
OECD average	93.1	19.8
OECD median	100	16.5

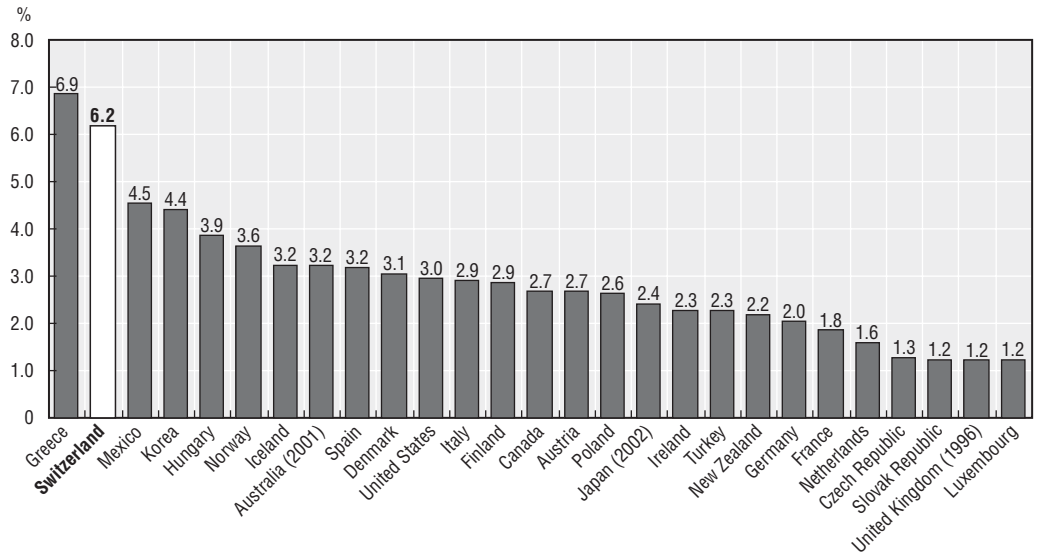
est.: estimates.

1. Coverage data refer to the share of the population with access to government or social health insurance. It does not reflect the depth of coverage, which can be more or less comprehensive depending on what services are covered and on cost-sharing rates.
2. 2001.
3. 1997.
4. 2002.
5. 1996.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

steady increase in the importance of premium subsidies (which went from 3.5% of household disposable income in 1998 to 5.9% in 2004), the net amount paid by families for the purchase of mandatory insurance has steadily grown, reaching 7.8% of disposable income in 2004 (Balthasar, 1998, 2001 and 2003; Balthasar *et al.*, 2005). Subsidies appear inadequate to attain the Federal Council indicative threshold for pensioners in all cantons, and for middle-income families in four-fifths of the cantons. Difficulties also persist for large families in about half of the cantons and for sole parents in one out of four cantons (Balthasar *et al.*, *ibid.*). These data are confirmed by findings from a representative survey of individuals, according to which a third of respondents find the payment of LAMal premia

Figure 3.2. **Out-of-pocket expenditure as a share of total household consumption, 2003 or latest available year**



Note:
Payments borne directly by a patient without the benefit of insurance. They include cost-sharing and informal payments to health-care providers. (OECD (2000), *A System of Health Accounts*, Paris.
Data for Hungary, Norway and Turkey are estimates.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

excessive (4% cannot afford any more premium payments) (Eisler, 2005). These individuals consist mainly of young people from middle-income households and those with children.

The impact of premium reductions also varies across cantons. The indicative threshold of 6% of disposable income was not attained in 17 cantons in 2004, and in eight cantons net premium payments exceeded 8% of disposable income (Figure 3.3) (Balthasar *et al.*, *ibid.*). The average subsidy received by individuals is (only weakly) correlated with the level of insurance premia in the canton, and the subsidy decreases as the number of beneficiaries in each canton rises. On the other hand, there are not necessarily more beneficiaries in cantons with higher premia, and the average cantonal subsidy is not related to canton income (Figure 3.4). Cross-cantonal variation is in large part due to differences in the way subsidies are administered (Chancellerie fédérale, 2004e) (Box 3.2).

Finally, tax-deductions on the purchase of private health insurance are likely to have a regressive impact on health financing, insofar as this voluntary cover is predominantly purchased by higher-income groups and tax deductions reduce the progressivity of income tax. Furthermore, deductions from taxable income lead to a tax loss.

There are no studies evaluating the adequacy of cost-sharing exemptions.[6] However, co-payments and co-insurance requirements in the mandatory health-coverage system are no higher than in most OECD countries (OECD, 2004b, Table 3.2). In fact, the share of cost-sharing in total out-of-pocket payments does not appear to be particularly high. Conversely, 83% of out-of-pocket payments are made of direct payments and self-medication by households (Office fédéral de la statistique, 2004e).[7] The widespread and growing use of high-deductible LAMal-insurance products (half of overall LAMal policies in 2003, see Table 3.5) raises nonetheless policy challenges. Although high-deductible insurance enables individuals to reduce the premium burden, it also results in a shift away

Table 3.4. **Subsidies to low-income individuals for the purchase of health insurance**[1]

Canton		Percentage of residents receiving subsidies		Average subsidy as percentage of average per capita premium	Cantonal subsidies as percentage of federal subsidies
		Individuals[2]	Households[3]		
CH	Switzerland	32	40	55	50
AI	Appenzell Inner-Rhodes	46	40	45	30
AR	Appenzell Outer-Rhodes	24	21	92	27
AG	Aargau	28	26	43	58
BL	Basel-Country	38	41	40	67
BS	Basel-Town	27	33	67	115
BE	Bern	30	36	66	25
FR	Fribourg	36	40	56	17
GE	Geneva	35	58	46	104
GL	Glarus	35	46	64	38
GR	Grisons	32	38	51	28
JU	Jura	36	49	51	10
LU	Lucerne	40	44	52	28
NE	Neuchâtel	32	41	53	24
NW	Nidwalden	32	41	44	79
OW	Obwalden	56	67	50	9
SH	Schaffhausen	32	38	57	53
SZ	Schwyz	35	43	57	68
SO	Solothurn	23	24	62	37
SG	St. Gallen	35	37	42	40
TG	Thurgau	44	63	49	40
TI	Ticino	30	45	69	43
UR	Uri	43	46	48	21
VS	Valais	32	47	70	9
VD	Vaud	24	29	69	51
ZG	Zug	33	43	52	193
ZH	Zurich	30	45	51	106

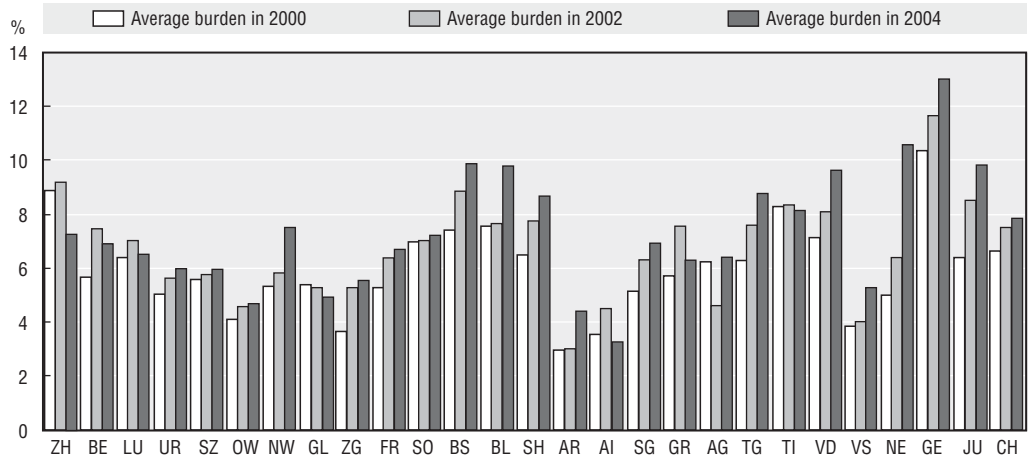
1. All data refer to 2004.
2. Number of individuals receiving subsidies as percentage of the resident population for 2004.
3. Number of households receiving subsidies as percentage of households considering the last population census 2000.

Source: Office fédéral de la santé publique (2005), *Statistique de l'assurance-maladie 2004*, Bern.

from collectively pooled expenditure and may create problems for lower and middle-income individuals.

Overall, while the financing of the Swiss health system remains regressive, the impact on affordability has been mitigated to some extent by social-protection mechanisms. Looking to the future, continued premium inflation well above the growth of income (see Chapter 4) will necessarily push a larger number of middle-income households – that are currently not eligible for premium subsidies – and other vulnerable population groups to fall below the indicative targets of the confederation. This could lead the cantons to increase the number of eligible families and the value of income subsidies, as has been the trend over time (Table 3.6), raising concerns over the financial viability of the subsidy arrangements. But it could also encourage cantons to set tighter thresholds to ensure that their subsidies do not increase, leading to greater difficulties for lower and middle-income households. Whatever the outcome in terms of financing, cross-canton horizontal inequities for households with similar income levels and household structures are likely to persist as a result of the lack of coherence across cantons in the rules governing their subsidy systems.

Figure 3.3. **LAMal premia as a share of disposable income, after the payments of premium-reduction subsidies**



Note: The order of cantons follows the one used by Swiss authorities to present cantonal data.

Source: Balthasar, A. *et al.* (2005), *Die sozialpolitische Wirksamkeit der Prämienverbilligung in den Kantonen. Monitoring 2004*, Office fédéral de la santé publique, Bern.

3.1.3. Equitable pooling across risk groups

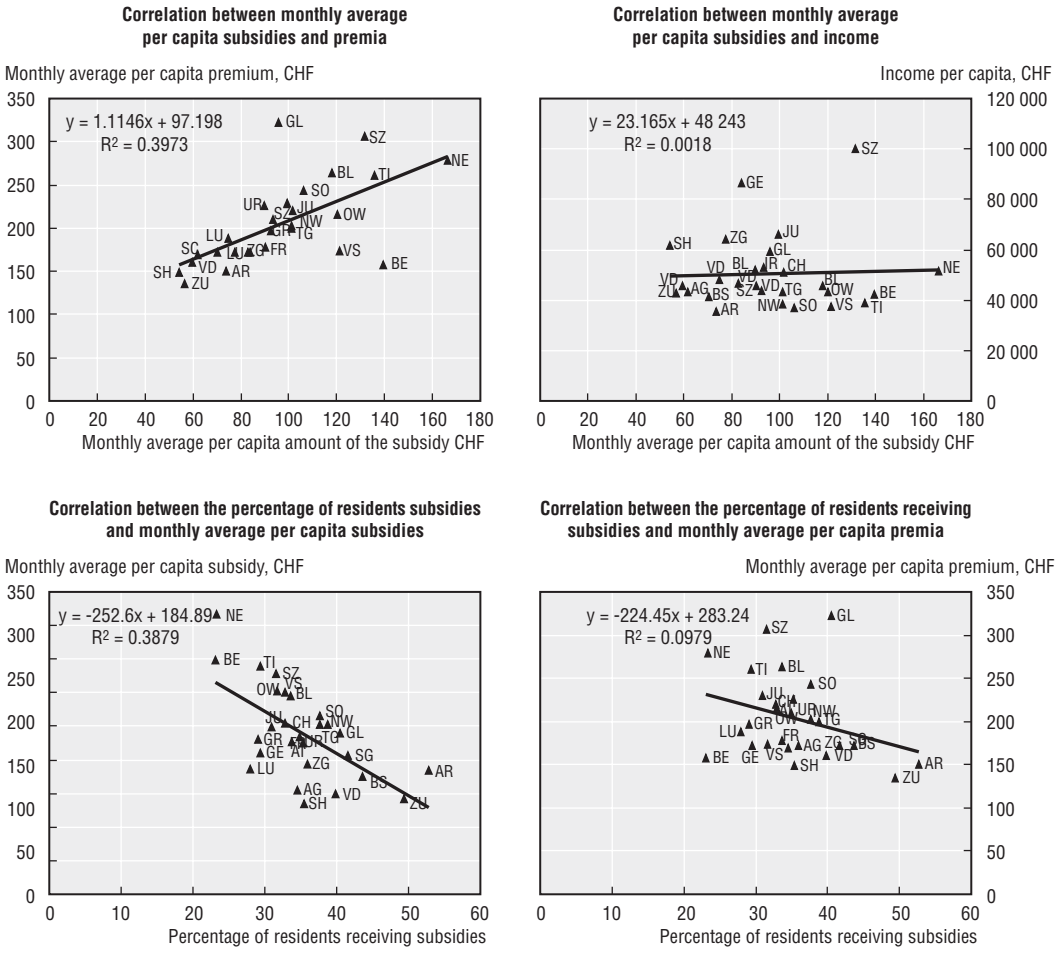
The mandatory health-insurance system guarantees cross-subsidisation among individuals of different risk status through community rating. This requirement promotes risk pooling between healthy and sick individuals, men and women, and different age cohorts, representing a clear improvement from the preceding system. Nonetheless, in spite of community rating within individual insurers, there is a large variety of products and premium differentiations in the Swiss health system by age (children, young adults and adults), geographical area and insurance product (high deductible, managed-care products, bonus).[8] Some proposals have also been made to introduce a further premium differentiation for elderly people over 65. While such differentiation reflects variations in cost and utilisation across different population groups, they also reduce the effectiveness of the community-rating requirements by creating partial and fragmented pools. In particular, the ability of individuals to choose among different insurance products with different levels of coverage enables individuals to self-select themselves into the product best matching expected health-care utilisation, and insurers to link premia to the health costs of a smaller sub-pool promoting premium differentiation with respect to risk. Such cost and risk differences are only imperfectly adjusted for, and pooled in, the risk-equalisation mechanism (see Chapter 4).

3.1.4. Access to care resources and their distribution

High levels of supply compared with other OECD countries (Table 1.7), as well as generous health-system financing, enable the Swiss population to have widespread and prompt access to the health services they need.

For a start, distance to care facilities is not an impediment to obtaining care even in rural areas. Transport is of good quality and the distribution of hospital facilities is far-reaching. People find no obstacle to travel across cantons when need arises or services are unavailable in the canton of origin. In 2001, 13% of hospitalised patients were from a different canton from that of their residence (Klauss *et al.*, 2005a). High-tech medicine is

Figure 3.4. **Income per capita, premia, subsidies and number of beneficiaries: correlations**



Source: Calculated with data from Office fédéral de la santé publique (2004), *Statistiques de l'assurance-maladie obligatoire 2003;* and Office fédéral de la santé publique (2004), *Primes de l'assurance de base, délais de résiliation, primes plus avantageuses*, Bern.

available at five university hospital centres – a large number given the small size of the country. Also, Switzerland does not experience waiting times for elective surgery,[9] a situation that is common in some other countries with high levels of health spending and acute-care beds (Siciliani and Hurst, 2003). Despite some waiting for admission to nursing homes for the elderly, the share of the elderly living in an institutional environment is high relative to many OECD countries (near levels found in the Nordic countries), while the share of those receiving care in their homes is relatively low (OECD, 2000).

Disparities can be observed nonetheless in the distribution of health-care resources across cantons (Crivelli and Filippini, 2003). The cantons of Geneva, Vaud, Basel, Zurich and Ticino are comparatively better served than Schwyz, Obwalden and Nidwalden. The medical density varies by a factor of three and the number of beds per 1 000 population by a factor of five between the best endowed canton of Basel-Town and the least endowed canton of Obwalden, while Ticino has ten times the density of pharmacies as in Nidwalden and Glarus (Table 3.7). There are some positive correlations between cantonal health resources, LAMal spending and cantonal per capita income, suggesting that health costs

Box 3.2. **Cross-cantonal differences in the management of premium subsidies**

Premium-subsidy systems are a cantonal responsibility. Although the federal authorities monitor the way cantons allocate resources to ensure that federal subsidies are effectively used for premium reductions, the level of canton subsidies to reduce premia are not harmonised across cantons. For example, the LAMal revision that will require reductions of premia, from 2006-07, for children and young people in training living in lower- and middle-income families does not define an income threshold, which will be set by the canton authorities.

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 by cantons. More than half of the cantons make use of the LAMal clause that allows them to limit the amount spent on subsidies (see Chapter 1), leading to a corresponding reduction in the federal allocation. Differences also exist in eligibility thresholds and the severity of asset-testing. Cantons have their own fiscal laws, and therefore do not follow the same method for calculating taxable income. As a consequence, the size of the beneficiary population varies across cantons. Families with the same income and assets might be eligible to subsidies in one canton and exceed the threshold in another. The amount of the subsidy also differs. About half of the cantons fix a maximum percentage of income to be spent on premia and subsidises any additional amounts. Another half grant subsidies as a percentage of premia paid by eligible families or individuals. Finally, the procedures for application for subsidies vary. Timing and deadlines are not uniform. In some cantons, households are automatically informed whether they are entitled to subsidies. In others, each individual is responsible for searching out eligibility criteria and conditions for obtaining a subsidy.

Table 3.5. **Importance of different mandatory health-insurance products, 1996-2003**

	Ordinary deductible		Higher deductible		Bonus insurance		Limited choice of provider (managed care)	
	% of total insurees	Year-to-year growth rate	% of total insurees	Year-to-year growth rate	% of total insurees	Year-to-year growth rate	% of total insurees	Year-to-year growth rate
1996	65.9		32.0		0.4		1.7	
1997	56.6	–13.8%	37.9	18.7%	0.2	–58.7%	5.3	215.0%
1998	55.4	–1.7%	37.6	–0.4%	0.2	2.9%	6.8	29.0%
1999	55.0	–0.4%	37.4	–0.4%	0.1	–13.3%	7.5	9.7%
2000	54.0	–1.9%	38.0	1.6%	0.1	–4.4%	8.0	6.6%
2001	53.0	–1.0%	38.7	2.7%	0.1	–4.8%	8.1	3.1%
2002	51.8	–1.8%	40.5	5.2%	0.1	–5.4%	7.6	–6.5%
2003	49.7	–3.6%	42.0	4.2%	0.1	–5.9%	8.2	8.3%

Source: Office fédéral de la santé publique (2004), *Statistique de l'assurance-maladie obligatoire 2003*, Bern.

tend to be higher where capacity is largest, and that resource disparities might be linked to differences in the economic capacity of cantons (Table 3.8).

Health resources also tend to be lower the higher the share of the population living in rural environments. The increasing trend towards specialisation and urbanisation of medical doctors has in fact raised concerns about the availability of GPs in rural areas – particularly as young doctors may find it more attractive to serve urban centres. The

Table 3.6. **Evolution of subsidies for low-income individuals and number of beneficiaries, 1996-2003**

	LAMal subsidies (federal and cantonal) Million of CHF	Year-to-year growth rate	Number of beneficiaries	Year-to-year growth rate
1996	1 493	–	1 656 431	–
1997	1 994	33.5%	1 955 994	18.1%
1998	2 446	22.7%	2 240 522	14.5%
1999	2 690	9.9%	2 334 267	4.2%
2000	2 545	–5.4%	2 337 717	0.1%
2001	2 657	4.4%	2 376 421	1.7%
2002	2 892	8.8%	2 433 822	2.4%
2003	3 066	6.0%	2 427 518	–0.3%

Source: Office fédéral de la santé publique (2004), *Statistiques de l'assurance-maladie obligatoire 2003*, Neuchâtel.

freeze in the opening of new doctor offices does not appear to have reduced or disrupted the supply of ambulatory-care services, but it has not increased the flexibility needed to address existing imbalances in the distribution of medical doctors both in terms of geography and specialty (see Box 4.2). Analysis of need is also constrained by the lack of adequate indicators (Office fédéral des assurances sociales, 2004). The number of practising doctors and their level of activity, for example, are not known with certainty in Switzerland.[10]

Inequalities in the use of health-care services

Clearly, the distribution of resources and capacity is an imperfect indicator of any inequities in access. One major goal of policy makers is to attain equal access for individuals with equal needs. A study on inequalities in the use of health-care services in 21 OECD countries has revealed that, in Switzerland, the rich do not have greater access to in-patient care and GPs than do the poor, after adjusting for perceived need. On the other hand, there seems to be a pro-rich bias in utilisation of dental care and specialists visits, in line with results from other OECD countries (van Doorslaer *et al.*, 2004). These results are confirmed by a similar analysis that applies the same methodology to data from the 1992, 1997 and 2002 Swiss Health Surveys (Leu and Schellhorn, 2004). The health system seems therefore to accord treatment based on individual need, rather than ability to pay, at least as far as hospital and primary care is concerned. Specific population groups, such as migrants and illegal resident groups, face access problems due to institutional, cultural and information barriers.

In addition to issues of equal access for equal need, countries are also concerned over equality terms of outcomes of health care. There is some evidence that there are significant differences in health outcomes by social class. For example, breast cancer mortality rates in the canton of Geneva are nearly 2½ times higher for lower social classes relative to other upper social classes. This difference is much larger than in other European countries where it is estimated to be between 1¼ and 1½ (Bouchardy *et al.*, 2006).

Although marginal population groups may experience difficulties in access to care, the federal authorities and non-governmental organisations have implemented several initiatives aimed at minimising such risks. The Swiss Federal Office of Public Health has developed a strategy to remove any cultural, language, and informational barriers that obstruct effective access to care for migrants, as well as to adequately train health

Table 3.7. **Health-care resources by canton**

Canton		Hospital beds[1]	Medical density[2]	Pharmacies per population[3]	Nursing-homes beds[4]	LAMal per capita monthly health expenditure[5]
CH	Switzerland	5.8	2.0	2.2	11.6	202
AI	Appenzell Inner-Rhodes	7.6	1.3	0.7	8.4	138
AR	Appenzell Outer-Rhodes	10.8	1.7	0.9	19.4	153
AG	Aargau	6.1	1.5	1.9	9.7	176
BL	Basel-Country	5.2	1.9	1.4	8.9	212
BS	Basel-Town	12.7	3.6	3.6	14.4	277
BE	Bern	5.6	2.1	1.8	14	201
FR	Fribourg	3.7	1.5	2.7	10.4	189
GE	Geneva	6.8	3.3	3.9	7.9	277
GL	Glarus	3.3	1.4	0.5	21.5	168
GR	Grisons	7.9	1.7	1.9	14.1	168
JU	Jura	6.4	1.7	2.8	10	209
LU	Lucerne	4.2	1.5	0.9	13.3	162
NE	Neuchâtel	5.4	2.1	3.3	12.7	242
NW	Nidwalden	2.5	1.2	0.5	11.7	147
OW	Obwalden	2.4	1.1	0.9	14.1	151
SH	Schaffhausen	6.4	1.9	1.8	17.4	192
SZ	Schwyz	2.2	1.2	0.8	11.1	163
SO	Solothurn	3.8	1.6	1.1	9	193
SG	St. Gallen	5.0	1.6	1.0	13	167
TG	Thurgau	6.1	1.3	0.9	12.8	179
TI	Ticino	6.6	2.0	5.4	12.5	252
UR	Uri	4.1	1.3	0.6	13.1	154
VS	Valais	5.6	1.7	3.8	8.1	182
VD	Vaud	6.1	2.4	3.7	8.3	245
ZG	Zug	4.7	1.7	1.2	10.1	165
ZH	Zurich	6.0	2.3	1.7	12.6	197

1. Includes all beds in Swiss hospitals (private, public and subsidised) per 1 000 population. The number differs from the figure presented in Table 1.7 because it includes acute care, psychiatric care, acute geriatric care and all other specialised care.
2. Number of self-employed doctors practising in the private sector (generalists and specialists) per 1 000 population. The total number is lower than the figure provided in Table 1.7, which includes doctors employed in hospitals.
3. Number of public pharmacies per 10 000 population.
4. Per 1 000 population (excluding institutions for handicapped individuals and "other institutions").
5. Monthly costs per insured, in Swiss francs. It includes insurer's spending and cost-sharing.

Source: Office fédéral de la statistique (2005), *Statistiques des hôpitaux et des établissements de santé non hospitaliers 2003*, Neuchâtel ; Office fédéral de la statistique (2005), *Statistique de l'état annuel de la population (ESPOP) 2003*, Neuchâtel ; Office fédéral de la santé publique (2004), *Statistique de l'assurance-maladie obligatoire 2003*, Bern.

providers to address the health needs of migrants who have faced particular traumatic experiences (violence, war, torture, etc.) (Office fédéral de la santé publique, 2003b).[11] The Swiss Red Cross also targets several programmes towards refugee groups needing assistance, including strengthening health promotion, facilitating access to the health-care system, and providing special assistance and social counselling to people who have experienced torture and violence.

3.2. Responsiveness of the Swiss health system

Despite growing consumers' anxiety about the explosion in health costs, patients appear to be broadly happy with the process of care in Switzerland. The majority of the population is satisfied with the health system and the perceived quality of care, the wide degree of choice of providers and the care options and timing of care that they offer. Yet, the

Table 3.8. **Cantonal health-system resources, LAMal spending and the economic capacity of cantons**

	Density of acute-care beds[1]	Medical density[1]	Per capita LAMal monthly health expenditure	Cantonal income per capita	Share of the population living in rural areas
Density of acute-care beds[1]	1				
Medical density[1]	0.63	1			
Per capita LAMal monthly health expenditure	0.42	0.88	1		
Cantonal income per capita	0.32	0.56	0.31	1	
Share of the population living in rural areas	–0.20	–0.60	–0.57	–0.46	1

1. Per 1 000 population.

Source: Office fédéral de la statistique (2005), *Statistiques des hôpitaux et des établissements de santé non hospitaliers 2003*, Neuchâtel; Office fédéral de la statistique (2005), *Statistique de l'état annuel de la population (ESPOP) 2003*, Neuchâtel; Office fédéral de la santé publique (2004), *Statistique de l'assurance-maladie obligatoire 2003*, Bern.

lack of well-developed data on system responsiveness and patient-centred care makes it difficult to draw firm conclusions. For example, the Swiss Health Survey does not investigate reasons for dissatisfaction with medical services, nor does it report the degree of satisfaction with specific aspects or functions of the care experience. Furthermore, information on consumer satisfaction is difficult to compare across countries and is not a good indicator of system responsiveness.[12] The role of consumers is generally weak and few mechanisms are in place for addressing patients' complaints and to redress tort. And, despite freedom of choice in the insurance market and large premium differences across insurers, relatively few individuals take advantage of options at their disposal.

