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Foreword

This review of the Swiss health system was undertaken jointly by the OECD Secretariat and the World Health Organization (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), Finland (2005) and Turkey (2008, in co-operation with the World Bank) and updates the first review of the Swiss health system, published in 2006.

The review assesses the institutional arrangements and the performance of the Swiss health system. It particularly focuses on the issue of solidarity and efficiency of health insurance, the health workforce, and the reforms and governance of the Swiss health system. It also 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.

Francesca Colombo (OECD) and Pascal Zurn (WHO, Geneva) managed and co-ordinated the review of the Swiss health system. The main authors of this report are, in alphabetical order, Francesca Colombo (OECD), Ann-Lise Guisset (WHO Regional Office for Europe), Elke Jakubowski (WHO consultant, Department of Epidemiology, Social Medicine, and Health System Research at the Hannover Medical School), Ankit Kumar (OECD), Inke Mathauer (WHO, Geneva), Howard Oxley (OECD), Valérie Paris (OECD) and Pascal Zurn (WHO, Geneva), with significant contributions from Peter Donnelly (University of St Andrews) and Laura Stormont (WHO, Geneva). The authors wish to thank for their comments and suggestions John Martin, Stefano Scarpetta, Mark Pearson and Michael Schönstein from the OECD Secretariat; Jean-Marc Braichet, Manuel Dayrit, David Evans, and Jean Perrot from WHO, Geneva; as well as Hans Kluge, Joseph Kutzin, and Galina Perfilieva from the WHO Regional Office for Europe. They also wish to thank, from the OECD Secretariat, Margarita Xydia-Charmanta for statistical assistance, Judy Zinnemann for assistance and Marlène Mohier for her editing work, as well as, from WHO headquarters in Geneva, Lawrence Loh and Jennifer Edge for their contribution to the review and, especially, for their statistical and editing support.

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 February 2011. These included officials from different federal offices and agencies, in particular the Federal Office of Public Health and the Federal Office of Statistics; cantonal authorities; health insurers; hospitals, nursing homes and health professionals; consumer associations and non-governmental organisations; the pharmaceutical industry; and other health experts. René Schwendimann (University of Basel) provided useful information on RN4CAST study. 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, Patrizia Sieber-Zuercher and Gaudenz Silberschmidt. A draft report was sent to Swiss authorities for comments. The final report has benefited from comments by Swiss health experts and Swiss authorities.

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Introduction

This report reviews Switzerland's health system. It provides an update to the information and analysis presented in the *OECD Reviews of Health Systems: Switzerland* published by the OECD and the WHO in 2006. In addition, it discusses three central policy issues for Swiss authorities: health insurance, the health workforce and governance of the Swiss health system. The report seeks to examine key aspects of Switzerland's health system with a view to suggesting priorities for reform and providing insights from which other countries can learn.

The Swiss health system is high performing and responsive, reflected in high levels of patient satisfaction and one of the longest life expectancies in the world. Switzerland has combined a highly decentralised health care system with an almost unconstrained choice of providers and a comparatively high availability of health care services. However, this comes at a significant cost, with Switzerland spending more than most OECD countries on health care. The demands on the health system, and the economic pressures that are likely to accompany them, will only continue to increase as technology advances, the population ages and persons living with chronic disease become more common.

These changes will bring new challenges for policy and necessitate ongoing reforms. Health insurance through managed competition in Switzerland has delivered comprehensive coverage and choice. Improving the quality of care (particularly for those people who will need care with greater frequency and across multiple settings) while constraining costs, should be the focus for future reforms. This could begin with a more systematic use of cost-effectiveness criteria to determine what services should be available under the manadatory health insurance benefit package. Addressing costs and quality will also demand that Switzerland overcome co-ordination problems to define national policies for prevention and health promotion – where evidence already suggests value for money lies. So as to ensure that future reforms are well targeted, Switzerland should focus on improving health information and information technologies that can help drive improvements in the quality of care. These reforms ought to be undertaken along side the development of a long term national view on how to train more health personnel and make the most of Switzerland's exisiting health workforce.

Reforms undertaken over the past half decade should bring dividends over the years ahead. In particular, reforms to the financing of hospitals that are currently being implemented hold the potential to reduce the utilisation of hospitals in Switzerland. Reforms to pharmaceutical pricing have already begun to deliver rewards, and there is potential for future reforms to further increase value for money in pharmaceutical spending.

Driving future health policy reforms will require that the unique structures of governance in the Swiss health system continue to encourage services to be locally responsive and innovative. But they are also likely to demand that the governance

structures of the Swiss health system become more agile in delivering changes that are in the interests of all Swiss people. With an enhanced ability to adapt to the changing nature of future health challenges, there is every reason to think that Switzerland's health system can continue to remain amongst the best in the OECD.

This report contains five chapters which detail the OECD and WHO's analysis and suggestions for reform to Switzerland's health system. It first proposes some recommendations to improve the Swiss health system today and help address future challenges. Chapter 1 provides a description of the political, demograhic and economic context and outlines the key characteristics of the Swiss health system. Chapter 2 analyses trends in health insurance markets in terms of equity in health care financing and the nature and intensity of competition between insurers, with a particular a particular focus on the risk equalisation mechanism, managed care plans and the current insurance reform agenda. Chapter 3 examines the recent trends in Switzerland's health workforce, including training and migration, and discusses some challenges for the future. Chapter 4 assesses recent developments in several domains: hospital financing, prevention, quality of care and pharmaceutical policies. Chapter 5 examines governance in the Swiss health system and the process of reform.

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Assessment and Recommendations

Switzerland's health system is high-performing and fit for purpose, but it is also costly

People in Switzerland live longer than almost anywhere else in the world, supported by a high level of economic development and a responsive health system. Swiss residents benefit from their proximity to health services, a wide range of choice of providers and insurers, and broad coverage of essential medical and pharmaceutical services. The Swiss health system is among the best in the OECD. But this excellence comes at a price, with Switzerland spending 11.4% of GDP on health in 2009, well above the OECD average of 9.5% of GDP.

With 26 cantons each playing a key role in the health of the Swiss population, local flexibility and innovation is a strength of the Swiss health system. Switzerland's uniquely high level of direct political participation at all levels of government also provides citizens with scope to influence the direction of health policy. The high performance of Switzerland's health system is reflected in high levels of patient satisfaction.

Demands on the system are expected to increase further, particularly in dealing with chronic disease

Despite these remarkable achievements, policy makers will face significant challenges in maintaining and improving the Swiss health system in the future. Switzerland's population is older than that in most other OECD countries. At the same time, lifestyle changes today presage the rise of health risks within the Swiss population in the future. While still low, the prevalence of obesity is rising, particularly amongst young people. These trends, along with advances in medical technology, should result in Swiss residents being more likely to live with a chronic condition over the next few decades than they are today. Indeed, they may live with more than one chronic condition or morbidity. As these trends continue, demands on Switzerland's health services will increase.

The strengths of the Swiss system are also holding it back from dynamically responding to impending challenges

The Swiss health system of today will need to adapt to deal with these future challenges. In particular, the high availability of hospital services which has served Switzerland well in the past may not be sufficient for a future where the system will need to support increasing

numbers of people with ongoing care needs of potentially less acuity than hospitals are geared to deliver. The balance of effort needs to shift urgently to bolstering the other end of the spectrum – in promoting good health through a focus on public health, prevention and primary care.

Moreover, Switzerland has one of the most expensive health systems in the world as a share of the national output, even though the rate of growth in spending has slowed in the past few years. There are good reasons to think that expenditure pressures will remain high in the future. The hospitals sector is often a key driver of costs and, compared with other OECD countries, Switzerland has a high number of hospitals for its population and geographic size. The broad range of services covered by insurance is expanded regularly. This would be a good thing were it accompanied by a strong and transparent framework for assessing cost-effectiveness. However, outside health insurance plans with high deductibles or managed care, consumers and providers have few incentives to use appropriate quantities of health services. Nor have the different levels of government involved in health care employed hard budgetary controls. While information is limited, prices for health services in Switzerland appear to be relatively high. Expensive health care does not always equate to high-quality health care: the Swiss system needs to ensure it is receiving good value for money.

Having delivered universal coverage, high levels of access to services, and high levels of patient satisfaction, Switzerland should persist in pursuing health reforms. The Swiss political process places a premium on achieving consensus. This helps in securing broad commitment to reforms, but it can also make worthwhile changes difficult to implement or delay them unduly. The challenge for the years ahead will be to develop a system that can respond to the changing health risks and care needs of Swiss residents, such as:

- Reforms are needed to encourage the efficient co-ordination of care across multiple services and providers and over a lengthy period rather than a particular point in time, such as moving away from payment for single episodes of service.
- A different mix of skills will be required from Switzerland's health personnel and this will create an increased need for general practitioners and nurses in primary care.
- The multiple and highly decentralised levels of government involved in health need to be able to respond more quickly to changes, and develop more effective (and at times, more centralised) ways of delivering on national priorities.
- Inter-cantonal variations in health financing and access, while a function of Swiss preferences, may also mask inequities. Information currently available does not allow monitoring income-related inequities in financing health care.

Sketching out the directions that the Swiss system ought to follow to meet future challenges is hampered by a poor health information system. Policy cannot be "evidence-based" if inadequate effort is put into collecting the information necessary to generate evidence. Greater information on health outcomes and morbidity amenable to health care is required so that Swiss policy makers can accurately determine key health risks and who in their population faces them. Monitoring and reporting on the quality of care is currently limited to a selection of hospital indicators – which are not sufficient to empower patients, insurers and governments to make informed choices between all kinds of health service providers and settings. Statistics on outpatient activity and health personnel must also be developed. Well-informed policy requires a national minimum dataset encompassing key health information.

Managed competition amongst health insurers has delivered comprehensive coverage and choice. It must next address quality and costs

Swiss health insurance is comprehensive and offers consumers a significant range of choices. Health insurance is supported by subsidies to help families and those with lower incomes to afford health premiums. But even after taking into account these subsidies, the effective premium burden of households varies considerably both within and across cantons. Health insurance financing remains regressive, and together with relatively high out-of-pocket payments for health care, places financial stress on some households. At the same time, increases in health insurance costs are putting cantonal budgets under strain.

Insurers still have weak incentives and few levers to compete on efficiency and quality of health care services. Prices of services are most often negotiated at cantonal level between associations of insurers and providers, and for most insurance products, regulation obliging insurers to contract with *all* providers in a canton continues to restrain insurers from using purchasing to drive improvements in the quality of care.

Although rates of consumer switching among insurers have increased recently, especially amongst the young and healthy individuals, they are still low and suggest that consumer choice is not driving premium competition amongst insurers as proactively as it potentially could. Large variations in insurance premiums persist within cantons and insurers still compete on risk selection. The strengthening of the risk-equalisation scheme, with the addition of a new variable based on previous hospitalisation and stays in nursing homes from 2012 onwards, will partly address this problem. However, without a more active role in purchasing health care, the multiplicity of insurers only limits the capacity to pool funds and health risks, and can generate high administrative costs.

Although a growing number of insurees are subscribing to managed care products – such as physicians' networks, HMOs and call centres performing a triage function – they are not having a major impact on the health system today. It is likely that today's managed care contracts are being underutilised by insurers to deliver innovative care approaches and drive improvements in the quality of care. As they offer premium discounts in exchange for accepting a limitation in the choice of providers, managed care contracts are known to attract people with good health risk profiles. Higher risk insurees have been reluctant to switch to managed care contracts and to accept limitations in provider choice, both for fear that access to needed health care would be rationed and a lack of confidence in managed care's ability to offer better quality care for those with substantial health needs or multiple chronic conditions. However, as healthier persons are choosing managed care plans, the rising popularity of managed care (as well as high-deductible products) may further fragment the insurance market by separating citizens according to their health status and risks.

Nevertheless, managed care products still provide a framework with which the Swiss health insurance market could yield higher performance. Better incentives for both insurers and insurees are required to encourage managed care products that are successful in improving quality, efficiency and care co-ordination. Managed care products should encourage care providers to work as teams to deliver co-ordinated care, driven by incentives for quality and evidence on best-practice medicine. For example, these could encourage more widespread adoption of products that improve the effectiveness of care

delivered to people with chronic conditions (such as disease management approaches), or products that use electronic medical records and decision-making tools to address quality shortcomings and unexplained practice variations. They could also be used to encourage the introduction of alternatives to fee-for-service payment arrangements.

Switzerland should use cost-effectiveness criteria to determine what is in the benefit package

Expenditures on health are increasing in most OECD countries, and many of them are increasingly taking into account the cost-effectiveness of new treatments in deciding what insurers are obliged to cover. In Switzerland, the health insurance benefit package is centrally determined and the Health Insurance Law requires effectiveness, appropriateness and efficiency for inclusion of goods and services in the benefit basket. However, cost-effectiveness is not systematically assessed according to a well-defined and rigorous methodology and the decision-making process lacks transparency. As financial pressures from the health system increase, ensuring that investment is driven by evidence on cost-effectiveness would be worthwhile.

Future health workforce shortages demand a long-term national view, more health personnel and getting more out of Switzerland's existing health workforce

Switzerland enjoys a greater density of health professionals than most OECD countries, but there are some concerns about shortages in particular professions and geographical areas. At a time when Switzerland will need to rely increasingly on primary care personnel to co-ordinate and support patients living with chronic disease, the number of general practitioners has been declining relative to specialists, and there are substantial differences across cantons.

Looming workforce shortages are likely to occur at a time when the demography of the health workforce will change. The Swiss medical and nursing workforce is ageing and a significant number are expected to retire in the next two decades. At the same time, the increasing feminisation of the workforce, combined with the preferences of new generations, is driving a shift towards more flexible working hours. This desirable trend could be enhanced by further encouraging the development of group practices, which would also limit the professional isolation that doctors in independent practice often face.

Moreover, there is a need to develop a long-term national strategy for the health workforce. Health workforce policies require more co-ordination and planning – particularly between the education and health sectors. Further increases in medical and nursing student numbers beyond those recently implemented will be required to meet future health needs of an ageing population. Switzerland's traditionally high reliance on migrant health workers to tackle projected shortages will not be an efficient strategy in the longer run as it could make Switzerland too dependent on immigration to fill in demand for health professionals. It also raises international fairness issues with source countries. Efforts at national level should be undertaken to anticipate future shortages and ensure that educational institutions and training locations have the capacity to handle an increased number of students while maintaining the quality of education programmes. Of particular

importance will be the capacity for training in primary care, but other specialities in shortage require attention too.

At the same time, there is scope to improve working conditions through greater and better-designed financial and non-financial incentives. These include changes to relative payment schedules to support less popular professions and specialties, using managed care contracts to develop payment models that provide financial rewards for improved quality of care, and payments that provide greater flexibility to employ professionals engaged in care of chronic conditions (such as nurses in advanced roles). These changes could help attract and retain health workers, and will be needed if Switzerland is to continue to provide some of the best care in the world to its citizens.

Financing reforms hold the potential to reduce the utilisation of hospitals in Switzerland

More care is often not better care, yet the way hospitals are currently organised and financed in Switzerland encourages their utilisation. Fee-for-service arrangements in the ambulatory hospital sector and subsidies from cantons to public hospitals reward hospitals for doing more and provide weak incentives for cost moderation. This helps explain why, despite reductions over the past decade, hospital stays in Switzerland are longer than the OECD average and there are fewer day cases as a share of overall hospital cases in Switzerland than in several other countries. Recent reforms to introduce case-mix financing are a major step towards improving hospital efficiency. They will provide an incentive to reduce costs and focus on those services in which certain hospitals are most efficient. They should also discourage previous practices which encouraged loose budgetary controls, such as cantonal subsidies to help hospitals cover financial losses at the end of a year.

While these worthwhile reforms to hospital financing will help improve efficiency, the extent to which they do will depend on how they are implemented. Anticipated efficiency gains from case-mix payments could be compromised if cantonal governments subsidise hospitals beyond case-mix payments. Similarly, the dual roles of cantons in both financing and running hospitals may distort resource allocation in a way that compromises efficiency. With one of the highest number of hospitals relative to population in OECD countries, financing reforms are also likely to raise important questions about whether certain hospitals (particularly small hospitals) receive sufficient volumes to be viable under a case-mix system. In planning decisions about what level of hospital availability is desirable in the future, cantons should harness new information on the cost of hospital services, along with information on whether these hospitals are safe and deliver improved patient outcomes.

Switzerland should overcome co-ordination problems to define national policies for prevention and health promotion

A sustained and co-ordinated effort on prevention and health promotion is needed in Switzerland. The recently introduced smoking ban is one of the few major prevention policies since the previous OECD and WHO review five years ago (2006). This is a comparatively small development compared with those achieved in many other OECD

countries in recent years. The highly decentralised nature of the Swiss health system has encouraged the development of locally-relevant prevention programmes, but made it difficult to deliver broad-based policies to address major chronic disease risk factors, such as alcohol abuse and obesity. Similarly, progress on implementing measures with a proven value – such as a national programme for breast cancer screening – has been too slow.

This in part reflects fragmented leadership in prevention in Switzerland. Considerable discussions over recent years have delivered a proposed national law on prevention, which includes a proposal to place a body in charge of co-ordinating public health priorities and efforts across cantons. It remains to be seen whether this will have the institutional influence and financial clout needed to deliver broad-based prevention policies in practice. With cantons continuing to hold responsibility for implementing (and paying for) public health programmes, there is a need to develop human resources and expertise in public health within the existing organisational structures of Swiss governments. This will help support the development of health policies which re-orient the health system from curative care to proactively promoting good health.

In contrast to non-communicable diseases, co-ordination over health protection for communicable diseases in Switzerland has improved considerably. However, the decentralised nature of responsibilities across cantons can still create significant challenges (as experienced with the H1N1 outbreak). The proposed revision of the Federal Law on Epidemics offers an opportunity to better define clear lines of accountability and improve international linkages. This would help Switzerland respond more rapidly and effectively to future challenges.

The paucity of information on health inequities and quality of care makes it difficult to assess whether Switzerland receives value for money for its major financial investment in health care

While improving, there is still little information available on health inequities in Switzerland. With an incomplete picture of how health risks vary across the population, it is difficult for governments and health providers to target policy. Nationally comparable data on health outcomes and mortality amenable to health care are needed to highlight differences across socio-economic and geographical cross-sections of the Swiss population.

As reflected by the incomplete coverage and complicated structures of cancer registries in Switzerland, it is difficult to collect data to inform improvements in health care within a system of many small and highly autonomous cantons. Information on the quality of care delivered by health service providers is too often limited to acute care and only available through local or cantonal-level initiatives. Switzerland remains largely dependent on individual clinicians to keep up with best practice themselves, and has only limited capacity to benchmark the quality of health care services across the country. While consumers have significant choice between multiple health care providers, they often have surprisingly little information on quality to inform their choices. Recent efforts to introduce nationally consistent measurement of cases, mortality and other selected quality-of-care indicators for hospitals are very welcome steps, but could be improved by broadening the scope of the indicators and supplemented with efforts to measure quality of care outside of hospitals.

Further reforms could help Switzerland increase the value-for-money of pharmaceutical spending

The Swiss population enjoys affordable access to a wide range of pharmaceuticals. The list of medicines reimbursed by health insurance is comprehensive and cost-sharing requirements are relatively low. New products are quickly adopted by health providers. Spending for outpatient pharmaceuticals accounts for only 10% of total health spending, a relatively low level compared with the OECD average of 17%. This reflects both relatively low volumes of consumption and high costs of other health care inputs.

In the past six years, the government has taken steps to reduce relatively high prices of patented drugs and to boost generic markets, with some success. Prices of patented medicines are more in line with those of comparator countries than they used to be. Nevertheless, generics still only account for 10% of the pharmaceutical market, significantly lower than in many other countries. Additional efforts should be made to reap the potential benefits from competition in generic markets, for example through further price reductions and the use of evidence-based practice guidelines to encourage the use of less expensive products where appropriate.

Pricing and reimbursement decisions of pharmaceuticals could be more transparent and evidence-based in line with more formalised processes employed in other countries. Swiss authorities should anticipate changes about to take place in a number of comparator countries in the years to come. For example, France and Germany will conduct economic evaluation to set maximum reimbursement prices for medicines, and the United Kingdom has announced its intention to switch to value-based pricing.

Governance structures provide local responsiveness but can also stifle changes that need to be made in the national interest

Split governance between cantons and the federal level can sometimes lead to a lack of political leadership and drive for reforms in the Swiss health system. While the federal government has significant responsibilities for regulating managed competition, it does not have the required levers to drive system-wide improvements. Small and highly decentralised cantonal governments are usually both payers and service providers, which can dilute their incentive to develop highly accountable and responsive arrangements. Swiss health insurers operate in an environment where they are regulated by one level of government and co-finance hospital inpatient services with another level of government. This constrains their capacity to use their financial influence to drive change.

These governance arrangements have made it hard to introduce reforms that involve changing the priorities of the system, or to achieve institutional change. Cantons face the difficult task of constantly balancing their resource-intensive role in running hospitals while delivering on other important national priorities. Within cantons, local resources for prevention and public health policies often compete with the expensive, but apparently "immediate" curative gains that hospitals provide. At the same time, the federal government has little budgetary influence to encourage cantons to focus on prevention, making it difficult to compel change and deliver broad-based policies from central government.