3.2.1. Consumer satisfaction

According to a study by the Picker Institute, satisfaction with hospital services in a non-representative sample of nine large Swiss hospitals is high and generally above that of hospitals in four other OECD countries (Germany, Sweden, the United States and the United Kingdom) (Coulter, 2001).[13] Over half of the population surveyed in the Swiss health survey considers medical services adequate, although another third expects more. This perception has been improving over time for all age and gender cohorts. German-speaking groups displayed higher levels of satisfaction with medical services than French and Italian-speaking groups in 2002. Satisfaction is as high in rural areas as it is in urban zones. However, such high ratings are not matched with perceptions about the insurance systems. Nearly one in two Swiss residents expects more from insurers, with generally lower satisfaction among young people, French and Italian groups (Table 3.9). These results are confirmed by another survey showing that in 2002 over two-thirds of the Swiss population – and especially those using the system more intensively – were satisfied with the way the health system functions. However, acceptability of the growing cost of the system is low: three quarters of the population found the burden of LAMal premia high or very high (Bolgiani *et al.*, 2003). Cost represents the single most important reason of consumer dissatisfaction with the health system.

While satisfaction about the health system is high overall, available information on system responsiveness is inadequate and not always made public. Four cantons participate in the "Outcome" initiative (Box 2.3) to measure hospital patients' satisfaction, but results are not made public. Similarly, while hospitals have been required since 2002 to carry out satisfaction surveys, data are not disclosed. More generally, results from surveys are not incorporated into broader performance assessment frameworks.

Table 3.9. **Perceived adequacy of Swiss medical services and payers, 1992-2002**

Percentage

	Medical services				Insurers		Cantons			
	Adequate		Expect more		Adequate	Expect more	Adequate		Expect more	
	1992	2002	1992	2002	2002	2002	1992	2002	1992	2002
Total	**45**	**54**	**35**	**23**	**24**	**45**	**17**	**23**	**43**	**39**
By age groups										
15-24	56	62	24	18	23	41	15	22	43	31
25-34	44	55	37	27	21	56	14	21	49	42
35-44	42	54	39	26	24	50	17	22	46	45
45-54	40	53	38	25	26	46	20	26	41	41
55-64	43	51	34	25	25	44	21	25	38	37
65-74	41	52	34	18	24	35	19	23	34	33
75+	n.a.	51	n.a.	16	24	28	n.a.	21	n.a.	28
By gender										
Men	47	55	33	23	26	46	21	27	44	39
Women	42	54	37	24	21	45	13	19	43	38
By language spoken										
German	44	59	35	19	26	41	17	24	42	35
French	47	44	34	34	17	57	16	19	46	48
Italian	40	42	40	38	19	55	27	20	49	54

Note: Data on adequacy on insurers are not available for 1992.
n.a.: not available.
Source: Office fédéral de la statistique (2003), *Enquête suisse sur la santé 1992 et 2002*, Neuchâtel.

3.2.2. Patients and insurees' rights

Relatively little attention is being paid to patient rights in Switzerland, although the Swiss Medical Association and cantons developed procedures regarding patient complaints. The role of consumer and patient associations is weak *vis-à-vis* the authorities, providers and in parliament, despite significant initiatives by some actors (Box 3.3). Each canton has legislation on patients' rights, but, according to some commentators, implementation is weak, and no legal framework exists at the federal level. Codes of professional ethics are being developed,[14] focussing on specific issues such as assisted suicide, stem-cell research and the definition of cerebral death. There seems to be a general lack of transparency towards patients, for example in terms of deficiencies in disclosure of treatment information and of medical records to the patient. In the case of medical errors, no system is in place for dispute resolution based on conciliation and arbitration – a cheaper way to solve disputes between providers and patients than recourse to the court system. On the other hand, an ombudsman for resolving disputes with insurers appears to operate fairly well. The federal government has also taken steps to improve the access to care of migrant populations.

3.2.3. Consumer choice

The Swiss health system offers a very high degree of choice. Patients enjoy mostly unconstrained freedom of consulting with any doctor and of being treated in the hospital of their choice. They can obtain second opinions simply by seeking advice from another provider. With the exception of insurance policies with limited provider choice, there is no gatekeeping system and patients have direct access to specialists.[15]

Box 3.3. **Mechanisms to address consumer protection in Switzerland**

Switzerland uses mainly legal mechanisms for addressing consumers' disputes regarding the health system. For insurance-related complaints, an independent ombudsman was appointed in 1993. Consumers' organisations also play an important role.

Disputes between patients and providers can only be taken to court. Redress in the case of patient-provider litigation differs depending on whether the medical error concerns a public or a private hospital. In the former case, cantonal law applies and the fault is considered to be a collective responsibility (*i.e.* the responsibility of the canton); for private hospitals, it is the responsibility of the individual doctors as governed by the penal code.

For disputes regarding the application of the LAMal, two systems operate: a legal procedure, and mediation through the Ombudsman. Usually, insurees first make a free-of-charge declaration directly to the insurer, who is required to send the consumer a written response stating the motivation for the decision. If the consumer is dissatisfied with the decision, s/he can appeal to the cantonal insurance court and, eventually, to the federal insurance court. Consumers can also apply to the insurance Ombudsman, who acts as mediator. Appeals to the Ombudsman are free for consumers. The system is voluntary and does not preclude insurees pursuing legal action. Most of disputes addressed by the Ombudsman refer to reimbursement decisions and to the catalogue of benefits. Eighty per cent of the cases are initiated by German-speaking insurees (Ombudsman de l'assurance-maladie sociale, 2004), who represent 65% of the population.

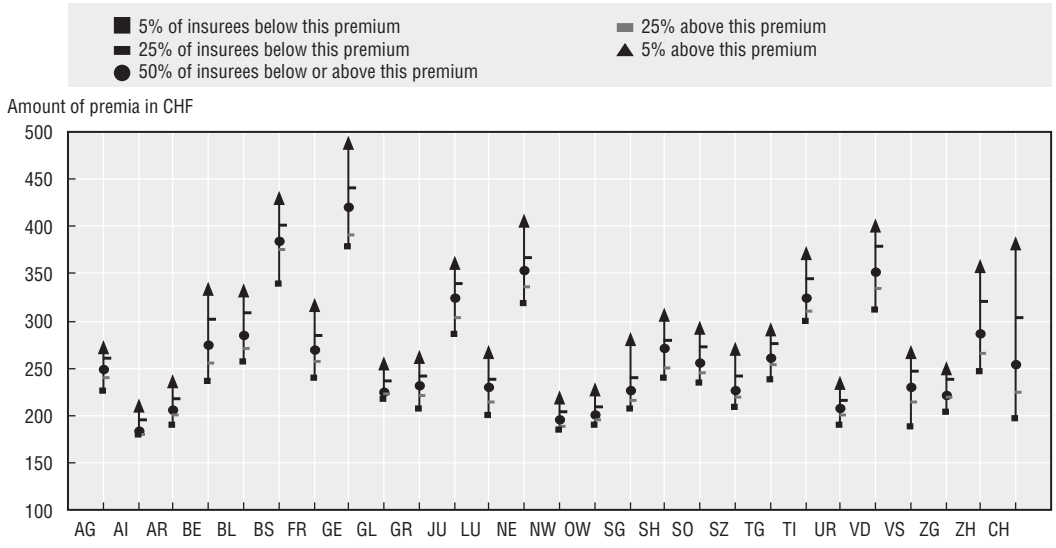
A number of consumer, insuree, and patient associations currently operate in Switzerland, such as the Swiss Organisation for Patients and the Insured, the Swiss Federation for Patient Services, the Consumer Protection Foundation and the Federation of Swiss-Romand Consumers. Their main role is to provide advice to members, disseminate information, provide consumer/patient defence, and undertake lobbying. For example, the Federation of Swiss-Romand Consumers plays a key information role regarding premium increases and subsidies to low-income individuals. It also edits a magazine ("J'achète mieux") containing articles to better inform and facilitate consumers' choice in various domains, including health. The association also takes public positions on issues being debated in parliament and participates in parliamentary commissions to defend consumer rights.

Attachment to unrestrained provider choice is high. For example, 44.6% of the population considers free choice of specialist as very important, and another 27.4% as rather important, with higher rates assigned by the Italian and French-speaking population (Office fédéral de la statistique, 2003c). There are no data, however, confirming the extent to which individuals effectively make use of available care options, and the absence of performance information on hospitals or ambulatory providers suggests that individual choice may not be based on "objective" measures, for example, of care quality.

Only few people take advantage of the opportunity to change insurer, despite large premium differences across insurers in each canton (Figure 3.5) and widely available information on the switching procedures. According to data from a representative survey of Swiss residents,[16] switching rates decreased from 5.4% in 1998 to 2.1% in 2000 (Colombo, 2001). Switching was more prevalent in French and Italian-speaking cantons, and among young people or those with good or very good health status. Other studies have confirmed asymmetric mobility of individuals, with the few switchers concentrated among individuals

Figure 3.5. **Premium variation within and across cantons, 2004**

Distribution of premia for adults (26 years and over) in Swiss francs



Source: Office fédéral de la santé publique (2004), *Statistique de l'assurance-maladie obligatoire 2003*, Bern.

with significantly lower health-care expenditure in the year prior to the decision to change (Beck, 2000; Beck *et al.*, 2003) and those aged between 20 and 29 (Eisler, 2005).

While some recent data indicate that switching increased again to 4% in 2002 (Laske-Aldershof *et al.*, 2004), barriers to changing insurer remain. Reasons proposed to explain this limited degree of switching range from relatively low price sensitivity, to important transaction costs for the insured person, satisfaction with the services offered by the insurer and long-term institutional loyalty. Inadequate risk adjustment that under-compensates insurers for high-risk enrollees encourages them to attract only the more mobile good risks.[17] Links between mandatory and supplementary health insurance can reduce consumer mobility in the LAMal cover. Even if ties-in on the sale of the two products are prohibited by law, it is often not practical for consumers to keep the two products with different insurers[18] (Colombo, 2001; Beck *et al.*, 2003). High-risk people may also be reluctant to switch because mobility in voluntary cover is not guaranteed and they may face higher premia. Indeed, evidence indicates that having supplementary health insurance is negatively related to consumers' propensity to switch (Beck, 2004a). Finally, although comparative information on premium levels is freely available and comparable on the internet,[19] the wide range of available options (between different levels of deductible and insurance types) allows individuals enough flexibility to align their insurance needs with their budget without necessarily changing the insurer. In fact, a growing number of insurees seem to opt for insurance with higher levels of deductibles (Table 3.9).[20, 21]

Notes

1. However, immigrants without residency papers remain one group often lacking insurance coverage.
2. The Swiss Health Survey, carried out by the Federal Statistical Office, covers the health status of the Swiss population over 15 years old.
3. These data are not meant to provide a fully-fledged analysis of the degree of regressivity of the Swiss health system.
4. One possible explanation of the high proportion of out-of-pocket payments in Switzerland is that data may overestimate long-term care expenditure, a large share of which is paid for directly by individuals.
5. According to some earlier studies by van Doorslaer *et al*. (1999), Wagstaff and van Doorslaer (1992) and Wagstaff *et al*. (1999), the structure of health financing of Switzerland is less progressive than in other OECD countries, when considering each source of finance individually as well as the combination of diverse funding sources.
6. For example, no household-survey data are available to assess the frequency, magnitude, and distribution of health payments across income groups and therefore on the effectiveness of protection against catastrophic out-of-pocket payments.
7. Out-of pocket payments include both direct payments (self-medication) and cost-sharing at the time health-care services are received. These latter mainly include payments for dental care, long-term care in nursing homes, glasses, and over-the-counter drugs.
8. In particular, there is considerable variation across cantons. Cantons with the highest premiums pay around twice as much as the cantons with the lowest.
9. Apart from organ-transplant surgery (where the problem is often a lack of donors).
10. The medical association (FMH) collects data on registered doctors. However, the data include those who stopped practising or retired and do not adjust for doctors working part-time. The association of LAMal-insurers (Santé Suisse), on the other hand, has an administrative database based on insurance claims for LAMal-reimbursed services. Data on consultations per capita, based on the Swiss Health Survey, are not considered to be entirely reliable. The Swiss Health Observatory and the Federal Statistical Office consider improvements in ambulatory-care statistics to be a top priority for data development.
11. The strategy is based on five key areas of intervention *i)* education; *ii)* public information, *iii)* health-care provision, *iv)* therapy for traumatised asylum seekers; *v)* research. About 20% of the Swiss resident population is comprised of migrants with increasingly diverse origins (although many of those comprise of people who has resided in Switzerland for a fairly long period of time).
12. Responsiveness has been defined as a measure of how well the health system responds to the population's legitimate expectations of non-health aspects of health services (WHO, 2000).
13. The study is based on a survey of patients' experiences of care. It looked at aspects such as information and communication, co-ordination of care, respect for patient preferences, emotional support, physical comfort, and involvement of family and friends.
14. For example, guidelines are developed by the Swiss Academy of Medical Sciences and the National Commission for the Ethics of Human Medicine.
15. According to Telser *et al*. (2004), the Swiss health system displays a number of advantages resulting from its high cost, particularly the high degree of freedom of choice of provider, and generous supply.
16. The survey – which looked at the impact of the LAMal on the Swiss population – was commissioned by the Swiss Federal Office of Social Insurances (OFAS). Survey data were collected during the year 2000 across a statistically representative sample of Swiss households and individuals.
17. See also Chapter 4 for a discussion of the risk-compensation mechanism. In addition, when a person changes insurer, she or he does not bring with him the corresponding reserves held by the original insurer. As the need for reserves is likely to be higher for the elderly, this may encourage risk selection by insurers.
18. Most LAMal-insurers offer voluntary cover, often through an affiliated insurance company selling products under the same brand name.

19. At the Web site *www.comparis.ch/comparis/default.aspx*.

20. Colombo (2001) found that a larger number of people decide to change the level of deductible or insurance type rather than to switch insurer.

21. Factors explaining enrollee mobility in other social health-insurance systems are similar to those found in Switzerland. Mobility in the Dutch health-insurance system (prior to the 2006 reform) was much lower than in Switzerland. Although the risk-adjustment mechanism is highly sophisticated, tie-ins with supplementary health insurance were strong and the financial gains of switching low, because only a small share of the premium was set competitively by insurers (Schut *et al.*, 2003). In Germany, only private insurers offered supplementary insurance until 2004. Since then, sickness funds are allowed to act as agents for private health insurers (Laske-Aldershof *et al.*, 2004). But individuals and employers can obtain large financial gains from switching, resulting in significantly higher levels of mobility (Schut *et al.*, *ibid.*), particularly for the young and healthy. This led to increasingly large differences in risk structures across sickness funds, and, as a consequence, an increasing percentage of total sickness-fund resources are being redistributed in the risk-adjustment scheme (Busse and Riesberg, 2004).

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Chapter 4

The Performance of the Swiss Health System: Efficiency and Financial Sustainability

This chapter first examines factors underlying the rapid increase in spending and possible future trends if current arrangements for supply, demand and governance remain unchanged. Section 4.1 also examines some of the reasons for the relatively high level of health spending in Switzerland. Identifying these factors may suggest areas where efficiency gains and improved value for money could be achieved (Section 4.2). These could help offset the impact of rising demand for health on the costs of the health system.

Health spending in Switzerland is the second highest as a share of GDP amongst OECD countries and spending growth continues to largely outstrip the increase in GDP. Ageing populations, coupled with technological change and other institutional factors, suggest that the demand for health spending will continue to rise, raising concerns over the longer-run financial sustainability of the system.

The health system appears to be largely unconstrained on the demand side and this is combined with ample supply. There are strong provider incentives to respond to and stimulate increased demand, and these are likely to be sustained over the future. Cost-containment relies on some government planning and controls in the hospital sector and on competition in the insurance markets. However, none of these mechanisms in their present forms appear sufficient to control supply and moderate demand, leading, overall, to only weak incentives for efficiency.

4.1. The financial sustainability of health spending

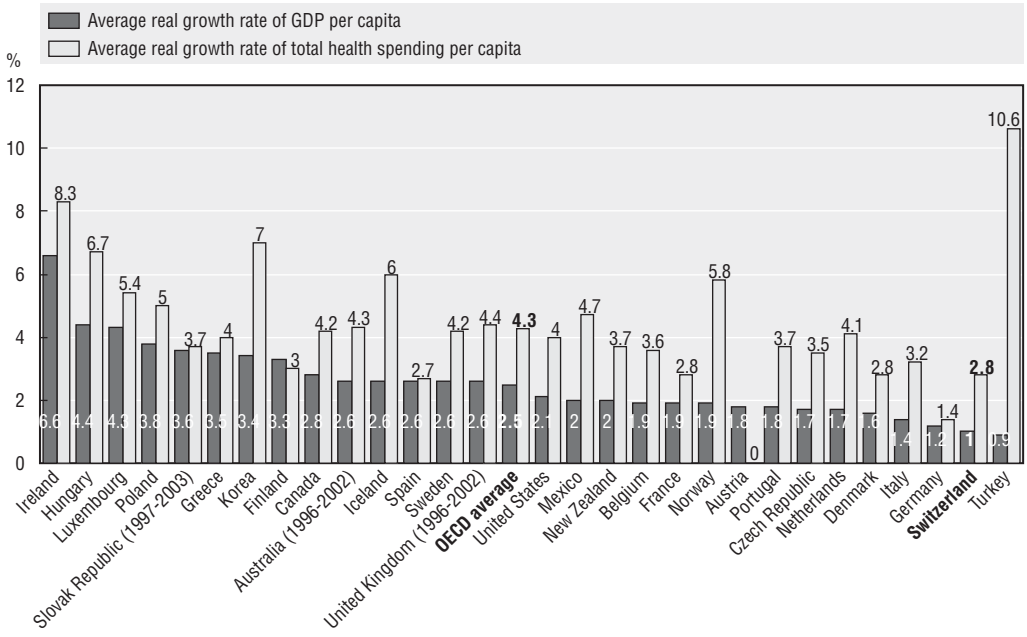
4.1.1. The growth of spending

Total health costs as a share of GDP have been on an upward trend and now represent over 11% of GDP. Since the introduction of the LAMal in 1996, total real health spending per capita has grown by slightly less than 3% per year on average (Figure 4.1). While this is roughly one and a half percentage point less than the OECD average over the period, it remains considerably higher than the rate of growth of Swiss GDP per capita, which has averaged 1% over the same period.[1] This has been reflected in an above-average increase in the share of health spending in GDP of 1.4 percentage points over the period 1996-2003 (Figure 4.2). With strong built-in incentives encouraging expenditure growth (Section 4.1.3), recent health-cost increases seem likely to continue and the ability to finance the Swiss health system may become "unsustainable" over the longer run if the current sluggish growth in incomes and in the tax base continues.

The evolution of spending under the mandatory health-insurance system deserves particular policy attention. In the past five years, such spending has tended to be 1.4 percentage points higher than total health spending (Sturny, 2004). Claims for in-patient hospital care and doctors' services represent the main items of LAMal outlays (Figure 4.3). Ambulatory-care spending experienced the fastest increase between 1999 and 2002, but hospital claims have outpaced doctors' services since (Sturny, *ibid.*). In 2004, in-patient hospital claims accounted for almost a quarter of total LAMal health spending, with an increase from the previous year (11%) well above the average for other health-spending items (Office fédéral de la santé publique (2005e). The evolution of in-patient costs in Switzerland is above the OECD average for the period (OECD, 2004a). Long-term care in nursing homes and Spitex account for much lower proportions of total LAMal claims, as these services are only partially reimbursed.

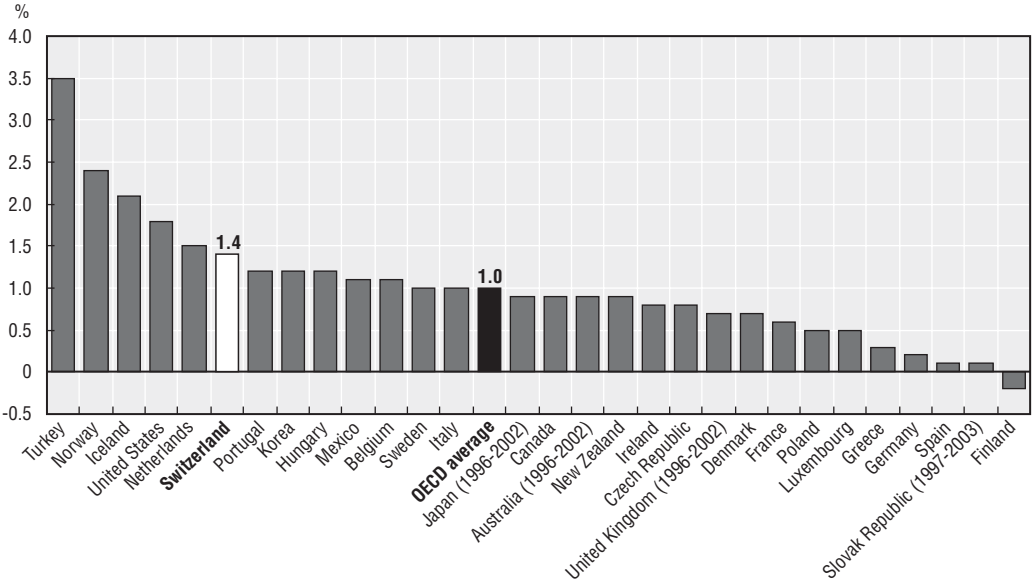
These trends have significant implications for the financial sustainability of the Swiss health systems. Per capita growth of LAMal expenditure has lead to rising health-insurance

Figure 4.1. **Average annual real growth rate of per capita GDP and health spending in the OECD, 1996-2003**



Note: GDP prices for 2000.
Countries are ranked by decreasing average real growth rate of GDP per capita.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

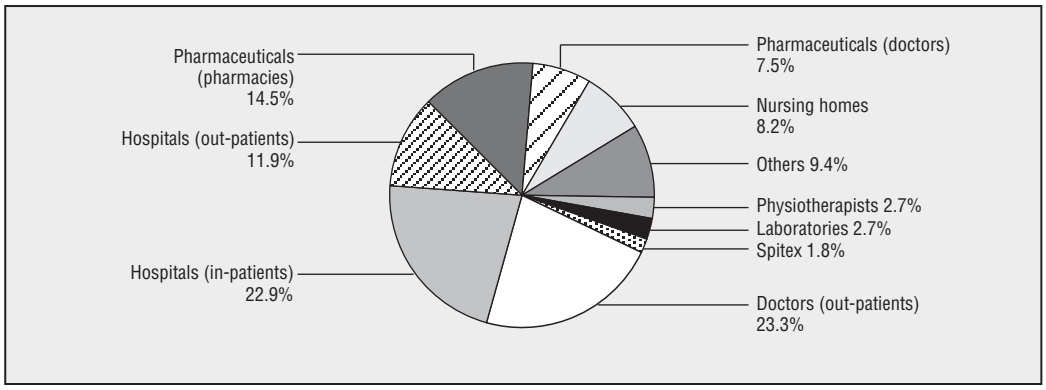
Figure 4.2. **Change in health expenditure as a share of GDP between 1996 and 2003**



Source: OECD (2005), *OECD Health Data 2005*, Paris.

premia for households and increased government spending on hospitals and on targeted transfers to low-income households. Premia for ordinary-insurance products have grown on average by 5.5% per year for adults between 1996 and 2005, reaching 5.6% in 2006, a much faster pace than the increase in general consumer prices, not unlike several other

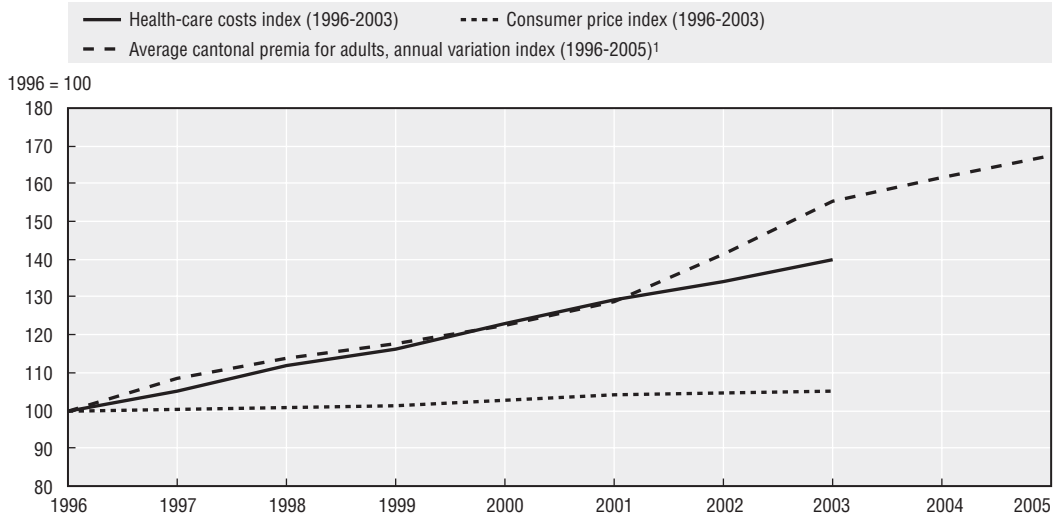
Figure 4.3. **Health expenditure under the LAMal, 2003**



Source: Office fédéral de la santé publique (2004), *Statistiques de l'assurance-maladie obligatoire 2003*, Bern.

OECD countries (Figure 4.4). This has come at a time of growing pressure on the public finances. Low economic growth has had a negative impact on canton and federal fiscal resources, while subsidies for institutional providers have increased by 49% between 1996 and 2003 and those for low-income households have doubled.

Figure 4.4. **Growth in LAMal premia and in the consumer price index**



1. Estimate based on average monthly premia (ordinary deductible and risk accident included).

Source: Office fédéral de la santé publique (2004), *Statistiques de l'assurance-maladie obligatoire 2003*, Bern.

4.1.2. The impact of ageing and demographic factors on future health and long-term care costs

The Swiss population has grown slowly over the past few years, leading to only a marginal increase in the number of LAMal insurees between 1996 and 2003. Nonetheless, the insured population is undergoing a steady process of ageing (Chapter 1). There are several recent projections of the likely effect of ageing on health and long-term care costs.

Swiss estimates of the impact of ageing on long-term care costs (using population structure and the cost by age group) suggest that costs could rise by 31% up to 2020, and 77% over the period 2000 to 2040 from ageing alone.[2] This would correspond to a rise in real

annual growth of health spending of 1.4% (Office fédéral des assurances sociales, 2003c). This estimate is based on the impact on cost due to the increase in the proportion of old people (over 80) in the population, assuming that current costs by age group remain unchanged. However, it does not take into account the possibility that the demand for care might rise more slowly if old people tend to live healthier and longer lives.