There is scope for central government to use its influence over insurance to become a leader in assessment, and in the long term, encourage the development of national arrangements within the Federal Health Insurance Law:

- While the central government has the legislative capacity to do so, evaluation of services covered under mandatory health insurance is currently conducted in ad-hoc ways.
- Similarly, health technology assessment is often not used for new products. Central government should ensure that it is.
- Insurers have a constrained ability to use their purchasing power to drive down costs and raise quality. This situation could be improved if insurers had greater capacity to selectively contract with providers and had to account for the full costs of hospital services.
- Enhanced "surveillance" of insurers, as foreseen by a proposed new law, has the potential to increase transparency in health insurance governance.

There are a number of features inherent in Switzerland's political system that makes it difficult to achieve large-scale reform while facilitating innovation and policy flexibility at the local level. Switzerland has to balance the varying preferences of multiple cultural regions. The influence of prominent lobby groups is enhanced in a political system with the potential of veto power through referendum and lengthy decision-making processes. Yet for the longer run, the health system will need to become more adaptable to respond to the changing health needs of the Swiss population. This will require institutions that can help disseminate innovations and align actors, driven by a strategic vision on how to adapt the health system to changes in morbidity and disability – most particularly to encourage prevention, improve the quality of care, and develop the skills and practice-mix needed in the health workforce. The national health strategy project and a prevention law (if concluded) are important milestones in this direction. Further progress could be achieved in mapping and aligning incentives for citizens, providers, municipalities, cantons and insurers. In particular, financial and organisational incentives for prevention and ambulatory care could be revised, *e.g.* through joint responsibilisation at the local level.

As advocated in the new European Health Policy of the WHO Regional Office for Europe (*Health 2020*), platforms will be needed to improve policy development and practices across cantons and municipalities. Effort should be made to support the sharing of expertise and practices at the local level. In this regard, it will be important to establish strong public health institutions with national influence to develop strategic policy objectives and assess policy options. This need for strong public health institutions is heightened in Switzerland where cantons are of varying sizes and hence have varying capacities for policy development.

Strong public institutions will need to be complemented by better health information. Health information systems are currently limited and information on key indicators is too often left to the initiative of willing parties or health service providers. There is a need for the confederation to institutionalise the collection of a minimum health data set across all cantons to help overcome inconsistencies in data measured across cantons. In the longer run, efforts to collect data on the quality of care, public health and ambulatory care would be best located at the national level. This would help ensure that the data collected are consistent and comparable, but more importantly, it would separate the level of government responsible for running services from that which is responsible for monitoring their performance. Health information will also help in informing the public about the

rationale for key transformations, such as re-orienting the system towards prevention and primary care, aligning hospital supply with population needs and improving collaboration between hospitals and residential care.

Over time, the balance of responsibilities between the confederation and the cantons ought to evolve. Initially, the task is to develop better mechanisms of ensuring co-ordination. In the longer term, a more ambitious approach is needed, to develop a different mix of responsibilities that better supports the delivery of national policies without stifling scope for local tailoring of delivery that has long been a central feature of Switzerland's health care system.

A final comment

The Swiss health system delivers good-quality care to the Swiss population today. As in other OECD countries, the Swiss health system will require ongoing reform to adapt to the challenges of the future. More information is needed to compare the quality of care across providers; providers need to share information among themselves more seamlessly; a greater focus on primary care is necessary; inter-cantonal co-operation is needed to secure a health workforce with the appropriate skill-mix for the future and to foster broad-based initiatives on prevention. To drive ongoing reform, the Swiss health system will need better co-operation across providers and collaboration across cantons in planning for the future. This will be critical to developing a dynamic capacity for change that can ensure that the Swiss health system remains amongst the best in the OECD.

Policy recommendations for reforming the Swiss health system

The overarching challenge for the Swiss health system is to effectively respond to the *shift towards chronic disease and multiple morbidities*. This will require changes in the following directions:

1. Improve strategic governance and develop better information for the Swiss health system by:
   - Designing an *overarching legal framework* for health at the federal level that clearly defines a common vision for the health system with clear goals, while recognising diverse approaches and the diversity in resources, needs and preferences across cantons. This should also make more explicit the roles and responsibilities of different levels of government and strengthen platforms for data sharing, providing evidence and analysis to support policy development and disseminate best practice.
   - Establishing nationally-agreed timetables and standards for better *health information systems* and mandatory reporting of a minimum data set by all cantons. Databases and regular surveys should cover: health risks; primary care, health personnel (including nursing and other allied health professions) and outpatient activity; the quality of ambulatory, hospital and long-term care services; morbidity and mortality amenable to health care; and health inequalities (*e.g.* by income, education and other social characteristics).
   - Introducing *electronic patient records, a unique patient identifier, and individual computerised smart cards* to improve the co-ordination and delivery of health care.
   - Strengthening and institutionalising co-ordination between the federal and the cantonal levels and between cantons, notably to improve the organisation and planning of health care supply.
2. Reform *health financing and purchasing arrangements* to:
   - *Enhance quality, effectiveness, efficiency and co-ordination of care*. Cost-effectiveness analysis of benefits covered by the LAMal should be strengthened, through a more formal and systematic use of health

Policy recommendations for reforming the Swiss health system *(cont.)*

technology assessment. Cost-sharing arrangements should be designed to encourage the use of cost-effective medical goods and services and prevention. Integrated and managed care models should be promoted by monitoring and reporting on quality outcomes and their success at disease management. Network providers should have incentives to incorporate prevention in their offerings and provide a continuum of care for their patients.

- *Improve value-based competition in health insurance*. Selective contracting between insurers and providers should be gradually allowed and the risk-compensation mechanism further refined by including morbidity-related risk factors and a change to prospective calculation of risk-equalisation payments.
- *Monitor health financing equity*, in particular the impact of high out-of-pocket payments and high-deductible insurance contracts on access to health care. The effectiveness of social protection mechanisms (e.g. premium subsidies) should continue to be monitored and consideration given to setting minimum standards for the allocation of premium subsidies to eligible households.

3. Reinforce strategic and national health workforce planning to ensure that the future Swiss health system can respond to growing demands and changes in morbidity patterns, by:
   - Strengthening information systems on the health workforce, particularly for nurses and allied health professionals and introducing systematic *monitoring, evaluation and reporting* of health workforce policies at the national level.
   - Encouraging medical and nursing schools to increase progressively the number of health care professionals trained domestically, especially in specialties where shortages are forecasted, such as general medicine.
   - Addressing fairness and efficiency issues related to international health worker migration through the WHO Global Code of Practice on the International Recruitment of Health Personnel,
   - In the short term, revising TARMED to increase relative payment levels for general practice services and other specialties with shortages.
   - Promoting good practices, such as inter-disciplinary and inter-professional collaboration.
   - Disseminating information on best practice human resource management in hospitals ("magnet hospitals") to encourage the replication of such experiences.
   - Developing policies to improve attraction and retention (particularly in remote and mountainous areas) and professional reintegration.
   - Supporting inter-professional approaches and continued professional development, such as in the context of integrated care and disease management models.
   - Developing a more comprehensive and sustainable career structure in public health, as well as founding a national professional body bringing together public health professionals from service and academic posts and federal and cantonal administrations, to provide better evidence-based policy advice in public health.
4. Strengthen health improvement and health care quality assurance by:
   - Assessing systematically health promotion and disease prevention programmes with particular attention on how to deliver and monitor preventive public health measures which are not yet universally available (breast cancer screening), not universally taken up (vaccination), or which are cost-effective (tobacco and alcohol taxes).
   - Fundamentally elevating the place of prevention in the Swiss health system, for example by encouraging providers to incorporate prevention in their practice and by strengthening and concluding a federal law on public health and prevention that clearly assigns responsibilities and provides the financial capacity to implement policies across the country.

Policy recommendations for reforming the Swiss health system *(cont.)*

- Strengthening accountability and leadership within the health system to both enhance progress with health improvement and disease prevention, as well as better preparing for times of national emergency.
- Providing greater financial support to facilitate nation-wide initiatives on care quality.
- Mandating providers at both hospital and ambulatory level to collect and report on a nation-wide system of health care quality indicators.

5. Strengthen efficiency of health care provision and pharmaceutical spending by:
   - Considering moving from the current parallel funding of in-patient care from cantons and insurers to a system where cantonal funding is channelled to a single-payer arrangement.
   - Ensuring that the implementation of DRGs is coupled with increased autonomy for cantonal hospitals, new information on provider efficiency and quality is used to guide hospital planning, and DRG payments are supplemented to support the availability of essential services (such as accident and emergency services).
   - Addressing the incentives for overprovision inherent in fee-for-service payment arrangements by combining them with other provider payment elements.
   - Encouraging a shift from acute hospital care towards ambulatory care, the development of horizontal care in ambulatory or residential structures for persons in need of long-term care, the mentally ill or those needing palliative care.
   - Expanding policies to encourage a focus on quality and cost-effectiveness in the prescription and use of pharmaceuticals (such as the use of health technology assessment and further encouraging generics).

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Chapter 1

Key Features of the Swiss Health System

This chapter describes key features of Switzerland's health system. With a small and ageing population, Switzerland enjoys some of the best health outcomes amongst OECD countries, albeit at greater cost than most others. Health care is a major contributor to the Swiss economy. The central feature of the Swiss health system is its mandatory health insurance, provided through regulated competition between insurers. Mandatory health insurance supports Swiss citizens for the full spectrum of their basic health needs, from ambulatory care through to hospital care. Cantons play a significant role in financing, organising and delivering health care services.

Along with many OECD countries, the development of the Swiss health system over the 20th century reflects the strong emphasis placed on curative care. Switzerland's cantonal governments are at the centre of this system, and have held a critical role in delivering and paying for health for over 150 years. Throughout this time, there has been discussion about the roles and responsibilities of cantons, and more recently, a modest expansion in federal responsibilities beyond the Federal Health Insurance Law. Health promotion and disease prevention policies have gained greater attention in the last 25 years.

At the turn of the 20th century, only a fraction of the Swiss population had health coverage. It was estimated that there were some 2 006 community insurers in 1903, covering only 14% of the population. Membership of community health insurers was often based on trade union affiliation, employment, religion and geography. These community insurers were often small (half had less than 100 members) and half of them only operated in a single municipality. There was a lack of co-ordination between insurers, arbitrary selection of members and unclear mechanisms to fix premiums (Mulheim, 2003).

The first Federal Law on Sickness and Accident Insurance (LAMA)[1] was adopted in 1911, with a less ambitious scope than the government's original proposal to provide compulsory coverage for all workers up to a certain income level. This law sought to subsidise recognised health insurers and impose minimal regulatory requirements (Box 1.1). Various revisions to this law have been introduced over the years, to facilitate portability of insurance and clarify the benefits it covers. Finally, 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] in 1994. This law provides the major platform on which Switzerland's mandatory health insurance operates today.

Today, compulsory health insurance finances around one third of the Swiss health expenditures. Insurers set community-rated premiums designed to avoid differentiation on the basis of risk. In 2009, more than 7.7 million Swiss residents had mandatory insurance, of which 73% were adults, 19% were children, and 9% were young people in training (OFS, 2009a). The number of insurees has remained fairly stable since 1996 and there are virtually no uninsured people.

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

The 1911 Federal Law on Sickness and Accident Insurance (LAMA), 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 the range of non-profit sickness insurance funds. Individual premiums were calculated on age of entry into the fund and sex. Premiums for women could be up to 10% higher, and age of entry led to large variations in premiums. Those with sickness or carrying high risks could not move freely across

Box 1.1. **The social health insurance system under the LAMA** *(cont.)*

insurers as funds could refuse cover and set premiums irrespective of the premiums charged with a previous sickness fund. Universal treatment of patients was difficult to achieve under such conditions.

Competition across sickness funds was also not fair. Sickness funds received financial subsidies from the government that imperfectly accounted for differences in risk structures across insurers. Funds with a higher proportion of bad risk persons were forced to charge higher average premiums, creating incentives for younger and healthier people to leave the fund. This environment saw some sickness funds disappear from the market or merge with others to avoid bankruptcy. While there was recognition of the need to modernise the LAMA since the 1960s to better deal with growing cost pressures and concerns about universal treatment and access, voters rejected all attempts to address these matters until the new Federal Health Insurance Law was adopted by the parliament (and in a popular referendum) in 1994 and came into effect in 1996 (Gilliand, 1990).

Source: Adapted from Colombo (2001).

1.1. Key features of Switzerland

Switzerland is a small country of 7.7 million inhabitants covering a territory of 41 285 km^2. It is a federal state made up of 26 cantons. There are three official languages, with around 64% of the population speaking German, 20% speaking French and 6.5% in Italian. A small fraction of the population speaks Romanish or other non-official languages.

Social and economic context

Switzerland is one of the richest OECD countries. Its per capita GDP of more than USD 46 000 after adjusting for differences in price levels across countries (purchasing power parities, PPPs) is the fourth highest in the OECD (after Luxembourg, Norway and the United States) and a third higher than the OECD average of USD PPPs 34 200 (Figure 1.1). Major industries in the Swiss economy include microtechnology, biotechnology, pharmaceuticals and banking and insurance. Openness to international trade and investment are a key characteristic of the Swiss economy, though there remain some major barriers to imports and high levels of subsidies to domestic producers (OECD, 2009).

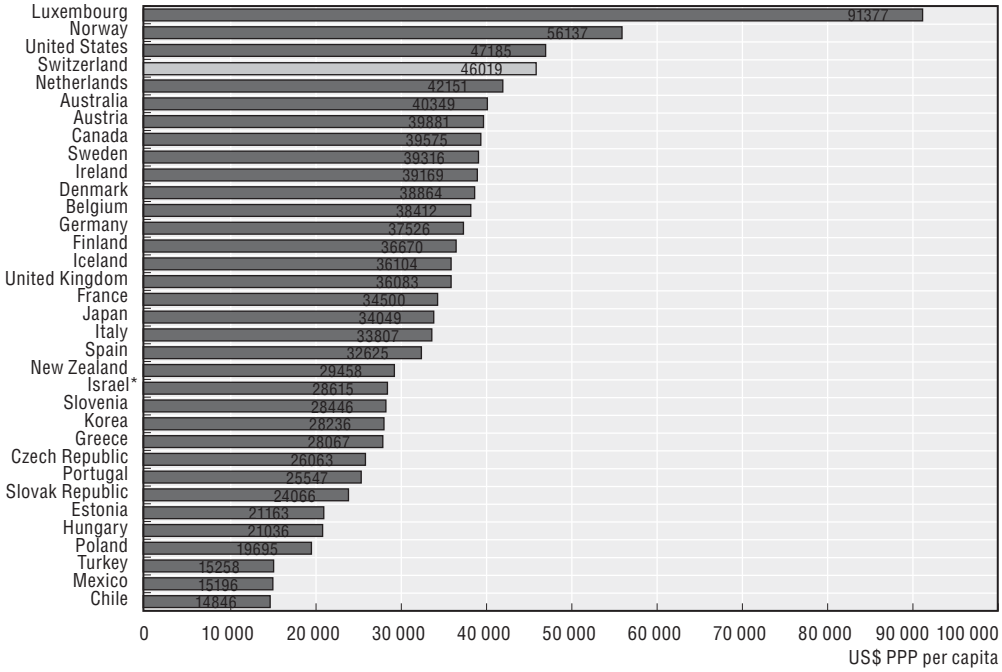
There are wide inequalities in income and financial capacity across Switzerland. As shown in Table 1.1, the income per capita of the canton of Basel-City, the highest in Switzerland, is three times that of the canton of Jura, the lowest (OFS, 2005). The confederation and wealthiest cantons support those cantons with lower tax revenues through a fiscal equalisation mechanism. Despite its low unemployment rate (3.5% in 2008), the Swiss economy lacks dynamism and recent productivity gains have been weak compared with other OECD countries (OECD, 2009).

Population and demographic trends

Switzerland's population is expected to continue to grow in line with the OECD average. With almost 7.7 million people in 2010, compared to 5.3 million in 1960, Switzerland's population has been rising at a yearly average rate of 0.8%, in line with the OECD average of 0.9% (OECD, 2010a). The number of foreign residents in the Swiss

Figure 1.1. **GDP per capita in OECD countries, 2010**

In USD PPPs[1]



1. Purchasing power parities (PPPs) are the rates of currency conversion that equalise the purchasing power of different currencies by eliminating the differences in price levels between countries.

* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD Health Data 2011.

Table 1.1. **Per capita national income by canton, 2005**

Canton	Income per capita (in CHF)
Basel-City	115 178
Zug	93 753
Nidwalden	73 286
Glarus	73 236
Zurich	68 804
Geneva	62 839
Schaffhouse	55 126
Basel-Land	53 502
Vaud	52 901
Schwyz	50 170
Neuchâtel	49 775
Graubünden	49 355
Aargau	49 209
Solothurn	46 844
Appenzell Inner-Rhodes	45 936
Uri	45 712
Bern	45 644
Thurgau	44 918
St. Gallen	44 866
Appenzell Outer-Rhodes	44 215
Lucerne	43 910
Ticino	41 335
Obwalden	39 646
Fribourg	39 559
Valais	38 385
Jura	38 070

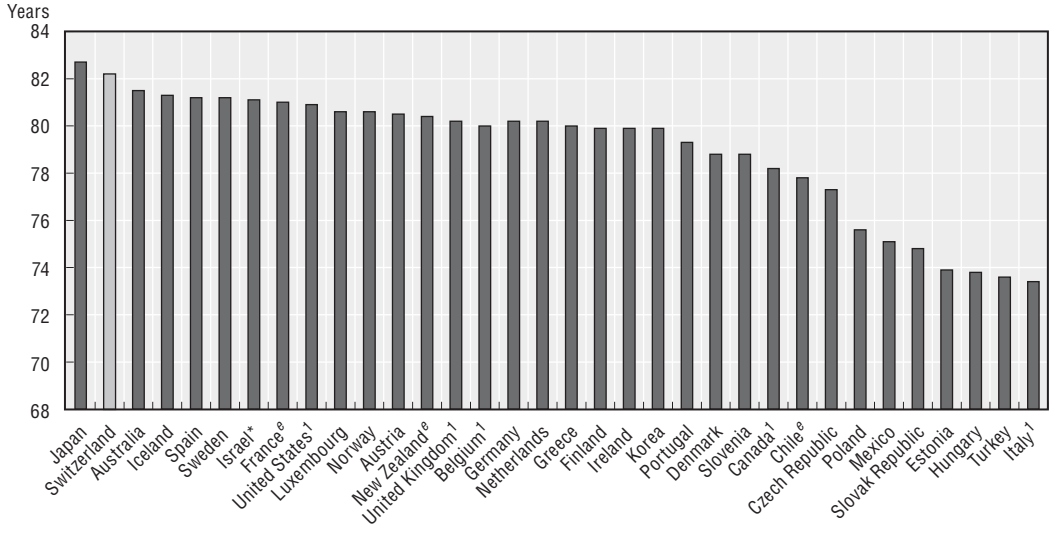
Source: OFS – Office Fédéral de la Statistique (2005), *Comptes nationaux, Revenus cantonaux selon les bénéficiaires*.

population is estimated at 21%, which is amongst the highest in the OECD (OECD, 2010b). Assuming the continued lengthening of lifetimes, current fertility rates and immigration levels, population growth rates are projected to continue to decline over the next half century (OECD, 2011b).

The Swiss population is relatively old when compared with other OECD countries and is expected to continue to grow older. In 2008, the share of the population over 65 was 16.5%, while 21.4% were below the age of 20, compared with OECD averages of 14.7% and 24.4%, respectively (OECD, 2010a). This reflects the long-term trends of declining fertility rates since the 1970s and rising life expectancies over the past century. With an estimated life expectancy at birth of 79.8 years for men and 84.6 years for women, Switzerland is 3.4 years and 2.6 years above the OECD average for men and women respectively. Switzerland has the highest life expectancy for men amongst OECD countries and the second highest life expectancy for women amongst OECD countries, after Japan (Figure 1.2) (OECD, 2010a). These trends have seen the number of people over 65 years old more than double since 1950, while the number over 80 years old is more than five times 1950 levels. It is projected that the old age dependency ratio (the percentage of those over 65 years old to those aged 20-65 years) will increase from 26.5% of the population in 2008 to almost 50.8% in 2050 (OECD, 2011b). Conversely, this is projected to see working age people decrease from 68% of the population to 59% in 2050 (Figure 1.3) (OECD, 2011b).

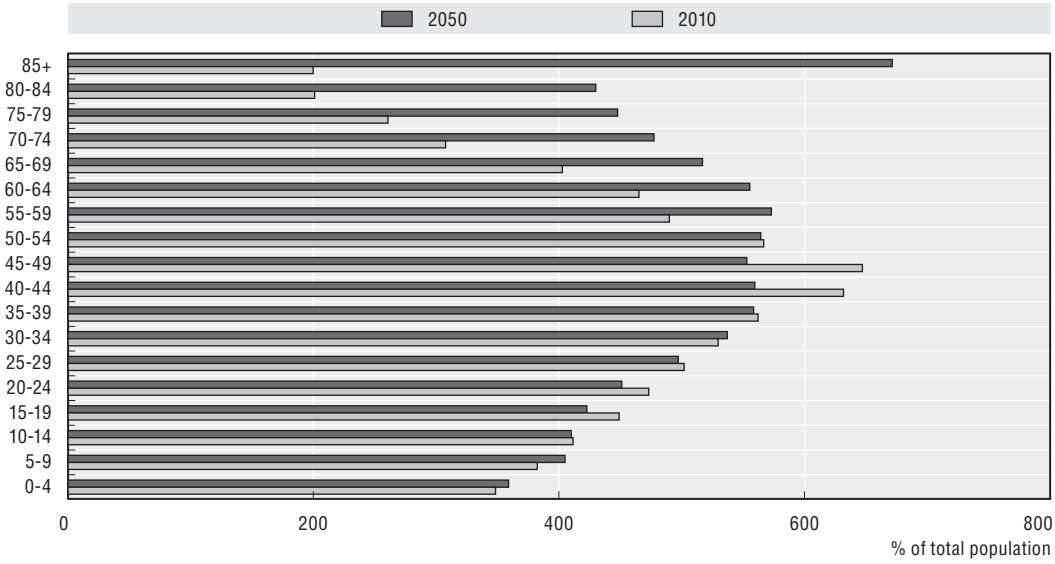
While the majority of Switzerland's population lives in urban areas, there are large differences in population density. Around 75% of the Swiss population lives in urban areas, with 35% living in the largest cities[3] of Zurich, Geneva, Basel, Bern and Lausanne (OFS, 2009a). Population density varies by a factor of 190 between the most densely populated Canton of Basel-City and the more sparsely populated Canton of Graubründen (OFS, 2009b) (Table 1.2).

Figure 1.2. **Life expectancy at birth in OECD countries, 2008**



e: Estimates.
1. Data refer to year 2007.
* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.
Source: OECD Health Data 2010.

Figure 1.3. **The Swiss population by age group, 2010 and 2050**



Source: OECD (2011b).

Table 1.2. **Basic demographic indicators in Switzerland, 2009**

		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	7786	74	26	195	33	27
AI	Appenzell Inner-Rhodes	16	0	100	91	41	29
AR	Appenzell Outer-Rhodes	53	53	47	218	36	29
AG	Aargau	600	66	34	430	34	25
BL	Basel-Land	273	92	8	527	33	32
BS	Basel-City	188	100	0	5078	26	33
BE	Bern	974	62	38	167	32	31
FR	Fribourg	273	56	44	171	39	23
GE	Geneva	453	99	1	1844	35	25
GL	Glarus	38	0	100	57	34	29
GR	Graubünden	192	50	50	27	31	29
JU	Jura	70	30	70	84	40	31
LU	Lucerne	373	51	49	261	35	26
NE	Neuchâtel	172	75	25	239	37	30
NW	Nidwalden	41	88	12	169	32	26
OW	Obwalden	35	0	100	73	36	25
SH	Schaffhouse	76	76	24	254	32	32
SZ	Schwytz	145	80	20	170	34	24
SO	Solothurn	253	77	23	320	33	29
SG	St. Gallen	475	67	33	243	36	26
TG	Thurgau	245	50	50	284	35	25
TI	Ticino	336	87	13	122	31	34
UR	Uri	35	0	100	33	36	30
VS	Valais	307	57	43	59	34	28
VD	Vaud	702	75	25	249	37	26
ZG	Zug	111	96	4	535	33	24
ZH	Zurich	1351	95	5	814	31	26

1. Thousands of people.
2. As defined by the 2000 population census (RFP: Recensement Fédéral de la Population, 2000).
3. Inhabitants per squared km.
4. Number of people aged below 20 years for every 100 people aged between 20 and 64 years.
5. Number of people aged 65 years and over for every 100 people aged between 20 and 64 years.

Source: OFS – Office Fédéral de la Statistique, online statistics on population.

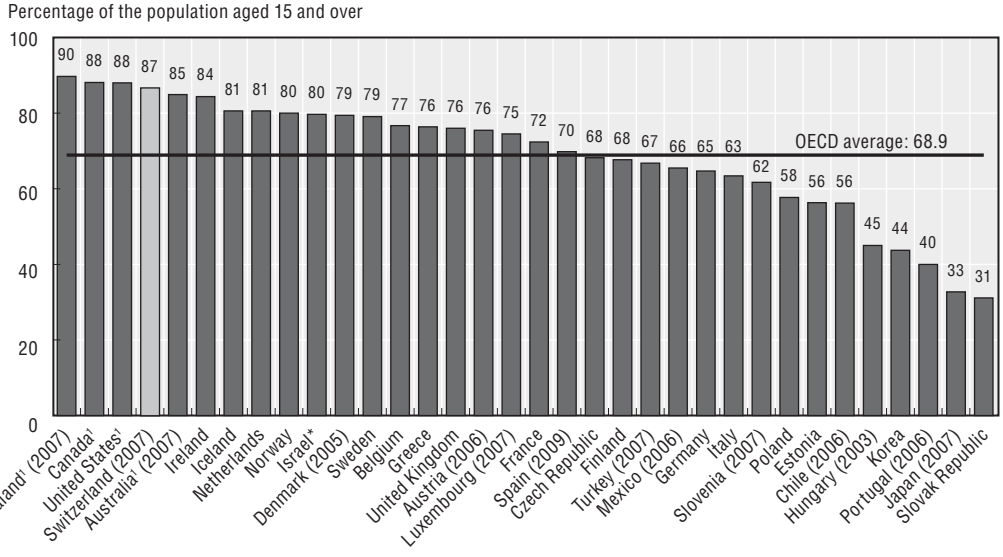
Epidemiological profile

More Swiss people generally perceive their health status to be good compared to most OECD countries. Around 87% of the population living in private households identified themselves as having good or very good health, compared with an OECD average of 69% (Figure 1.4) (OECD, 2010a). Only New Zealand, Canada and the United States reported more people perceiving their health status as being good. However, around 27% of the population reported that they have a long term health condition or a disease and between 9.8% and 11.4% of over 65-year-olds living in a private home reported that they are no longer able to live independently and need support for daily actions (such as dressing, eating and going to the toilet) (OFS, 2007).

While the share of the population that is overweight or obese is below the OECD average (37% of the Swiss population compared with an OECD average of 50%), excess body mass is increasingly becoming an important public health concern. Other indicators of public health risks show that tobacco consumption across the population is slightly lower than the OECD average while per capita alcohol consumption is slightly higher than the OECD average (Table 1.3) (OECD, 2011c).

Mortality rates in Switzerland are lower than most OECD countries with age related conditions and non-communicable diseases accounting for the majority of deaths. At 8.0 deaths per 1 000 population, Switzerland's mortality is below the OECD average of 8.8 deaths per 1 000 population (OECD, 2010a). The majority of these deaths are due to diseases of the circulatory system (37%), malignant neoplasm or cancers (25%) and respiratory diseases (6%) (Figure 1.5). The decline in deaths from circulatory problems in the recent years has helped reduce overall mortality. However, mortality from mental health conditions has been increasing, mainly explained by increasing mortality from Alzheimer's disease and dementia (OFS, 2010a).

Figure 1.4. **Share of the population considering their health to be good or very good in OECD countries, 2008**



1. Results of these countries are not directly comparable with those for other countries, due to methodological differences in the survey questionnaire resulting in an upward bias.

* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD Health Data 2010.

Table 1.3. **Indicators of public health risks in OECD countries, 2009**

	Alcohol consumption (Liters per capita for population over 15 years)		Tobacco consumption (% of daily smokers in the population over 15 years)		Overweight and obese population[1] (% of the population with BMI > 25kg/m^2)	
Australia	10.1		16.6	2007	56.0	2007
Austria	12.2		23.2	2006	47.7	2006
Belgium	9.7	2006	20.5	2008	46.9	2008
Canada	8.2		16.2		47.9	
Chile	8.6	[2]	29.8		55.5	
Czech Republic	12.1		24.6	2008	54.3	2008
Denmark	10.1		19.0		46.7	2010
Estonia	12.0		26.2	2008	49.6	2008
Finland	10.0		18.6		49.3	
France	12.3	2008	26.2	2008	38.2	2008
Germany	9.7		21.9		51.4	
Greece	9.2	2008	39.7	2008	58.9	2008
Hungary	11.8	2008	26.5		53.6	
Iceland	7.3	2008	15.8		60.2	2007
Ireland	11.3		29.0	2007	51.0	2007
Israel*	2.5	2005	20.3		47.7	2008
Italy	8.0	2006	23.3		46.3	
Japan	7.4		24.9			
Korea	8.9		25.6			
Luxembourg	11.8	2005	19.0			
Mexico	5.9	2008[2]	13.3	2006		
Netherlands	9.4		28.0		47.2	
New Zealand	9.3		18.1	2007		
Norway	6.7		21.0		46.0	2008
Poland	10.2		27.0		45.3	2004
Portugal	12.2	2005	18.6	2006	51.6	2006
Slovak Republic	9.0	[3]	19.4	[3]	47.6	2003
Slovenia	11.5		18.9	2007	55.1	2007
Spain	10.0	2006	26.2		53.6	
Sweden	7.4		14.3		46.3	
Switzerland	**10.1**		**20.4**	**2007**	**37.3**	**2007**
Turkey	1.5		27.4	2008	47.6	2008
United Kingdom	10.2		21.5			
United States	8.8	2008	16.1		63.5	
OECD average	**9.3**		**22.3**		**50.1**	

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+) and are based on national health interview surveys for most countries (self-reported data). The exceptions are Australia, Canada, Chile, the Czech Republic, Ireland, Japan, Korea, Luxembourg, Mexico, New Zealand, the Slovak Republic, 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. Break in the series.
3. Estimates.

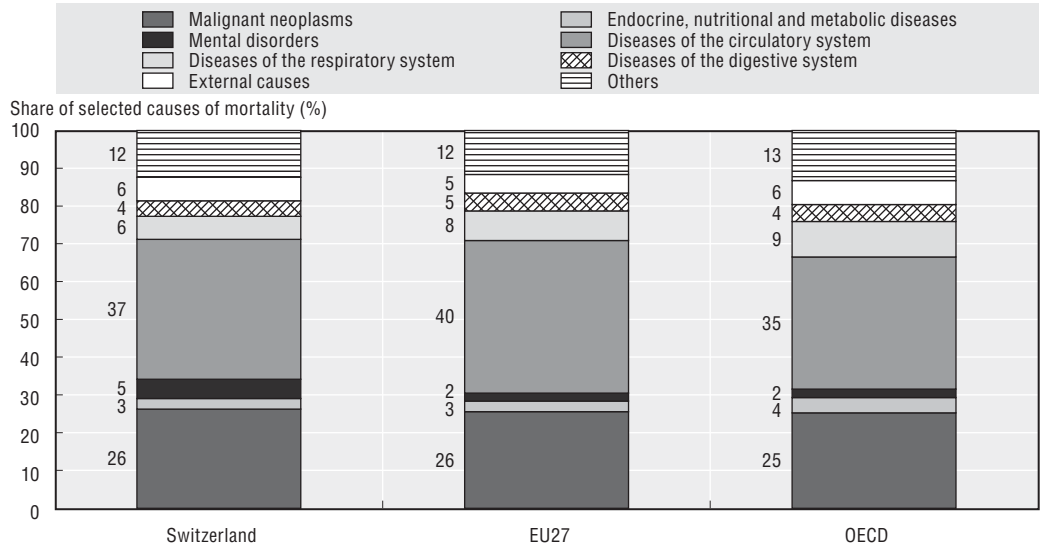
* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD Health Data 2011.

Political and administrative structures

There are three levels of government in the Swiss federal structure, with the majority of responsibilities belonging to cantons. The confederation holds varying degrees of responsibilities in areas such as foreign policy, national security, monetary policy, environment, health and transportation. Switzerland's twenty six cantons have a high degree of independence and exercise significant control for health care, education and

Figure 1.5. **Share of selected causes of mortality, 2007**



Source: OECD Health Data 2010; Eurostat Statistics Database.

culture. Each canton has its own constitution, parliament, government and courts and holds all powers not specifically delegated to other levels of government. Finally there are some 2 551 municipalities which can exercise varying levels of responsibility across education, social policy, and local planning, with varying levels of autonomy in decision making across cantons.

The Swiss confederation has been characterised by the stability and continuity of its political institutions. 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.[4] Members of both chambers are elected directly by the people.[5] 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 judicial bodies are the Federal Supreme Court in Lausanne and (since 2004) by the Federal Criminal Court in Bellinzona.

The right of initiative and referendum by the population is a unique feature of the Swiss political system. Citizens can lead popular initiatives to change the federal constitution with the signatures of at least 100 000 voters over an 18-month period. Similarly, decisions of the parliament on new or amended legislation can be put to referendum if requested by 50 000 voters. In some cases, a referendum is mandatory, such as to change the constitution or when joining supra-national organisations.

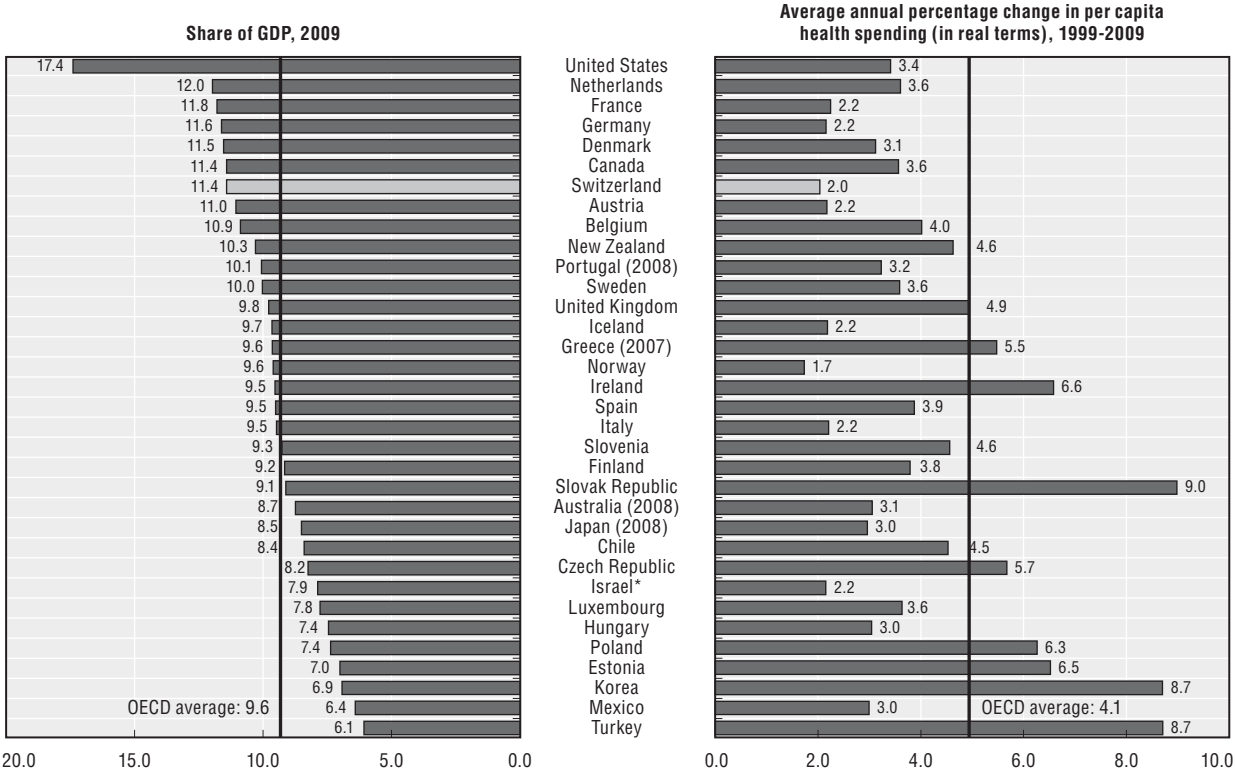
Switzerland has pursued closer relations with the European Union through bilateral agreements. The European Union accounts for half of Switzerland's trade and agreements have facilitated the free movement of persons between EU member states and Switzerland. There has also been a progressive opening of labour markets between the European Union and Switzerland. The mutual recognition of diplomas of medical doctors and nurses is one measure in the health sector illustrating this trend.[6]

1.2. The economic size of the health sector

As a share of its economy, Switzerland devotes more resources to health spending than most OECD countries. In 2009, Switzerland spent 11.4% of its GDP on health, the seventh highest amongst OECD countries (Figure 1.6). Switzerland's levels of health spending remain amongst the highest when measured in per capita terms (Figure 1.7). While health expenditure as a share of GDP has been increasing steadily, the rate of growth has moderated in recent years to 2.0% a year between 1999 and 2009, below the OECD average increase of 4.1%. To a certain extent, this decrease is explained by higher growth prior to the global economic slowdown and some recent moderation in government spending on health. Health accounted for 20% of total government spending in 2008 (OECD, 2010a).

Health care is one of the largest and fastest growing employers in Switzerland. In 2008, it employed around 13.5% of Switzerland's population, more than half a million people. Employment in health far outpaced the rest of the economy, growing by 20% between 2001 and 2008 compared with 9% for the entire Swiss economy over the same period (OFS, 2010b).

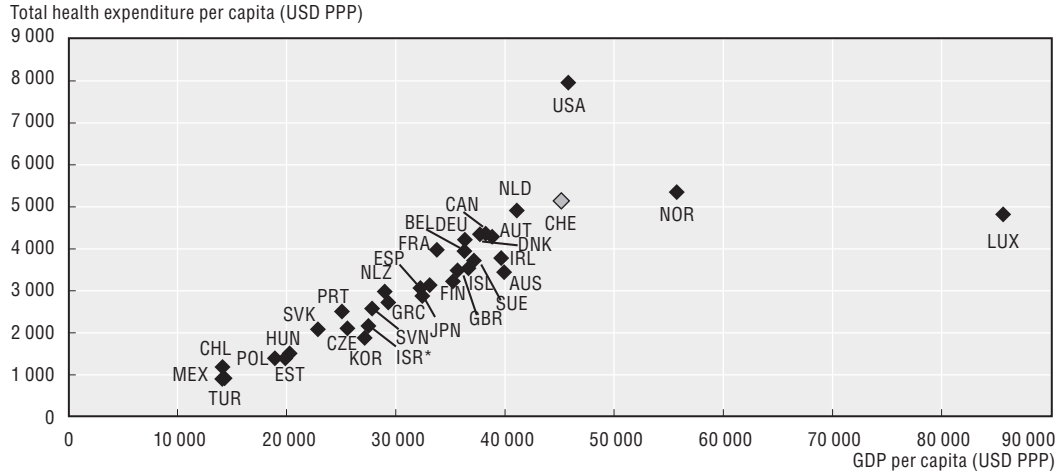
Figure 1.6. **Health expenditure in OECD countries as a percentage of GDP, 2009, and changes in per capita health spending, in real terms, 1999-2009**



Note: The following series present breaks, years in brackets:
Greece (1999-2007), Portugal (1999-2008), Australia (1999-2008), Japan (1999-2008), Korea (1999-2006).
Switzerland may overestimate expenditure for long-term care, one component of total health expenditure.
* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD Health Data 2011.

Figure 1.7. **Per capita health expenditure and per capita GDP in OECD countries, 2009 (or latest year available)**



* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD Health Data 2011.

1.3. Governance of the Swiss health system

Reflecting the historical evolution of the confederation, cantons sit at the centre of delivering and funding health services in Switzerland. Cantons share joint responsibilities with the confederation in policy making, regulation and monitoring and can often delegate functions to municipalities. Over time, decisions at a cantonal level have led to slightly different health systems in each of the 26 cantons.

Over time, the confederation has taken on more responsibilities for system-wide aspects of the health system. This has generally been undertaken at the behest of cantons, or through new laws and changes to laws at a federal level. For example, the establishment of Swissmedic[7] has seen responsibility for registration and authorising market entry for pharmaceuticals and medical devices placed at a national level. Similarly, the confederation has begun to play a more active role in research and postgraduate education. Responsibilities for the health workforce remains fragmented between federal and cantonal authorities. Cantons, which often bear the cost of training, are influential in determining the number of domestic medical education places while the confederation exercises broad policy over health worker migration.

While cantons generally have their own health departments, various institutions have also been established to improve co-ordination and co-operation at both federal and cantonal levels. At a federal level, these include 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 part of the Federal Department of Home Affairs. A political co-ordination body – the Swiss Conference of the Cantonal Ministers of Public Health (CDS) – has operated since 1919 to promote co-operation and common policies between cantons, and in some cases, with the confederation. However, the CDS is largely a forum that seeks to facilitate consensus building and not a deliberative body. A Swiss National Policy Dialogue for Health (Dialogue de la Politique Nationale de la Santé) was also established in 2003 to provide a permanent forum where confederation and cantonal health policy makers could discuss common challenges and issues.

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

Federal level

- Legislative and supervisory role in the following areas:
  - Sickness and accident insurance.
  - 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, assisted reproduction, 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.

Source: European Observatory on Health Care Systems (2000), Kocher (2007).