More recent ageing-related work at the OECD suggests that strong increases in the public cost of health and long-term care are to be expected over the next half century (Bjørnerud *et al.*, 2006) (Box 4.1). In the absence of sustained efforts to control costs, public health spending in the OECD area might increase on average by around 4 percentage points of GDP over the period, with long-term care costs contributing an additional 2 percentage points. For health care, the impact of the non-ageing-related cost drivers is expected to dominate ageing-related effects by a considerable margin. Projections for Switzerland show increases marginally lower than the OECD average. But they still show a substantial estimated rise of 3.3 percentage points of GDP for health care and 2.2 percentage points of GDP for long-term care to 2050. While these projections are very long-term and are based on a specific set of underlying assumptions, they do suggest that health-care spending is likely to place continuing pressure on public finances and the overall costs of the health systems over coming decades.

4.1.3. Volume and price determinants of high health costs

Broadly speaking, Switzerland has a high level of inputs (Table 1.7), lacks effective mechanisms to contain their growth, and features weak controls over prices and volumes of health-care consumption.

The structure of spending

The structure of spending on health and long-term care in Switzerland provides a first indication as to where health costs may be out of line with developments in other countries. In-patient care in Switzerland accounts for just under half of total health expenditure, a share well above the OECD average (Table 1.11). In real per capita terms, in-patient care has grown slightly more rapidly than total health costs since 1985 (Table 4.1). The high level of spending on in-patient care – when compared with the OECD average – largely reflects the development of long-term care. Although many countries have difficulty in distinguishing between acute and long-term care, this spending component has increased considerably more rapidly than other areas of spending in Switzerland. The share of expenditure on acute in-patient care has declined in parallel. However, the increase in long-term care cost has left the overall share of in-patient spending in the total broadly unchanged since the mid-1980s. Just under a third of spending takes place in the ambulatory care sector, roughly in line with the OECD average. While its share in total health expenditure has remained unchanged over time, growth in real ambulatory-care spending has been one of the fastest after long-term care. Spending on medical goods including pharmaceuticals represents only 13% of the total, a share considerably less than in other OECD countries, although this component has tended to increase only slightly less rapidly than spending on out-patient services.

Ambulatory-care supply

The number of practising doctors has been found to have an impact on health spending in countries that reimburse doctors on a fee-for-service basis (Gerdtham *et al.*,

Box 4.1. **Long-term projections for health and long-term care (LTC) spending**

The OECD has recently revisited the issue of the likely trends in government-financed (public) health and long-term care costs over the half century to 2050 (Bjørnerud *et al.*, 2006). Compared with earlier work (Dang *et al.*, 2001), this study takes into account more refined assumptions concerning the impact of aging and non-age-related factors.

As regards projections for public health-care spending, the study identified ageing and income growth as key elements explaining the rise in expenditures. However, past spending exceeds what can be explained using plausible assumptions about these two variables, leaving a large residual. This is thought to reflect a range of factors, but predominately includes technological change and developments in the price of health care relative to the rest of the economy. The modelling for health care and long-term care differs, and, for the latter, the degree of physical and mental dependency is the most critical factor. Key assumptions used in the central projections are:

Public health-care costs

- The impact of population ageing takes into account the hypothesis of "healthy ageing" such that costs at the time of death – which make up a significant share of overall health spending – are displaced into the future as lifetimes are assumed to lengthen. It is therefore assumed that longer lives mean longer healthy lives.
- The demand for health care continues to increase in line with per capita income (income elasticity of 1).
- The residual component for Switzerland in a baseline scenario is assumed to increase at a rate of 1% per annum (Cost-pressure scenario), in line with the OECD average for the residual calculated over the period 1981 to 2002. In a second scenario, governments are assumed to introduce cost-containment policies to reduce progressively the growth of the residual to zero by 2050 (Cost-containment scenario).
- The growth of the Swiss residual over this period was 2.9% *per annum*, considerably higher than for the OECD average. If the country-specific trends were used, the increases in spending over the period would be dramatically higher for Switzerland. However, all OECD countries are likely to face similar rates of technological change in the future such that a slower pace is likely for Switzerland depending, of course, on the pace of introduction of new medical developments. The strong Swiss residual shows that over the last decades country specific factors, including the institutional setting and the regulatory framework of the system, have been less efficient than elsewhere in constraining health-care cost growth. In absence of reform, spending pressures could well remain higher than in other countries.

Public long-term care costs

Dependency will rise in line with ageing populations. Dependency rates per age group are based on an average of four countries for which data were available (Germany, Italy, Spain, and the United Kingdom). It is also assumed that only half of the longevity gains assumed over the projection period are translated into a reduction in dependency.

The overall level of LTC costs for Switzerland was based on those of Germany. Costs per dependent were modelled on a cross-country time-series using age-structure and proxies for the scope for informal care and the impact of average income or relative prices.

Projections assumed that any relative price effects between the long-term care sector and the rest of the economy would be fully reflected in long-term care costs (Cost-pressure scenario) or by only half (Cost-containment scenario).*

Box 4.1. **Long-term projections for health and long-term care (LTC) spending** *(cont.)*

Real GDP growth

The projections for GDP and GDP per capita are built on national data and OECD assumptions. GDP estimates are based on projections of the labour force (using OECD estimates of participation rates by age and sex), and a growth of productivity that converges to 1.75% per annum by 2030, remaining constant thereafter.

Increase in public spending on health and long-term care, 2005-50

Change in percentage points of GDP

	Cost-pressure scenario			Cost-containment scenario		
	Health care	Long-term care	**Total**	Health care	Long-term care	**Total**
OECD average	3.9	2.2	**6.1**	2	1.3	**3.4**
Switzerland	3.5	1.4	**4.9**	1.8	0.7	**2.3**

Source: Bjørnerud, S., C. de la Maisonneuve and J. Oliveira Martins (2006), "Projecting OECD Health and Long-term Care Expenditures: what are the main drivers?", Economics Department Working Papers, No. 477, OECD, Paris.

* In the case of the latter, this assumes, implicitly, that the growth of wages in the long-term care sector rise at a slower rate than in the rest of the economy, a rather conservative assumption.

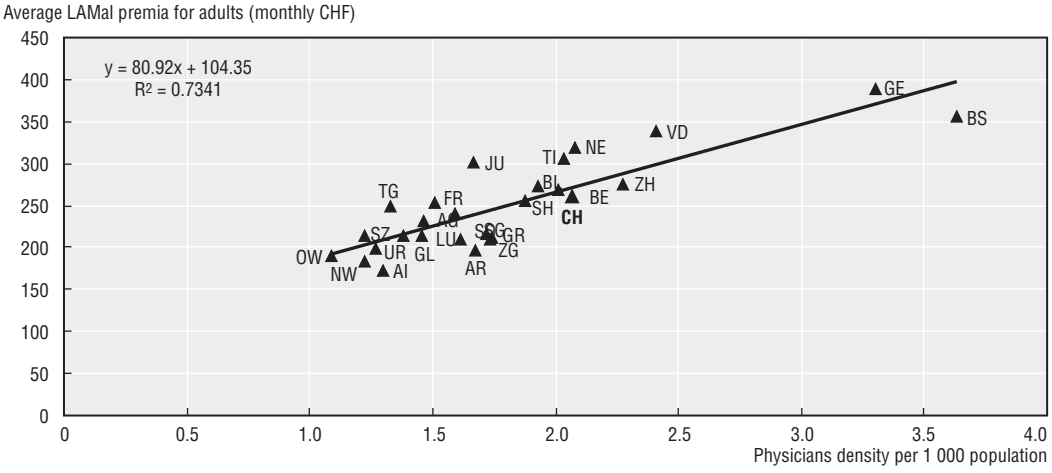
Table 4.1. **Expenditure on in-patient, out-patient and drugs in Switzerland, 1985-2003**

	1985	1990	1995	2000	2003	Yearly average growth rate (1985-2003)
Percentage of total health spending						
Total in-patient care	*46.7*	*47.9*	*47.9*	*46.8*	*47.9*	
In-patient curative/rehabilitative	36	34.7	31.3	29.4	29.9	
In-patient long-term nursing care	10.7	13.2	16.7	17.4	18	
Total out-patient	*27.3*	*26.6*	*27*	*27.8*	*27.3*	
Of which: physician services	14.2	14.3	14.2	14.3	13.5	
Total medical goods dispensed to out-patients	*13.4*	*12.2*	*11.9*	*12.6*	*12.7*	
Of which: pharmaceuticals	11.3	10.2	10	10.7	10.5	
Of which: others	2.1	2.0	1.9	1.9	2.2	
Per capita, CHF at 2000 GDP prices						
Total in-patient care	*1 834*	*2 209*	*2 486*	*2 827*	*3 159*	*3.1*
In-patient curative/rehabilitative	1 414	1 600	1 622	1 774	1 972	1.9
In-patient long-term nursing care	420	609	865	1 053	1 186	5.9
Total out-patient	*1 074*	*1 227*	*1 402*	*1 675*	*1 801*	*2.9*
Of which: physician services	559	659	734	861	890	2.6
Total medical goods dispensed to out-patients	*527*	*564*	*617*	*762*	*836*	*2.6*
Of which: pharmaceuticals	442	473	518	646	694	2.5
Of which: others	85	91	99	116	142	2.9
TOTAL health expenditure without long-term care	3 508	4 005	4 322	4 983	5 405	***2.4***
TOTAL health expenditure	***3 928***	***4 614***	***5 187***	***6 036***	***6 591***	***2.9***

Source: OECD (2005), *OECD Health Data 2005*, Paris.

1998). Switzerland is no exception. The density of Swiss doctors is positively correlated with the average premium paid across cantons (Figure 4.5). According to other available studies, the density of physicians and acute-care beds are the most important factors explaining health-expenditure differences across cantons, together with the age structure of the population (Crivelli, Filippini and Mosca, 2003 and 2006).

Figure 4.5. **Physician density and average LAMal premia across Swiss cantons**



Note: Physicians density includes both generalists and specialists. Monthly average LAMal premia refer to the adult population only.

Source: Office fédéral de la santé publique (2004), *Statistiques de l'assurance-maladie obligatoire 2003*, Bern.

At present, the density of doctors practising in Switzerland (and of human resources for health more broadly) is high by the standards of OECD countries – 3.6 per 1 000 population compared with the OECD average of 2.9. This higher supply could create conditions for supplier-induced demand (Domenighetti and Pipitone, 2002; Domenighetti *et al*, 1984; Crivelli, Filippinini and Mosca, 2006; Domenighetti *et al*., 1988; Domeniguetti *et al*., 1993).[3]

There is no clear policy towards the growth of human resources in Switzerland. Due to fears of cost escalation and of oversupply, particularly in the context of the reforms to medical school curricula[4] and the mutual recognition of medical diplomas with the EU, more stringent polices regarding admission to medical schools (numerus clausus) were adopted in some medical schools, but have not been accompanied by explicit plans on how to meet population health needs while containing cost. The freeze in the opening of the number of doctors in practice-based ambulatory care, which was implemented in 2002 with the aim of slowing down health expenditures, has generated much controversy among stakeholders and has had little effect on ambulatory-care costs thus far (Office fédéral des assurances sociales, 2004) (Box 4.2).

Whether planning in the ambulatory sector is the best instrument to prevent oversupply or, on the other hand, to create shortages of human resources are a subject of debate in several countries (Spycher, 2004a). Switzerland appears to be leaning towards those who prefer to leave the regulation of ambulatory-care supply to the market, with greater reliance on competitive mechanisms. The freeze was in fact introduced as a temporary provision that is supposed to be released once another measure – the removal of the obligation for insurers to contract with all providers – is adopted. Both current measures and a move towards greater reliance on the market are, however, unlikely to

Box 4.2. **The freeze in the opening of new medical practices**

On 3 July 2002, the Federal Council adopted a measure to limit authorisation for new doctors in ambulatory care to practise within the context of the LAMal. The measure, initially confined to three years, has been renewed in 2004 for a further three-year period. According to this provision, authorisation to open a new ambulatory office would be accorded only on proof of need, for example cantons can agree to new admissions in case of inadequate doctor coverage or in case of take-over of an existing office. The admission to practise, once accorded, expires after a certain period of non-use. Cantons have responsibility for the implementation of the freeze. They also have a certain freedom to implement the freeze for some categories of providers or in certain regions. Doctors who do not receive permission to open a new practice can be employed by hospitals or practise outside the LAMal.

At the end of 2003, 26 cantons had applied the limitation to the opening of new medical offices. About half of the cantons adopted their own internal criteria to regulate the establishment of new doctor offices, in addition to those established by the Federal Council (density, number). Since the announcement of the introduction of the freeze, the demand to open new practices has been three times and half higher than usual.

According to a recent evaluation, the measure has not resulted in a reduction in the supply of ambulatory care services (Office fédéral des assurances sociales, 2004). Hospital-based medical practices have increased their attractiveness. The measure did not seem to have had any significant impact on cost. Given the short time since its implementation and the large number of doctors who had asked for admission prior to the introduction of the measure, it is unclear whether this measure will contain cost over the medium-term.

address appropriately some major challenges facing the ambulatory-care sector, such as health workforce ageing and changes in working patterns which may turn the current oversupply of doctors into a shortage into the longer term (Box 4.3).

Supply of in-patient services

As regards hospitals, Switzerland has made significant progress in reducing the number of acute-care beds, which declined by 10.8% between 1997 and 2002 (Rüefli *et al.*, 2005). However, the number of long-term care beds remains twice as high as the OECD average. Popular opposition to hospital downsizing has made it difficult for cantons to close hospital units. In the acute-care sector, the diffusion of medical technology, one of the main drivers of health-expenditure growth among OECD countries, is generally high. For example, Figure 4.6 shows that four popular medical devices are typically available in Switzerland in numbers per capita close to the top among OECD countries.

Constraints on demand

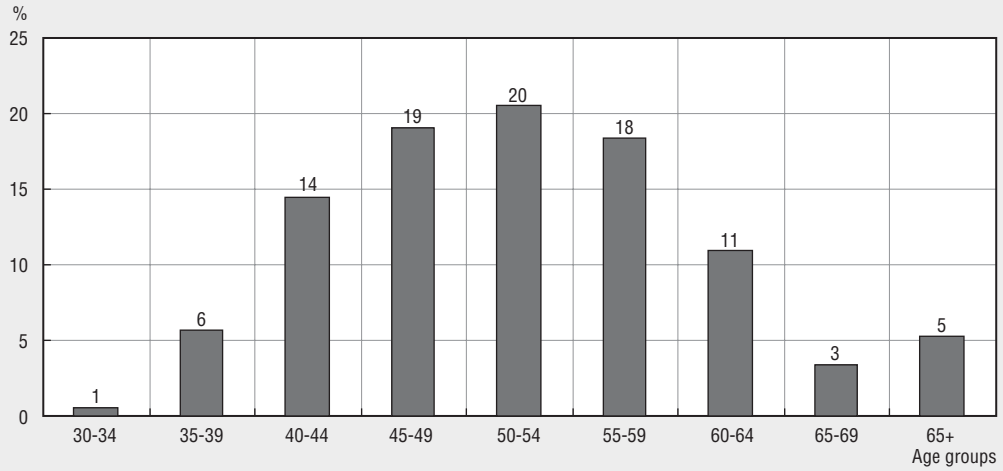
Demand-side incentives to control costs are weak. While five methods of complementary medicine have been recently removed from the list of therapies reimbursed under the LAMal, the broad and comprehensive package of benefits encourages medical utilisation. Unrestricted choice of providers, the virtual absence of gatekeeping systems and widespread use of fee-for-service reimbursement of providers in the ambulatory sector give doctors and patients powerful financial incentives to provide and consume more (and more costly) services. Given the public attachment to freedom of choice, insurance policies that limit provider choice are not popular (see Section 4.2.7 below).

Box 4.3. **Ageing of the Swiss workforce and other emerging trends**

As in most OECD countries, the Swiss health workforce is ageing. Doctors aged 55 or over represent 34% of all doctors in independent practice in Switzerland (see Figure below). This proportion is as high as 16% for doctors aged 60 or over. Substantial retirement can therefore be expected in the next 15 years. This trend is likely to be reinforced by the increasing feminisation of the workforce, as women tend to retire earlier than their male counterparts. While studies have repeatedly revealed that women doctors have a more humane and personalised approach to patient care (Notzer and Brown, 1995), the feminisation of the medical profession is also bringing changes in working patterns as female doctors tend to concentrate in primary care (family medicine, paediatrics and psychiatry) and have a greater tendency to work part-time than their male counterparts (Danon-Hersch and Paccaud, 2004). More generally, working patterns have changed in recent times. There is a growing trend, especially in rich countries, toward social values that aim to achieve a balance between work, leisure and family activities. Evidence suggests that many doctors are working fewer hours, especially young doctors who tend to place greater emphasis on personal time (Schroeder, 2004; Buske, 2004).

Age distribution of doctors in independent practice in Switzerland, 2004

Percentage



Source: Fédération des médecins suisses (2005), *Statistiques médicales*, Bern.

In addition, population ageing is also likely to contribute to increase the demand for health workers, in particular for the long-term care workforce such as home care assistants, nursing assistants and nursing aides. However, attracting these workers may be more difficult in the future, as more opportunities arise for them in other parts of the health sector which will also have a greater need of health personal.

Another concern relates to the geographical distribution of the health workforce. Virtually all countries suffer from such problems, and the primary area of concern is usually the physician workforce. Urban areas almost invariably have a substantially higher concentration of physician than rural areas. In Switzerland, with the exception of Ticino, the highest medical density is found in cantons with large cities or with a university hospital. The density of doctors in the ambulatory sector varies from 1.1 per 1 000 population in Uri to 3.8 per 1 000 population in Basel-Town (Fédération des médecins suisses, 2005). Those difference seem unlikely to narrow in the near future as some evidence suggest that it is becoming increasingly difficult to attract young medical doctors in rural and remote areas.

Box 4.3. **Ageing of the Swiss workforce and other emerging trends** *(cont.)*

Density of doctors in the ambulatory sector in Swiss cantons, 2004

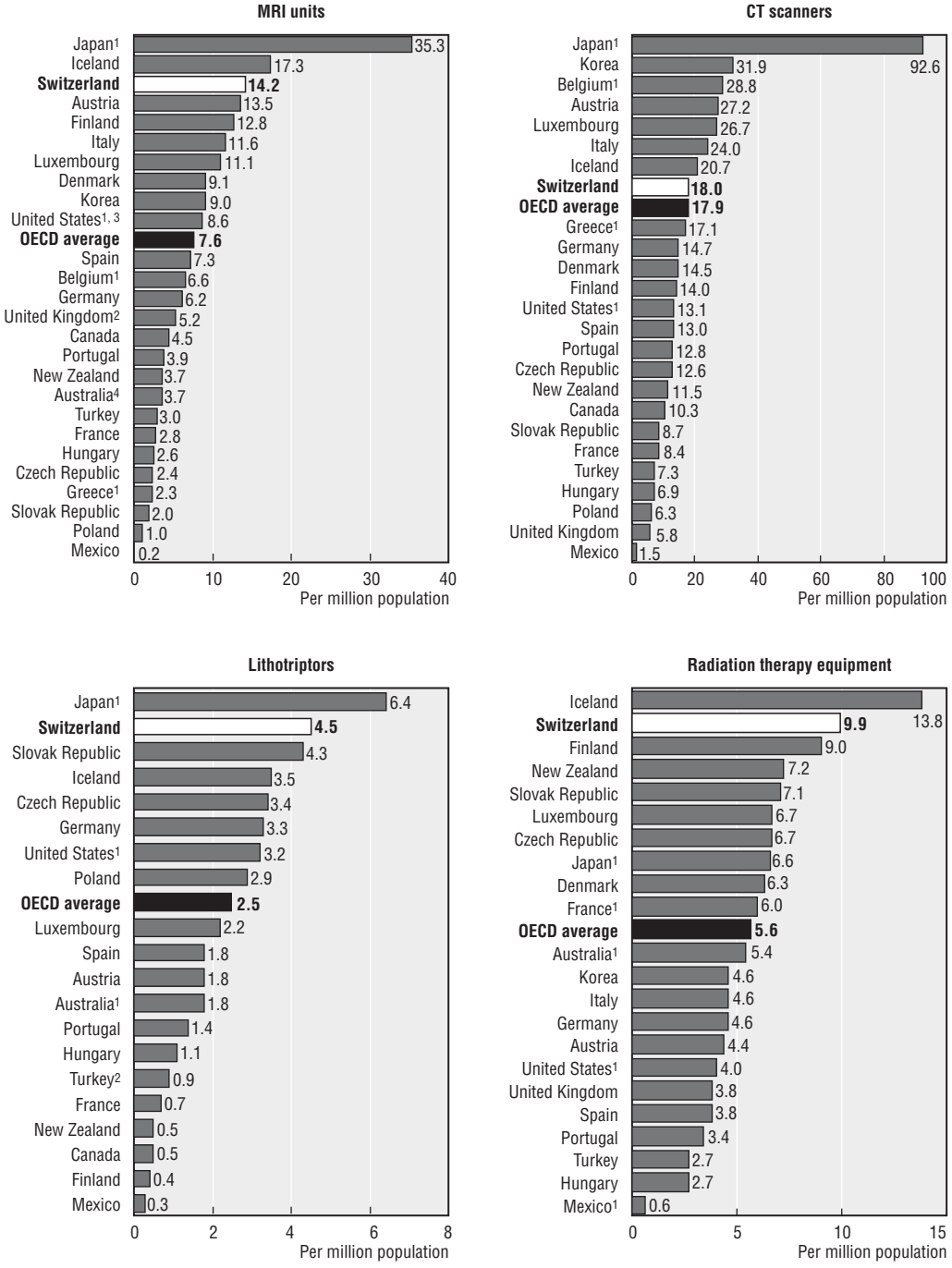
		Population[1]	Total number of doctors in the ambulatory sector	Number of doctors per 1 000 population
CH	Switzerland	7 364	15 199	2.1
ZH	Zurich	1 250	2 971	2.4
BE	Bern	952	2 026	2.1
LU	Lucerne	353	537	1.5
UR	Uri	35	44	1.3
SZ	Schwyz	135	175	1.3
OW	Obwalden	33	38	1.1
NW	Nidwalden	39	47	1.2
GL	Glarus	39	55	1.4
ZG	Zug	104	187	1.8
FR	Fribourg	247	388	1.6
SO	Solothurn	247	394	1.6
BS	Basel-Town	187	718	3.8
BL	Basel-Country	264	516	2.0
SH	Schaffhausen	74	138	1.9
AR	Appenzell Outer-Rhodes	53	91	1.7
AI	Appenzell Inner-Rhodes	15	18	1.2
SG	St. Gallen	457	742	1.6
GR	Grisons	187	335	1.8
AG	Aargau	561	846	1.5
TG	Thurgovia	232	309	1.3
TI	Ticino	317	646	2.0
VD	Vaud	639	1 583	2.5
VS	Valais	285	498	1.7
NE	Neuchâtel	167	354	2.1
GE	Geneva	424	1 430	3.4
JU	Jura	69	113	1.6

1. Thousands of people at 31 December 2003.
Source: Office fédéral de la statistique (2005), *Encyclopédie statistique de la Suisse*, Neuchâtel; Fédération des médecins suisses (2005), *Statistiques médicales*, Bern.

All those factors are contributing to changing the health workforce landscape and need to be addressed adequately. However, the development of health workforce policies is hindered by the relative weakness of health workforce information for Switzerland. This is especially the case for nursing and allied health professions for which very limited information is available, particularly in the wake of the current education reforms for nursing and other non-medical professions.

The impact of cost-sharing requirements on overall demand and cost may well be less than might be expected considering the high share of out-of-pocket spending. First, out-of-pocket expenditure mostly comprises of self-medication on services not covered by the LAMal, while cost-sharing represent only a fifth of the total. Second, the same flat 10% co-insurance applies to services with different price elasticities. For example, the decision to undertake high-cost hospital care is probably little determined by cost-sharing

Figure 4.6. **Medical technologies in Switzerland and other OECD countries, 2003**



1. 2002.
2. 2001.
3. The figures for the United States under-estimate considerably the real number of devices in that country, because they refer to the number of hospitals reporting to have at least one of these equipments rather than the total number of equipments in hospitals and in other locations (*e.g.*, specialised clinics).
4. For Australia, the data on the number of MRI are only for those that are Medicare-eligible (60% of the total in 1999).

Source: OECD (2005), *OECD Health Data 2005*, Paris.

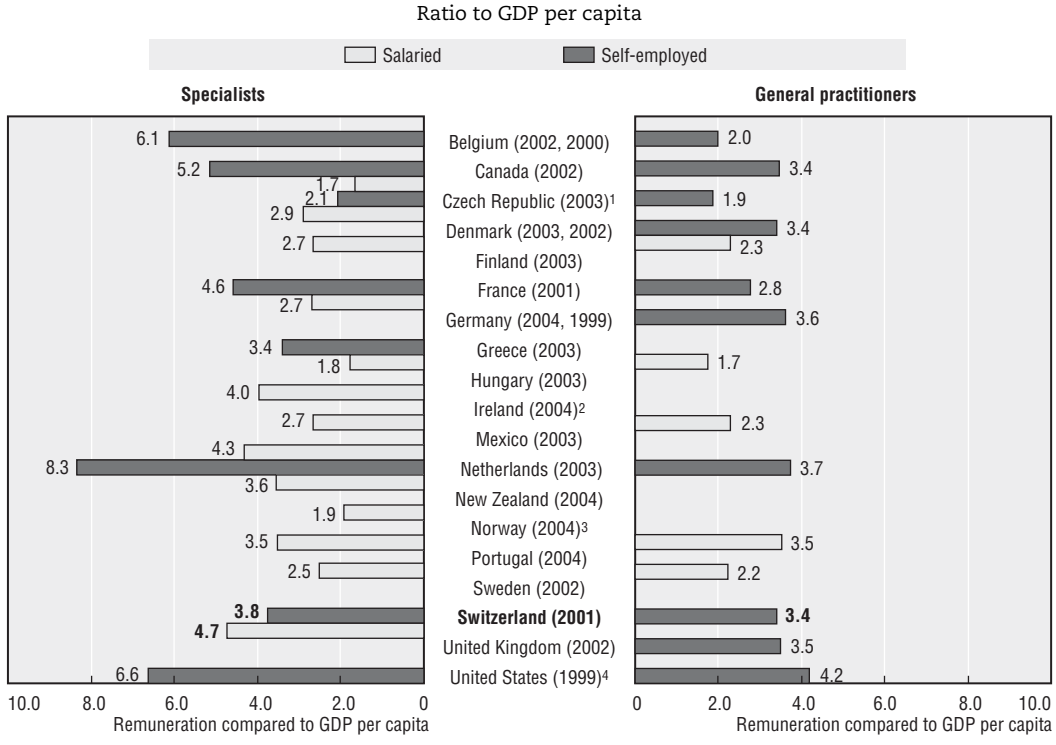
considerations, as opposed to ambulatory-care visits. Third, deductibles may have little impact on patients who have costs approaching the thresholds for the deductible. And with the bulk of health cost concentrated among a small portion of patients with serious illness, deductible and cost-sharing thresholds will have limited impact at the margin.[5]

This does not mean that higher levels of cost-sharing would be necessarily desirable. In fact, the Swiss population already finances a large share of cost out-of-their-pockets. But it may suggest the need for revising the cost-sharing structure, with a view to reducing the use of unnecessary health services, without discouraging those clinically needed.