1.4. Financing health care in Switzerland

Each person living in Switzerland is obliged to purchase mandatory health insurance from an authorised insurer since the introduction of the Health Insurance Law in 1996. Health insurers are the vehicle through which an individual is provided their entitlement to basic health care, and together with government (mainly cantons) account for the majority of health care expenditure in Switzerland. Out-of-pocket costs – either through cost-sharing in an insurance policy or directly from an individual – also contribute significantly to the Swiss health system. These three key sources are supplemented by other social insurance schemes (such as accident insurance) and by voluntary health insurance products offering services beyond the mandatory benefit package.

Sources of health expenditure

Mandatory health insurers accounted for 35% of total Swiss health expenditure in 2009, making them the single largest source of expenditure (see Table 1.4). Government outlays on health expenditure were 19% in the same year, consisting of 16% from cantons, 2% from municipalities and 0.4% from federal government. Government funding is spent on subsidies to institutional providers (hospitals, long-term care institutions, home care), as well as prevention, public health and administration charges.[8]

Individual out-of-pocket costs – accounting for 31% of health expenditure – are a significant source of financing for the Swiss health system. Switzerland has amongst the highest percentage of out-of-pocket costs as a share of health expenditure in the OECD (Figure 1.8). A further 9% of health spending is channelled through voluntary private health

Table 1.4. **Financing of health expenditure in Switzerland, 2009**

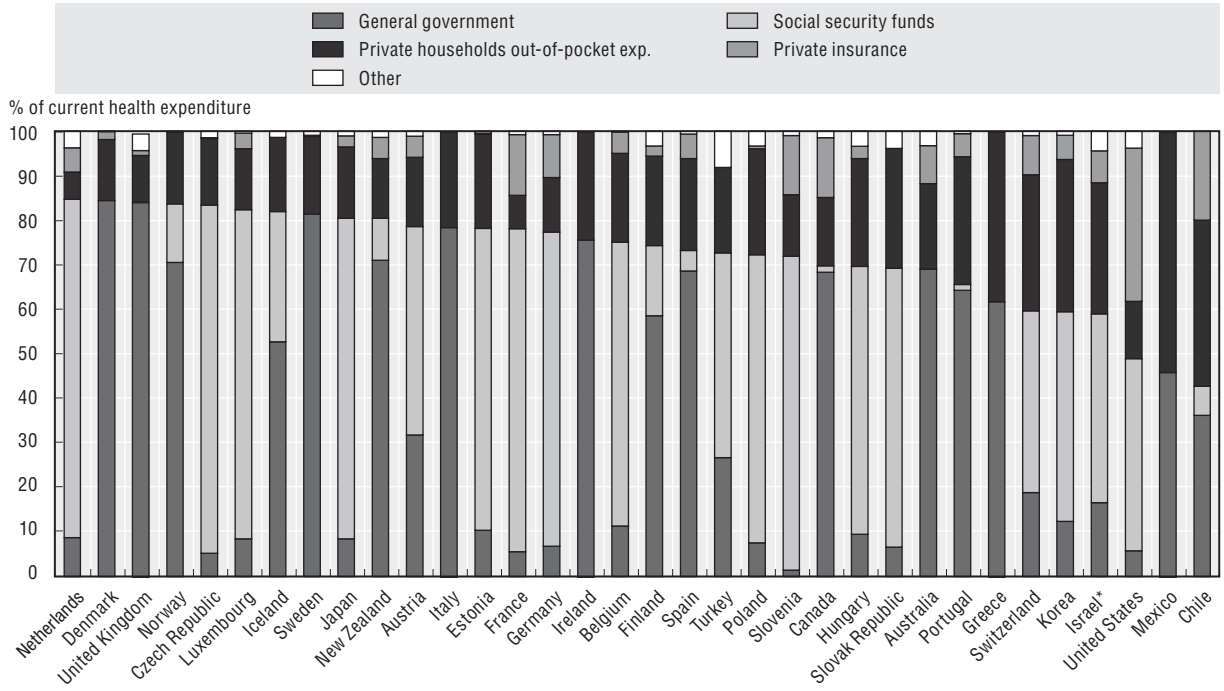
Share in total financing (%)	2009*
Total	**100.0**
State	**18.9**
Confederation	0.4
Health institutions	0.0
Prevention	0.4
Administration	0.0
Cantons	16.3
Health institutions	13.0
Home care	0.5
Prevention	0.5
Administration	0.3
Invalidity	1.9
Public health safety and emergency services	0.1
Municipalities	2.2
Health institutions	1.2
Home care	0.5
Prevention	0.2
Administration	0.1
Invalidity	0.1
Public health safety and emergency services	0.1
Social insurance	**40.8**
Health insurance (LAMal)	35.1
Accident insurance (LAA)	3.0
Old age and disability insurance (AI-AVS)	2.7
Military insurance	0.1
Private insurances	**8.8**
Supplementary health insurances (LCA)*	2.6
Other private insurances	6.2
Households	**30.5**
Cost-sharing, social insurances	5.5
Cost-sharing, private health insurance	0.1
Out of pocket	24.9
Other private agents	**1.0**

* Provisional data.

1. Supplementary health insurance according to LCA.

Source: Office Fédéral de la Statistique, online tables on cost and financing of the health system, consulted 5 April 2011.

Figure 1.8. **Spending on health by type of financing, 2009**



* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD *Health Data 2011*.

insurance, which is rather high for a country where private health insurance only supplements basic coverage. In this category, only Canada, France, Slovenia and Ireland have higher shares of funding by private health insurance.

Mandatory health insurance

The 1994 Health Insurance Law (Loi Fédérale sur l'Assurance Maladie, LAMal)[9]

Switzerland's regulatory architecture for mandatory health insurance is set out in the LAMal, which seeks to maintain a competitive market for access to high-quality basic health services while promoting equal coverage and containing health expenditure.[10] This law sets out the basic features which insurance companies must offer to Swiss residents and within which authorised insurance companies must operate (see Box 1.3 for details of the regulatory environment for insurers).

The main features of mandatory health insurance for patients are:

- Enrolment in a basic health insurance plan is *compulsory* for every Swiss resident, with each member of the family insured individually. This insurance is not sponsored by employers.
- Insurance covers the costs of medical diagnoses and treatments for Swiss residents in the event of illness, maternity and accidents – which all insurers must cover.
- Individuals must sign on with an *insurer operating in their canton*. This entitles them to visit any provider within their canton and where they wish, to seek treatment outside their canton by paying for the difference between reimbursements available in their canton and prices charged in hospitals outside their canton.[11]

- Each person is *free to choose* their insurer and insurers must accept all individuals living in the canton. Individuals have freedom to choose and change their insurer at one of two nominated times each year.
- For the standard insurance policy, an insurer should charge the *same premium* for everyone in a canton (community rating). Premiums are not related to earnings, with the poor paying the same as the rich.
- Eligible low-income individuals receive *financial support* from the canton to help reduce the cost of premiums. Subsidies are co-financed by the confederation.
- *Individuals contribute to the cost* of their services through a deductible, co-insurance and co-payments (except for those eligible for an exemption).[12] The extent of cost-sharing differs between basic health insurance and other special types of insurance contracts.
- With certain "*special*" *types of insurance*, individuals may be able to reduce their premium in exchange for agreeing to restrictions on ordinary conditions of cover. These special types of insurance can either involve greater financial liability for individuals or accepting a limited choice of providers.

Box 1.3. **Key features of the regulatory environment faced by insurers under the LAMal**

Non-profit requirement and separation of basic health insurance from other insurance activities

Authorised health insurance providers cannot profit from providing basic health insurance. Basic cover needs to be separated from any voluntary (additional) health insurance they choose to provide.

Risk equalisation

A risk-equalisation system seeks to compensate insurers for differences in costs they face from the varying risk profiles of their membership. An insurer's risk profile is calculated by categorising their membership into age and sex-based groups. Insurers with a fewer number of women and the elderly than the average must pay money into a common pool ("Institution Commune") which is then redistributed to insurers with a greater than average number of women and the elderly. The "Institution Commune" also provides transfers between cantons to help account for varying risk profiles throughout Switzerland. It was originally envisioned that risk equalisation would be discontinued as the risk structures of insurers would have equalised over a ten year period. Instead, the parliament has successively extended risk-equalisation and will introduce a third risk-equalisation factor (hospitalisation beyond three days in the previous year) in 2012. Active discussions continue on the inclusion of more risk factors in the future.

Free choice of insurer

Individuals can switch their mandatory health insurance between authorised insurers in their canton at the end of June and December each year. Individuals must provide three months notice of their intention to change. Similarly, authorised insurers have to provide written notice of any changes to premiums in the upcoming year at least two months in advance of the change. Where a premium is changed, individuals are entitled to switch insurers with one month's notice. The insurer can only oppose a switching decision if the individual's premium has not been paid. Insurers are also required to notify the previous insurer to certify that an individual has taken up cover. People with special insurance contracts can only switch insurers on the 31st December and those with bonus insurance must take out a policy for five years to receive the maximum bonus of 45% of the standard insurance policy premium.

Community rating of premiums

While the overarching objective of the LAMal is to promote similar premium for different individuals, there is some legislative scope for variation in premiums. Considerable variances in premiums exist across cantons: the difference between the canton with the highest median premium and the canton with the

Box 1.3. **Key features of the regulatory environment faced by insurers under the LAMal** *(cont.)*

lowest median premium was 75% in 2010. Further, individuals who already hold mandatory accident-insurance can ask for a reduction in the basic health insurance premium. The confederation has defined up to three premium tiers within some cantons, to reflect variations in health costs within a canton. Third, insurers can specify three age-related categories of (progressively higher) premium for children (0-18 years), young people (19-25) and adults. Lastly, individuals choosing special health insurance forms (see Box 2.1) obtain premium reductions.

Premium reductions for low-income people

The confederation makes a certain amount of subsidies available annually to cantons, earmarked for premium reductions. In order to receive federal subsidies, cantons must themselves pay a minimum amount. The overall federal subsidy is distributed across cantons on the basis of the resident population of the canton. Each canton establishes the amount of the individual subsidy, eligibility criteria, and procedures. Cantons are also 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 2009, one third of Swiss residents received subsidies.

Benefit package

The package of health care services covered is outlined in a text of law ("Ordonnance sur les prestations dans l'assurance obligatoire des soins en cas de maladie"). These services broadly seek to cover Swiss residents in the event of illness, maternity and accident.* For medical services, mandatory coverage is based on a non-exclusive catalogue of diagnostic services and treatments. Hospital services cover the cost of treatment received in a shared ward, with the law specifying some exclusions. Pharmaceuticals, complementary medicine, and non-medical services (*e.g.*, physiotherapy) are covered on the basis of a pre-determined list. Some prevention and screening measures, such as pap smears, HIV tests, colonoscopies, and vaccinations (including for influenza) are also covered but, generally, on the basis of a positive list. Dental care is covered where it concerns a serious illness. Since 2011, spectacles are no longer covered, while five alternative medicine therapies will be covered for six years while effectiveness is evaluated.

Special forms of insurance

There are three "special" kinds of insurance products which vary from the basic insurance product (*franchise ordinaire*). Firstly, insurers are entitled to offer a choice of deductibles (*franchise à option*), where individuals can reduce their premium by agreeing to make higher upfront payments when they first incur expenses. Similarly, bonus insurance (*assurance avec bonus*) entitles individuals who do not make a claim in a particular year to obtain a premium reduction in the following year. Lastly, individuals who agree to only use designated providers (in a managed care type arrangement) can also be entitled to premium reductions on the basic policy. Most LAMal-insurers provide ordinary insurance and insurance with choice of deductibles.

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

Source: OFSP (2010) ; LAMal mise à jour 1er janvier 2011 ; Brunner *et al.* (2007); Gilliand and Rossini (1997); Colombo (2001).

Surveillance of different aspects of mandatory health insurance occurs at multiple levels of government, with the confederation holding overarching responsibility for the LAMal. Insurers seeking to offer mandatory health insurance need to seek authorisation from the Federal Department of Home Affairs and must meet obligations on the adequacy of their financial and organisational structures. The Federal Office of Public Health (OFSP) is responsible for overseeing the implementation of the law. LAMal insurers have to submit annual reports, their budgets and financial reports to the OFSP, and communicate the list

of premiums for the following year for approval. The OFSP is also responsible for ongoing monitoring of the financial viability of LAMal insurers. While both commercial and (not-for-profit) health insurers can become LAMal-insurers, so far there have been no cases of commercial health insurers asking for authorisation to provide basic cover. A new bill on insurance surveillance and governance will be presented to the parliament (see Chapter 3). Cantons are responsible for monitoring that individuals hold basic health insurance and have the ability to force enrolment for individuals that have not done so themselves. These individuals will have to enrol with a provider chosen by the canton and will be liable for paying the basic health insurance premium.

Other social-insurance schemes paying for health costs

Switzerland's mandatory health insurance operates alongside social insurance schemes that can sometimes help residents finance their health costs: accident insurance, disability insurance and military insurance.

All workers employed in Switzerland receive employer sponsored accident and professional illness insurance, under the Federal Law on Accident Insurance (LAA).[13] Premiums are set as a proportion of salaries and depend on an individual's occupation. Benefits are provided both in cash and through the provision of services in kind. The latter can often include invalidity and survival pensions as a result of an accident or professional illness. Accident insurance amounted to 3% of total health expenditure in 2008 (OFS, 2008b) (Table 1.4).

Mandatory accident insurance generally provides products customised for an occupational sector, as designated by law. The Swiss National Accident Insurer (SUVA) covers 53% of all workers, primarily operating in the secondary sector (industry, artisans, industrial commerce, etc.). Other insurers include private companies, sickness funds, and public accident-insurance funds (Ludwig, 2007). Unlike many mandatory health insurance products, the SUVA adopts case management, with staff engaging actively in selecting and co-ordinating an individual's care needs in order to help them return to the workforce. Individuals who hold accident insurance are entitled to a percentage reduction on the ordinary LAMal premium established by the insurer.

Disability insurance is provided under the legal framework of the Law on Disability Insurance (LAI).[14] It is organised in a decentralised manner with offices in each canton jointly administering old-age and disability benefits (AVS-AI) (Leuenberger and Mauro-Potenza, 2007). Half of disability expenditure is financed by the government (confederation and cantons), with the remainder through salary-based contributions. Benefits cover spending for rehabilitation (including the cost of medical, nursing and other rehabilitation services), disability pensions, and disability allowances. Supplementary benefits are also available. Health-related expenditures under the AVS-AI represented 3% of total health expenditure in 2008 (OFS, 2008b).

Military insurance was established in 1852 and covers all individuals employed in the field of defence and maintenance of security (Gebel and Stampfli, 2007). Benefits provided range from loss of income compensation 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 2008 (OFS, 2008b).

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 taken by employers on behalf of their employees to assist with their obligation to pay wages in the event of illness or hospitalisation. Insurers may offer daily cash-benefit insurance under the legal regimes of the LAMal or the Insurance Contract Law (LCA).[15]

LAMal insurers[16] and other life or non-life insurers can offer *supplementary health insurance* under the legal framework of the LCA. Supplementary health insurance seeks to provide enhanced benefits or broader coverage to those available under mandatory health insurance, such as accommodation in private or semi private rooms or services such as dental care. Insurers providing supplementary insurance can adjust premiums to an individual's risk, refuse cover and terminate contracts if an individual failed to disclose all health and medical conditions. Supplementary health insurance is usually purchased individually. Since 2001,[17] supplementary insurance has been prohibited from covering cost-sharing obligations on mandatory health insurance.

The size of the supplementary health insurance market has been falling since the introduction of mandatory health insurance. The market has also evolved from being dominated by LAMal insurers to being predominantly offered by commercial insurers.

1.5. Delivering health services

Cantons are central to delivering health services needed by the population. Most hospitals – the major economic entities in the Swiss health system – are owned by cantons and municipalities, although specialist hospitals are often privately owned. Ambulatory care doctors not employed by hospitals tend to be self-employed and work in independent practices. Responsibility for public health initiatives, disease prevention and health promotion programmes lies with the cantons and, to some extent, with the confederation.

Consistent with its higher than average spending, the resources allocated to delivering health care services in Switzerland are generally higher than the OECD average. This is especially the case for health care employment, practising nurses, long-term care beds and some technology devices such as MRIs (Table 1.5).

Public health programmes

Similar to other OECD countries, spending on health promotion and prevention is a small fraction of that for curative care. Around CHF 1.3 billion (2.3% of total health expenditure) is devoted to disease prevention and promotion, which is slightly lower than the average of 2.7% for all OECD countries (Figure 1.9) (OECD, 2010a).[18] This is financed by contributions from all levels of government and private organisations. 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 1.11).

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

Table 1.5. **Resources available in the Swiss health delivery system and other OECD countries, 2008**

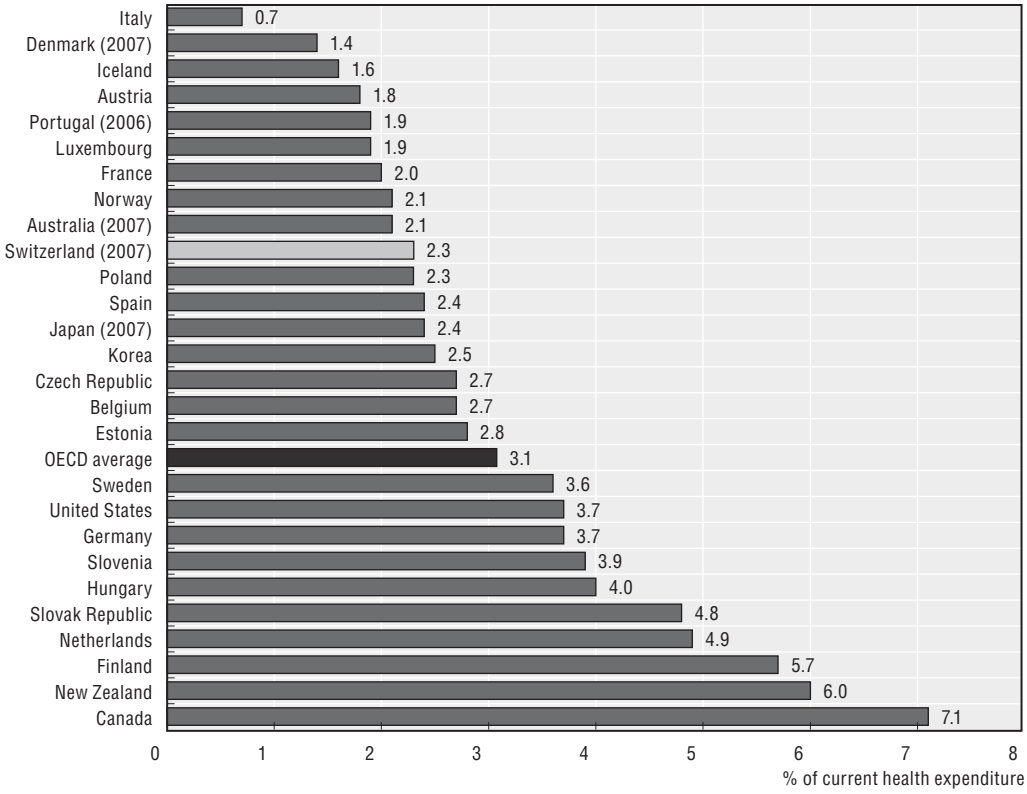
	Employment (per 1 000 population)						Hospital beds (per 1 000 population)						Beds in nursing and residential care facilities (per 1 000 population)		Medical technologies (per million population)			
	Total health and social employment		Practising physicians		Practising nurses		Total		*Curative care*	*Psychiatric care*	*Long-term care*	*Other*			CT scanners		MRI units	
Australia	52.7		3.0	2007	10.1	2007	3.9	2006	*3.5*	*0.4*	. .	. .	7.9		38.8	2009	5.6	
Austria	43.8		4.6		7.5		7.7		*5.6*	*0.8*	*0.3*	*1.0*	. .		29.9		18.0	
Belgium	53.6		3.0		. .		6.7		*4.3*	*1.8*	*0.2*	*0.4*	12.3		13.6	4	10.6	4
Canada	57.5		2.3	1	9.2		3.5	2007	*2.7*	*0.3*	*0.4*	*0.1*	. .		12.7	2007	6.7	2007
Chile	. .		. .		. .		. .			. .	. .	. .	. .		. .		. .	
Czech Republic	31.9		3.6		8.1		7.3		*5.2*	*1.1*	*0.7*	*0.4*	2.7		13.5		5.1	
Denmark	94.0		3.4	2007	14.3	2007	3.6		*3.0*	*0.6*	. .	. .	2.3		21.5		15.4	2009
Estonia	. .		3.4		6.4		5.7		*3.8*	*0.6*	*1.1*	*0.2*	5.8		14.9		8.2	
Finland	72.4		2.7		15.5	2007	6.5		*1.9*	*0.8*	*2.3*	*1.4*	10.1		16.5	2007	16.2	
France	38.5	2006	3.3	1	7.9	1	6.9		*3.5*	*0.9*	*1.5*	*1.0*	8.4		11.0	4	6.1	4
Germany	54.2		3.6		10.7		8.2		*5.7*	*0.5*	. .	*2.1*	9.7	2007	16.4	4	8.6	4
Greece	21.5	2007	6.0	1	3.4	1	4.8		*4.0*	*0.8*	. .	. .	. .		30.7		19.6	
Hungary	24.8		3.1		6.2		7.0		*4.1*	*0.3*	*1.1*	*1.5*	8.1		7.1		2.8	
Iceland	81.4		3.7		14.8		5.8	2007		. .	. .	. .	7.3		31.3		18.8	
Ireland	52.7		3.2	2	16.2	1	5.2	2007	*2.7*	*0.9*	*1.6*	*0.1*	5.4		15.1		9.4	
Israel*	. .		3.4		5.0		3.6		*2.0*	*0.6*	*0.9*	*0.1*	2.3		7.1		1.8	
Italy	28.2		4.2	1	6.3	2	3.8		*3.0*	*0.1*	*0.2*	*0.4*	3.2		31.0	2007	20.0	2007
Japan	46.8		2.2		9.5		13.8		*8.1*	*2.7*	*2.8*	*0.1*	5.8		97.3		43.1	
Korea	17.5		1.9		4.4		7.8		*5.4*	*0.8*	*1.6*	*0.0*	1.4		36.8		17.6	
Luxembourg	53.3	2007	2.8	2007	10.9	2006	5.8		*4.5*	*0.9*	. .	*0.4*	6.8	2007	27.6		12.7	
Mexico	12.0		2.0		2.4		1.7		*1.6*	*0.0*	. .	. .	. .		4.2		1.5	
Netherlands	83.6		3.7	2007	10.5	2007	4.3		*2.9*	*1.4*	*0.0*	*0.0*	10.3		10.3		10.4	
New Zealand	47.8		2.5		9.7		. .		*2.2*	. .	. .	. .	. .		12.4		9.6	
Norway	105.3		4.0		14.0		3.5		*2.5*	*0.9*		*0.1*	9.5		. .		. .	
Poland	22.9	2007	2.2		5.2		6.6		*4.4*	*0.6*	*0.4*	*1.2*	2.3		10.9		2.9	
Portugal	28.7		3.7	2	5.3	1	3.4		*2.8*	*0.6*	. .	*0.0*	. .		26.0	2007	8.9	2007
Slovak Republic	28.6		3.0	2007	6.3	1	6.6		*4.9*	*0.8*	*0.7*	*0.1*	5.7		13.7		6.1	
Slovenia	. .		2.4		7.9		4.8		*3.8*	*0.7*	*0.0*	*0.2*	. .		10.9	2007	3.5	2007
Spain	28.8		3.6		4.8		3.3		*2.6*	*0.4*	*0.3*	*0.0*	3.6	2006	15.3	4	9.9	4
Sweden	78.2		3.6	2006	10.8	2006	3.0	2005	*2.2*	*0.5*	*0.3*	. .	14.7	2007	. .		. .	
Switzerland	**68.4**		**3.8**		**14.9**		**5.2**		***3.3***	***1.0***	***. .***	***0.9***	**11.9**		**32.0**		**14.0**	**5 2006**
Turkey	7.9		1.5	1	1.3	1	2.3		*2.2*	*0.1*	. .	*0.0*	. .		10.2		6.9	
United Kingdom	60.1		2.6	3	9.5	3	3.4	3	*2.7*	*0.6*	. .	*0.0*	8.7		7.4	3	5.6	3
United States	59.9		2.4		10.8	1	3.1	2007	*2.7*	*0.3*	*0.1*	*0.1*	5.4		34.3	2007	25.9	2007
OECD average	**48.6**		**3.2**		**8.7**		**5.3**		**3.4**	***. .***	***. .***	***. .***	**6.9**		**21.3**		**11.3**	

1. Data include not only physicians/nurses providing direct care to patients, but also those working in the health care sector as managers, educators, researchers, etc.
2. Data refer to all physicians/nurses who are licensed to practice.
3. Data do not include the private sector.
4. Data include equipment in hospital only.
5. Number of hospitals running one or more MRI units.

* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD *Health Data 2010*.

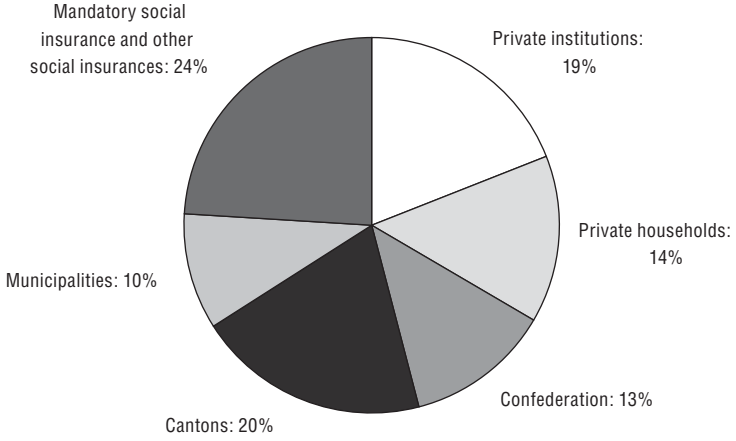
Figure 1.9. **Expenditure on promotion and prevention as a share of current health expenditure in OECD countries, 2008**



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

Source: OECD Health Data 2010.

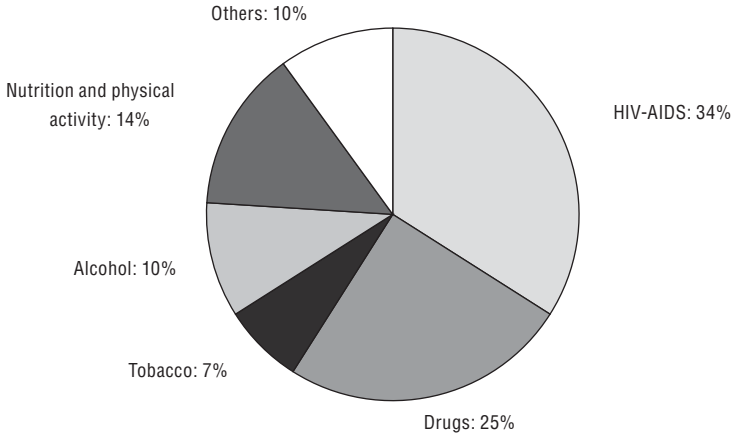
Figure 1.10. **Funding of health promotion and prevention activities in Switzerland, by financing agent, 2009**



Source: Communication from Swiss authorities.

activities, and health promotion and prevention related to the LAMal and accident insurance (OECD and WHO, 2006). Over the past few years, the confederation has endeavoured to strengthen its role in health promotion and prevention by establishing

Figure 1.11. **Main health promotion and prevention programmes of the Swiss Federal Office of Public Health by level of funding, 2011**



Source: Communication from Swiss authorities.

national policies in areas where it previously had no or limited responsibilities. For example, new and revised national programmes concerning HIV/AIDS prevention, tobacco, alcohol, narcotics, as well as nutrition and physical activity, have been introduced. Efforts are also underway to co-ordinate policy development on tobacco, alcohol and diet and physical activity. Since late 2009, the Swiss Parliament has been debating a new law on prevention and health promotion that seeks to clarify the roles of different levels of government in meeting national objectives and establish a new Swiss Institute for Prevention and Health Promotion (Institut Suisse pour la Prévention et la Promotion de la Santé) at the federal level (see Chapter 4).

Cantons are responsible for primary prevention activities, such as the implementation of immunisation programmes and vaccination-coverage surveys.[19] Both secondary and tertiary prevention fall under the responsibility of cantons. For instance, while national policies can clarify insurance support, each canton is responsible for setting up its own programmes.[20] 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[21] (see Box 1.4).

Ambulatory care

The ambulatory care sector provides general medical advice, diagnostic services, obstetrics care, perinatal care, care for children, family planning, minor surgery, rehabilitation, dental care and home-based care. Ambulatory services are largely provided by physicians operating as independent/single-person practices. In addition to independent practices, ambulatory services are also provided by outpatient departments of public and private hospitals and by managed-care-style organisations. Health services such as physiotherapists, occupational therapists, nursing services, speech therapists and dieticians also tend to operate as independent services.

Swiss citizens are free to choose their health care physician and have unlimited access to general practitioners or specialists working in ambulatory care services. While there is no formal gatekeeping system in place, most individuals seem to have a regular or family doctor. Some individuals hold a special insurance policy where they receive premium reductions in exchange for agreeing to a managed care arrangement. In these circumstances, individuals' choices of services are directed by their primary care providers. These providers are typically Health Maintenance Organisations (HMOs), a family-doctor gatekeeping scheme, Independent Practice Associations (IPAs), Preferred Provider Organisations (PPOs).

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 organisation's three priority programmes relate to healthy body weight, mental health and stress and strengthening health promotion and prevention in Switzerland. 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 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

This association seeks to improve co-ordination in health promotion between cantons and between the cantons and the federal government. The association includes four regional groups: Latin Switzerland, North-West Switzerland, Eastern Switzerland, and Central Switzerland, which seek to co-ordinate health promotion activities across their region.

Radix

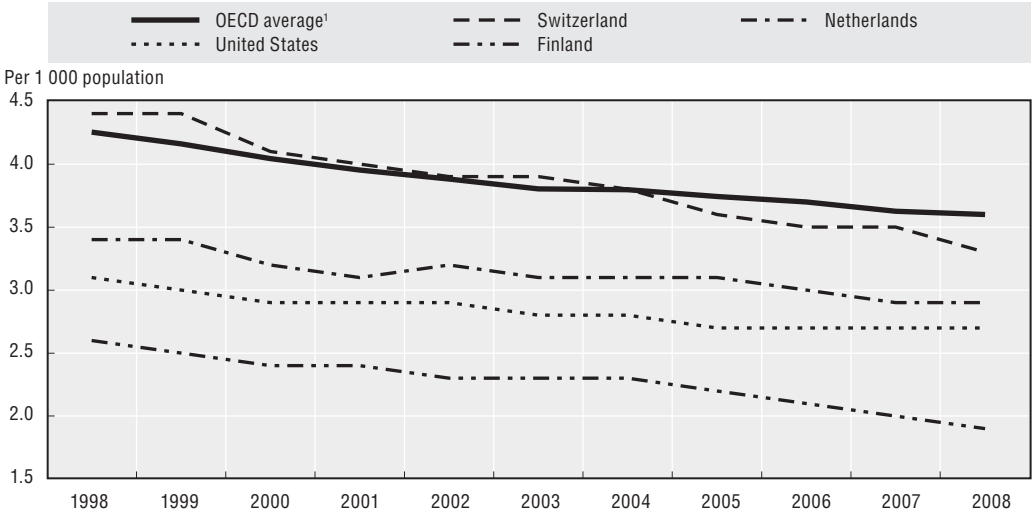
Radix is a foundation specialising in health promotion activities for municipalities, schools and companies. It aims at encouraging municipalities and cantons to consider health promotion as an important issue. It provides services to municipalities, schools, and companies and has an annual budget of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

Hospitals

Hospital supply of acute care beds in Switzerland, at 3.3 per 1 000 population, is slightly below the OECD average of 3.4 beds (Figure 1.12). There has been a reduction in the number of beds per capita over the last two decades, in line with the trend across OECD countries. This can be explained by hospital rationalisation in certain cantons as well as reductions in average lengths of stay (see Chapter 4).

The ownership and services offered at hospitals vary considerably. Public hospitals are owned and often run by cantons, municipalities or foundations. Private hospitals are either for-profit or not-for-profit. Most emergency services are delivered by public hospitals.

Figure 1.12. **Acute care beds in Switzerland and in selected OECD countries, 1998-2008**



1. OECD unweighted average. It excludes Chile, Iceland, Luxembourg and New Zealand.

Source: OECD Health Data 2010.

Specialised hospitals for rehabilitation and psychiatric care operate alongside general hospitals. High-tech and highly specialised medical treatments are supplied by several facilities, including five university hospitals (Zurich, Bern, Basel, Lausanne and Geneva), and some large cantonal hospitals. Private hospitals generally provide standard surgical treatments, day-care and elective surgery and represent about one fifth of overall hospital beds. A small number of private hospitals also provide highly specialised care services (Saladin *et al.*, 2007).

While the confederation has recently issued criteria for hospital planning, the planning process remains a responsibility of the cantons. There is significant variation in the way cantonal plans have been established. All public hospitals and some private hospitals within a canton are generally included in the planning process.

Long-term care

Cantons carry responsibility for long-term care. They can delegate the organisation and provision of care to municipalities. Formal care is provided in medical nursing homes, in nursing departments of old age or disability homes, and at the homes of the care beneficiaries (by an organisation called "Spitex"). Informal carers providing help with the activities of daily living also play an important role, engaging up 10.8% of the population (OECD, 2011a). In 2009, the proportion of over 65s receiving long-term care services has been estimated to be close to 19% (corresponding to about 243 000 elderly), of which 12.5% received care at home and 6.3% were recipients of long-term care in an institution or health care facility (*OECD Health Data 2011*).

The overall (public and private) cost of long-term care (both medical and non-medical) for the frail elderly is estimated at around 2.1% of GDP, of which 1.8% for institutional care, and 0.3% for care services at home, placing Switzerland above the OECD average of 1.5%. This appears partly related to the higher share of those over 80 in the total population when compared with other OECD countries (OECD, 2011a).

Table 1.6. **Public and private hospitals in Switzerland, 2009**

	Number of hospitals					
	Private		Public or subsidised		Total	
	Number	Rate	Number	Rate	Number	Rate
Zürich (ZH)	16	1.2	32	2.4	48	3.6
Bern (BE)	15	1.5	18	1.9	33	3.4
Luzern (LU)	4	1.1	3	0.8	7	1.9
Uri (UR)			1	2.8	1	2.8
Schwyz (SZ)	1	0.7	3	2.1	4	2.8
Obwalden (OW)			1	2.9	1	2.9
Nidwalden (NW)			1	2.5	1	2.5
Glarus (GL)			1	2.6	1	2.6
Zug (ZG)	2	1.8	3	2.7	5	4.5
Freibourg (FR)	2	0.7	7	2.6	9	3.3
Solothurn (SO)	2	0.8	2	0.8	4	1.6
Basel-Stadt (BS)	3	1.6	10	5.3	13	6.9
Basel-Landschaft (BL)	7	2.6	6	2.2	13	4.8
Schaffhausen (SH)	1	1.3	2	2.6	3	4.0
Appenzell Ausserrhoden (AR)	5	9.4	3	5.7	8	15.1
Appenzell Innerrhoden (AI)	1	6.4	1	6.4	2	12.8
St. Gallen (SG)	4	0.8	10	2.1	14	3.0
Graubünden (GR)	6	3.1	12	6.3	18	9.4
Aargau (AG)	11	1.8	10	1.7	21	3.5
Thurgau (TG)	11	4.5	3	1.2	14	5.8
Ticino (TI)	12	3.6	8	2.4	20	6.0
Waadt (VD)	11	1.6	22	3.2	33	4.7
Wallis (VS)	2	0.7	11	3.6	13	4.3
Neuchâtel (NE)	2	1.2	7	4.1	9	5.3
Genève (GE)	9	2.0	6	1.3	15	3.3
Jura (JU)	1	1.4	3	4.3	4	5.7
Switzerland	**128**	**1.7**	**186**	**2.4**	**314**	**4.1**

Note: "Rate" refers to the number of hospitals per 100 000 persons.
Source: Office Fédéral de la Statistique, online data on hospital statistics.

Two-thirds of nursing homes and other providers of institutional care are public institutions or non-profit organisations, while the remaining third are private for-profit (OECD, 2011a). Cantons generally subsidise the construction and running costs of public and certain private nursing and old age homes. Total bed capacity is close to 89 000 and occupancy rates were 95-97% in 2005 (OFS, 2011; Mosle, 2005). The majority of nursing-home residents are aged 80 and over. There are 72 beds in institutions per 1 000 population aged 65 years and over, amongst the highest in the OECD (OECD, 2010a). While supply has been shifting away from long-stay wards in general hospitals, some elderly people requiring nursing care are admitted to hospitals due to waiting lists for entry to nursing homes.

According to the Swiss health accounts, about 40% of long-term care is directly financed by health insurance, cantons and municipalities, with the remaining 60% financed by households. However, the financial burden faced by households is reduced significantly through social benefits such as invalidity allowances and supplementary benefits for the elderly (accounting for around 24% of the total expenditure), resulting in a final estimate of about 36% of total spending from households after subsidies. The LAMal

covers medical costs and provides a contribution to care costs incurred in nursing homes (daily living support), as well as part of the cost of home care services.

The above mentioned new system of paying for long-term care was introduced in 2011, covering home care services, care in dedicated facilities and nursing homes. Under the new arrangements, a national schedule of rates will be prescribed for different levels of nursing and basic care services for older persons under their mandatory health insurance. In addition, this new system will see mandatory health insurance help pay for transitional care for the elderly of up to two weeks following a hospital stay, where prescribed by a physician. The cost of board and other (non-health) social services will continue to be borne by social insurance or individual contributions and capped at 20% of a maximum contribution that is set by the Federal Council.

Growing concerns about population health needs has seen home-based care receive more attention that it had in the past. Spitex is the Swiss-German acronym for care services provided outside hospitals. 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.

Health workforce

Health care represents an important sector in terms of employment. It is estimated that around 542 000 individuals work in this sector which represents 13.5% of the active population. The greatest number of positions in the health sector are in hospitals (163 000 positions), followed by the nursing homes (155 000 positions), and the ambulatory sector (100 000 positions) (OFS, 2010b). The pharmaceutical and medical device industry employs 61 000 people. The health sector remains dynamic and has experienced various fluctuations in employment over the years. Employment growth in the health sector reached 2.6% between 2001 and 2008 in Switzerland (including 4.4% for the pharmaceutical and medical devices industry), whereas the average employment growth at national level only increased by 1.2% during the same period (OFS, 2008a). Switzerland has also experienced a continuous increase in health professional density over the past decades. For example, the number of practicing doctors rose from 2.4 to 3.9 per 1 000 population between 1980 and 2008.

Nurses represent the main category within the Swiss health workforce. The total number of practicing professional nurses in Switzerland is estimated at 79 000 (OFS, 2011). In terms of nurse employment, most tertiary nurses work in a hospital setting (64%) followed by long-term care settings (25%) and community care settings (11%) (OFS, 2006, based on information provided to the Institute of Nursing Science, University of Basel). As for practicing physicians, their total number is close to 30 000 (OFS, 2011). The majority (53.1%) work in the ambulatory sector and hospital settings are also popular, representing 45.3% of all practicing doctors. Only 1.6% work outside these two sectors (Kraft, 2011). In the ambulatory sector, independent practitioners may choose their specialisation and location. However, a freeze in the opening of new medical practices for independent practitioners working under the LAMal was adopted in 2002 and has since been extended until the end of 2011.

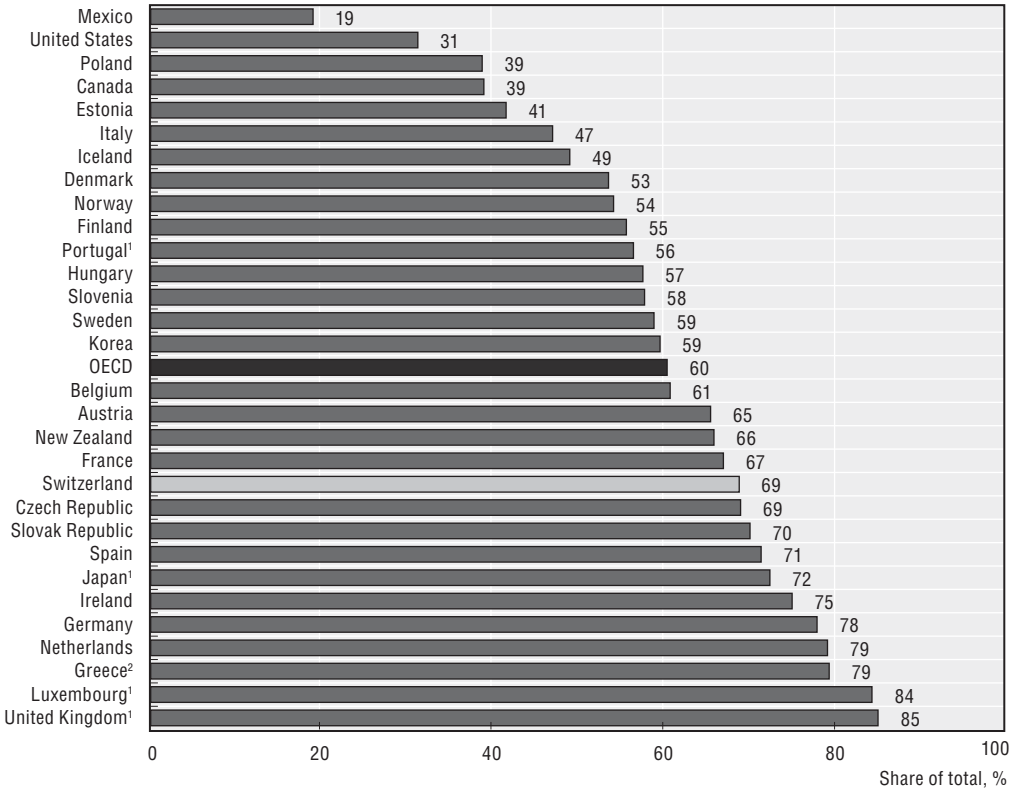
A large number of allied health professions who work alongside doctors and nurses are also key to the health workforce. This includes health professionals such as anesthesia technicians, dietitians, emergency medical technicians, physiotherapists, medical assistants, medical laboratory technicians, radiographers and surgical technicians.