Prices of health services

While information is scarce,[6] available data suggests some difficulty in controlling prices for health services overall in Switzerland. Differences in health prices and costs across cantons remain large, even though insurers have been able to negotiate reductions in prices in some of the higher-cost cantons.[7] Comparable data on doctor remuneration across selected OECD countries suggest that physicians in Switzerland have relatively higher incomes, expressed in current international prices, than their counterparts in other OECD countries (OECD, 2005a). The gap is narrower when examining income relative to GDP per capita (Figure 4.7). Swiss salaried specialists have higher remuneration than

Figure 4.7. **Doctors' income in Switzerland and other OECD countries, latest available year**



1. Salaried specialists in the Czech Republic also include general practitioners (GPs) working as employees (about 15% of all GPs).
2. Given that GDP per capita overstates the average income in Ireland, the ratio under-estimates the relative income of doctors.
3. Salaried specialists in Norway also include assistant doctors.
4. Data include both self-employed and salaried physicians (salaried physicians account for about one-third of all physicians).

Source: OECD (2005), *OECD Health Data 2005*, Paris.

salaried doctors in other OECD countries for which data are available. However, Swiss self-employed doctors have lower remuneration than self-employed physicians in other OECD countries, particularly in the case of specialists. This might be the consequence of somewhat lower consultation rates in Switzerland by OECD standards (Section 4.2.3).

Although price comparisons in the pharmaceutical area are notoriously difficult, in part due to cross-country differences in product specifications, several studies suggest that Swiss producer prices were high relative to many European countries during most of the last decade and in the early years of the current one (INFRA BASYS, 2002; Ess *et al.*, 2003, IMS Consulting, 2003). Price comparisons with Germany by the Swiss Price Surveillance Authority – on the basis of data for December 2005 – indicate that price differences are still 20.6% higher for drugs included in the specialty list (SL) and 41.7% higher for those not included (Surveillant des prix, 2005, Table 1). A further breakdown of drug prices into those introduced prior to, and after 1996 suggest prices of drugs introduced after 1996 tend to be significantly lower than those introduced before that year relative to Germany.[8] This suggests that new policies in 1996 – which introduced international price comparisons in price setting – seem likely to have narrowed price differentials on new drugs, at least relative to Germany.

4.2. The efficiency of the Swiss health system

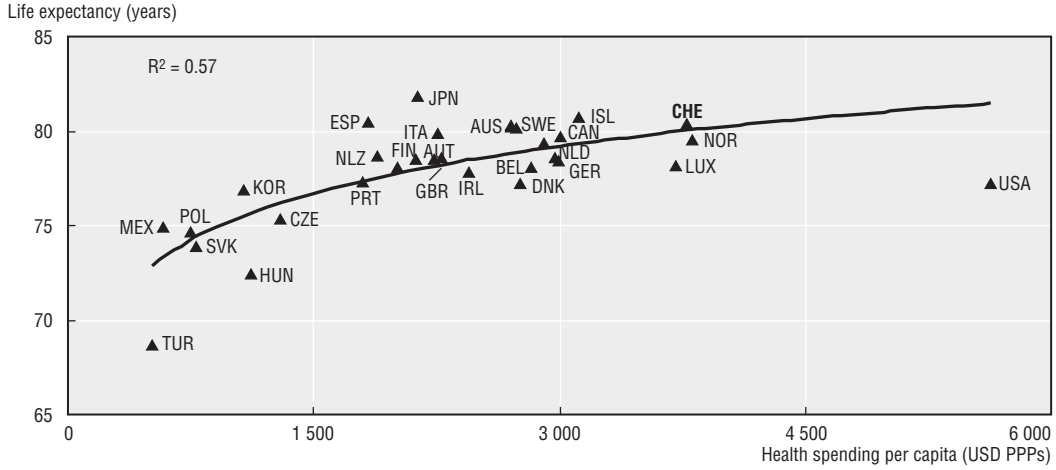
The preceding paragraphs suggest, albeit on the basis of limited data, that high levels of health spending in Switzerland may reflect both generous and underutilised supply combined with higher unit costs and limited constraints on demand. The system does not have a binding macroeconomic budget constraint to cap the growth in health spending. The presence of multiple financing agents or third-party payers can encourage shifting of costs onto others rather than focusing attention on controlling or managing cost. Furthermore, the multi-purchaser environment for hospital services and the fact that hospitals are subject only to soft budgetary constraints distort incentives for efficiency. Thus, there appears to be ample scope for improving cost-efficiency in the Swiss health system. Provider, insurer and patient incentives to enhance efficiency are weak. There is a growing demand for increased value from spending among several stakeholders, especially as cost continues to increase at high rates. This section examines evidence on the efficiency of the Swiss health system and areas where this may need improvement.

4.2.1. Value for money

While Switzerland has generally good health-status indicators, the high cost of the health system raises concern about its performance in terms of value for money. Life expectancy is about as high as would be expected for a country with a level of health spending per capita as high as in Switzerland, but several OECD countries with lower spending do as well or even better (Figure 4.8). Switzerland appears to have mixed performance compared with other OECD countries with respect to a number of indicators, for example it performs well in terms of mortality from all causes, celebro-vascular diseases and all cancers, but not equally well as far as mortality from breast and prostate cancer, and infant and maternal mortality are concerned (Chapter 2). The high level and the increase in Swiss health costs do not match the performance of the system (Domenighetti and Quaglia, 2001).

Spending patterns differ widely across cantons, but they do not seem to be correlated to measures of outcomes or effectiveness. Cross-canton variation in the density of medical

Figure 4.8. **Life expectancy at birth and health spending per capita, 2003**



Note: The regression line is log-linear to illustrate that there may be a cap on life expectancy.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

doctors and hospital beds and in health spending is not significantly correlated with avoidable mortality, revealing that a higher level of doctors or per capita health spending is not necessarily linked to better health outcomes (Crivelli, 2004; Crivelli and Domenighetti, 2003). Furthermore, the average level of satisfaction with the Swiss health system is uniformly high across cantons with different levels of health spending and productive capacity. Together, these indications suggest that not all cantons maximise value for money (Crivelli, Domenighetti and Filippini, 2006).

4.2.2. The impact on efficiency of current methods of paying providers

Despite recent initiatives, current payment arrangements in both the ambulatory and hospital sectors do not provide strong incentives to improve clinical and cost-efficiency.

Fee-for-service payment of providers in ambulatory care creates incentives to oversupply as it rewards providers for doing more, even though the additional care may not necessarily be in the patients' best interest, both financially and clinically (Enthoven and Tollen, 2005).[9]

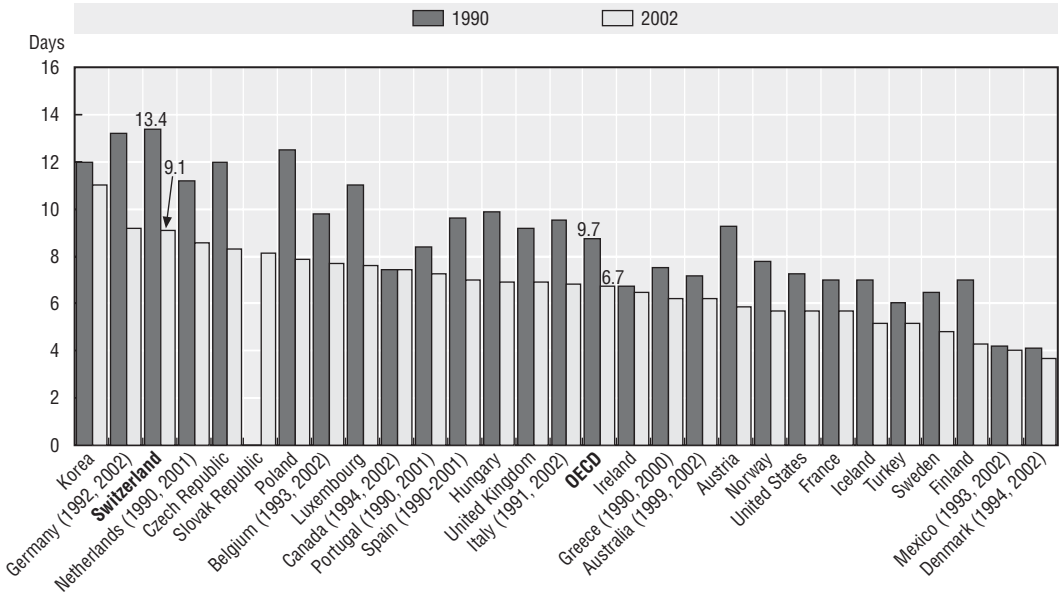
The establishment of TARMED on 1 January 2004 is a positive step forward. This tariff structure, applicable to out-patient care throughout Switzerland and to all social-insurance payers (health, accident, invalidity and military insurance), fixes a unified relative fee system, where a component of the payment – the resource-based points – is standardised across Switzerland. The aim of TARMED was to improve cost-control, transparency, and allocative efficiency. Compared with previous arrangements, the relative fee structure gives greater weight to non-technical services (consultations) and less weight to technical services (radiology, special tests), thus discouraging excessive recourse to these types of care. The reassessment of the relative point scale of intellectual and technical services was also intended to reduce income disparities across specialties. And the introduction of the TARMED system was to be cost-neutral over the first 18 months, with the value of the "point" adjusted to keep overall costs unchanged.[10]

The introduction of the TARMED has however not been without difficulties. According to anecdotal evidence, the loss of income of certain specialists has reduced provision of

services in some areas requiring insurers to provide lump-sum supplements to some providers. Maintaining cost-neutrality for a period of 18 months after the introduction of the tariff (there are no explicit objectives regarding the impact of TARMED on costs beyond this introductory period) is posing some major difficulties for ambulatory services in hospitals, as some hospitals have experienced billing problems.[11] The objective of placing greater relative emphasis on consultative services rather than on "technical" services by reassessing the relative point scale of intellectual and technical services is likely to be met only partially.[12] And, despite greater availability of comparative information on services provided, this information has, thus far, not been used either by the authorities or by the public to facilitate informed choice of provider and analyse the cost-effectiveness of different medical treatments (Office fédéral de la santé publique, 2004i), although it is fair to say that it is probably too early to expect this to happen.

In the hospital sector, prevailing payment on a per diem basis encourages long lengths of stay. While the average length of stay decreased from 13.4 days in 1990 to 9.1 days in 2002, it remains well above the OECD average of 6.7 days (Figure 4.9). The move towards prospectively determined case-based remuneration for hospitals is desirable, but should be accompanied by efforts to downsize hospital capacity. A Swiss Diagnosis-Related-Groups (DRGs) schedule is to be established, and this will be a clear improvement on per-diem payment arrangements. In those cantons where DRGs have already been implemented as of 2000, significant reductions in the average length of stay have been achieved without, seemingly, adverse impact on outcomes.[13] Nonetheless, in the absence of real reductions of hospital capacity, it is not clear whether the marginal cost saving from a one-day decrease in ALOS would be offset by the increase in service intensity per day. In fact, evidence from several European countries suggests that the introduction of DRG-type financing systems has been associated with a decline in lengths of hospital stay, as well as a rising number of

Figure 4.9. **Average length-of-stay for acute care in OECD countries, 1990 and 2002**



Note: Countries are ranked from the highest to the lowest for the year 2002.
Source: OECD (2005), *OECD Health Data 2005*, Paris.

cases, an increase in reported case-mix intensity (often referred to as DRG creep) and lower costs per case (Rochell and Roeder, 2000; Hofmarcher and Riedel, 2003).[14]

4.2.3. Productivity and the use of health-care services

Despite that high level of inputs is relative to many other OECD countries and payment mechanisms that encourage provision, indicators of the intensity with which the resources are used and of productivity are low by OECD standards for ambulatory care. They are around the OECD average for hospital care (Table 4.2 and Table 4.3). This seems to reflect,

Table 4.2. **Indicators of intensity of use of health-care resources in OECD countries, 2003 or latest available year**

	Doctor's consultations per capita	Discharges, all causes, per 1 000 population	Total surgical procedures per 1 000 population	Acute-care beddays per capita
Australia	6.0	156.6[1]	91.4[1]	1[1]
Austria	6.7	302.0[1]	n.a.	1.7
Belgium	7.8[1]	159.9[1]	100.6[2]	1.3[3]
Canada	6.2[2]	88.2[1]	120[1]	1[1]
Czech Republic	13.0	227.6	n.a.	1.8
Denmark	7.3	197.4	207.4	1[4]
Finland	4.2	249.8	92.0	0.8
France	6.9[1]	251.1[1]	n.a.	1.0
Germany	7.3[5]	201.6[1]	n.a.	1.9
Greece	n.a.	160.9[5]	n.a.	1[4]
Hungary	12.2	257.5	217.0	1.7
Iceland	5.6[2]	181.2[1]	79.7[6]	1.1[7]
Ireland	n.a.	124.1	208.3	0.9
Italy	6.1[4]	140.5	78.3	1[1]
Japan	14.1[1]	101.9[1]	n.a.	2.1
Korea	10.6[1]	110.6[1]	n.a.	n.a.
Luxembourg	6.3	175.2	216.6	1.4
Mexico	2.5	42.0	33.2	0.2
Netherlands	5.6[1]	97.1	73.3	0.8[2]
New Zealand	3.2	203.9	44.6	0.3[6]
Norway	n.a.	170.9	n.a.	0.9
Poland	6.1	n.a.	n.a.	1.4[1]
Portugal	3.7	78.2	59.7	0.9
Slovak Republic	12.4	187.9	n.a.	1.4
Spain	9.5	108.9[1]	69.8[2]	0.8[2]
Sweden	2.9[2]	160.0[1]	n.a.	0.8[8]
Switzerland	**3.4**[1, 9]	**154.9**	**122.7**	**1.2**
Turkey	2.6[2]	81.0	n.a.	0.4[1]
United Kingdom	5.2	236.6	134.7	1.1
United States	8.9	117.1[1]	n.a.	0.7
OECD average	**9.7**	**162.9**	**116.9**	**1.1**

1. 2002.
2. 2001.
3. 1997.
4. 1999.
5. 2000.
6. 1998.
7. 1995.
8. 1996.
9. Data on doctor's consultations per capita in Switzerland are based on survey data, which generally result in lower reported consultations than using administrative data.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Table 4.3. **In-patient productivity and bed-operating ratios in OECD countries, 1993 and 2003**

	Acute-care occupancy rate (% of available beds)		Acute-care turnover rate (cases per available bed)		ALOS: acute-care (days)[1]		Discharges per acute-care bed[2]	
	1993	2003	1993	2003	1993	2003	1993	2003
Australia	71.2	73.9[3]	40.0	44[3]	6.4	6.2[3]	38.7	43.3[3]
Austria	76.5	76.2	34.0	48.0	8.2	5.8[3]	34.5	49.7[3]
Belgium	81.1		25.5		9.8	7.7	32.8	40.1[3]
Canada	78.5	86.6[3]	23.9	32.1[3]	9.8	7.4[3]	32.9	27.9
Czech Republic	71.6	73.9	24.6	34.4	11.2	8.3	22.9	34.9
Denmark	82.2	84[4]	49.5	54[4]	6	3.6	49.5[5]	55.6[5]
Finland	70.1		28.2		5.7	4.3	51.5	109.4
France	76	74.8	43.0	48.7	6.4	5.6	48.0	63.8[3]
Germany	83.1	77.6	24.2	31.9	12.5	8.9	23.3[5]	30.4[3]
Greece	62.1		34.0		6.6	6.2[6]		
Hungary	67.6	77.2	27.5	42.6	9.8[5]	6.7	37.5[7]	43.4
Iceland					6.4	5.2[3]	45.3	
Ireland	83.7	84.7	45.5	47.5	6.7	6.5	36.4[8]	42.0
Italy	70.8	76.9[3]	28.1	40.1[3]	9.2	6.8[3]	27.4[8]	37.9[3]
Japan	81.0[5]	79.5	8.6[5]	14.0	34.4	20.7	7.9	11.3[3]
Korea	76.8	71.6	25.9	23.2	11	10.6	27.7[5]	19.6
Luxembourg	75	68.8	39.4[7]	41.5	10.2	7.4	31.4[7]	30.6
Mexico	68.1	73.7	55.7	64.9	4.2	3.9	38.4[7]	41.8
Netherlands	72	66[4]	25.2	28.3[4]	10.4	8.6[4]	25.1	29.2[3]
New Zealand								
Norway	79.9	88.5	42.6	55.1	6.8	5.4	42.6	54.9
Poland	67.4	77[3]	21.0	35[3]	11.4	7.9[3]	22.9	
Portugal	67.6	70.5	32.0	38.1	7.7	7.3[4]	26.05[5]	25.2
Slovak Republic	80.3[8]	65.4	27.2[8]	30.3	10.8[8]	7.9	27.8[8]	31.7
Spain	74.7	77.2[4]	31.7	40.4[4]	9.1	7	29.4	34.6[3]
Sweden	76.2		32.0		5.5	4.8[3]	53.8	67.2[3]
Switzerland	**78.4**	**85.2**	**31.4**[7]	**34.5**	**12.1**	**9**		**39.8**
Turkey	55.6	61.9	31.2	39.2	5.9	5.2[3]	28.6	35.2
United Kingdom	74.2	84.5	38.9	47.5	7.3	6.7	52.6[8]	64.0
United States	64.4	66.2	33.4	42.7	7	5.7	33.5	41.0[3]
OECD average	**73.3**	**75.9**	**33.2**	**39.9**	**8.2**	**7.1**	**30.6**	**37.4**

1. ALOS stands for average length of stay.
2. Australia, the Czech Republic, France, Hungary, New Zealand and the United States include same-day separations whereas other countries exclude them.
3. 2002.
4. 2001.
5. 1994.
6. 2000.
7. 1999.
8. 1996.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

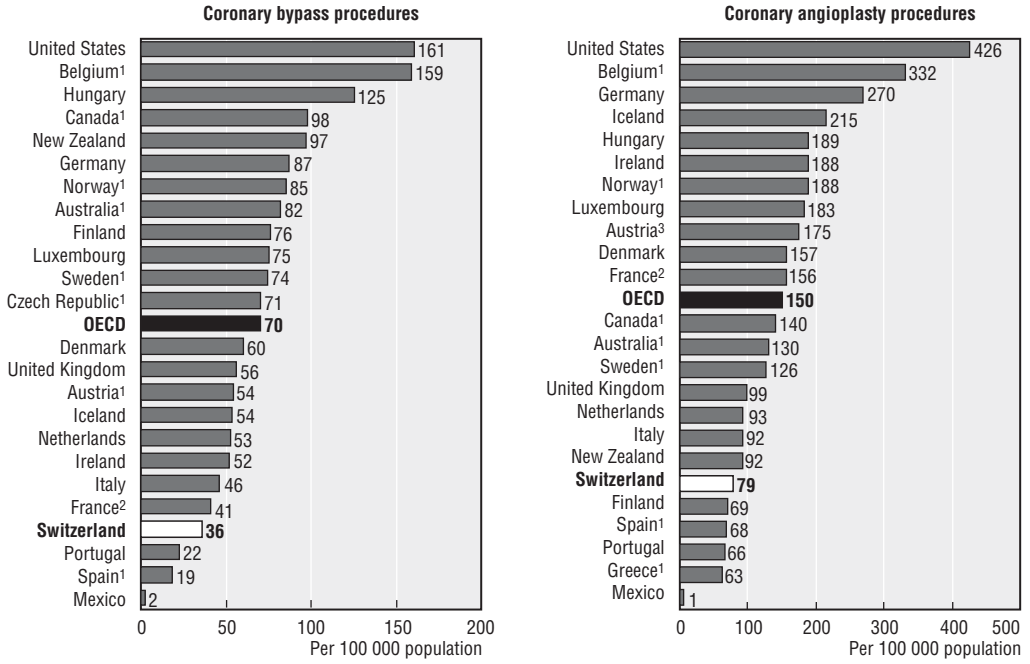
at least partly a relatively low revealed demand for health-care services when compared with other OECD countries. It may indicate relatively good underlying health status of the population and cultural attitudes that limit the use of health services. More importantly, it suggests that the same levels of outputs (and possibly outcomes) could be achieved with lower resources, thereby improving efficiency in the use of available resources and reducing outlays.

Per capita consultations with doctors' – at 3.4 in Switzerland in 2002 – are lower than the OECD average of 9.7 (Table 4.2), although these data may be underestimated. Given the

relative high number of doctors, this may result in lower-than-average consultations per practising physicians per year, reinforcing perceptions of oversupply and low-efficiency in the use of the ambulatory-care sector.

As to hospital activity, most indicators rank around the OECD average (Table 4.2 and Table 4.3). Switzerland is a below-average user of cardiovascular procedures (Figure 4.10), partly thanks to the low incidence of disease. Discharge rates are low by OECD standards for most diagnostic groups. Reductions in average length of stay for all procedures and in hospital capacity could encourage further productivity improvements.

Figure 4.10. **Cardio-vascular procedures, Switzerland and OECD countries, 2003**



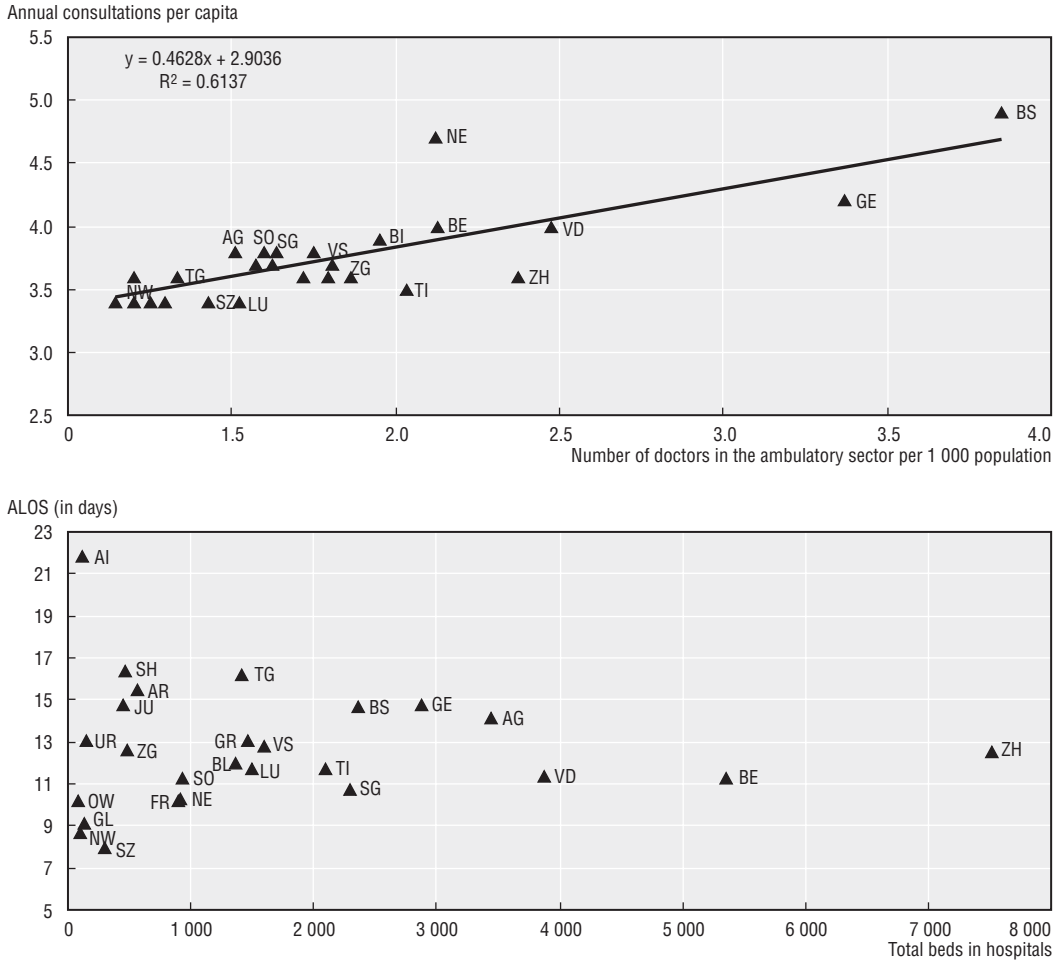
1. 2002.
2. 2001.
3. 2000.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

Large variation in health-service use also exists *across cantons* with similar levels of supply (Figure 4.11). Despite structural changes in the hospital sector,[15] Swiss hospitals show a great variability in the level of efficiency and productivity by hospital type and complexity of case mix (Filippini and Farsi, 2005).[16] This reveals that resources are not utilised at the highest level of productivity. Limited evidence is, however, available to link such variation in use to needs. In addition, there appears to be a positive relation between consultations per capita and the number of doctors per capita.

Finally, the mix of inputs and services might not be optimal. As noted, payments for in-patient care in public or publicly subsidised hospitals are based on a system of parallel financing, with – on average – at least half of the cost paid by the canton with the remainder coming from mandatory health insurance (Table 4.4). This renders financing of in-patient care cheaper to insurers compared with ambulatory care, creating perverse incentives for the mix of treatments and limiting the costs associated with overuse of in-patient care. In fact, the share of cataract surgeries and tonsillectomy carried out as day

Figure 4.11. **Health-care resources and utilisation across Swiss cantons**



Note: ALOS: Average length of stay.