In Switzerland, migrant health workers constitute an important proportion of the health workforce and their figures are above the OECD average (OECD, 2007). The majority of migrant health workers are from neighbouring countries, and particularly Germany for doctors (see Jaccard-Ruedin and Widmer, 2010 and Chapter 3).

Pharmaceuticals

The Swiss population spent USD PPP 499 per capita on pharmaceuticals in 2009, above the OECD average of USD PPP 410 per capita (OECD, 2011). Drugs dispensed to *out-patients* accounted for 10.3% of total health expenditure in 2008, a share which was significantly below the OECD average of over 17%. Over two-thirds of pharmaceutical spending is paid by mandatory health insurance or other social insurers, a slightly higher share than the OECD average of 60% (OECD, 2011c) (Figure 1.13).

Figure 1.13. **Share of expenditure for out-patient pharmaceuticals paid by the government or social insurers in the OECD, 2009**



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

1. 2007.
2. 2006.

Source: OECD Health Data 2011.

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. 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, and drugs with 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.

The large majority of pharmaceuticals sold in Switzerland are branded products, and most of these are subject to prescriptions. In 2010, 85% of the overall turnover of the domestic pharmaceutical market consisted of drugs requiring a medical prescription (Interpharma, 2010). The sales of generics have risen substantially in recent years, along with the introduction of differentiated co-payments for generics and today account for 11.5% of the market of medicines reimbursed by funds.

About 52% 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 (25% of the market), followed by hospitals (21%) and drugstores (2%) (Interpharma, 2010). Only independent physicians with a special license accorded by cantons are allowed to dispense medication, in principle these are intended to be 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.*, 2007). Over the last decade the number of pharmacies has been increasing, while the numbers of drug stores and dispensing doctors have declined (Interpharma, 2010).

1.6. Provider payments, reimbursement and contracting

Switzerland spent 46% of its total health expenditure in 2008 on in-patient care, 29% on out-patient care and 10% on pharmaceuticals dispensed to out-patients. The share of in-patient care is much higher than OECD averages while the share of pharmaceuticals is lower (Table 1.7). The relative share of expenditure by type of care has remained stable over time.

Swiss health care providers receive payments from insurers, cantons and directly from patients. At present, ambulatory-care services are mostly paid on a fee-for-service basis, while hospital payments are currently under transition from a variety of payment structures across cantons to nationally consistent funding on the basis of cases treated.

The law establishes that providers' bills should be based on tariffs agreed by convention between insurers and providers, or fixed by the authorities.[22] For LAMal-covered services, insurers are required to reimburse services delivered by all providers authorised to practise within the scope of mandatory health insurance. LAMal and other social insurers (LAA, AI, AM) have independent negotiations with providers. Payments for services not reimbursed by social insurers are based on market prices.

Table 1.7. **Distribution of health expenditure by type in OECD countries, 2008**

	Percentage of total health expenditure				Medical goods	
	In-patient	Out-patient	Home care	Ancillary services	Total dispensed to out-patient	Of which pharmaceutical and other medical non-durables
Australia (2007)	35.4	31.4	0.0	5.7	17.4	14.3
Austria	40.0	22.9	6.4	3.0	17.1	13.3
Belgium	38.1	20.0	7.9	2.3	16.2	15.1
Canada	27.3	25.4	2.2	6.0	19.8	17.2
Czech Republic	32.1	25.7	0.8	5.5	24.0	20.4
Denmark	36.4	26.9	12.7	4.5	12.7	8.6
Estonia	33.0	22.1	0.4	9.7	23.8	20.7
Finland	35.0	29.5	1.7	3.0	17.0	14.4
France	37.3	17.1	2.8	5.0	20.8	16.4
Germany	34.1	22.2	6.0	4.5	19.8	15.1
Hungary	29.6	20.4	0.3	4.4	35.5	31.6
Iceland	45.4	25.4	1.0	2.3	16.0	13.9
Israel (2006)*	35.0	46.0	n.a.	n.a.	14.3	n.a.
Italy	45.6	30.6	n.a.	n.a.	18.4	18.4
Japan (2007)	38.3	32.1	0.5	0.7	21.2	20.1
Korea	29.4	32.9	0.3	0.2	25.7	23.9
Luxembourg	38.1	27.7	5.0	5.3	11.3	9.1
Mexico	15.2	37.4	0.4	0.7	28.5	28.3
New Zealand	31.7	26.0	10.4	4.7	10.9	9.6
Norway	42.4	18.3	9.5	6.1	11.7	7.6
Poland	32.0	19.5	5.8	5.5	25.1	22.6
Portugal (2006)	20.8	33.8	2.5	8.2	23.6	21.8
Slovak Republic	20.8	23.0	0.7	7.1	35.1	27.6
Slovenia	33.7	24.2	2.4	2.9	21.8	18.7
Spain	28.2	29.5	2.9	5.1	22.7	20.5
Sweden	29.2	33.3	4.0	4.6	16.0	13.2
Switzerland (2007)[1]	**45.6**	**29.3**	**2.2**	**3.3**	**12.2**	**10.3**
United States	24.5	44.2	2.8	n.a.	13.1	11.9
OECD average[2]	**33.4**	**27.7**	**3.5**	**4.4**	**19.7**	**17.2**

1. Switzerland may overestimate expenditure for long-term care, an important component of in-patient health spending. Data on in-patient expenditure also includes capital investment, which other OECD countries account for separately. These factors may push up the overall share of in-patient health spending compared to other OECD countries.
2. The OECD average excludes Italy and Israel for home care; Italy, United States and Israel for Ancillary services; Israel for pharmaceuticals and other non-durables.

No data or limited data was available for Chile, Greece, Ireland, Netherlands, Turkey and the United Kingdom – hence these countries were excluded from this table.

n.a.: stands for not available.

* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD Health Data 2010.

Payment mechanisms, price and tariff levels

Ambulatory care

GPs and specialist doctors working in ambulatory-care settings and in ambulatory units of hospitals 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). 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.[23] 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 paid directly by the insurer.

Most hospital doctors and health professionals are salaried. Doctors treating patients who have chosen a special policy with limited choice of provider are paid differently depending on the specific managed-care model.

Within social-insurance schemes, all medical and medical-related professions have a nationally agreed tariff structure that attributes a resource-based relative weight to services they can provide. These relative weights have been negotiated between the relevant professional associations[24] and insurers (health, accident, military and disability), with a certain number of "points" being attributed to each service (European Observatory on Health Care Systems, 2000). For example, medical fees have been based on this kind of unified relative tariff system (TARMED) since 1 January 2004. The TARMED specifies a number of points for each type of medical treatment, based on the resources they are likely to consume. This is then used as the basis for setting tariffs for ambulatory services delivered by doctors in private practice and in hospitals. The number of points attached to each type of service is also set nationally for accident, military and disability insurance. For LAMal-insurers, national agreements exist specifying the number of points for dentists and dieticians. However, for medical fees, the value attributed to points is negotiated between the cantonal associations of insurers and providers, and can reflect the differences in salaries and other medical prices across cantons. Similar canton-based agreements exist for chiropractors, ergotherapists, nurses and physiotherapists.

Outside of mandatory health insurance, providers set their prices freely, although usually with reference to the nationally agreed point structure. This situation applies for 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 due to the freeze on the opening of new office-based practices.

Hospitals and nursing homes

Remuneration based on cases is becoming the dominant payment mechanism for hospitals. Since 2009, hospitals have been transitioning to a new remuneration system which provides case-based payments by diagnostic related groups (or DRGs). This new system will be introduced by 2012. A schedule of relative values for DRGs has been computed from data taken from 40 hospitals (accounting for 60% of hospitals' activity). The canton-based rates for these values will be negotiated between hospitals and insurers within each canton, and approved by cantonal governments. Investment costs are included in the DRG costings but not costs for other activities such as research, and university level education.

Cantons will cover at least 55% of the remuneration per case for a hospital inpatient with insurers providing the remaining share. 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 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. Once the new national system is fully

implemented, it is anticipated that 100% of hospital inpatient treatments will be paid for through DRG payments.

Mandatory health insurance contributes to the financing of 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, in line with the national schedule of prices being implemented from 2011. As for hospitals, cantons have traditionally provided subsidies to public and certain private nursing homes.

Pharmaceuticals

The Swiss Federal Office of Public Health is responsible for pharmaceuticals' reimbursement and pricing under mandatory health insurance. Only pharmaceuticals included in a positive drug list by the OFSP (the "specialty list") 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 2.5% VAT; and a manufacturer's selling price. In 2011, the speciality list included about 2 600 medicines, corresponding to 8 600 variants.[25] 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 Commission. The Federal Drug Committee reviews the efficacy, adequacy and cost-effectiveness of the drug before advising the OFSP. 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 (Austria, France, Germany, Denmark, the Netherlands, and the United Kingdom). 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. As in France, Switzerland also considers the degree of innovativeness for the purpose of negotiating the prices of new drugs being considered on the positive list. An "innovation premium" of around 10% to 20% over the price of therapeutic comparators already on the market is sometimes awarded to products that are the first or second entrants in a class. An innovation premium may be granted to products with added therapeutic value.

Prices set by the Federal Office of Public Health are reviewed periodically. Examinations take place upon the drug's listing on the speciality list and every three years. On these occasions, the price of the drug is aligned to the average price in the reference countries. On market entry in Switzerland, generics must be priced from 10% to 60% below the price of original (branded) drugs, depending on market size (see Chapter 5 for further details).

Once a drug has been included in the speciality list, 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. There have also been recent changes to pharmacists remuneration to link payments to services delivered and not to the volumes of medicines dispensed (see Chapter 4).

Contracting

The law allows providers flexibility over whether they choose to join a tariff agreement. A provider (*e.g.*, doctors, pharmacist or a nurse) can decide to join in an agreement even if they are not a member of a professional association. Moreover, members are not obliged to adhere to a tariff agreement stipulated with insurers (Brunner *et al.*, 2007). Those who decide not to join – only a few at present – must negotiate a separate tariff with insurers.

Insurers have a *de facto* obligation to reimburse services delivered by providers authorised to practise within 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.[26] Apart from doctors in managed-care settings, insurers do not have freedom to contract selectively.

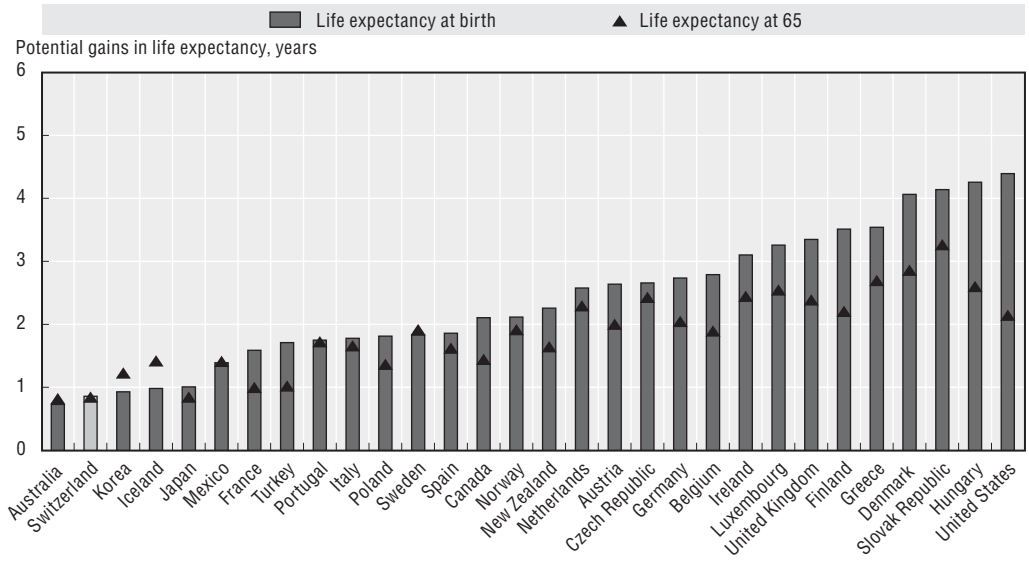
For ambulatory care, cantonal tariffs apply to all treatments delivered by the providers of the respective canton. In the inpatient sector, providers can set higher fees for patients coming from a different canton. If the individual receives a treatment outside of the canton of residence, his or her 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. 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.[27] From 2012 individuals will be free to receive hospital treatment from any Swiss hospital of their choice, independent of the canton of residence, and will be reimbursed at the tariff of their canton of origin.

1.7. The system's efficiency: international benchmarking and future challenges

While it is considered to be costly, the Swiss system ranked well in the recent OECD study on health systems efficiency (OECD, 2010d). In this report, the OECD assessed the efficiency of its member countries' health systems using Data Envelopment Analysis (DEA) to estimate efficiency frontiers. Life expectancy was used as the best available proxy of health outcomes and total health spending and the number of health staff were both used alternatively to measure inputs. Other determinants of life-expectancy were taken into account in the model through a composite indicator (income, socio-economic conditions and life styles) and the sensitivity of the model to different outcomes and input combinations were tested.

This methodology provided estimates of potential gains in life expectancy that could be achieved by each country if it was able to increase its efficiency to the level implied by the efficiency frontier – inputs were held constant and a hypothesis of non-increasing returns to scale was adopted (see Figure 1.14 below). According to these estimates, Switzerland ranks amongst the most efficient countries.

Figure 1.14. **Potential gains in life expectancy through improved efficiency**[1]



Note: Potential gains are measured by the number of years of life that could be saved if efficiency in country were to be raised to the level implied by the estimated efficiency frontier.

1. In this panel, all Data Envelopment Analyses (DEAs) were performed with two inputs: health care spending per capita and a composite indicator of the socio-economic environment (GDP per capita, educational attainment) and lifestyle factors (nitrogen oxide emissions, consumption of fruit and vegetables, lagged consumption of alcohol and tobacco, 1990 data). All DEAs refer to 2007 except in the case where amenable mortality rates were taken as the outcome since these are only available until 2003 and for 27 countries.

Source: OECD (2010d).

Like many other high-income countries, Switzerland faces the challenge of maintaining the achievements of its health care system to date. Today, nearly all Swiss residents are insured and enjoy coverage of a wide range of benefits, however with a rather high share of out-of-pocket expenditure. Maintaining universal coverage with a wide range of benefits will increasingly be a challenge in light of demographic change, more persons living with chronic diseases, expanding health technologies, increasing medical costs and higher expectations and demands by people. The World Health Report 2010 *Health Systems Financing – A Path to Universal Coverage* outlines options and recommendations also for high-income countries (see Box 1.5).

Box 1.5. **Recommendations from the *World Health Report 2010 – Health systems financing: the path to universal coverage*: Key messages relating to high-income countries**

The challenge

In many countries, millions of people suffer because they cannot get the health care they need or because paying for health services is a financial burden to them. Financial hardship is not restricted to low and middle income countries: almost 4 million people in just six OECD countries (Greece, Portugal, Mexico, Korea, Hungary and Poland) experienced some form of financial hardship because they had to pay directly for health care. Medical debt has been the principal cause of personal bankruptcy in the United States.

Even in countries where health services have traditionally been accessible and affordable, governments are finding it increasingly difficult to respond to growing demands and expectations from their populations and to pay for rapidly expanding technologies and options for improving health. High-income countries that have achieved elevated levels of financial risk protection and coverage also need to engage in

Box 1.5. **Recommendations from the *World Health Report 2010 – Health systems financing: the path to universal coverage*: Key messages relating to high-income countries** *(cont.)*

continuous self-assessment to ensure the financing system continues to achieve its objectives in the face of increasing demands and evolving fiscal constraints. Moreover, many high-income countries are facing a decline in the proportion of their working-age population and have to consider alternatives to traditional sources of revenue in the form of income taxes and health insurance contributions from workers and their employers. Finally, typically some part of health spending is wasted, depriving many people of needed care.

WHO recommendations

By adjusting their health financing systems – sometimes a little, sometimes a great deal – every country can increase health coverage and reduce the suffering associated with illness and the need to pay for services. All countries, rich and poor, can do more to move closer to universal coverage or to protect the gains they have made in the past. The 2010 World Health Report offers practical guidance on ways to increase health service coverage, protect people from financial catastrophe and impoverishment linked to using services, and to enhance efficiency and equity. Importantly, increasing efficiency is a way of increasing coverage, financial protection and health outcomes for the available resources, not a way to reduce funds for health. Building on country experiences, the report presents approaches in the following three broad areas:

1. ***Raising sufficient money for health from traditional sources as well as using innovative approaches***

Options include making health a higher priority in existing government spending and diversifying sources of revenue, such as value-added taxes and "sin" taxes (particularly on tobacco and alcohol). Making revenue collection more efficient is equally important, even in some high-income countries, as tax evasion and poor tax and insurance premium collection can be serious problems.

2. ***Relying largely on forms of prepayment* (e.g. *insurance and/or taxes*)**

Prepayment serves to raise funds, then pool them to ensure access and spread financial risks; this means minimising reliance on direct, out-of-pocket payments.

3. ***Spending money more efficiently and equitably***

All countries can strive for improving efficiency and equity by taking a more strategic approach when deciding which services to provide or purchase based on information on the health needs of the population. Efficiency, and thus also equity, can be enhanced through some of the following approaches:

- Reducing unnecessary expenditure on medicines through a more systematic use of generics, more rational prescription and use, adequate pricing strategies and improved quality control.
- Improving hospital efficiency by avoiding unnecessary admissions and inpatient days, by optimising the size and range of services offered and by increasing hospital productivity.
- Choosing the right set of interventions by opting for lower-cost, higher-impact interventions, and ensuring the right mix between prevention, promotion and treatment.
- Finding an optimal balance of provider payment incentives to provide the right level of care by linking payments with performance and to information on service costs, quality and impact. Particular care should be taken with fee-for-service payments, which offer incentives for overprovision of services. Capitation payments could cover all the health needs of each person registered with a provider, and could also encourage a focus on prevention.
- Avoiding fragmentation in funding channels, pools and care structures in order to reduce duplication and administrative costs.

Source: WHO (2010).

This report focuses on three core topics: health insurance, health workforce and governance in the Swiss Health System. A further chapter also (more briefly) profiles a range of policy areas where there has been change over the past half decade or are particular areas of interest. Together, this report seeks to suggest how Switzerland can further improve its performance in delivering health care in a more efficient, accessible and equitable way.

Notes

1. Loi fédérale sur l'assurance-maladie et accident, 13 June 1911.
2. Loi fédérale sur l'assurance-maladie, 18 March 1994. The law came into effect on 1 January 1996.
3. Including suburban areas of these cities.
4. One member in the case of half-cantons, such as Basel-City and Basel-Land.
5. The National Council has 200 members and the Council of States has 46 members.
6. Switzerland and the European Union have over the years increased interest in health as a common policy field.
7. 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.
8. 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 premiums.
9. This section draws heavily on previous work on the mandatory health insurance system by Colombo (2001) and OECD and WHO (2006).
10. These objectives were contained in the Message concerning the revision of the 1911 Sickness and Accident Law (LAMA), 6 November 1991, pp. 3-5.
11. 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.
12. 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 15) paid for per day for each episode of hospital care (*e.g.*, a night in hospital).
13. Loi fédérale sur l'assurance accident, 20 March 1981.
14. Loi fédérale sur l'assurance invalidité, 19 June 1959.
15. Loi fédérale sur le contrat d'assurance, 2 April 1908.
16. Article 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.
17. Date of enactment of a LAMal revision of 24 March 2000.
18. 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.
19. 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.
20. 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"). While insurance coverage is provided on a national basis, only a limited number of cantons have developed a systematic quality-assured breast-screening programme (*cf*. Chapter 4 for further details).

21. 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.

22. 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.* 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.

23. 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. Pharmacists receive a fee for handling the prescription and advising the patient, and a fee for keeping patients' records (Jordan and Ray, 2007).

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

25. The list is available on the Internet at *www.bag.admin.ch/kv/gesetze/sl/d/index.htm*.

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

27. 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-City and Basel-Land in co-operation with the German county of Lörrach.