Source: Office fédéral de la santé publique (2004), *Statistiques de l'assurance-maladie obligatoire 2003*, Bern; Office fédéral de la statistique (2005), *Statistiques des hôpitaux et des établissements de santé non hospitaliers 2003*, Neuchâtel; Observatoire suisse de la santé (2005), *Nombre de consultations médicales par habitant et par an* (based on the Enquête suisse sur la santé, 2002). *www.obsan.ch/monitoring/statistiken/6_5_3_2/2002/f/6532.pdf*; Fédération des médecins suisses – FMH (2005), *Statistiques médicales*, Bern. *www.fmh.ch/ww/fr/pub/fmh/statistique_medicale_2002.htm*.

cases is lower in Switzerland compared with many other OECD countries (Figure 4.12). Improved working conditions in hospitals, following on – among other factors – a reduction in working hours from January 2005, and, as noted, the freeze in the opening of new ambulatory offices, have led to increasing employment of doctors in the hospital sector. This may, in the long run, and together with the introduction of DRG-based hospital payments, lead to a rise in hospital-service volumes.

4.2.4. Care co-ordination

Fee-for-service reimbursement, unconstrained freedom of choice of provider and the lack of gatekeepers discourages co-ordination and continuity of care across health-care providers, which can reduce efficiency in the health-care system. Services received by patients under the LAMal are often not integrated across care segments and settings, for example across out-patient and in-patient care and between acute, rehabilitative and long-term care. Rather, patients tend to have multiple contacts with different health-care

Table 4.4. **Parallel hospital financing in Switzerland, 2002**

In-patient hospital costs for LAMal-reimbursed services

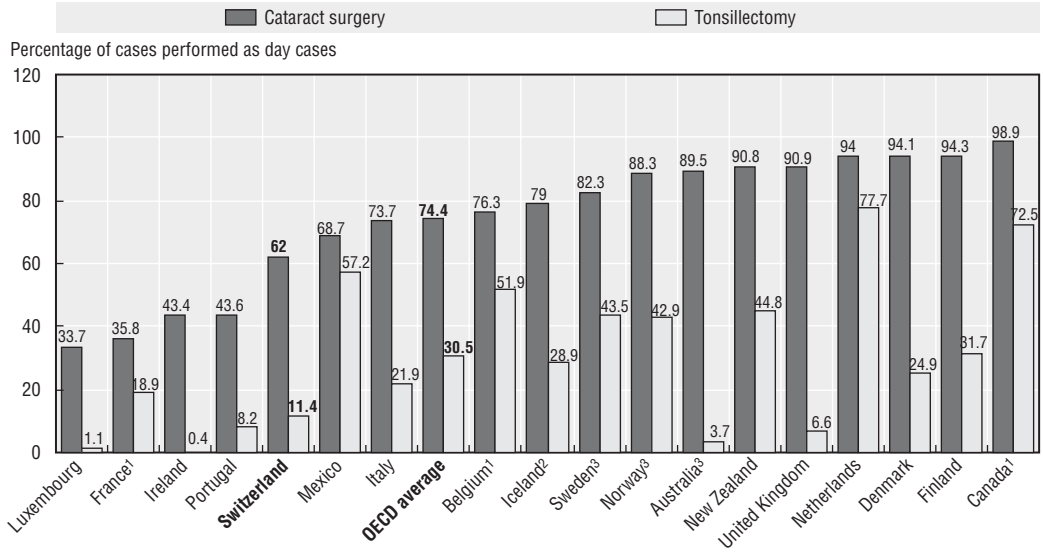
Cantons	Excluding investment			Cantons	Including investment		
	Cantons	LAMal-insurers	Total		Cantons	LAMal-insurers	Total
Aargau	43%	57%	480	Aargau	48%	52%	527
Appenzell Outer-Rhodes	55%	45%	54	Appenzell Outer-Rhodes	57%	43%	57
Appenzell Inner-Rhodes	35%	65%	11	Appenzell Inner-Rhodes	40%	60%	12
Basel-Country	55%	45%	334	Basel-Country	58%	42%	360
Basel-Town	64%	36%	355	Basel-Town	70%	30%	423
Bern	68%	32%	1 397	Bern	71%	29%	1 542
Fribourg	52%	48%	259	Fribourg	57%	43%	290
Geneva	74%	26%	1 011	Geneva	75%	25%	1 066
Glarus	54%	46%	41	Glarus	62%	38%	50
Grisons	58%	42%	213	Grisons	63%	37%	239
Jura	55%	45%	103	Jura	55%	45%	103
Lucerne	54%	46%	305	Lucerne	61%	39%	356
Neuchâtel	57%	43%	260	Neuchâtel	61%	39%	286
Nidwalden	60%	40%	34	Nidwalden	62%	38%	36
Obwalden	52%	48%	25	Obwalden	54%	46%	26
Schaffhausen	57%	43%	91	Schaffhausen	64%	36%	107
Schwyz	64%	37%	143	Schwyz	64%	37%	143
Solothurn	60%	40%	291	Solothurn	62%	38%	309
St. Gallen	60%	40%	520	St. Gallen	61%	40%	531
Thurgau	38%	62%	234	Thurgau	38%	62%	236
Ticino	41%	59%	419	Ticino	44%	56%	439
Uri	58%	42%	34	Uri	65%	35%	40
Valais	58%	42%	301	Valais	63%	37%	343
Vaud	54%	46%	779	Vaud	58%	42%	862
Zug	50%	50%	95	Zug	54%	46%	104
Zurich	59%	42%	1 536	Zurich	63%	37%	1 732
Total Switzerland							
%	59%	41%	100%		62%	38%	100%
Million CHF	5 483	3 838	9 322		6 379	3 838	10 218

Source: Estimated by the Office fédéral la statistique and the Office fédéral de la santé publique.

providers and resources are fragmented across different payers, although there is, *de facto*, *ad hoc* collaboration across sectors. The lack of national (or for that matter, cantonal) policies, and of data collection and management systems for quality of care, surely does not favour a more efficient co-ordination. Care co-ordination is higher in managed-care contexts (Section 4.2.7).

Lack of information and communication difficulties have also proven hard to overcome in the Swiss system. There is only limited sharing of clinical information between professionals working in the hospital and ambulatory-care settings, as well as across different institutions. In fact, no information system to oversee the flow of patients throughout the system is operating in Switzerland, particularly for patients with chronic conditions. Disagreement exists among stakeholders about who should have ownership of such data. The proposal, to set up an insuree card by 2008 – approved by the Federal Council in 2005 – is a step forward. However, concerns over disclosure of patient information have limited its use to administrative data. The patient card will essentially be utilised to facilitate billing. This has reduced its potential as a tool to encourage care

Figure 4.12. **Share of cataract and tonsillectomy surgeries carried out as day cases in OECD countries, 2003**



1. 2001.
2. 1998.
3. 2002.

Source: OECD (2005), *OECD Health Data 2005*, Paris.

co-ordination and sharing of diagnostic information, although it will provide access to basic medical data (*e.g.*, blood group, allergies) if the individual so wishes.[17]

4.2.5. Pharmaceutical policy

Available evidence suggests that, overall, Swiss drug prices are high by the standards of many European countries (Section 4.1.3). Several plausible reasons have been suggested to explain this outcome. First, the policy introduction of price comparisons in 1996 left the prices of the then existing prices largely untouched. Second, in taking pricing decisions for reimbursed drugs since 1996, Swiss authorities make reference to a panel of European systems that contain countries with – on the whole – relatively high pharmaceutical prices (OECD, 2006a).[18] Third, few products face competition from abroad, because parallel import of patented products is prohibited.[19] Finally, there is still limited competition from generic bioequivalents. Only about 3% of the products authorised for entry in the Swiss market are generics (Conseil fédéral suisse, 2004) and only 10% of the pharmaceuticals for which the patent has exhausted face competition from generic products – even if 37% of reimbursed products have fallen into the public domain (Conseil fédéral suisse, *ibid.*).

Recent measures taken by the Swiss authorities to reduce mandatory health-insurance costs envisage more frequent revisions of drug prices and a larger use of bioequivalent substitutes. A September 2005 measure (to become effective in April and July 2006) is expected to stimulate a 20% to 30% reduction in the prices of reimbursed drugs by requesting an extra revision of older-drug prices.[20] Generics prices are supposed to be at least 30% lower than those of original products and to undergo a further 15% reduction following a re-assessment two years after their inclusion in the positive list. The Swiss authorities expect an annual 1% reduction in LAMal expenditures from this decree. To encourage the use of generics, cost-sharing on pharmaceuticals which have a

bioequivalent substitute – and for which the price is below 20% of the original product – has increased from 10 to 20% since 1 January 2006. Pharmacists have also been allowed since 2001 to replace a branded product with a generic. This measure, together with the 2001 reform to remunerate pharmacists and dispensing doctors based on a flat amount per act of dispensing rather than on margins on the price of drugs, encourages a greater distribution of generics and has unlinked distribution costs from drug prices.

Despite such measures, pharmaceutical policy may not fully exhaust all of the potential for improved cost-effectiveness of the drugs prescribed and utilised in Switzerland. While the prices of older drugs are expected to be reassessed more frequently, the Swiss pharmaceutical market continues to be sheltered from competitive pressures. The Federal Council has, on various occasions, rejected proposals to allow parallel imports, on grounds that this would pose health risks, undermine incentives for research while the impact on costs would be small (OECD, 2006a). Nonetheless this is only part of the market and barriers to the entry and use of generics persist. In general, market authorisation is quick relative to other countries and there is a simplified procedure for market entry of generic bioequivalents. Nonetheless, significant barriers to market entry appear to remain.[21]

In addition, pharmacists may be reluctant to substitute a generic product for a branded one as they are required to inform the doctor every time they propose one. Doctors have few incentives to prescribe generics. Finally, as many as a quarter of all practising doctors in independent practice dispense drugs (a practice which is authorised in thirteen cantons and allowed with some restrictions in an extra four cantons). It is not entirely clear whether this can be justified on the basis of access and of public-health considerations.[22] Most OECD countries have prohibited the dispensing and the sale of drugs by physicians, as this produces perverse incentives for doctors to promote over-consumption of pharmaceuticals.[23]

4.2.6. The system of decentralised governance and cantonal planning

The current governance arrangements lead to inefficiencies both in health-service supply, particularly of hospital services, and in the insurance market.

Switzerland is a small country by the size of its territory and population; nonetheless it comprises 26 decentralised health systems, governed by different cantonal health laws and featuring diverse levels of productive capacity and health-spending patterns. The 26 cantons are responsible for defining and supplying heath services. While mandatory health insurance is governed by a federal law, the LAMal has itself created or reinforced frontiers between cantons by subjecting insurees' reimbursements to the use of health services within their canton of residence, with some exceptions. Competition among insurers, and individual freedom to choose their insurer, is restricted to the canton as well.

These governance arrangements reflect historical factors and the strong attachment of cantons and residents to local control over the health sector. However, they are one additional factor obstructing the full play of competition in the insurance market. Moreover, they have led to narrow catchment areas and the duplication of care services across cantons, resulting in an inefficient organisation of hospital supply that does not make a cost-effective use of available human and financial resources. Some cantons have developed hospital facilities for specialised treatments in order to reduce charges from hospitalisation of their population outside of the canton.

Despite some efforts, planning at regional level has proved neither easy nor effective. Cantons have jointly elaborated recommendations and principles for hospital planning (Conférence suisse des Directrices et Directeurs cantonaux de la santé, 2002 and 2005). Numerous one-off arrangements between hospitals and cantons have helped ensure the provision of adequate care to individuals living in areas close to the cantonal borders. However, only a few cantons have implemented inter-cantonal agreements (Rüefli *et al.*, 2005; Rothenbühler, 1999)[24] However, planning remains essentially a cantonal-level activity and the organisation of hospital supply is not approached at a regional level, due both to political choices and the absence of an obligation to establish inter-cantonal planning. The area of highly specialised medicine is a clear example of how the canton-based organisation of supply can create inefficiencies. In this area, national-level planning is necessary to achieve efficiency, quality and effective coverage of the population health needs. Thus far, however, cantons have failed to reach an agreement on co-ordinating supply.[25]

Furthermore, the potential to use hospital planning as a mechanism to optimise resource allocation in the hospital sector has been underutilised (Rüefli *et al.*, 2005). Cantonal planning does not seem to have triggered, or at most only slightly accelerated, structural changes that had been occurring in the hospital system since the mid-1980s. Planning has not been used as a mechanism for selecting hospitals to be included in the hospital list on the basis of performance. Capacity requirements and performance mandates are included in less than half of the cantons. Hospital planning is often elaborated outside of analyses of the ambulatory-care system, which limits its potential as an instrument for care co-ordination and planning of overall population health needs (Rothenbühler, 1999).

Financial and political pressures faced by cantons might have slowed down rationalisation decisions in the hospital sector and the potential to use hospital planning as a cost-containment and capacity-control tool. Cantons play different roles that can give rise to conflicting positions; for example between their political and governance role, on the one hand, and their responsibility for the planning, financing and delivery of hospital services, on the other. Direct cantonal ownership of many hospitals makes it difficult to be objective in choosing the most efficient hospitals to go in the cantonal hospital lists and obliges cantons to cover deficits incurred by their hospitals. It is often difficult for cantons to apply decisions resulting from their planning obligations, even when these would result in improvement in the efficiency and quality of the delivery system. Strong resistance encountered by cantons against the closure of a hospital and the redefinition of its functions can have an impact on the turnout of the next political election. This means that decisions affecting the hospital landscape have been influenced by political cycles and dynamics, and not simply by economic decisions about improvements of the quality of hospital supply and the best allocation of resources.

4.2.7. The impact of competition on insurance markets on efficiency

Competition in the insurance sector is weak and has not provided much incentive to improve provider efficiency.

For a start, despite a large number of insurers (Box 4.4) and considerable differences in premia within each canton, the mobility of insurees across insurers remains small and confined to young and healthy individuals, even though information on premium levels is easily accessible (Chapter 3). Reduced mobility weakens demand signals and promotes

Box 4.4. **Number and size of LAMal insurers**

The Swiss health-insurance market is fragmented across the cantons and, within each canton, across a large number of insurers. While the market has underdone a process of progressive concentration, weak market dynamics result in the survival of a very large number of insurers, many of which are small-sized. In 2003, 13% of all insurers had less than 1 000 insurees and, all together, they covered as little as 0.1% of the Swiss population. Nearly half of all insurers had each less than 10 000 enrolees, while taken together they covered only 1.6% of the Swiss population. In 2003, nearly 50 insurers operated in each canton an average (see tables below).

Size of LAMal insurers

Insurer size (number of insurees)	% of LAMal insurers by size			% of individuals insured by size of LAMal insurer		
	1996	2000	2003	1996	2000	2003
> 1 000 001	1.4	2		28	30.5	
100 001-1 000 000	9	11.8	17.2	56.2	51.7	80.1
10 001-100 000	17.9	27.5	37.6	12.4	15.5	18.3
1 001-10 000	45.5	39.2	32.3	3.1	2.2	1.5
< 1 000	26.2	18.6	12.9	0.3	0.1	0.1
TOTAL (%)	100	100	100	100	100	100
TOTAL – Number of LAMal-insurers	145	101	93			
– Number of individuals (thousands)				7 195	7 268	7 363

Source: Data provided by the Office fédéral de la santé publique.

LAMal insurers by cantons, 2003

		Number of insurance companies	% insurers offering bonus insurance	% insurers offering HMO insurance	% insurers offering product network (gatekeeping insurance, etc.)	% insurers offering other type of managed-care products
AG	Aargau	54	15	13	35	6
AI	Appenzell Inner-Rhodes	40	15	3	25	8
AR	Appenzell Outer-Rhodes	44	14	2	25	7
BE	Bern	53	15	25	42	8
BL	Basel-Country	48	17	15	33	8
BS	Basel-Town	49	14	14	22	6
FR	Fribourg	48	15	2	19	8
GE	Geneva	46	9	4	33	4
GL	Glarus	47	13	2	15	6
GR	Grisons	49	12	8	20	6
JU	Jura	40	10	3	10	5
LU	Lucerne	52	13	25	31	6
NE	Neuchâtel	42	10	2	7	5
NW	Nidwalden	39	18	13	18	8
OW	Obwalden	44	16	11	16	7
SG	St. Gallen	51	14	4	31	8
SH	Schaffhausen	45	16	4	36	9
SO	Solothurn	51	14	10	18	25
SZ	Schwyz	50	14	14	24	6
TG	Thurgau	47	13	4	34	6
TI	Ticino	47	11	2	11	6
UR	Uri	41	17	12	17	7
VD	Vaud	48	10	2	29	6
VS	Valais	65	9	2	5	3
ZG	Zug	49	14	16	18	6
ZH	Zurich	58	14	22	33	7
CH	**Average per canton**	**48**	**13**	**9**	**23**	**7**

Source: Calculated from Office fédéral de la santé publique (2005), *Aperçu des primes 2005*, Bern.

stability in the health-insurance market. This encourages both efficient and less efficient insurers to survive and slows down an on-going process of market concentration.

Competition has developed on the selection of risks rather than on value and quality grounds. Encouraged by a risk-equalisation system that is not fully effective in compensating for risk differences across funds, insurers find risk selection a more convenient ground for competing. Risk equalisation is considered necessary to remove incentives for insurers to select good risks (Box 4.5), especially given community-rating requirements and large differences in insurers' risk structures in each canton. The current system, however, uses age and gender as the basis for calculating compensation, which are known to be weak predictors of insurees' cost and thereby provides inadequate

Box 4.5. **Improving risk-equalisation mechanisms**

In health systems with competing health insurers, especially where premia cannot be risk-rated, insurers face incentives to exclude poor risks. Even if Swiss insurers are not legally permitted to select the better risks, they have several means at their disposal – both legally permitted and illegal ones – to do so (Colombo, 2001; Beck, 2000; Beck *et al*., 2003). They can, for example, target certain risk groups by choosing where to locate their premises; provide selective advice to individuals; selectively advertise and use target mailing; offer appealing complementary insurance options to low-risk individuals; vary customer service; and make aggressive use of sales agents. Finally, insurers can enter and exit cantons with the aim of attracting good risks or exiting an unprofitable market. For example, one of the largest insurers, Visana, dropped out of eight cantons in 1998.

Compensation mechanisms either among insurers or between insurers and the government/regulator can help maintain solidarity. Their main aim is to reduce incentives for insurers to compete on the selection of risks by compensating those with a worse risk structure for the higher costs they may incur. Such systems exist in, among others, the Swiss mandatory health insurance, the Australian and Irish private health-insurance markets, the US Medicare programme, and the German, Dutch and Belgian social health-insurance systems.

Risk compensation can take different forms. Equalisation can be centrally determined on the basis of a capitation formula adjusted by predictors of individual health-care expenditures. Insurers can be left to determine at the start of the period the fraction of their insurees whose costs will be pooled. Pooling might apply to the totality of insuree's costs, a regulated level of benefit coverage, a percentage of insurees' costs, or to the insurees' costs above a certain threshold. Finally, risk compensation can consist of risk-sharing arrangements between insurers and a central fund, where insurers do not bear the risks of financial deficits nor benefit from financial surpluses. Each of these mechanisms creates different incentives for risk selection, efficiency, and cost-containment.

A good compensation mechanism should not compensate insurers for differences in costs arising from their own inefficiency, otherwise risk compensation dampens insurers' incentives for cost-effective management of high-cost cases. Mechanisms based on retrospective compensation of differences across insurers' profiles (age, sex and region) – as is currently the case in Switzerland – do not incite insurers to seek efficiency gains. On the other hand, prospective compensation formulae might unjustly make insurers responsible for cost differences that are not within their control capacity. An adequate balance between prospective and retrospective compensation needs to be stuck.

Box 4.5. **Improving risk-equalisation mechanisms** *(cont.)*

Risk-adjusters can include socio-demographic factors (*e.g.*, age, sex, income, region); prior utilisation and diagnostic information (*e.g.*, diagnostic-related groups); disability and functional health status (*e.g.*, severe disability measured by Activity of Daily Living or Instrumental Activities of Daily Living); indicators of chronic medical conditions (*e.g.*, indicators on conditions more frequently associated with high consumption of medical services). The socio-demographic risk-adjusters, though easy to apply, do not have as high a predictive power as the other indicators, for example indicators based on health status. Inscription in disease-management programmes is another new method to better capture risk differences – now used in Germany. Many countries have limited the range of predictors, often over concern for patient confidentiality or lack of adequate data.

A risk-compensation mechanism is effective if it makes the insurers' marginal cost of selecting risks higher than the marginal benefit. The mechanism should calculate compensation on the basis of enough risk-adjusters to make it costly for insurers to predict the likelihood of individual health expenditures better than the compensation formula does. If insurers can easily derive a more accurate prediction, they will be able to identify costly cases and exclude them. Consideration should also be given to practical concerns, particularly data availability and cost, and the possible resistance of insurers should the compensation mechanisms be perceived to discourage efficiency efforts.

Although there is no optimal risk equalisation mechanism, the Dutch case offers an example of a well-functioning system. This uses several risk adjusters such as demographic variables (age and sex), region, employment or social security status, disability, diagnostic cost groups and pharmacy cost groups. It also combines *ex-ante* risk equalisation with a retrospective correction for actual client numbers, cost discrepancies due to unforeseeable circumstances and extremely high claims (Ministry of Health, Welfare and Sport, 2006).

Source: Revised from OECD (2004c).

compensation for differences in insurers' risk structures. It also provides retrospective compensation of cost incurred by insurers rather than risk compensation, thus removing insurers' incentives to search for efficiency gains from providers. Several studies concord on the weaknesses of the current mechanism of risk equalisation (Beck, 2004b; Beck and Zweifel, 1998; Beck *et al.*, 2003; Holly *et al.*, 2004; Spycher, 1999, 2000, 2002 and 2004b), and have proposed solutions to tackle them, including:

- making the risk-adjustment system a definite part of the LAMal; the system is supposed to operate only for a temporary period, although its initial ten year "mandate" was recently extended by five years;[26]
- refining and improving the adjustment formula, by including health indicators based on diagnostic information, in addition to demographic adjusters;
- if the above is not possible in the short run, introducing a formula based on previous-year hospitalisation as a transitory measure;
- establishing a high-risk pool as a short-term measure.

Furthermore, there is little or no feed-through of insurance-market competition into provider markets. Insurers have few tools at their disposal to influence providers. This, in addition to an imperfect compensation system, creates further encouragement for competition to take place on the basis of risk selection rather than value.

Negotiations between providers and insurers take place in a bilateral-monopoly environment between cantonal professional associations, with the cantons sometimes stepping in to arbitrate where agreement proves impossible. Only in the case of managed-care products, can insurers selectively contract with providers. While some cantons with higher-than-average costs report that the insurers had significantly reduced their provider remuneration levels, forcing providers to restructure, it is unclear whether such collusive practices would be an effective mechanism to encourage long-term efficiency gains through increased competition. The Federal Council has proposed to introduce contractual freedom between insurers and providers as part of the partial revision of the LAMal currently underway, a measure which has been debated since the introduction of the LAMal (see Chapter 5).

Managed-care techniques used by insurers to steer the way health care is delivered have not spread widely in Switzerland. Only LAMal insurers offering products with limited choice of provider make use – to varied extent – of such practices (Box 4.6). Yet these insurance models account for only 7-8% of the whole LAMal health-insurance market and the rate of growth of these insurance types has been fairly low (Table 3.9). Slow development can be attributed to a range of factors: many doctors resist limitations to their clinical freedom and most do not agree on being paid by capitation; patients are attached to free choice of provider and are not willing to restrict their care options; and insurers tend to incur higher administrative costs on this type of cover (Beck *et al.*, 2003).

Managed care seems to have had some effects on improved co-ordination of care in Switzerland (Box 4.6). However, its impact on the cost of mandatory insurance has not been particularly encouraging.[27] Several factors could explain this outcome. First, overall insurers do not take many steps to influence care and control cost even in managed-care environments, possibly because of fears of a consumer backlash. Second, providers often have few economic incentives. Many managed-care contracts, for example, include a deficit guarantee by the insurer, thereby eliminating risk transfer from the insurer to the provider (Beck, 2000). Third, insurers have few incentives to manage care in the hospital sector because they are only liable for a share of in-patient costs, the remainder being paid by cantons. Managed-care techniques appear to be applied mostly in ambulatory settings, and insurers have little influence over the full continuum of care. Last, because risk selection is a profitable ground for insurers to compete, managed-care plans have been used for attracting good risks rather than to contain health-care cost. Three quarters of the savings from managed-care insurees can be explained by favourable selection into these products by low-risk individuals who expect lower use of health services (Beck, *ibid.*; Gardiol *et al.*, 2005).

A slightly different picture has emerged from the experience of SUVA, the quasi-monopolist accident insurer. SUVA has been more effective in extracting cost savings from applying demand constraints and greater bargaining power on providers, as well as from investing heavily in case management for its accident victims. Incentives for a more hands-on approach arise from the fact that SUVA insures lost wages as a result of the accident as well as the associated medical costs. Thus, an early return to work and lower rates of disability can reduce the overall insurance cost significantly. The use of techniques to manage care and cases appears to have significantly contributed to keeping the accident-insurance premia unchanged over the past few years. The experience of SUVA and the poor results achieved thus far by insurers in promoting cost-efficiency have spurred a proposal for a unique insurer in the LAMal context, which will be voted on a popular referendum in 2007 (Comité national mouvement populaire des familles, 2006). While there appears to be much debate about this and other reform proposals in the context of the partial revision of the

Box 4.6. **Measures taken by insurers to influence care delivery and control cost**

Managed care comprises a set of techniques to steer the way health care is delivered, such as pre-utilisation approval/requirements; utilisation audits; clinical guidelines; restriction on treatments; different methods of paying providers than fee-for-service; charging of higher fees to insurees seeing doctors other than those agreed in the managed-care insurance.

According to the LAMal, contracts between insurers and providers should include measures for controlling costs. In practice, insurers do very little in this respect. Many insurers conduct statistical analyses and benchmarking of average costs per patient, average costs for prescriptions and average costs for certain referrals. Providers over a certain percentile will have their cases reviewed, and in some extreme cases, insurers can claim back payments made earlier. Insurers can also ask for a pre-utilisation approval for certain treatments.

Managed-care products adopted by Swiss insurers include very different models, involving varying degree of use of managed-care techniques. The most widespread type of these insurance policies – fee-for-service gatekeeping insurance, accounting for two-thirds of the market and available in 16 cantons (Bauer, 2004) – requires individuals to see a family doctor as a precondition for referral to higher level of care. No or little other managed-care technique is used within this insurance model.

HMOs and IPA-type (such as budget-holder group practices) are more active in seeking to influence, in particular, ambulatory-care treatment. The budgets of these organisations may also encompass hospital costs, but not the most expensive procedures. Both these insurance models set up pre-utilisation approvals, utilisation audits, and develop guidelines or adapt existing ones. Certain contracts may include the obligation for the networks to establish quality circles and for GPs to attend the meetings of these circles. These insurance types represent only a small fraction of the managed-care market (about 15% of the market for HMOs, and a very low market share for budget-holder group practices).

Care co-ordination appears to be greater in a managed-care context than in ordinary LAMal-insurance, particularly in HMOs and budget-holder provider networks. These settings tend to group professionals and specialists in adequate numbers and qualifications to provide the ambulatory treatments to patients. When the group does not provide in-patient care, doctors may steer patients' choice of hospital and maintain close links with hospitals where treatment is delivered in order to reduce risks that the care process is disrupted and enhance the chances of a prompt recovery. Doctors participating in managed-care practices are often supported by the use of tools (such as monitoring, peer-pressure, and reminders) to reduce practice variations and quality shortcomings. They are also encouraged to adopt evidence-based medicine and clinical guidelines and have the opportunity to participate in continuous education. Information on practice and the medical history of patients are shared across professionals working in team.

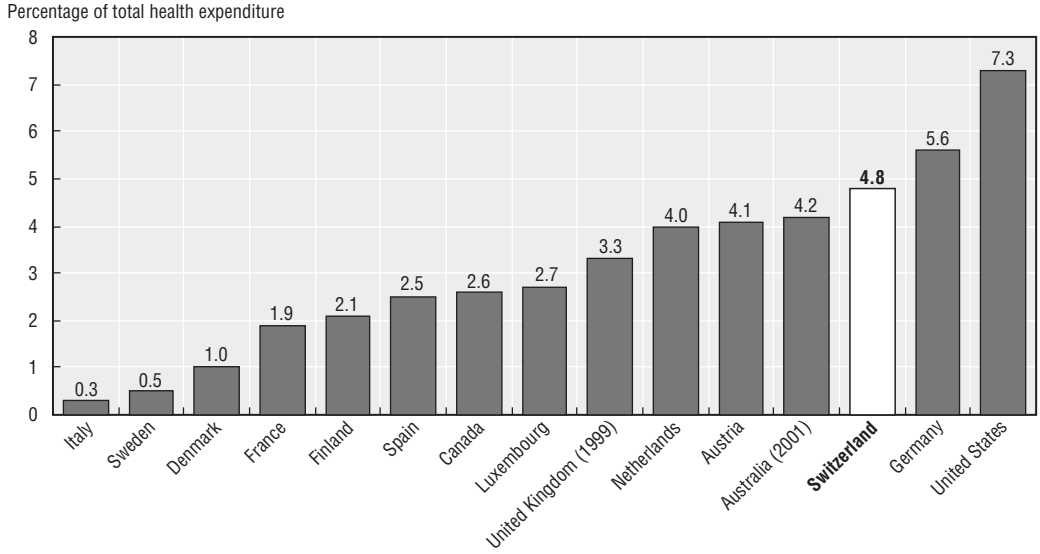
LAMal currently underway (Chapter 5), the experiences of the SUVA and of LAMal-insurers suggest that managed-care techniques have the potential to improve care co-ordination and – if incentives for insurers and providers were better aligned – to have an impact on cost.

4.2.8. Administrative costs

As in other health systems with multiple payers, the administrative and governance costs of the Swiss health system are high by international standards, although

comparability is weakened by cross-country differences in definition. In 2003, administrative costs accounted for 4.8% of total heath expenditure in Switzerland, the third highest among OECD countries after the United States and Germany (Figure 4.13).

Figure 4.13. **Administrative expenditure as a share of total health spending in selected OECD countries, early 2000s**



Source: OECD (2005), *OECD Health Data 2005*, Paris.

High administrative costs reflect the much decentralised structure of the Swiss health-care system with so many responsibilities being borne by cantons. It would be very surprising if this did not result in duplication of administration structures and in fewer opportunities to exploit economies of scale. Financial flows across multiple social insurers can make payments for health services (health, accident, disability and military) complex. The lack of good co-ordination across the spectrum of care and poor system integration also contribute to increase the management costs of the system.

While there are margins for improving administrative efficiency at system level, it is also fair to say that the share of administrative cost in total health spending in Switzerland is not higher than other federal countries, except the United States, suggesting that the system may not be as wasteful in administration as might be expected on the basis of its system of operation.

Although administrative expenses of insurers in the mandatory health-insurance system have been reducing from 8.2% in 1996 to 5.7% in 2003, loss ratios – which represent the ratios of claims to premia – have dropped from 97% to 91%, signalling that over time a smaller share of health-insurance premia is being absorbed by the cost of health-care service (Table 4.5). The high level of reserves accumulated by LAMal insurers and its recent increase from 12.8% of earned premia in 2002 to 14.2% in 2003 has also attracted much recent criticisms. As insurers cannot make profits, these are used to reduce premia or to increase reserves. A reduction in the reserve rate might therefore be employed to lower pressures for premium increases. While cutting the legal rate of reserves for LAMal-insurers is a possible measure for consideration, the share of premia represented by financial reserves has been on a downward trend since the introduction of the LAMal

Table 4.5. **Administrative costs, loss ratios and reserves of LAMal-insurer, 1996-2003**

Percentage

	1996	1998	2000	2002	2003
Administrative costs (% of total insurance and running costs)[1]	8.2	6.6	6.1	5.9	5.7
Loss ratio (benefits paid as % of premiums earned)	96.9	93.9	98.1	95.0	91.2
Reserve rate (% of premiums earned)	25.7	23.5	21.1	12.8	14.2

1. Note that administrative costs includes depreciation of fixed capital. *Source*: Office fédéral de la santé publique (2004), *Statistiques de l'assurance-maladie obligatoire 2003*, Bern.

in 1996 (Table 4.5). A reduction in the rate of reserve might reduce pressures on premium increases in the short term, but it would have a one-off effect without solving the underlying problem of cost inflation in the Swiss health system.

Notes

1. Since 1996, Switzerland has had the third lowest rate of real GDP growth in the OECD area (OECD, 2006a).
2. In 2000, long-term care costs accounted for 1.5% of GDP, 85% of which were for nursing homes and the remainder for Spitex.
3. Several studies discuss how an increase in supply can lead directly to an increase in demand. Fuchs (1978) analyses differences in the supply of surgeons and the demand for operations across geographical areas of the United States, showing how surgeons shift the demand for operations. Domenighetti and Pipitone (2002) estimated the cost of supply-induced demand to be 17% of total LAMal expenditure for 2000. Another study by Domenighetti *et al.* (1993) shows how better informed patients, such as doctors, consume significantly less of common surgical procedures than do ordinary, less well-informed patients. Domenighetti *et al.* (1984) also show that in the canton of Ticino the high density of gynaecologists is a key factor explaining the high rate of hysterectomies. Using time-series and cross-section data for 26 cantons over the period 1996-2002, Crivelli, Filippinini and Mosca (2006) analyse how physicians paid on a fee-for-service basis swell expenditures, highlighting a possible phenomenon of supply-induced demand. Finally, Domeniguetti *et al.* (1988) show how furnishing better information to patients, for example through information campaign by the mass media, can limit demand inducement.
4. Restrictions on entry to medical schools have been introduced in Basel, Bern, Friburg and Zurich. This development partly reflected the cost implications of changing methods of teaching (problem-based learning, tutorials and group teaching).
5. For example, Berk and Monheit (2001) find that only 10% of the population accounts for 70% of total health-care costs in the United States (see also Sommer and Biersack, 2005).
6. In particular, there is little evidence as regards the level of unit costs in Switzerland when compared with patterns in the rest of the OECD. This makes comparisons of health-price levels complex.
7. Unfortunately, no reliable data exist to compare the level of Swiss fee schedules with other OECD countries.
8. Prices for products introduced after 1996 remain 8.9% higher than Germany.
9. Evidence from Japan, Canada, and Belgium, among others, show that a simultaneous use of fee-for-service and hard budgets does not necessarily lead to higher costs, although it may still lead to oversupply.
10. This is similar to the German "point system".
11. As for independent practitioners, several rounds of adjustments to the tariff point value have been implemented and it is expected that cost neutrality will be maintained. However, there has been a significant increase in the volume of medical services provided since TARMED was introduced. Changes in the value of the points allocated to each item have been made to correct costs

downwards and maintain the planned cost-neutrality, although the elapsed time is too short to make conclusive statements for the future.

12. Based on claims data. Furthermore, TARMED has not been designed to provide stronger financial incentives to enhance services in rural areas, which are currently undersupplied, because in Switzerland the value of the points does not vary to take into account differences in the density of providers.

13. According to one estimate, a one-day decrease in the average length of stay, which tends to be especially low in small basic-care hospitals, can lower hospital costs by about 4% (Filippini and Farsi, 2005).

14. See also Docteur and Oxley (2003) for an analysis of reforms of hospital contracting and payment systems to improve cost-efficiency in OECD countries.

15. Financial pressures have induced many cantons to implement business-management practices and structural changes in the hospital sector since the mid-1980s. These have included consolidation, conversion, mergers and closure of hospitals, reduction in the number of beds, and reduction in the average lengths of stay (Rüefli *et al.*, 2005). The areas most commonly affected were surgery, gynaecology and obstetrics, internal medicine and long-term care/geriatrics. These structural changes affected cantons differently. Bed reductions were achieved in 13 cantons, and about half of them in Zurich and Bern.

16. According to the study, several small hospitals do not attain the size needed to achieve scale economies and quality standards, while large university hospitals show large margins for efficiency improvements, even after controlling for case-mix differences (Filippini and Farsi, 2005).

17. An intermediate report on the introduction of the insuree card is available at: *www.bag.admin.ch/themen/krankenversicherung/00305/00306/index.html?lang=de*. Two cantons have launched pilot projects to set up an electronic patient health card (Ticino) and an electronic medical network (Geneva).

18. See Chapter 1. Swiss authorities use prices of pharmaceuticals in France, Italy, and Austria only as "supplementary" information. These countries have on the whole lower prices than the key comparator countries: Germany, Denmark, the Netherlands, and the United Kingdom.

19. Parallel import of off-patent drugs has been authorised since January 2002, subject to certain conditions. Parallel imports need to be authorised by Swissmedic, fulfil Swiss quality and packaging requirements, and originate from certain areas (such as the European Economic Space, the United States, Canada or Japan).

20. From 1 April 2006 the prices of all off-patent branded drugs on the reimbursement list since 1990 will be re-examined. From 1 July, prices of drugs admitted on the specialty list (SL) before 1990 will also be re-examined. Prices of drugs will regularly be reviewed seven years after their inclusion in the list of reimbursed products (where the use of the drug has not been extended to the treatment of additional medical conditions). This will help reduce the higher prices of older drugs noted in Section 4.1.3. Finally, patented-drug prices should be reviewed as soon as the patent expires and two years after.

21. The acceptance and importing of drugs – either generic or those where the patent has expired – appears to be significantly restricted by the current regulatory environment. Thus, after more than three years of administrating the law on therapeutic products, only three drugs have obtained the authorisation permitting their parallel import but these had to confront, first, other bureaucratic obstacles (Surveillant des prix, 2005).

22. The lack of pharmacists in some regions is an argument in favour of allowing doctors to dispense drugs.

23. See, for example, the recent reform experience of Korea. In 2000, Korea introduced a reform to separate the function of prescription of drugs from the function of dispensing drugs, attributing the former exclusively to physicians and the latter exclusively to pharmacists. While the reform gave rise to a wave of doctors' strikes and the government had to intervene to partly compensate doctors for their income loss, it also led to a reduction in the overconsumption of pharmaceuticals (particularly antibiotics), in greater patient awareness of the use of pharmaceuticals, and in improved quality of prescribing (OECD, 2003b).

24. For example, an inter-cantonal hospital has been established between the Vaud and the Valais and also between Fribourg and the Vaud. Moreover, conventions for the free movement of patients between bordering areas of Argovia and Lucerne, and between Tessin and Grisons have been signed (Unternäher, 2005). Finally, intercantonal planning exists, thus far, in two cases only: Basel-Town and Basel-Country and Lucerne/Obwalden/Nidwalden.

25. In November 2004, the CDS had adopted an intercantonal agreement related to the co-ordination of highly specialised medicine, which established a legal framework for intercantonal planning. The agreement, to become effective, required cantonal ratification. Cantons that signed the agreement would have consented to give up part of their authority over hospital planning. The agreement, however, never came into effect as one canton refused to sign it (the agreement required approval by 17 cantons, including all the cantons with university hospitals). For more details, see *www.gdk-cds.ch/117+M52087573ab0.0.html*.

26. When the LAMal was introduced in 1996, legislators expected that both good- and bad-risk individuals would switch across insurers in search of the best-priced option. After some time, risk structures would have equalised across funds. This is why the law limited the operation of the risk adjustment system (which had been in place since 1993) to the period up to 2005. However, initial expectations were not borne out. Few individuals, mostly good risks, switched across insurers, and differences in risk structures remained largely unchanged. The net amount paid through risk equalisation has increased at an average annual rate of 10% since 1996. Transfers are concentrated among a few insurers, signalling an unequal distribution of risk in the market (Beck *et al*., 2003).

27. Evidence from the United States shows that managed-care had only short lived effects on overall cost, while the overall evidence on the impact on quality is mixed (OECD, 2004c).

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Chapter 5

Recent and Proposed Reforms to the Swiss Health-insurance System

While the LAMal's goals of access and insurance coverage have been broadly achieved, health-system costs continue to rise more rapidly than GDP, creating pressures on the ability of the system to finance the growth in outlays. This has led the Swiss authorities to consider further ways to improve the cost performance of the system, again within the framework of the federal Health-insurance Law. Since 1996, different revisions to the LAMal have been discussed by parliament, the latest of which is ongoing. This chapter described these revisions and their current legislative status.

Since the introduction of the LAMal in 1996, there has been ongoing discussion among Swiss authorities and stakeholders about how the system could be reformed to improve its performance. After a first revision in 2001, which consisted of several individual and unlinked measures, the authorities have been pursuing the introduction of more important revisions to promote, in particular, efficiency-improvement and cost-containment goals. However, the process of reform has been stalled by difficulties in finding agreements among parties about the appropriate directions for change.

5.1. The first revision of the LAMal

A first proposal for the revision of the LAMal was put forward by the Swiss Government in 2000 and enacted on the 1 January 2001, included:

- a suppression of the obligation to purchase mandatory insurance for individuals who have had military insurance for over 60 consecutive days;
- the standardisation of the three areas in each canton where insurers can apply different premia (reflecting variations in health costs across regions within any canton). Previously, these areas where defined by, and therefore varied across, insurers;
- the introduction of a new method of remuneration of pharmacists and prescribing doctors, based on fee-for-service rather than retail-price margins on dispensed drugs (RBP, see Chapter 1);
- the right to substitute a branded product with a generic bioequivalent by pharmacists (under the condition that the prescribing doctor is informed and that s/he did not require the dispensing of a branded product);
- the introduction of a three-year freeze on the opening of new medical offices (from 2002 until 2005);
- some improvements in the system of premium subsidies for low-income individuals and families (*e.g.*, by requiring cantons to pay subsidies at the time individuals need to pay the premia and not long after);
- some changes in the system of cost-sharing: *i*) the removal from the deductible of the cost of mammography screening carried out within the context of structured programmes of prevention organised by cantons; and *ii*) a ban on the coverage by supplementary insurance of any cost-sharing incurred under the LAMal;
- the introduction of measures to facilitate switching between LAMal insurers (*e.g.*, insurers are no longer permitted to cancel voluntary health-insurance contracts when an individual switches to a different insurer for their basic cover);
- the reinforcement of surveillance powers over LAMal insurers (*e.g.*, the right for the Federal Office to make unannounced audits of insurers' activities with access to all relevant data; and the right to impose monetary sanctions in case of irregularities).

However, these reforms did little to attack the main causes of the poor cost performance of the system such that they were soon followed by additional reform proposals.

5.2. The second revision of the LAMal

In 2002, the government made proposals to parliament for a second revision of the LAMal. These reforms were inspired by a model of managed competition across LAMal insurers. They aimed at addressing some of the barriers preventing more effective competition from taking place, such as abolishing the obligation for insurers to contract with all providers and reforming the system of parallel financing of hospitals (Leu, 2005).[1] The proposals were presented as a single package to parliament. However, they were therefore rejected by parliament in winter 2003 in the absence of the needed consensus.

After the rejection of the second revision, the Federal Council is attempting to pass the same set of measures in another revision of the LAMal. This has been presented in the form of two legislative packages, each one containing a revision of different aspects of the system, to be discussed separately. The main focus of the latest revisions is to control costs by better aligning economic incentives faced by various actors in the health-care system. (A summary of the measures is presented in Table 5.1.)

However, the lack of political consensus as regards several of the proposed measures is once again emerging as a threat to the passage of the reforms. In particular, there are wide differences in views concerning how best to combine more reliance on regulated competition among insurers and providers, (which the reforms of the LAMal intend to push forward), with the planning and financing role of the states. There is, thus, no assurance that these measures will be accepted or in what form.

5.2.1. Access and equity: revisions to the premium subsidy system

As noted, the LAMal has broadly attained its goals of improved access to care for all of the population. Discussions on how to further improve the system have therefore been confined to ways to improve the system of premium subsidies for low-income individuals in order to ensure better equity in financing, both horizontally and vertically. Revisions of the premium subsidy system had been discussed for several years. In the winter of 2001, parliament considered a proposal according to which subsidies granted to low-income families should be high enough to ensure that premia did not exceed 8% of households' income. Following disagreement, a new proposal was presented as part of the second revision of the LAMal. In this revised proposition, cantons were asked to define four different revenue groups, each of which would be associated with a different threshold of social adequacy. Premia paid by these groups should not have exceeded between 2% and 10% of individual income (depending on the group), and between 4% and 12% of household income. While cantons agreed to the principle, they could not achieve a consensus over issues of practical implementation, and the proposal was subsequently rejected by parliament in the context of the second revision of the LAMal. In the latest set of measures, parliament finally agreed to an alternative measure whereby cantons committed themselves to a reduction of the premia of at least 50% for children and young people in training from middle- and low-income families. The cost of this reform is to be partly covered by an increase in federal subsidies of CHF 100 million in 2006 and in 2007.

Table 5.1. **Federal Council's proposals to Parliament for the latest revision of the Health-insurance Law (LAMal)**

1st LEGISLATIVE PACKAGE (A)		2nd LEGISLATIVE PACKAGE (B)	
Proposals for revisions of the LAMal prepared by the Federal Council	**Progress with parliamentary approval (at end May 2006)**	**Proposals for revisions of the LAMal prepared by the Federal Council**	**Progress with parliamentary approval (at end May 2006)**
Project 1A *Strategic and urgent measures.*	*Adopted by the Parliament in autumn 2004 and finally adopted without referendum on 1 January 2005.*	***Project 2A*** *Hospital financing:* Hospital financing would be based on the services actually supplied, rather than being calculated on the basis of average daily costs as it usually is or as a block grant for the institution as a whole. The cost (including investment) of the services provided by both public and private hospitals appearing in the cantonal planning system would be financed half by the cantons and half by LAMal-insurers (so-called "dual-fix financing"). The Federal Council has also committed to make a proposal for a single-financing system (whereby there would be a unique payer) to replace the current parallel financing system (which is based on two separate payment flows, one from the cantons and the other from the LAMal-insurers).	The Council of States has adopted an amended proposal (march 2006). The main change consists of a more flexible dual financing scheme between cantons and insurers, whereby the cantons' contribution would be at least 45%. The proposal is now being examined by the second chamber.
• Introduction of an insuree card.	• The insuree card will be introduced in 2008.		
• Extension of the risk-compensation mechanism after 2004 (from the initial mandate expiring in 2005).	• The risk-compensation mechanism was prolonged by five years without any modification to the formula.		
• Transitory measures on the financing of long-term care (LTC) services.	• Freeze of the tariffs for LTC services until the enactment of a reform on LTC financing.		
• Federal law on adapting cantonal subsidies to the cost of hospital treatments.	• Extension of the federal law on cantonal subsidies for hospital cost, until adoption of a new hospital-financing system. Parliament also extended for a further three years the freeze in the opening of new physicians' offices (initially adopted in 2002 for a three-year period).		
Project 1B *Contractual freedom:* The obligation for LAMal-insurers to contract with all providers would be suppressed in the ambulatory sector. This is proposed as an alternative to the freeze in the opening of new physicians' offices.	None of the Parliament chambers has begun to consider this proposal. The Council of States will be the first chamber to discuss this issue in summer 2006.	***Project 2B*** *Managed care:* Managed-care insurance models would be explicitly legislated as a special health-insurance product in the LAMal (which currently refers to insurance with "limited choice of provider"), with the aim to encourage the diffusion of this model.	The project will first be examined by the Council of States in summer 2006.
Project 1C *Premium reductions:* A national threshold would be set up. Based on the threshold, premium payments borne by the household net of subsidies received should not exceed a certain percentage of disposable income.	*Adopted by the Parliament in spring 2005 and enacted as of 1 January 2006.* No national income threshold is established and eligibility criteria remain with the cantons. Each canton is required to provide premium reductions for children and young people from low-income families of at least 50%. Cantons define income eligibility criteria. The federal subsidy will be increased by CHF 100 million in 2006 and 2007.	***Separate legislative proposal*** *Financing of LTC costs.* The LAMal would cover all medical treatment costs and contribute a fixed amount to the cost of basic services (such as help for the elderly in getting washed, dressed or eating) in cases of serious disability. In case of mild disabilities, where medical treatments are not needed, the LAMal would not cover care costs. The AVS (pension and disability) system would pay an allocation to the cost of home-care services. The distinction between mild and serious disability is the same as is used in the AVS system. Finally, the annual ceiling on complementary AVS benefits would be lifted.	In February 2005, the Federal Council adopted a legislative proposal in February 2005 revising the LAMal, which was sent to Parliament for discussion. Two different variants on the model are proposed. The legislative proposal will first be examined by the Council of States in summer 2006.
Project 1D *Cost sharing:* The co-insurance rate would be raised from the current 10% to 20% for adults. The overall ceiling of CHF 700 per year would not be modified.	*The Council of States adopted the project in autumn 2004.* A commission of the National Council passed a motion in autumn 2004, according to which the proposal on cost-sharing and that on contractual freedom should be debated simultaneously in the second legislative package.		

Source: Based on information from the Swiss Federal Office of Public Health, available at: *www.bag.admin.ch/themen/krankenversicherung/00305/index.html?lang=de*.

5.2.2. Measures targeting cost control and efficiency goals

As noted, most of the changes proposed by the Federal Council aim at implementing better cost-control mechanisms and improving efficiency-related incentives in insurance and provider markets. The Swiss authorities intend to achieve these goals by increasing the individual responsibility for their health-care expenditure through greater cost-sharing. The proposed changes also aim at strengthening the role of health insurers in controlling costs by increasing competitive pressures in provider markets.

Increased cost-sharing

A proposal to introduce higher rates of co-insurance (20% of the cost of medical goods and services) was discussed and rejected within the context of the second revision of the LAMal. The Council of States has nonetheless decided to increase the cost-sharing by raising the co-insurance to 20%; it has also delegated to the government (Federal Council) the possibility of differentiating this increase in cost-sharing between different types of care. In the context of the partial revision of the LAMal, the Federal Council has proposed institutionalising a higher co-insurance rate of 20% along with government freedom to set lower (or higher) rates for specific services. The annual ceiling on the overall amount of co-insurance paid by an individual would be maintained at CHF 700. This, combined with the CHF 300 ordinary deductible, results in a maximum amount of cost-sharing to be borne by an individual covered by an ordinary insurance policy of CHF 1 000. The Council of States adopted the proposal in the autumn of 2004. A commission of the lower chamber passed a motion in the autumn of 2004, according to which the proposal on increasing cost-sharing and that on contractual freedom between insurers and providers should be debated simultaneously.[2]

Measures to increase competition between insurers and providers

In the autumn of 2004, parliament adopted a series of strategic measures, of a one-off nature, which the authorities felt could not be delayed. These changes included:

- The extension of the risk-compensation mechanism for a further five years, without any modification to the formula.[3] This left, until later, the refinement of the risk-compensation formula using better methods of risk adjustment across LAMal insurers.
- The extension of the freeze on the opening of new physicians' offices for a further three-year period. The government underlined the temporary nature of this measure, which would have to be replaced, in the medium-term, by contractual freedom between insurers and providers.

Contractual freedom. Discussions over the obligation for LAMal insurers to contract with all providers have taken place since the introduction of the LAMal. Selective contracting aims at providing insurers with the tools needed to place greater pressure on providers to improve their quality and efficiency. While rejected during discussions over the second revision of the LAMal, this measure has been reintroduced by the Federal Council.

However under the current proposals, contractual freedom will only appear to apply to the ambulatory and ambulatory-hospital (out-patient) sectors where individual providers would negotiate with individual insurers. In the ambulatory sector, negotiations could concern, for example, the point value of TARMED but could also include other payment arrangements (*e.g.* per hour or per patient). In contrast, prices in the inpatient hospital

sector would continue to be fixed through bilateral negotiations between insurers and providers as a group – at least at the present state of discussions.

Hospital financing. The government made a proposal to reform hospital financing aimed at removing some of the distortions of the current system of parallel financing by cantons and insurers. The main elements are:

- A shift from a system of financing hospitals (by the cantons, in particular) based on global budgets or block-grant transfers to a system of financing of the services actually delivered.
- A move to a system of so-called "dual-fix" financing: all recurrent and capital costs of the services provided in shared and private wards[4] of both public and private hospitals appearing in the cantonal planning system (canton lists) would be financed 50-50 by the cantons and LAMal-insurers.
- In the medium-term, the Federal Council intends to put forward a proposal to replace the current system of parallel financing by LAMal insurers and cantons with a single-payer mechanism. Under the new system, insurers would be the sole purchasers of hospital services, and the cantons would channel their contribution to insurers rather than to hospitals.