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Chapter 2

Health Insurance

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

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

2.1. General trends in the Swiss health insurance market

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

Swiss health insurance offers comprehensive coverage of health care

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

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

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

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

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

Consumers can choose between different options for health insurance plans

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

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

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

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

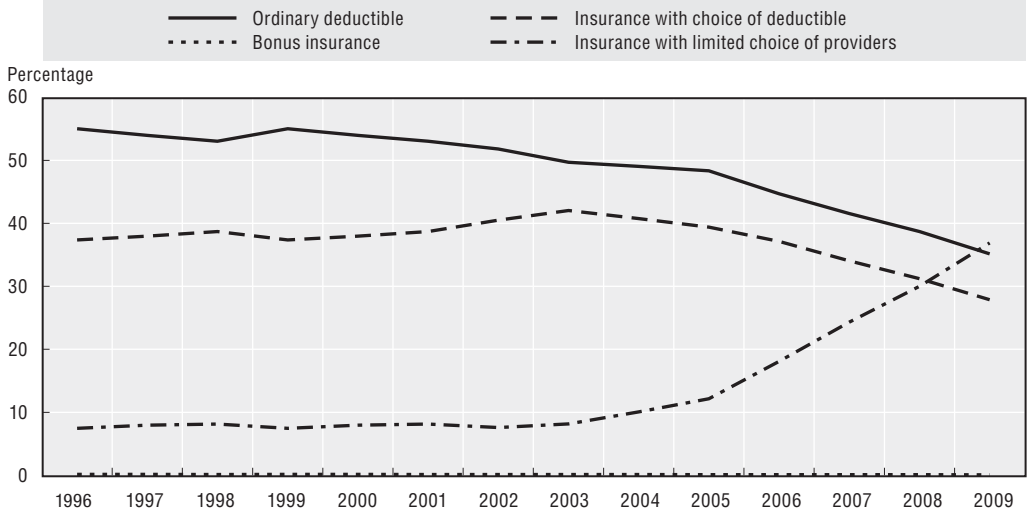
Table 2.1. **Types of insurance contracts within the mandatory health insurance (LAMal)**

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

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

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

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



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

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

Private supplementary health insurance covers one third of the population

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

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

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

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

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

Switzerland has reached universal coverage

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

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

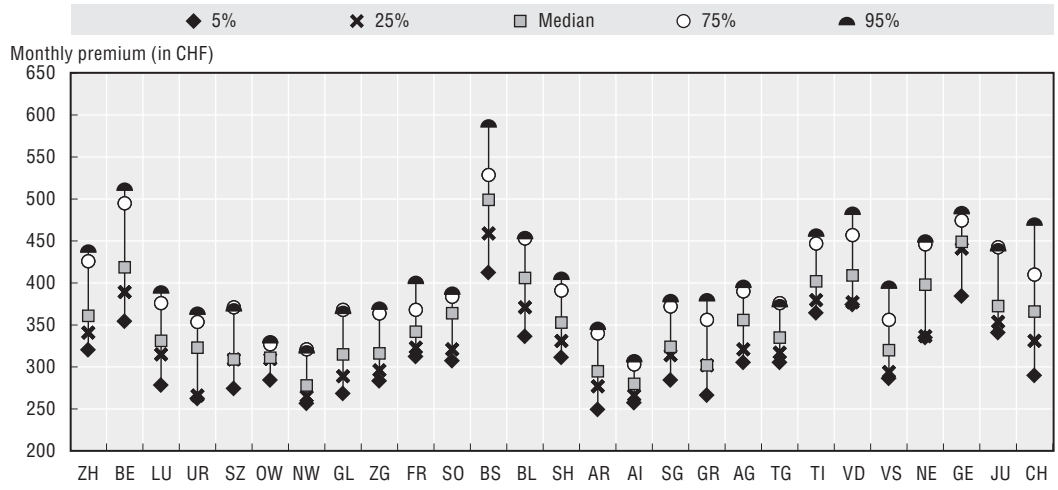
However, health professionals have recently expressed concerns about people seeking care without insurance coverage. In March 2010, the parliament revised the law with the objective of protecting people facing serious financial problems for paying premiums: from January 2012, cantons will pay 85% of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

Health insurance premiums vary widely across and within cantons

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

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

Premiums estimates for plans with ordinary deductibles and insurance accident

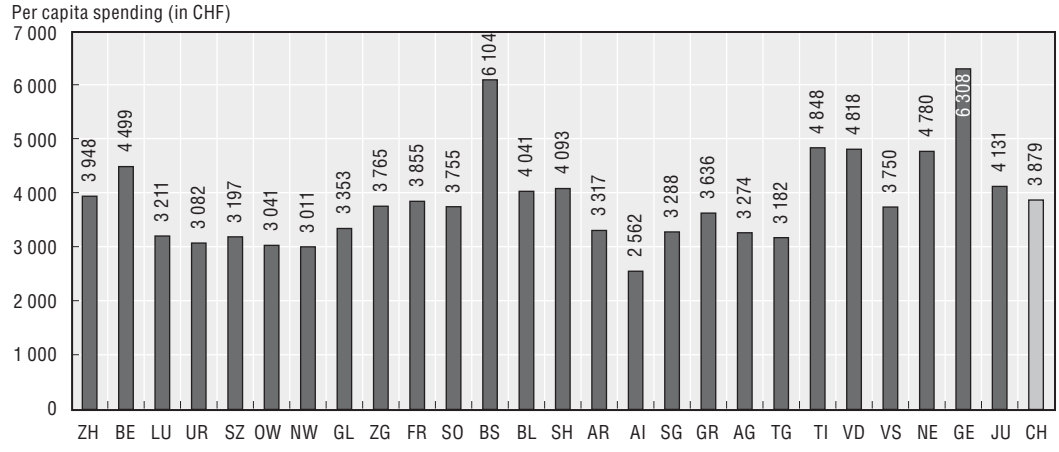


Lecture: In the canton of Zurich, 5% of adult insurees pay less than CHF 322 per month for health insurance, 50% of insurees pay less than CHF 361 and 5% pay more than CHF 441.

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

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

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



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

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

Public subsidies help some individuals and families pay health insurance premiums

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

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

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

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

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

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

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



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

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

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

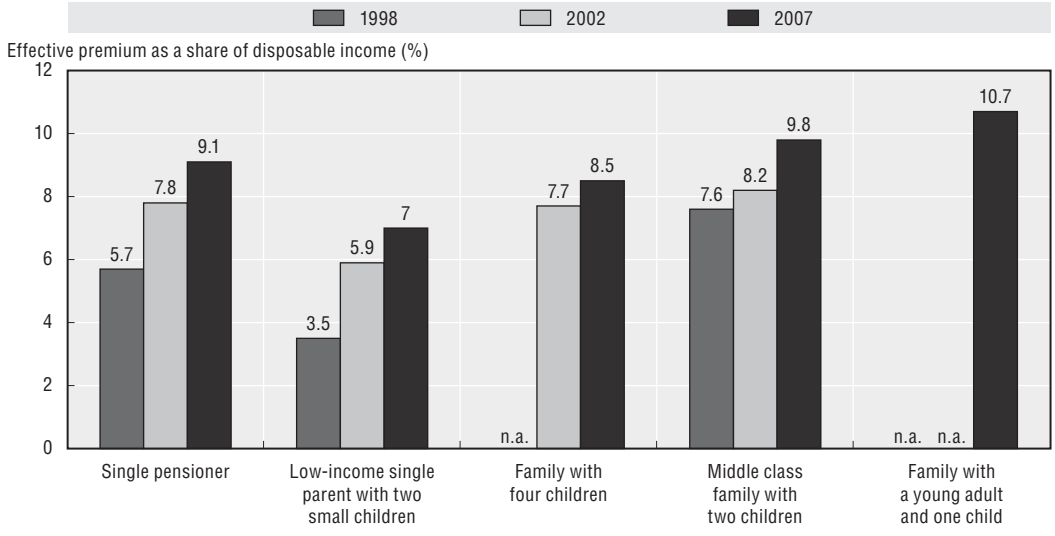
Source: OFSP (2011a), *Statistiques de l'assurance maladie en 2009*.

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

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

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

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



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

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

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

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

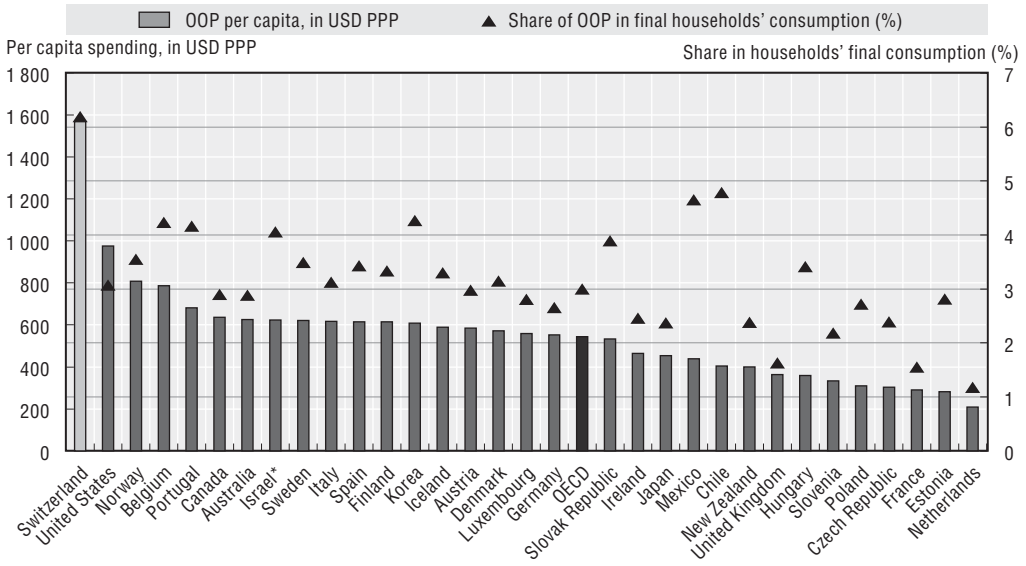
Several population groups are exempted from all or part of cost-sharing. For ordinary insurance contracts, there is no deductible for children. In addition, the sum of cost-sharing paid by families for the health costs of their multiple children must not exceed the cap set for an adult for the deductible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

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

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

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

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



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

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

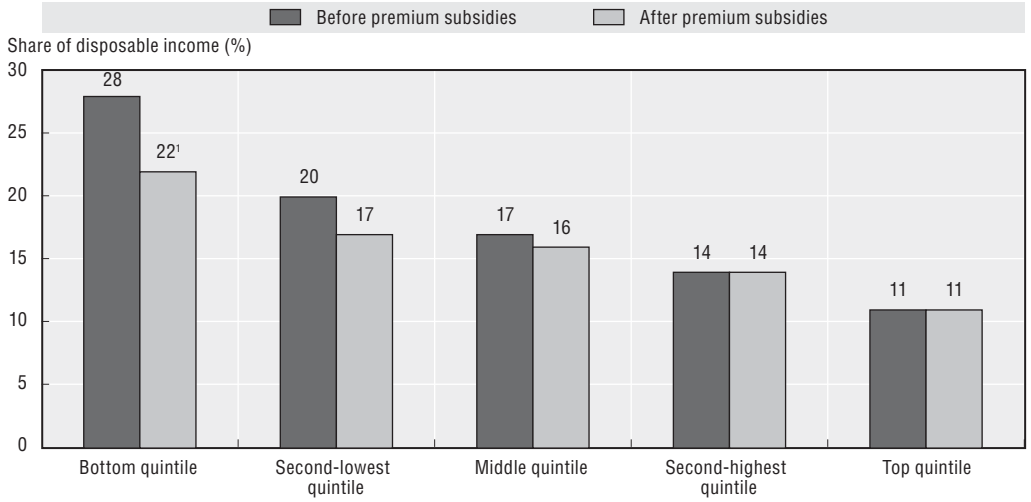
Contributions to the financing of health spending are inequitable

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

Fragmentation increases administrative costs and premiums

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

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

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

Health insurers mainly compete on risk-selection

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

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

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

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

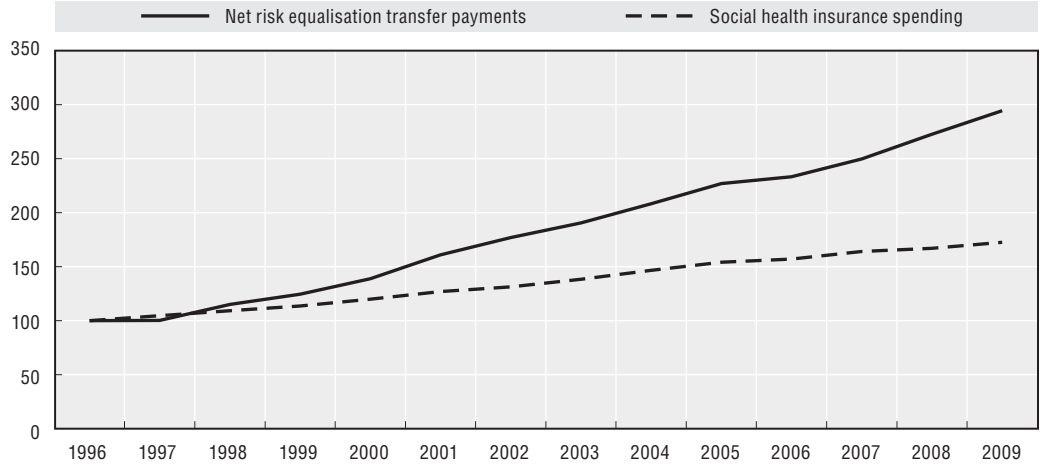
The inclusion of another risk factor into the risk-equalisation formula is a good step but may not be enough

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In Switzerland, managed care plans take several forms:

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

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

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

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

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

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

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

2.4. The reform agenda

Reform proposal to develop integrated care networks

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

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

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

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

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

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

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

Disease management programmes in Germany

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

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

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

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

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

Integrated care and bundled payments In the Netherlands

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

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

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

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

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

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

Reform project to improve functioning of health insurance markets

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

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

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

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

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

Notes

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

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Chapter 3

Health Workforce

This chapter examines the health workforce in Switzerland. Section 3.1 provides an overview of the health workforce in Switzerland in terms of distribution and evolution. It also discusses the forecasted health workforce shortage. In Section 3.2, trends shaping the health workforce are reviewed and health workforce ageing, feminisation of the medical profession, as well as the expectations of younger generations of doctors in terms of professional and private life balance are all discussed. In Section 3.3, the recent reforms in the field of education are briefly reviewed and their implications are discussed. This section also examines whether or not Switzerland is training enough health personnel. The issue of international health worker migration is addressed in Section 3.4, and policies aiming to ensure better use of the existing health workforce are presented in Section 3.5. Finally, the major challenges to addressing health workforce issues in Switzerland are discussed in Section 3.6.

3.1. Health workforce distribution and evolution

A health workforce supply above the OECD average…

The overall supply of health personnel in Switzerland is superior to the OECD average. Switzerland, with a ratio of 68.4 persons employed in the health and social sector per 1 000 population, compares favourably to the OECD average of 48.6 (OECD, 2010). Switzerland is notably above the OECD average for nursing, with 10.15 professional nurses[1] per 1 000 population and 4.76 associate professional nurses per 1 000 population compared to the OCED average of 6.88 and 2.26, respectively. The number of physicians, pharmacists, dentists and caring personnel per 1 000 population is also higher than the OECD average. In contrast, with a ratio of 0.28 midwives per 1 000 population, Switzerland is below the OECD average of 0.35 midwife per 1 000 population.

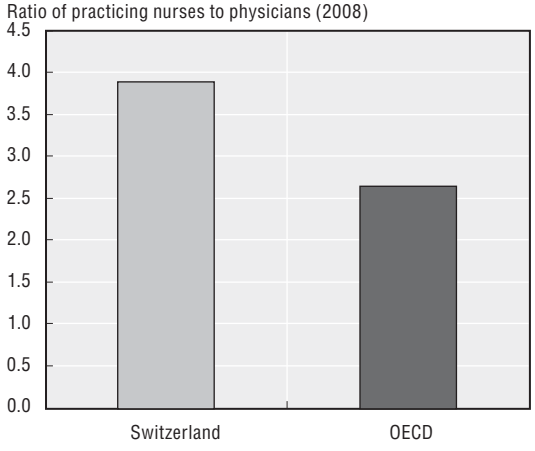
… but characterised by variations across professions and in geographical distribution

While the overall supply of health personnel in Switzerland is higher than the OECD average, there have been notable variations across health professions in recent years. Over the past decade, the nurse to doctor ratio has increased from 3.67 to 3.90. This ratio is higher than the OECD average, as illustrated in Figure 3.1.

In the ambulatory sector, the proportion of general practitioners[2] *vis-a-vis* medical specialists has declined over the years. Between 1980 and 2010, the proportion of general practitioners within the health workforce decreased from 37% to 30% (FMH, 2011).

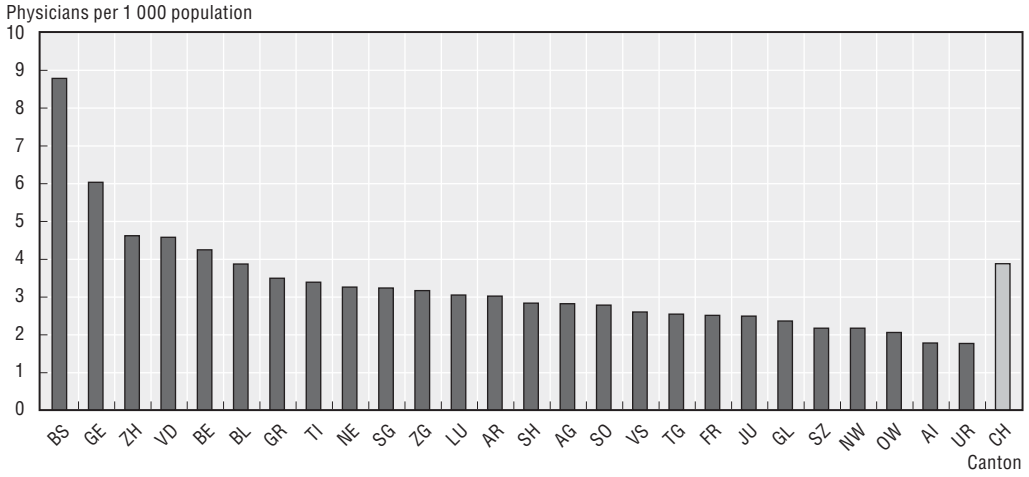
In terms of geographical distribution, significant variations can be observed across Swiss cantons. Not surprisingly, cantons with university hospitals such as Geneva, Vaud, Bern, Zurich and Basel-City have the highest density of physicians as depicted in Figure 3.2.

Figure 3.1. **Nurse/doctor ratio in Switzerland and OECD average**



Source: OECD Health Data 2010.

Figure 3.2. **Number of physicians per 1 000 population per canton, 2009**

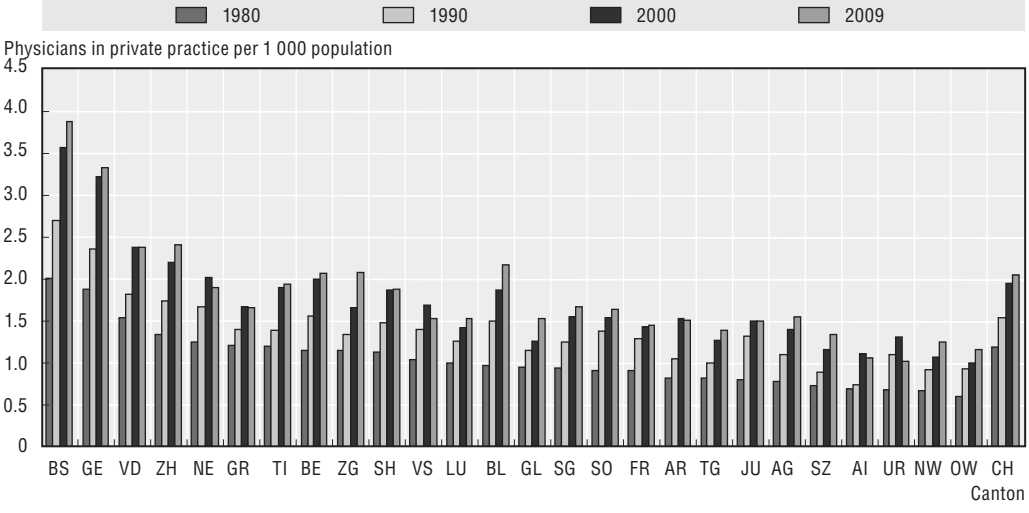


Source: FMH (2011).

In the ambulatory sector, the density of physicians in independent practice grew significantly between 1980 and 2009 from 1.2 to 2.0 physicians per 1 000 population (FMH, 2011). The growth was more marked however for the time period 1980-90, as well as for 1990-2000, than for the time period 2000-09, as depicted in Figure 3.3.

Indeed, between 2000 and 2009, cantons experienced different evolutions. Cantons such as Geneva, Basel-Land, Basel-City, Zug, Glarus, Nidwalden and Obwalden experienced continued growth in the density of physicians in independent practice, while the density declined in cantons such as Neuchâtel, Wallis, Appenzel Inner-Rhodes and Uri. The density remained relatively stable in the Cantons of Vaud, Shaffhausen, Aargau and Jura. As a result, while in 1980, the cantons with the highest density of doctors in independent practice were Basel-City, Geneva, Vaud, Zurich, Neuchâtel, Graubünden and Ticino, in 2009,

Figure 3.3. **Number of physicians in independent practice per 1 000 population and per canton, 1980, 1990, 2000 and 2009**



Source: FMH (2011).

the Cantons of Basel-Land, Zug and Bern reached a higher density of physicians in independent practice than the Cantons of Neuchâtel, Graubünden and Ticino.

In 2002, the Swiss Parliament decided to initiate a freeze in the opening of new medical practices for practitioners working under the LAMal. This decision is also likely to have played a role in the evolution of the density of doctors in ambulatory practice over the last decade (see Box 3.1).