The Commission for social security and health of the Council of States submitted a different proposal to the upper chamber, according to which insurers would pay for all services covered by the LAMal, and cantons would channel to insurers 30% of the combined costs of hospital and ambulatory care. Following strong disagreement by the cantons, this proposal was rejected by the Council of States. The Council of States subsequently made a new proposal in March 2006 whereby cantons would pay at least 60% of hospital costs[5] (and not ambulatory-care costs), the remainder being financed by insurers. This new model is similar to the initial proposal made by the Federal Council for a 50-50 split of hospital costs between cantons and insurers, however it does not include a move to a single-purchaser system.[6]

Managed care. The government also intends to encourage managed-care insurance. These models can potentially improve quality and efficiency of health-care services through a tighter grip over the way care is delivered and by imposing constraints on patient choice. According to the government proposal, managed-care insurance models would be institutionalised as a special health-insurance product in the LAMal (currently, these models are generally offered as insurance with limited choice of provider) and offered as an alternative to ordinary insurance. Insurers would not be obliged to offer this type of insurance product. Similarly, providers could decline to participate in these models. Rather, the Federal Council proposes to achieve its goal of wider market diffusion by relying on financial incentives[7] and measures to improve consumer confidence in these products. At the time of writing, this proposal had not been discussed by either of the parliamentary chambers.

While the proposed revisions have already been the object of several years of discussion, most have not yet been approved or still await parliamentary discussion. The programme of reform is rather comprehensive and ambitious. However, differences in views across stakeholders increase the risk that many of the proposed measures will once again be rejected by parliament or adopted without substantial changes relative to existing arrangements such that, *de facto*, existing arrangements would remain. Furthermore, the reform agenda does not seem to address several key conditions that would be necessary for

a reformed system to meet the goals of the authorities. These include, for example, the lack of transparency and the absence of an adequate information base; the importance of improved mechanisms to measure and ensure quality of care and, in this context, the need to set standards of care and mechanisms to monitor market outcomes; and, consideration of the need for competition over larger geographical areas.

5.3. Further reforms in the area of long-term care

A final area of proposed reform concerns long-term care financing. According to the LAMal, insurers should cover all the cost of long-term care services when the need for care originates from an illness or medical condition. In this event, LAMal insurers are required to cover all the medical costs, as well as the costs of providing basic assistance to the patient. In practice, however, it has proven difficult to distinguish between costs linked to illness and those linked to other factors, such as age. Since its introduction in 1996, the LAMal has covered a progressively larger proportion of LTC costs (though these remain in large part financed directly by households), creating cost pressures for the system. In order to better control cost, standard fees for long-term care services were introduced on 1 January 1998. These are supposed to be abolished once a new reform of financing of long-term care is approved. The reform would aim at clarifying the responsibilities of different insurance schemes (LAMal, disability and old-age pension, social assistance, etc.) for financing LTC care. According to the model proposed by the government, and which will be discussed by parliament during the summer of 2006, the LAMal would need to cover all medical treatment costs (treatment, rehabilitation, palliative care), but would only contribute a fixed amount of the cost of basic services (such as help for the elderly in getting washed, dressed or eating).

Notes

1. Leu (2005) discusses the conditions necessary to operate successfully a model of managed competition, focussing in particular on proposals for changing the current system of hospital financing.
2. An initiative intended to reduce the basic health-insurance premium by narrowing the benefit package will be voted on in the course of 2006 or 2007.
3. At the time of writing, the Council of States has included "a stay in a hospital or nursing home" as an additional risk-adjustment criteria.
4. At present, the LAMal covers the cost of services received in private wards, up to the amount that is currently paid for shared wards.
5. This corresponds to the amount currently financed by cantons for recurrent and capital costs, as shown in Table 4.4.
6. A further proposal by the CDS, which groups the directors of health services in each canton, would limit cantonal funding only to shared wards of hospitals with which the canton has signed service agreements. The CDS opposes a move to a single-financing model whereby insurers would administer subsidies received from the cantons.
7. While no specific proposals were made in this respect, groups of experts have called for the introduction of the following financial incentives: *i*) authorising insurers to offer premium reductions and end-of-year rebates; *ii*) reducing co-insurance rates on these products from the 10% that applies to ordinary insurance; and *iii*) granting insurers greater freedom to set the geographical scope of these products (for example, a sole premium across different cantons and regions within cantons).

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Chapter 6

Policy Challenges and Options for Reform

This chapter provides a broad assessment of the performance of the Swiss health system, drawing on the analysis presented in preceding chapters. It highlights key challenges facing policy makers, as well as constraints on the implementation of these changes. It also makes policy recommendations for improving the Swiss health system, in both the short and the longer-term future.

Health status in Switzerland is among the highest in OECD countries and health inequalities are relatively low…

The Swiss population is living longer and healthier lives. In this respect, the Swiss health system performs well in international comparisons. Life expectancy – which was already high by OECD standards in the 1960s – has shown a further large increase compared with other OECD countries over the past four decades. Differences in health status across different socio-economic groups are also lower than in most other OECD countries.

… access to care is universal and coverage is generous…

Switzerland has achieved universal health-insurance coverage since the enactment of the federal Health-insurance Law (LAMal) in 1996. The LAMal promotes access to a broad range of health-care services and provides a large degree of financial protection against the medical cost of illness, maternity and some preventative services.

… and consumer satisfaction with the health system is high

Patients are largely satisfied with the health services they receive. Freedom of choice of provider within the system is, to a large extent, unconstrained and individuals can easily satisfy their preferences for care. Medical services are widely available, with virtually no waiting lists and rapid access to new technologies. And consumers' perceptions of the quality of care and of their interactions with health professionals are also high.

But Switzerland spends far more on health than most other OECD countries…

But these successes have a high price tag. Health spending as a share of GDP (or GNP) is among the highest in the OECD area, putting great pressure on both families and the public purse to finance the system. This high cost may reflect, in part, societal choice, *i.e.*, a willingness to pay for unconstrained choice and generous supply. However, there is no guarantee that this social consensus will persist in the future in the face of unrelenting cost and insurance premium increases.

… and the efficiency of the system can be improved

These cost pressures are increasing the demand for value for money. While Switzerland should be proud of the excellent outcomes its health system has attained, other OECD countries perform equally well, or even better, at lower levels of health spending and productive capacity. Incentives are not aligned to maximise efficiency and promote cost moderation. Generous supply – combined with high unit costs, limited demand constraints and prevailing provider-payment mechanisms that encourage high volumes of services – creates a favourable environment for providing additional services that may yield little or no benefit in terms of health outcomes. Competition across multiple third-party payers encourages cost-shifting, while efforts to manage cost in the health-insurance market are dampened by the lack of tools to adjust supply and the continuing incentives to select individuals with low health risks. Over the longer term, upward pressures on health-spending growth are likely to continue as a result of technological progress, an ageing population and, potentially, the higher wages that may be needed to draw more labour into this sector.

But implementing needed reforms is no easy task for the Swiss health system, due to its complicated governance structure…

The ability to tackle many of these challenges is complicated by the particular governance arrangements of the Swiss health system. For a start, the system is fragmented across different players, none of which has responsibility for setting and achieving national goals. The federalist structure of Switzerland enables cantonal policies to respond more easily to local preferences and priorities and facilitates the experimentation with innovative solutions at local level. The Swiss population shows a high degree of attachment to it. However, cantons lack, for the most part, the minimum size and the capacity to organise efficient health supply. Despite the need, the establishment of inter-cantonal agreements to address common initiatives and to pool resources has proceeded extremely slowly. Cantons also play multiple roles as owners, providers, financers and regulators of health-care services, potentially resulting in conflicts of interest and weak incentives to control costs and to cut back excess supply.

Second, an overarching federal framework for governance in the health sector is absent, as responsibilities for health are assigned by the Constitution to cantons. This makes the development of consistent national policies and the introduction of nation-wide minimum standards of care very difficult. The confederation has enlarged its role in some of these key areas over the years. However, this has tended to occur in response to emergencies or in areas where cantons' ability to co-ordinate has proven to be inadequate, and the confederation has stepped in to fill the gap.

… and the lack of adequate data

Third, the debate over the health reforms that are needed to address the system's shortcomings is taking place in an environment where data are most often inadequate to inform evidence-based decisions. Publicly available statistics are often limited by the

absence of comprehensive national reporting requirements. Data collection by cantons is often inadequate and not always standardised nationally. Privately collected and owned statistics (*e.g.*, insurers' databases) are not publicly disclosed or openly available to the statistical authorities.

And broader discussions on the systemic changes needed to improve performance are not being addressed

These difficulties, combined with the rejection of the comprehensive reforms proposed for the LAMal in 2003 and the lack of a consensus among stakeholders over the directions for change, are precluding broader discussion on the need for an overarching law on health policy within which the insurance system and the planning role of the state would be embedded. They also reduce the scope for the federal authorities to act in areas such as nation-wide programmes to enhance information, set standards and engage in broad prevention policies.

6.1. Effectiveness and quality of the Swiss health system

A broader legal framework for health promotion and disease prevention is overdue

The lack of clarity with regard to the responsibilities and roles of the different actors is particularly evident in the imbalance between prevention and cure in the health system. The existing fragmented legal framework for health promotion and disease prevention has favoured dispersed and largely un-co-ordinated activities. With public-health issues taking on a growing importance, designing a new legal framework to permit the establishment of national public-health policies should be a priority. Such a framework law would set the general objectives of disease prevention and health promotion in Switzerland, assign clear responsibilities to the confederation, cantons and other actors, and specify financing modes. These issues have been addressed in the preliminary report of the special commission on prevention and health promotion (PPS2010). However, greater focus should be placed on performance criteria, including the principles for identifying cost-effective health-promotion and disease-prevention activities, and for encouraging the financing of these activities by a broad range of stakeholders.

Greater attention should be given to using measures with proven cost-effectiveness to reduce the prevalence of public-heath problems…

Higher priority should be given to the use of measures with proven cost-effectiveness – for example in the areas of tobacco and alcohol consumption, salt intake, physical activity, and fruit and vegetable consumption – whose potential does not appear to have been fully exploited in Switzerland. Plausible reasons for the current limited use include poor oversight; the lack of adequate information and education; pricing policies that do not reflect externalities; and, the lack of adequate incentives for various actors in the system.

… higher sin taxes would be helpful…

A more comprehensive tax policy both to address public-health concerns and to favours an intersectoral public health approach would be desirable. While taxes on alcohol and tobacco are cost-effective measures to deter use, these are mainly seen at the moment as a source of government revenue or a tool for industry policy in Switzerland. More open discussion between the Swiss Federal Office of Public Health and other Federal Offices, in particular with the Federal Departments of Finance and Economic Affairs, may lead to taxing policies that assign a higher value to reducing excess consumption of tobacco and alcohol. Other cost-effective policies for curbing tobacco and alcohol consumption could include a comprehensive ban on tobacco and alcohol advertising, tougher legislation on drinking and driving and the development and enforcement of clean indoor-air laws. Following an increase in tobacco or alcohol taxation, the risk of substitution for these products by cheaper substances could be reduced through appropriate rules and regulations and, possibly, school-based health-promotion programmes. The elimination of subsidies to local alcohol and tobacco producers, while not directly affecting consumption, would also help enhance overall policy coherence and reduce public spending outlays.

… as would a nationwide breast-cancer screening programme

Expansion of some cancer-screening programmes should also be considered, in particular for breast cancer. Breast-cancer mortality rates tend to be lower in those cantons where screening rates are higher. Although there is continuing discussion in the scientific literature about optimal ages and periodicity, breast-cancer screening through regular mammography is a cost-effective method for ensuring early detection and improved patient outcomes. The vast majority of OECD countries have national recommendations and programmes for breast-cancer screening for women.

Mental illness and obesity are posing new challenges…

Further specific attention is needed for mental-health problems which now represent the leading disease burden in Switzerland. Despite recent attempts, a coherent national policy for tackling mental health is still lacking and efforts in this direction must remain a priority. Particular attention should be paid to the prevention of suicide, as well as to the prevention and treatment of depression and mental-health conditions affecting the elderly.

Increasing obesity among the Swiss population has prompted measures to promote healthier eating and to encourage physical activity. These are positive developments, but additional measures are needed, especially those targeting youth. In this context, schools should play a central role. Information campaigns in schools, the provision of healthier meals in cafeterias, the reinforcement of physical activity in the curricula and a ban on the sale of soft drinks and sweets in schools are all measures to be considered. Methods for reducing salt intake, such as a reduction in processed food, a measure of demonstrated cost-effectiveness, could also be introduced.

… and incentives to invest in health promotion and disease prevention should be developed

Additional measures could target the weak incentives faced by the various actors in the system for investment in health promotion and disease prevention. This could include mechanisms to enable insurers to benefit from their investments in prevention through the creation of a compulsory contribution to a common pool to be used for preventive activities, or requirements for insurers to spend a certain part of their budget on prevention, and subsidies to encourage them to develop prevention programmes. As for providers, specific incentives such as reimbursement or payment incentives could be examined. Such policies would be helped by a change in ambulatory health-care arrangements, with a move towards managed care or family-doctor arrangements and the introduction of practice protocols in this area. Finally, incentives for households and individuals could include greater use of mass-media information and health education on the consequences of unhealthy lifestyles and the introduction or extension of free screening, possibly in collaboration with enterprises. With child vaccination rates low by international standards, increasing the numbers of children that are vaccinated would also improve population health at little cost.

Measures to increase cost-effective investments in existing health promotion and disease prevention programmes should also be considered. For instance, the activities of Health Promotion Switzerland could be further developed and strengthened through an increase of the annual compulsory contribution, which can be decided by the Department of Home Affairs, from all persons insured with a statutory health-insurance fund.

Quality issues have started to gain policy attention…

Available indicators of quality of care for Switzerland are, in some clinical areas, better than those recorded for many OECD countries. However, performance appears to be poor in other areas. Self-regulation, the traditional mechanism through which Switzerland has ensured clinical quality up to now, may not be sufficient to guarantee that the level and scope of care meet best-practice standards. More importantly, quality improvement efforts are largely reliant on un-coordinated local initiatives led by individual providers. Nation-wide indicators of quality of care are not collected systematically, nor have country-wide programmes setting standards of care quality been established. New federal interest in evaluating and enhancing clinical performance, *e.g.* through patient-safety initiatives, are therefore a welcome recent development. However, they represent very cautious moves in the direction of improved monitoring and regulation of clinical outcomes.

… but further action is required, especially at federal level

External performance measurement and improvement initiatives should therefore be strengthened. First, there is scope for establishing a better mechanism of professional accountability. This would require modernising the role of professional self-regulation by encouraging the medical profession: *i)* to develop further best-practice guidelines; *ii)* to improve disclosure about medical errors and practice variation; and *iii)* to link performance

targets to internal rewards and sanctions. Second, a framework for collecting nation-wide indicators of quality of care is needed. The one adopted by the OECD Health Care Quality Indicators project could be a starting point for framing the quality measurement and standards debate. This would allow systematic monitoring of outcomes and support moves towards performance-based purchasing and payment of health-care services. Third, national programmes to enhance quality of care in key areas should be encouraged. This could ensure co-ordination of local-level initiatives and support the adoption of uniform standards of care. Finally, mechanisms to monitor providers' behaviour – with a view to identifying outliers that over-prescribe, over-intervene or who achieve worse than expected outcomes – would be desirable.

6.2. Access to care and financial protection

The system of premium subsidies to low-income individuals is broadly adequate…

With high out-of-pocket payments and health-insurance premia that are not related to income, the health-financing structure of the Swiss health system is regressive. However, the Swiss system of premium subsidies for low-income individuals – coupled with cost-sharing exemptions for certain vulnerable groups and annual ceilings on the overall level of deductibles – has markedly improved the financial protection offered against high health costs. This has thereby reduced the potential adverse distributional impact of the regressive health-financing system for low-income and, at least to some extent, middle-income individuals (a third of the Swiss population and 41% of households receive subsidies). This, coupled with the universal coverage for medical insurance, helps explain why there are few inequities in access to General Practitioners (GPs) and hospital services by income level in the Swiss health system after adjusting for perceived health status.

… but the lack of national standards reduces horizontal equity in health financing…

There are strong arguments for maintaining the current cantonal-based system of premium subsidies as such arrangements can better reflect local constraints, possibilities and policy preferences. Decentralised administration of the subsidy system can also reduce incentives for fraud through tight administration. Nonetheless, the lack of uniform eligibility and adequacy criteria for premium subsidies raises questions about horizontal equity in health financing *across* cantons. The newly introduced measure to reduce premia for children and young people in training from middle- and low-income families will further ease the financing burden on those households most likely to experience financial distress due to high health-insurance premia. However, it does not address cross-cantonal differences in either subsidy levels or eligibility conditions. Cantons also differ in their capacity to administer, monitor and assess the adequacy of subsidy arrangements. The key role played by cantons in administering a decentralised subsidy system should, therefore, be accompanied by the enhancement of federal powers to enforce agreed standards of social adequacy to which all cantons should conform. These standards should both specify a minimal national income cut-off point for receipt of a subsidy (so that premia do not exceed a given share of disposable income) and a minimal level of the subsidy in relation

to the level of the premia. These minimum standards could be set in the context of the overarching legal framework for health policy recommended below.

… and continued growth in health premia will pose policy challenges into the future

The high level and rapid growth of health-insurance premia are likely to pose further challenges in the future, particularly at the level of the cantons and households. Were premia to continue to rise at rates much above that of income, there will be growing pressure on household budgets and social-protection mechanisms are likely to be less effective, especially for large families, pensioners, and individuals with incomes just above the canton-set threshold for receiving subsidies. Premium inflation might also accelerate the existing trend towards greater reliance on high-deductible insurance policies. While these products enable individuals to reduce their premium burden, they also result in a shift away from collective to individual responsibility for the financing of care, necessarily weakening the degree of community-rating. This may lead the premium on ordinary insurance to rise more rapidly, so that any increases will fall more heavily on individuals with low deductibles who are likely to be in poorer health. While bonus insurance policies represent at present a very small share of the market, any increase in their take-up following pressures on households to finance larger premia would curb incentives, already low, for utilising preventive services. If social adequacy and access to care is to be preserved, cantons will eventually be required to increase subsidies (either in terms of the amount of the subsidy given to each individual or in terms of a larger number of eligible individuals).

Procedures for defining covered services need to be improved…

In the light of these trends, further efforts to improve the efficiency of the Swiss health system will be required. Concerning access and coverage issues, one key area for consideration over the medium to longer term is the desirability of more transparent and evidence-based procedures for determining the benefit package.

… even though this may be difficult to achieve

Although the list of benefits covered by mandatory health insurance is comprehensive, evaluations of the medical benefits and costs of services are not systematically undertaken. There are clearly limits to the ability to assess, scientifically, the services currently reimbursed under the LAMal, due to the fact that there is no positive list of procedures covered and that adequate information to evaluate the cost-effectiveness of individual medical procedures is lacking. In fact, other OECD countries have adopted procedures similar to those in use in Switzerland, whereby a complete evaluation is carried out only for selected procedures.

But a good start could be made in evaluating new medical technologies

To address this issue, Switzerland could adopt some useful practices regarding the evaluation of new technology, or technologies whose effectiveness is controversial, which have been implemented in other OECD countries. First, health services research must be strengthened in order to identify where Health Technology Assessment (HTA) is most needed. Second, a HTA programme should be established that would be responsible for evaluating technologies according to proven scientific criteria of efficacy, safety, effectiveness and efficiency. It should also seek co-operation with similar bodies in other countries to avoid duplication of the evidence of medical procedures. Third, the evaluation of technologies should be independently commissioned or carried out by an independent HTA programme, as opposed to the current system whereby an evaluation is carried out only in the case of differences in views between stakeholders over covered (or non-covered) benefits, and where evidence to support a case is provided by the parties involved. Finally, the analysis and assessment reports leading to recommendations on benefit coverage should be published, thereby improving the legitimacy of the process.

The current system of financing long-term care costs appears appropriate

Financing the increasing demand for long-term care (LTC) services will be a significant challenge for Switzerland, as it will be for many other OECD countries. The Swiss system of LTC coverage offers a combination of approaches adopted in other OECD countries. As in universal systems with population-wide access, the LAMal offers coverage of LTC costs to the entire resident population – albeit only for the *medical component* of overall LTC outlays. As in other countries that target public support only on lower-income individuals or on those with most severe disabilities, the system provides only targeted financing of non-medical LTC cost components, which is available through various social schemes on the basis of income and asset testing. This approach appears appropriate to prevent catastrophically high personal cost, while requiring those who can finance their own care to make a personal contribution. As LTC costs are likely to continue growing into the future, Swiss authorities should monitor that social-protection mechanisms for the coverage of non-medical costs are effective. In this context, programmes for delaying and preventing the need for long-term care among the elderly should be developed.

6.3. Efficiency and financial sustainability

Addressing health-system inefficiencies would help improving the cost performance of the Swiss health system

Swiss GDP has grown at a sluggish pace over the past decade. Even though the growth rate of health spending has been below the OECD average, the cost of health care has largely outstripped the growth of national income needed to finance it. As a consequence, there is great pressure to improve cost control and to raise the efficiency of provision. A

range of instruments, discussed below, may help improve the performance of the Swiss health system in these areas.

6.3.1. Payment mechanisms

Payment mechanisms in ambulatory care could furnish greater performance incentives…

Incentives for an efficient use of health-care resources could be strengthened. In the ambulatory-care sector, fee-for-service reimbursement encourages providers to supply unnecessary treatments as well as care at higher specialist level and cost. It also contributes to fragmented care and potentially to inadequate co-ordination of care, particularly for patients with chronic conditions and those requiring multiple contacts with the health system. The recent introduction of the TARMED, which brought the payment of ambulatory-care treatments more in line with the associated resource costs and assigned less weight to "technical" acts, has increased transparency in pricing and, as such, is a step in the right direction. Efforts to further refine this pricing tool to ensure cost neutrality beyond the initially planned period of 18 months, and to avoid reduction in services in certain specialities would be desirable. Such arrangements, if supported by adequate data, could permit closer tracking of provider behaviour, particularly as regards the tendency to over supply under fee-for-service payment arrangements.

But the TARMED is only one of a range of alternative payment arrangements that could include capitation, wages or flat-rate payments. Incentives to over-supply could be further reduced by combining fee-for-service with elements of prospective payments (such as population-based capitation), bearing in mind that no pure payment mechanism is optimal in terms of all health-system goals. Expanding such payment arrangements would first require extending the coverage of family-doctor gatekeeper or managed-care insurance products that can be offered by insurers (but are little used because of their unpopularity with insurees). The authorities could accelerate this process by introducing regulations and incentives to make such arrangements more attractive, for example by reducing rates of cost-sharing on these products and services. Alternatively, the authorities could require all insurees to choose a family doctor who would monitor access to specialised services, combined with higher co-insurance rates for individuals bypassing the referral system (as has recently been introduced in France). While this would mean some reduction in the complete freedom of choice of patients, it has the potential to improve quality through better continuity and co-ordination of care, and will discourage any unnecessary use of costly specialised services. Mixed-payment systems could also be used to improve supply of ambulatory care in rural and remote areas.

… and the pricing and financing of the hospital sector should be reformed

As regards the hospital sector, the shift to prospective per-case-payments, such as Diagnosis-Related Groups (DRGs), will encourage providers to deliver care more efficiently and effectively and, provided this is coupled with measures to reduce excess supply, this process should be accelerated. However, a single financing/payer mechanism for hospitals – with the DRG point value including both capital and running costs – is a necessary condition for encouraging the search for efficiency gains. At present, hospital running

costs are financed through approximately equal shares paid by cantons and by LAMal insurers. This method of dual hospital financing reduces the incentive to cut hospital cost and encourages a misallocation of resources between ambulatory and hospital care. Furthermore, the system also creates an uneven playing field between hospitals receiving cantonal subsidies and those not eligible for subsidies, making the former appear more cost efficient than they actually are. Additional cost and pricing distortions arise because, for the most part, the contracting costs do not include the capital costs that remain a charge to the cantons.

It would be more appropriate for insurers to take on the full role of purchaser of hospital services and that cantonal subsidies are channelled – with some exceptions as described below – into single-payer arrangements. This could take several forms. For example, cantonal subsidies could be allocated to insurees to reduce the burden of LAMal premia, either as flat "voucher" payments to each individual or as means-tested allowances to eligible insurees. Hospital prices paid by insurers would thus reflect full cost, thereby encouraging insurers to put pressure on hospitals to raise efficiency and allocate resources more efficiently between hospital and less-expensive ambulatory-care services. The higher insurance premia would also provide insurees with incentives to switch to lower-priced insurers. Alternatively, cantonal subsidies could be allocated directly to LAMal insurers (to reduce the net cost of LAMal to the insurer), thereby avoiding sharp increases in premia. Either option, as well as any others aimed at giving a stronger role to insurers, would need to be balanced by explicit contractual obligations by the insurers to ensure access and improved accountability to the insurees and to patients.

6.3.2. Pharmaceutical policy

Pharmaceutical policy could be better oriented towards cost-effectiveness

Reforms to encourage a more effective use of pharmaceuticals would be desirable. Further initiatives, beyond those recently taken by the government, could involve a mix of regulation and incentives directed both at the demand and supply sides.

Continued encouragement of cheaper bioequivalent generics would be desirable…

Demand-side measures should continue to require higher levels of cost-sharing for reimbursed drugs for which a cheaper bioequivalent substitute is available. In addition, drugs could be categorised depending on their therapeutic value, and this categorisation should be tied to different reimbursement rates, as is the practice in many other OECD countries. Measures directed at the dispensing of pharmaceuticals should also receive attention. For example, removing the obligation for pharmacists to inform the prescribing doctor whenever a branded product is replaced by a lower-priced generic would reduce pharmacists' disincentives to substitute the latter for the former.

… as would the removal of policies allowing doctors to dispense pharmaceuticals…

Cantonal policies that allow doctors to dispense drugs cannot be justified on access and public-health grounds. In fact, this policy creates incentives for doctors to over-prescribe and does not offer encouragement to dispense cheaper bioequivalent generics. Switzerland is unique in this respect compared with other OECD countries where, with very few exceptions concerning areas where access to pharmacies would pose extreme difficulty, doctors have been prohibited from dispensing pharmaceuticals, resulting in cost savings with no negative implications for patients. A possible alternative measure to the one banning physicians from dispensing drugs could be to change payment systems to ensure that doctors do not earn income from the dispensing of pharmaceuticals.

… and policies to encourage price competition

Although international drug price comparisons are difficult and have often been limited to Germany, pharmaceuticals appear relatively expensive in Switzerland, especially for drugs introduced prior to 1996. This has raised criticisms over the pricing and reimbursement policies in use in the mandatory health-insurance system. This is an area where reforms are both desirable and complex to design. Pharmaceutical pricing policies need to strike a difficult balance between providing incentives for research and development by pharmaceutical companies – a lead export industry in Switzerland – and ensuring affordable access to cost-effective treatments. The federal authorities have already taken steps in this area, for example through recent measures to cut prices of existing medicines in 2006 and by requiring more frequent revisions of the prices of reimbursed drugs.

Additional desirable measures would include a further opening of the market to foreign competition for reimbursed and non-reimbursed drugs where the patent has fallen into the public domain. Simplified procedures for market entry of generics exist but bioequivalent substitutes still account for a small share of the market. For these drugs, the insurers should be obliged to reimburse drugs in the Specialty List (SL) purchased abroad and pharmacists and other providers should be allowed to directly import these products once they have been authorised. In the same context, the admission and import of authorised drugs should be facilitated by eliminating any unnecessary regulations preventing market access.

For patented drugs, the group of reference countries used for international price comparisons should be enlarged. The transparency in the process of price setting for new innovative products covered by the LAMal could also be enhanced by publishing decisions and the reasoning behind them.

6.3.3. Cost-sharing measures

Demand-side measures should encourage better efficiency incentives for consumers

There is a case for revising the current pattern of cost-sharing. Insurees have few incentives to consume care prudently once they approach or exceed the level of

deductibles. In addition, the structure of cost-sharing is uniform across services with different price elasticities, cost-effectiveness and clinical need.

However, policies in this area should not focus uniquely on cost-containment or on reducing consumption of those services more subject to consumer discretion. The share of out-of-pocket spending in total health expenditure and household consumption is already high by international standards and yet more cost-sharing may cause access problems. International evidence also suggests that patients respond to increased cost-sharing by reducing the use of both medically necessary as well as unnecessary health services.

Rather, cost-sharing policies should attempt to steer health-care consumption towards more appropriate care (for example prevention services of proven clinical value) and away from less desirable or more costly but not always necessary clinical interventions (for example, discouraging the use of branded products when cheaper and equally efficacious generics are available).

6.3.4. New arrangements for contracting and regulating supply

More effective regulation of supply is needed but is politically unpopular…

Although international comparability of data on the supply of health-care services is not strong, available information suggests that current supplies of medical personnel and high-technology equipment are generous in Switzerland relative to the OECD average. In the hospital sector the number of acute-care beds is slightly below the OECD average. However, additional capacity could be freed up by reducing the long lengths of stay, for example through a move to DRG-type payments, by making a larger use of day-care surgery and by changing the dual hospital-financing arrangement to moderate incentives to hospitalise. Large cross-cantonal variation in hospital supply and in ambulatory-care services, which are associated with small differences in outcomes, also suggests that the same performance could be achieved at lower levels of inputs, thus contributing to higher system productivity and lower cost. The wider use of DRGs will also increase transparency by facilitating cross-cantonal comparisons of price.

Reducing capacity has, however, not proved easy. Switzerland relies on a mix of incentives emanating from the insurance market and the planning authority of the cantons to regulate supply in the hospital and ambulatory-care sectors, neither of which has been very effective. Higher overall costs have been placing pressure on cantons to increase the cost-efficiency of hospitals. However, efforts by the cantons to rationalise supply have resulted in strong public outcry, often leading, in turn, to a reversal of reforms. Insurers acting together have been successful in encouraging a few cantons to cut hospital costs by refusing to cover their above-average costs. The scope for further action on the part of the insurers is, however, limited by the current restrictions on selective contracting. In the ambulatory-care sector, the freeze in the opening of new office-based practices has probably reduced inflows of doctors into the medical labour market. But it does not pressure existing providers to improve quality and efficiency and may not be an adequate policy tool to address the challenges of an ageing medical workforce and the difficulty in finding enough doctors willing to practise in rural areas.

… and cantonal boundaries in the organisation of health-delivery and insurance markets should be removed

A unique feature of the Swiss system that strongly conditions the potential success of any reform is the current approach to regulating health-care provision and insurance markets at the canton level. Despite its small size and population, the Swiss health system is made up of 26, by and large self-governing, health systems. The LAMal, which requires health insurers to operate *within* cantonal boundaries and encourages patients to seek treatment in their home canton, has reinforced such divisions. This leads to limitations of consumer choice and shields poor-performing insurers and providers from market pressures to raise their game. While the LAMal allows for inter-cantonal hospital planning, it does little to encourage it and hospital planning with few exceptions takes place at the canton level. This results in the duplication and inefficient organisation in supply (particularly for complex and uncommon procedures) across cantons. It also reduces the scope for active competition at the insurer and provider level because of the small number of provider units. Irrespective of the model adopted for addressing current shortcomings of the system, both market-based and planning approaches should take place on the basis of wider catchment areas. This is particularly important for procedures where there is a relationship between the number of cases a doctor performs per year and mortality (or other types of health outcomes) during the procedure. Arrangements to organise activity around wider geographical areas than the canton have been introduced in other areas of cantonal responsibility, such as medical research and innovation, and there seems to be no good reason why similar approaches could not be applied to health care more broadly.

Different reform models are possible

There is no unanimous agreement on how best to structure and combine reforms in insurance markets and state planning to improve the ability to regulate health-care supply. Views differ as to whether this requires overhauling the system drastically, with a move to a single-insurer model or, conversely, allowing greater competition in insurance markets to rationalise the number of insurers nationwide and increase pressures on providers to control costs. Each model raises opportunities and challenges, not the least being the need to avoid negative effects on care quality and access. It also requires judging how feasible it would be to change existing structures and institutional arrangements.

There are arguments both in favour and against a single-insurer system…

A significant group in the population argues that reliance on a multiple-payer system should be abandoned in favour of a single insurer. One proposal for a unique insurer in health – drawing on the example of the main public accident insurer, SUVA – will be voted in a popular referendum in 2007. There are both advantages and drawbacks to a single-insurer model. In the arrangements proposed, premia would be income related. It can be more effective in containing cost by using its stronger purchasing position to place greater pressure on providers to cut costs and it should also have lower administrative costs than multiple-payer systems, as shown by the experience of other OECD countries (OECD, 2003b;

OECD, 2004c; Hussay and Anderson, 2003). A single-payer system also has greater incentives to invest in prevention and better co-ordination of care to handle high-risk cases and usually relies on a single database to monitor quality of providers and hospitals. On the other hand, a single insurer eliminates consumer choice among insurance funds and can inhibit innovation in insurance products and practices. If prices are kept too low through strong purchasing power relative to providers, there is a risk of underprovision and rationing of care. The absence of competition in insurance markets can enforce a monolithic organisation that is open to political pressures and has a bureaucratic management style with little incentives to innovate. There is also no assurance that such arrangements can sustain slower growth in the costs of providing health care over the longer haul. In this context, it is also worth noting that other insurance models could be considered. For example, Belgium combines the financing of health care expenditure through a single fund with competing insurers. The fund makes capitated transfers to competing non-profit insurers who provide the health cover and pay providers.

… but a move to a single insurer could pose a number of implementation challenges

While both single and multiple-payer systems have their own strengths and weaknesses, it is also fair to say that a move to a system based on a single insurer would – as with any major reform – raise a number of practical challenges. For a start, it is unclear how to deal with current health insurers going out of business. Furthermore, big-bang changes can be difficult to implement compared with a gradual change that builds on existing structures and traditions. This may be the case in Switzerland, where the tradition of consensus building and the functioning of direct democracy make the reform process slow.

Strengthening competition in a multi-payer system requires several conditions to be in place…

Rather than changing the system radically, the government has proposed to reform the Health-insurance Law by strengthening market-based cost-control mechanisms. This model of regulated competition would enhance provider competition and the ability of the market to regulate supply. The reform experiences of other OECD countries suggest, nonetheless, that this is not an easy path to take either. Furthermore, there is no clear international evidence that increased competition amongst insurers would improve the quality or efficiency of care. Unless a number of key features are put in place, the expectations of the government as regards the impact of the proposed reform on cost-efficiency are unlikely to be met.

… instruments to enhance competition in insurance markets…

To optimise the likelihood of success under this reform approach, competition in insurance markets needs first of all to be aligned with incentives to increase quality and efficiency. This requires measures both to discourage competition based on the selection of preferred risks and to stimulate insurees to act as informed purchasers of health insurance.

In this context, risk-adjustment mechanisms should be institutionalised as a permanent feature of the LAMal. Risk compensation is necessary to ensure effective competition in health-insurance systems with community-rated premia. As competition should ideally extend across cantonal boundaries, so compensation mechanisms should pool risks at the national level. Improved methods of risk adjustment are also desirable. Evidence from Switzerland and other OECD countries suggests that insurers find risk selection a convenient ground for reducing outlays by attracting clients with low risks. Such incentives are difficult to overcome, even where there is regulation forbidding cream-skimming. Nonetheless, the introduction of more effective risk equalisation could be a first step to help stimulate competition on the basis of value by making risk selection less profitable or easy. Although finding acceptable and effective indicators of individual risk remains difficult, the use of diagnostic information would be a clear improvement over the current reliance on demographic risk adjusters. In addition, existing arrangements based on *ex post* cost compensation across insurers should be replaced by a prospective approach, with the transfers based on the risk structures at the beginning of the period. The experience of other OECD countries that have implemented refined risk-equalisation systems, such as the Netherlands, could offer a possible model.

As long as insurers are themselves shielded from demand-driven competitive pressures – for example, because individuals do not switch to best-performing insurers – their incentives to cut costs and improve quality will remain low, especially in a context where funds are banned from making profits. A measure that might be considered to reduce the transaction cost of individual switching of insurer is to prohibit LAMal insurers from offering supplementary cover and requiring separate billing for services covered by basic and voluntary health insurance. The Swiss authorities have already taken steps to separate basic from supplementary insurance by prohibiting tie-ins in the sale of such cover. Furthermore, available comparative information on health-insurer premia is sufficiently transparent and appears by and large adequate to encourage consumers to make price-conscious choices. Thus, individuals may well be making a conscious choice about not switching from an insurer they feel particular allegiance to, even despite large premium differences across them. This revealed low price sensitivity may slow down the establishment of competitive pressures in the Swiss market.

… improved incentives for providers…

Second, the Swiss provider institutions need to face a harder budget constraint. At present, many public hospitals owned by cantons do not have sufficient managerial independence and budgetary accountability, with cantons often intervening to bail them out financially. Unless hospitals become freestanding, independent organisations (either non-profit or for-profit) with full responsibility to payers, the authorities may step into the market and unwind unpopular market outcomes, even when those changes produce efficiency improvements.

… and new contracting mechanisms operating at national level or in large regions grouping cantons

Third, selective contracting between insurers and providers should be allowed. Insurers are currently required to contract with all health-care institutions and medical

personnel, except in the case of managed-care arrangements. Selective contracting would permit insurers to negotiate contracts with individual providers, thereby putting greater pressure on them to perform. Current proposals that limit selective contracting to the ambulatory and ambulatory-hospital sectors need to be widened to include inpatient institutions, where there is greater potential for efficiency gains through, *inter alia*, reductions in supply.

Conditions should also be created for ensuring the application of cartel law to the health system, in particular rules forbidding professional associations negotiating tariffs collectively. However, selective contracting will be more complex – requiring individual contracts with providers rather than the current approach where insurers and providers negotiate as a group. This could be potentially more costly from an administrative standpoint than the current arrangements. This will depend on the degree of information asymmetry in favour of providers (a characteristic found in most health-care systems) and on the degree and intensity of oversight needed to achieve the desired cost savings and to assess quality. There is no firm international evidence that the efficiency gains of selective contracting exceed the higher transaction costs.

Furthermore, for competition to be effective, it must take place on a national level (or include large groups of cantons) in order to ensure that the threat of a refusal to contract by insurers is credible. This condition is likely to be satisfied at present only in a few larger urban areas where there are significant numbers of potentially competing providers. In addition, implementing selective contracting can also run into opposition from providers (who resist external influences on their clinical freedom), and consumers (who are unwilling to accept limitations to patient choice of doctor and hospital). These factors may diminish incentives for, and the ability of, insurers to engage in these new contractual arrangements.

New regulatory arrangements are also needed to ensure…

Finally, new regulatory arrangements would need to be designed to ensure:

- Better information on the performance of the health-care system to inform choices of insurers and providers in competitive markets.
- Improved standards of quality and patient responsiveness.
- An adequate supply of public-service components of health care, such as Accident and Emergency (A&E) services.
- Longer-term planning of supply – for both physical and human capital.

… better information on the performance of the health-care system…

At present, the ability of insurers to act as agents in the best financial and clinical interests of insurees has been widely questioned. As long as the public resists restrictions on its choice of providers or does not trust insurers to make optimal choices on their behalf, insurers themselves will have little incentives to engage in selective contracting for fear of losing market shares. Building confidence of the insurees in any new arrangements will require increased information on health-care performance. This is also needed to

provide insurers with adequate information to motivate and support their bargaining position and make value-based contracting feasible. In addition, efforts to introduce competition in other OECD countries have encountered problems of information asymmetry, where the insurers lack adequate oversight over providers' operations and claims. Improved information systems organised at a national level would help in this context. A clear example concerns information on quality of care, as mentioned earlier.

… improved standards of quality, access and patient responsiveness…

Accepted minimum standards for access (particularly in rural areas), quality of care and responsiveness to patient needs are required. These must be accompanied by a clear accountability framework for insurers and the publication of information to demonstrate that these goals are being met. The introduction of a system of monitoring of outcomes and use of services would provide additional assurance that high quality of care is being achieved. These standards would need to be set at national level and both cantonal and federal authorities should share responsibility for monitoring (and eventually sanctioning) undesirable provider and insurers' performance.

… assurance of public-service components of health care…

Related to this, the authorities will also need to ensure that public-service obligations – such as the availability of A&E services, of medical research, of training for medical personnel and of prevention services – are organised and provided for financially. These are areas where competitive markets tend to fail as insurers have no financial incentives to invest in these activities and it is easy for them to free-ride on the system. One way to overcome such market failures would be through the specification of contractual requirements for insurers to provide minimum standards of public service. If this proves difficult or impossible, public authorities would need to continue making direct subsidies to providers to ensure a desirable level of supply. Once again, these are best organised on a regional or national level.

… and longer-term planning of supply

Finally, the need to take a longer-term view over supply needs will require collective planning, even in a context of competing health-insurance markets. Ageing populations are already modifying the pattern of demand and the type of care that is needed. The hospital system will need to be progressively reorganised as specialisation increases and the content of care changes. As in other OECD countries, Switzerland will soon face declines in supply of health personnel as the baby-boom generation moves into retirement. Policies concerning the health-sector workforce are best discussed at the national level, while changes in the hospital sector would be best organised at the multi-cantonal level.

In the light of these future developments, the authorities may need to put in place – in good time – appropriate incentives and regulatory arrangements to ensure adequate supplies of health workers, as well as arrangements to ensure continuing improvement in

the human capital and skills of existing providers. In this context, policies may also need to focus on encouraging an increase in the number of generalists per head of the population, which appears to be low relative to most OECD countries. Over the shorter run, more attention may need to be paid to ensuring adequate ambulatory service supply in rural areas. For example, a mixed of financial and non-financial incentives could be introduced to attract health workers in rural and more remote areas.

6.4. Systemic issues for the longer-term

The governance of the Swiss health system needs strengthening

An obvious conclusion of this report is that the ability to sustain longer-term gains in system performance is dependent upon the capacity of the Swiss authorities to address systemic issues related to the governance of the Swiss heath system. These are summarised below.

The longer-term goal should be an overarching framework law for health to clearly delimit federal and cantonal responsibilities and set national standards…

Switzerland lacks an overarching framework law for health and its introduction should be a longer-term goal. Through such a law, the federal government should ensure that cantons and insurers meet certain agreed requirements or national principles. The law would clearly specify objectives and priorities, funding responsibilities, and address penalties. It would also set common governance structures for lower institutional levels and address shared tasks across different levels of government. These would guide cantons in shaping local-level policies throughout the country and would help steer cross-cantonal co-ordination initiatives. The law would also set the framework within which other federal laws, such as the LAMal and a possible future law on health prevention and promotion, would be operating.

To the degree that such a framework would require changes to the respective responsibilities of the federal authorities and the cantons, constitutional changes would be required. However, this should not be an insurmountable barrier. The recent constitutional changes in the area of education, which aim at a better harmonisation of education policy across cantons, illustrate that constitutional changes to improve policy coherence in the area of health are also possible.

… information systems must be improved…

The current weakness of information on system performance is a persistent obstacle to vigorous and objective evidence-based policy making, without which it will be more difficult to improve value for money. The opaqueness of the Swiss health system is evident in several areas and at several levels, including for example the lack of information on health-system quality and responsiveness, inadequate data on human resources and their utilisation, and the lack of detailed information on spending patterns, within and across

cantons. Lack of transparency reduces the ability to monitor and anticipate complex health-system changes. It makes it difficult to build accountability and performance mandates. It is also responsible for the absence of mutual trust across different actors in the system. Improved data collection and the establishment of adequate health-information systems must therefore be a priority. A better and harmonised information base for the Swiss health system would allow the setting of performance benchmarks across the cantons. The use of electronic patient records should also be strengthened and such information fed into the forthcoming system of insuree cards. This could possibly contribute to reduce duplication of services. Cantons should be required to supply a minimum set of data based on common methods and standards. Minimal requirements for data disclosure should apply to the medical profession and the insurers' association.

… and barriers between cantons should be gradually lifted

The analysis contained in this report has argued that a major weakness of the Swiss health system is its dependence on narrow geographical areas and small populations to organise competition across insurers and to manage providers. This calls for a progressive lifting of the barriers to inter-cantonal arrangements and a re-orientation of their responsibilities from the direct provision of care to enhanced responsibility for monitoring local health outcomes. This would require the development of a new general framework law and federal-cantonal agreement to set up an improved information base in order to enhance cost-efficiency. The LAMal should be formulated with this re-focusing of local responsibilities in mind, and this would be independent from the specific model of reform adopted by the Swiss authorities and population. Cantons should also play an increasingly important role of market oversight, ensuring that minimal standards of care are being met and that imbalances at the local level do not arise This would respect the Swiss emphasis on negotiation and consensus building.

*
* *

The Swiss health system has major achievements to its credit but looming challenges mean it should not rest on its laurels

With relatively good indicators of health status, unrestricted access to care, freedom of choice of provider, high levels of care quality and patient satisfaction, the Swiss health system appears to have successfully met a range of important goals. However, these successes have come at a cost. Health spending has been rising more rapidly than the capacity of the economy to finance it. Switzerland now has the second highest share of health spending in GDP among OECD countries. Up to the present, the benefits of the system appear to have outweighed the perceived costs, leading to broad public support that could continue into the future. But if costs continue to rise and weigh more heavily on the economy and living standards, the system will come under increasing pressure for reform. On the demand side, this may mean some loss of freedom of choice on the part of patients. It will also require measures to address current inefficiencies in supply. Such

reforms will require changes in the way the system operates, in particular with regard to system-wide governance. This report has suggested a range of proposals for consideration. While the public debate is likely to be lengthy and animated, it is to be hoped that these proposals will contribute to a broad consensus on how to preserve the existing Swiss achievements via a more efficient and effective health system.

Box 6.1. **Policy recommendations for reforming the Swiss health system**

1. Improve the overall **governance** of the Swiss health system by:
   - *a)* Designing an overarching legal framework for health at the federal level.
   - *b)* Establishing national health-information systems, especially in relation to: quality of medical care; system responsiveness; health workforce; and medical services.
   - *c)* Investing in new information technology, for example by introducing electronic patient records and individual computerised smart cards to improve the co-ordination and delivery of health care.
   - *d)* Creating a new regulatory framework to provide: *i)* comparative performance data on insurers and providers; *ii)* minimum guarantees of adequacy and quality of care; *iii)* adequate public-service obligations (*e.g.*, A&E services); and *iv)* long-term planning for supply needs.
2. Reform **financing arrangements** to stimulate efficiency in the Swiss health system by:
   - *a)* Encouraging the introduction of mixed payment mechanisms for ambulatory-care doctors and supporting the introduction of gatekeeping arrangements.
   - *b)* Creating harder budget constraints for institutional providers.
   - *c)* Shifting to a single financing system for hospitals with state subsidies allocated directly to insurees (or insurers).
   - *d)* Re-designing cost-sharing arrangements to encourage greater use of generics and the utilisation of cost-effective medical goods and services (*e.g.*, prevention activities of proven cost-effectiveness).
   - *e)* Implementing policies to monitor and encourage cost-effective prescribing and utilisation of pharmaceuticals, for example by opening up the market for non-patented drugs to foreign competition and banning doctors from dispensing drugs.
3. If the path of increased reliance on **market mechanisms** to regulate supply in the system is pursued, create better conditions for value-based competition in the health insurance and provider markets by:
   - *a)* Organising supply and competition between providers and insurers at a national or multi-cantonal level.
   - *b)* Modifying the risk-compensation mechanism to include risk adjusters based on health indicators.
   - *c)* Allowing selective contracting between insurers and providers and ensuring the application of cartel law to the health system.
   - *d)* Reducing impediments to and cost s of switching between insurers (*e.g.*, by enforcing a complete separation between the provision of LAMal insurance and voluntary insurance).

Box 6.1. **Policy recommendations for reforming the Swiss health system** *(cont.)*

4. Develop **public-health interventions** and strengthen the **cost-effectiveness** of covered services by:
   a) Designing a federal law on public health and prevention setting general objectives, assigning clear responsibilities and specifying financing methods.
   b) Assessing, systematically, health-promotion and disease-prevention programmes, implemented at both the national and cantonal levels.
   c) Facilitating the implementation of proven cost-effective prevention measures, for example by making greater use of tobacco and alcohol taxes to deter consumption and implementing a national breast-cancer screening programme.
   d) Ensuring that the benefits covered by the LAMal maximise value by introducing new procedures for independent assessment of services, strengthening the use of cost-effectiveness analysis and publishing assessment reports.
5. Promote better **management of clinical quality** by:
   a) Encouraging transparent mechanisms of professional self-regulation.
   b) Supporting nation-wide initiatives of care quality and strengthening data collection at the federal level.
   c) Developing a nation-wide system to monitor and improve the quality of care in terms of structure, process and clinical outcomes.
6. Encourage horizontal and vertical health-financing **equity** by:
   a) Specifying minimum national criteria to be met by cantons in administering subsidies to low-income individuals and households.
   b) Monitoring the effectiveness of social-protection mechanisms (premium subsidies, cost-sharing exemptions) in alleviating the adverse effects of the regressive health-financing structure.
   c) Ensuring that all medical long-term care (LTC) costs are covered by LAMal-insurers and that social-protection mechanisms for the coverage of non-medical cost sustained by low-income individuals are effective.

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List of Acronyms

AA	Assurance-accident (Accident Insurance)
A&E	Accident and Emergency services
AVS-AI	Assurance-invalidité, Assurance-vieillesse (Disability Insurance, Old-Age Pensions)
AM	Assurance-militaire (Military Insurance)
AP-DRG	All-patients Diagnosis-related Group classification
BMI	Body Mass Index
CDS	Conférence des Directeurs cantonaux des affaires sanitaires (Conference of the Cantonal Ministers of Public Health)
CHOICE	Choosing Interventions that are Cost-Effective
COPD	Chronic Obstructive Pulmonary Disease
DALY	Disability Adjusted Life Years
DRG	Diagnosis-related Group
EFTA	European Free Trade Agreement
EU	European Union
FMH	Fédération des médecins suisses (Swiss Medical Association)
FOPH	Federal Office of Public Health
GATT	General Agreement of Tariffs and Trade
GDP	Gross Domestic Product
GNP	Gross National Product
HMO	Health Maintenance Organisation
HTA	Health Technology Assessment
ICD	International Classification of Disease
IPA	Independent Practice Association
LAA	Loi fédérale sur l'assurance-accident (Federal Law on Accident Insurance)
LAI	Loi sur l'assurance-invalidité (Law on Disability Insurance)
LCA	Loi sur le contrat d'assurance (Insurance Contract Law)
LAMA	Loi fédérale sur l'assurance-maladie (Federal Accident and Sickness Law)
LAMal	Loi fédérale sur l'assurance-maladie (Federal Health-insurance Law)
LEPM	Federal Law concerning the Professional Practice of Doctors, Pharmacists and Veterinarians
LPMed	Law on University-based Medical Professions
LTC	Long-term care
OECD	Organisation for Economic Co-operation and Development
OFS	Office fédéral de la statistique (Federal Office of Statistics)
OFAP	Office fédéral des assurances privées (Federal Private Insurance Office)
OFAS	Office fédéral des assurances sociales (Federal Office for Social Security)
OFSP	Office fédéral de la santé publique (Federal Office of Public Health)

OPAS	Ordonnance fédérale sur les prestations de l'assurance des soins (Federal Ruling on Health Insurance Benefits)
PPO	Preferred Provider Organisation
PPP	Purchasing Power Parity
PPPS2010	Commission spécialisée prévention plus promotion de la santé 2010
PYLL	Potential Years of Life Lost
RBP	Rémunération basée sur les prestations (Fee-for-Service)
SL	Specialty List
SPITEX	Acronym for domestic aid and day-care services
SUVA	Schweizerische Unfall- und Versicherungsanstalt (Swiss National Accident Insurer)
SWISSMEDIC	Institut suisse des produits thérapeutiques (Swiss Agency for Therapeutic Products)
TARMED	Unified Relative Tariff System
WHO	World Health Organisation
WTO	World Trade Organisation

Canton Abbreviations

CH	Switzerland
AI	Appenzell Inner-Rhodes
AR	Appenzell Outer-Rhodes
AG	Aargau
BL	Basel-Country
BS	Basel-Town
BE	Bern
FR	Fribourg
GE	Geneva
GL	Glarus
GR	Grisons
JU	Jura
LU	Lucerne
NE	Neuchâtel
NW	Nidwalden
OW	Obwalden
SH	Schaffhausen
SZ	Schwyz
SO	Solothurn
SG	St. Gallen
TG	Thurgau
TI	Ticino
UR	Uri
VS	Valais
VD	Vaud
ZG	Zug
ZH	Zurich

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