In terms of health workforce distribution, differences between urban and rural, and particularly mountainous areas are also prevailing concerns. While in terms of geographical size, Switzerland does not experience the same challenges as countries like Canada and Australia, remote and mountainous areas do represent particular challenges for the delivery of health care services (see Box 3.2). There is increasing anecdotal evidence in Switzerland about the difficulties faced by family doctors to find successors in some remote and mountainous areas and to respond to medical emergencies in these areas. Also in rural areas, the growth of family medicine has been found to be relatively lower than for gynaecology, paediatrics, and for specialist doctors practicing surgery (Roth, 2010).

... and concerns about future health workforce shortages

Until recently, health workforce issues were not really considered a major concern in Switzerland and did not capture much attention by policy makers. However, discussions on cost-containment policies for the Swiss health system followed by growing concerns about future health worker shortages have contributed to raising the profile of health workforce issues.

Over the past decades, discussions on health workforce in Switzerland have been characterised by a move from concerns about an oversupply of health workers, particularly doctors, to a future shortage of health workers (Pécoud, 2006). Concerns about an oversupply of doctors and its perceived impact on health care costs gained momentum in the 1980s and 1990s not only in Switzerland but also in other OECD countries. During this period, Switzerland experienced a continuous increase in medical density, as many doctors were entering the health labour market following the significant increase in the number of medical students in the 1960s and the 1970s (Danon-Hersh and Paccaud, 2005). This concern was reinforced, as mentioned previously, by the signature of the bilateral agreements between the European Union and Switzerland. Indeed, there was a concern that such agreements would lead to possible large inflows of doctors from the European Union to Switzerland, notably because of attractive remuneration in Switzerland. Hence, more stringent policy regarding admission to medical school with the introduction of a *numerus clausus* policy at the Universities of Bern, Basel, Fribourg and Zurich was adopted, as well as the decision to freeze the opening of new medical practice for practitioners working under the LAMal (see Box 3.1).

While these policies attempted to reduce the perceived oversupply of medical workers in Switzerland, they rapidly gave way to concerns about future health workforce shortages. Population ageing, epidemiological shifts, technological progress, and changes in the characteristics of the health workforce, such as health workforce ageing, are among the factors contributing to this growing concern. These future health workforce shortages have been highlighted in recent studies (Seematter-Bagnoud *et al.*, 2008; Jaccard-Ruedin *et al.*, 2009; Jaccard-Ruedin and Weaver, 2009). According to these studies, it is estimated that by 2030 between 120 000 and 190 000 health workers will need to be recruited in

Box 3.1. **The freeze in the opening of medical practices**

Concerns about escalating health care costs and the possible large inflow of physicians from the EU following the signature of bilateral agreements[1] between Switzerland and the European Union, led the Swiss Parliament in 2002 to decide to restrict the number of authorisations for opening new medical practices for practitioners working under the LAMal. Under the terms of the ordinance of the Federal Council, the cantonal authorities are responsible for implementing the ordinance and have a certain degree of freedom in this task.

This temporary measure was initially adopted for a period of three years (Chancellerie Fédérale, 2002) and was subsequently extended until the end of 2011. The ordinance applies to Swiss as well as foreign-trained doctors working in independent practices under the LAMal, the main type of practice for physicians in Switzerland. Since January 2010, this measure no longer applied to general practitioners and for non-specialist pediatricians (Recueil Officiel 2009). Doctors that are not authorised to set up their own ambulatory medical practice can join an existing practice, set up a private practice outside the LAMal, or work in hospitals.

Whether this measure has achieved its objectives or not, can be disputed. Health care costs and physician migration from the European Union continued to increase since the ordinance was put in place, but it is unclear what would have been their respective increases had the freeze not been implemented. This measure strengthened cantons' power to regulate the supply of physicians working in medical practices under the LAMal. Cantonal authorities base their decisions regarding authorisations on various factors. Around half of them apply their own criteria in addition to the maximum numbers and densities set out in the Federal Council's ordinance. The freeze is likely to have played a role in the declining growth rate of doctors in ambulatory practice observed between 2000 and 2009 as depicted in Figure 3.3. Not surprisingly, a decline has also been observed in the opening of medical practices. However, this decline was preceded by a large increase in the number of medical practices that were opened in 2003, 2002 and to a lesser extent in 2001 (OFSP, 2009). This increase was most probably due to the large number of authorisation requests for the opening of independent practices sent to cantonal authorities in anticipation of the actual implementation of the freeze. The freeze did not seem to have reduced the gap between cantons with a high density of physicians in independent practice, like Basel City and Geneva, and those with a low density, like Uri and Appenzel Inner-Rhodes. Critics also argue that this measure makes it more difficult for young doctors to open group practices, or pushes doctors to stay longer in hospitals and become specialists, which often only reinforces the shortage of family doctors (ASMAC, 2007). In recent years, it also appears that the number of independent practices in the field of general medicine[2] only increased very slightly in comparison to medical specialties (Roth, 2010).

The freeze comes to an end in 2012 and therefore a decision will have to be made on whether to extend it or not. The freeze has already been extended twice, first in 2005 and subsequently in 2008. At that time, there were discussions to lift the freeze and to allow for selective contracting. In other words, LAMal insurers would not have the obligation to contract with all physicians in independent practice. However, the idea of selective contracting turned out to be very controversial and was not introduced. Since its implementation, the freeze has not given rise to major discussions or new proposals. Nonetheless, the absence of a systematic monitoring and evaluation of the impact of the freeze is certainly making it more difficult to have a thorough understanding of this issue and to have sound evidence-based decision making.

1. Under the bilateral agreements the mobility of workers between the European Union and Switzerland is made easier. For that purpose, the principle of mutual recognition of titles has been introduced for a number of professions, including doctors, pharmacists, dentists, veterinarians, nurses and midwives. As a result of the bilateral agreements, EU trained doctors are allowed to practice in Switzerland. In this context, they can also open a medical practice and work under the LAMal.
2. This assessment has been based on the number of "code créancier" which provides the figure of medical practices authorised to charge patients under the LaMal.

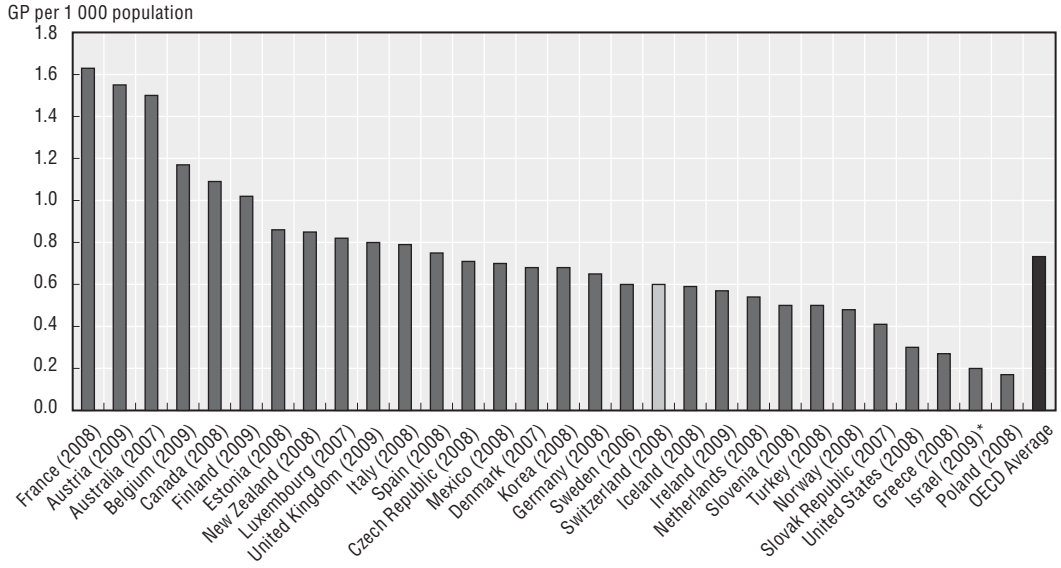
Box 3.2. **WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention**

One of the complex challenges for policy makers is to ensure that people living in rural and remote locations have access to trained health workers. Although approximately half the global population currently lives in rural areas, these areas are served by only 38% of the total nursing workforce and by less than one quarter of the total physician workforce. In July 2010, WHO issued a set of Global Policy Recommendations that provide guidance and present the evidence available on different retention strategies grouped into four categories: education, regulation, financial incentives, and personal and professional support (see *www.who.int/hrh/migration/retention/en/index.html*).

Switzerland. Of this figure, about two-thirds will be needed to replace those reaching retirement age, and the remaining will be needed to address increased population health care demand. A particularly serious shortage is predicted for general practitioners (Pécoud, 2006; Waeber *et al.*, 2009), as well as for nurses in long-term care such as nursing homes (Jaccard-Ruedin and Weaver, 2009). The concern surrounding low numbers of general practitioners is also reinforced by the fact that although medical density in Switzerland is currently superior to the OECD average, density for general practitioners is below the OECD average. As depicted in Figure 3.4, with a ratio of 0.6 family doctors per 1000 population, Switzerland is below the OECD average 0.73 family doctors per 1 000 population.

While predicting future health workforce demand and supply is always a challenging task, notably due to the uncertainty associated with this type of exercise, it has been acknowledged that recent trends are already shaping and changing the health workforce in Switzerland.

Figure 3.4. **General practitioner density in OECD countries**



* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

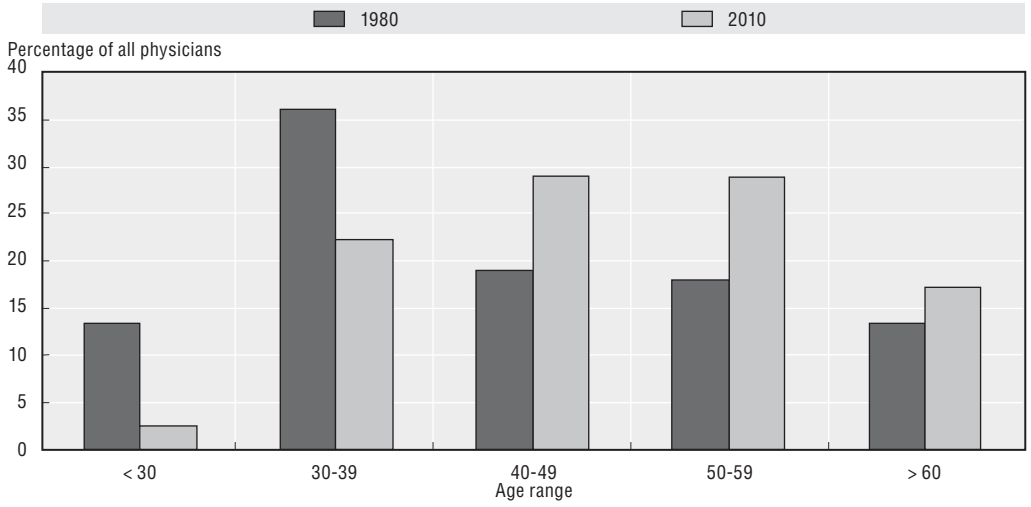
Source: OECD Health Data 2010.

3.2. Trends shaping the health workforce

Health workforce ageing, feminisation of the medical profession and new expectations regarding working conditions are among the key factors influencing the health workforce in Switzerland and also in other OECD countries (OECD, 2008).

As in many OECD countries, the health workforce is ageing in Switzerland. Between 1980 and 2010, the average physician age rose from 44 to 48.4 (FMH, 2011). However, the average age is higher in the ambulatory sector, reaching an average physician age of 53 in 2010 (FMH, 2011). As illustrated in Figure 3.5, the age group 30-39 decreased significantly while the age group 50-59 has become much more important over the past 20 years, and hence, a substantial number of doctors are expected to retire within the next 15 years.

Figure 3.5. **Practicing physician age distribution, 1980-2010**

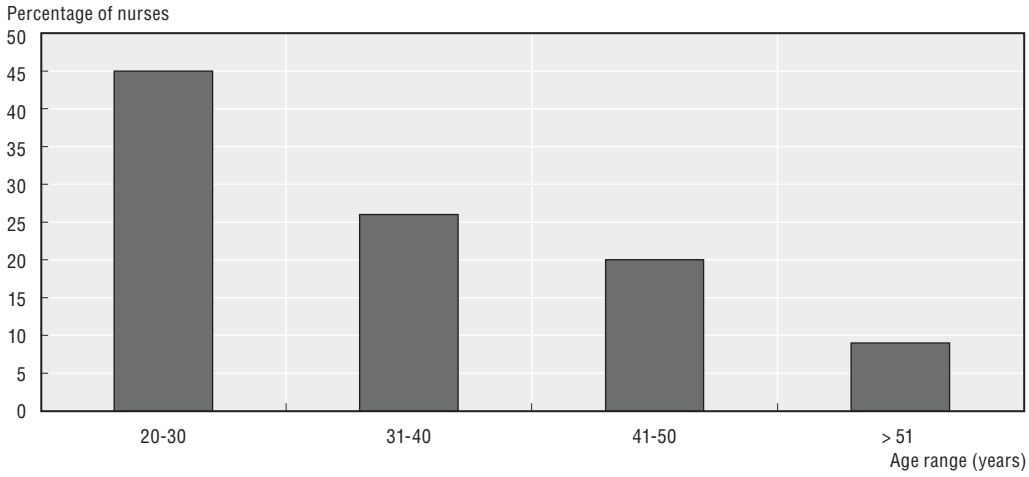


Source: FMH (2011).

While information is lacking on the extent to which the nurse workforce is ageing in Switzerland, preliminary results of the RN4CAST[3] study, which is the largest nurse workforce study ever conducted in Europe, indicate that a substantial proportion of nurses in Switzerland are aged 41 and over. The data displayed in Figure 3.6 show that while the age group of 20-30 years old is the largest group (45% of nurses), the age groups 31-40 and 41-50 are of similar importance and represent 26% and 20% of the nurses, respectively. In fact, when combining the age groups 41-50 and 51 and over, one includes about one third of all nurses. Finally, the large drop out in the number of nurses between the age group 20-30 and 31-40 might be partially explained by nurses permanently or temporarily leaving their job and perhaps deciding to work outside the nursing labour market.

An ageing workforce can also have consequences on the ability to perform specific tasks, notably physical tasks. In the context of an ageing nurse workforce, the need to perform physical tasks can become a serious issue. Nursing is a profession that demands significant physical work such as helping to transfer patients, heavy lifting and being quick to respond to any emergencies. It also often involves working in difficult body positions and prolonged standing (*e.g.*, in the operating room). The consequence of such conditions may directly lead to excessive fatigue, and when burdens are too great, prolonged or

Figure 3.6. **Nurse age distribution, 2010**



Source: RN4CAST (2011).

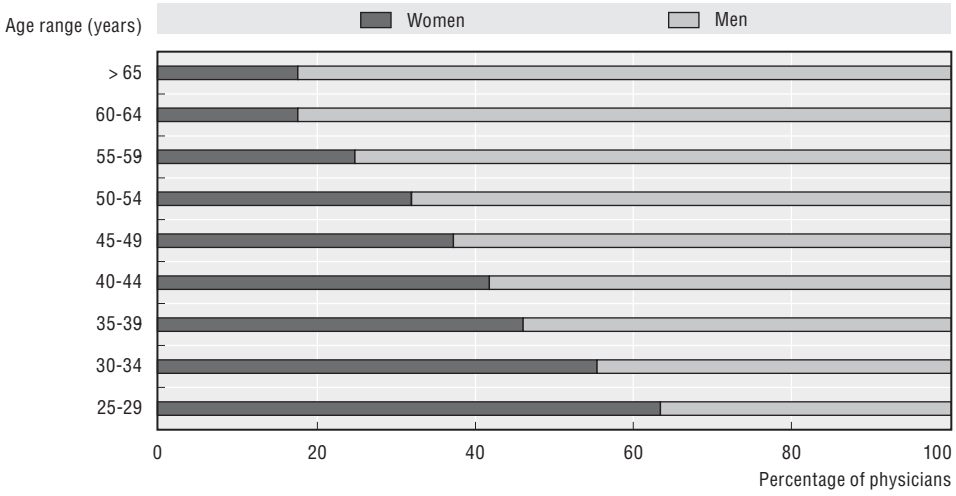
repetitive, this can lead to physical strain or accidents (Estryn-Behar *et al.*, 1990; Videman *et al.*, 1984). In Canada, for example, nurses have one of the highest sick leave rates of all workers, which is partly attributed to musculoskeletal injury (Shamian *et al.*, 2003).

The feminisation of the medical workforce is another trend shaping the health workforce in Switzerland. On average, the proportion of female physicians has doubled over the past decades as it increased from 17% in 1980 to 36% in 2010 (Kraft and Hersperger, 2009d; Kraft, 2011). While the proportion of female physicians is still greater in the hospital (40%) than in the ambulatory sector (31%), it is anticipated that the share of female doctors will increase more rapidly in the ambulatory sector (Kraft and Hersperger, 2009d). The feminisation of the medical workforce is expected to become more important in the future, as women have represented a higher proportion of new graduates than men in recent years. By comparison, in 2009, more than 60% of medical graduates were female whereas the proportion of female medical graduates was below 30% in 1980 (Personal communication with OFS, 2010) As a result, as is illustrated in Figure 3.7, the proportion of female doctors is already superior to the proportion of male doctors for the age group below 30 years (Kraft, 2011).

However, beyond this global feminisation trend, there are still marked differences in terms of medical specialty, as depicted in Figure 3.8. In specialties like orthopedic surgery, surgery and cardiology the proportion of women is below 15%, whereas it is above average for anaesthesiology, gynaecology and obstetric, psychiatry and psychotherapy for children and adolescents, ophthalmology, pediatrics, and psychiatry and psychology (Kraft and Hersperger, 2009d). The proportion of women among the senior medical staff in hospitals is still low, as less than 10% of senior doctors in hospitals are female (Kraft, 2011). Moreover, anecdotal evidence suggests that female physicians are also underrepresented in academia.

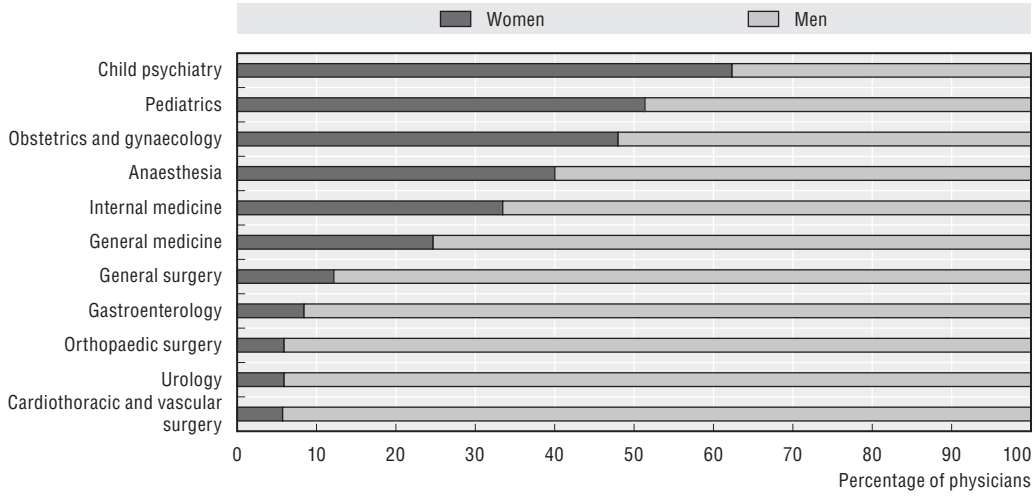
The feminisation of the medical profession is also having an impact on how medicine is practiced. In terms of working patterns, female doctors tend to work more part time than their male counterparts (Kraft, 2010). This difference is more important in the ambulatory sector where, on average, female doctors work one day less per week than male doctors (FMH, 2011). Female doctors also tend to favour group practice and while 47% of female

Figure 3.7. **Physician age distribution per gender, 2010**



Source: FMH (2011).

Figure 3.8. **Medical specialty and gender distribution**



Source: FMH (2011).

doctors work in a group practice, this figure is only 32% for male doctors (Kraft, 2010). International studies also show that female doctors spend more time with patients than male doctors (Roter *et al.*, 2002). Maybe in connection with this, it has also been found that female doctors communicate better and develop better relationships with patients (Contandriopoulos and Fournier, 2007). Hence, the feminisation of the medical workforce could also facilitate the development of a more holistic approach to patient care in line with the possible development of disease management programmes.

While the physician workforce is shifting towards a more gender-balanced distribution, this trend is not observed for the nursing workforce which remains largely a female-dominated profession. The share of male nurse remains low. It is estimated that only about 16% of nurses working in hospital settings in 2009 were male (OFS, 2009). This lack of males within the nursing workforce is likely to continue as, over the past decades,

male nursing graduates only represented on average about 10% of the total number of nursing graduates (OFS, 2007).

In addition to the impact of feminisation of the workforce, the health system will also have to respond to expectations of the new generations of health workers, notably in terms of better work-life balance (Buddeberg *et al*., 2008). Young doctors are often said to wish to work shorter hours than their predecessors did. For example, in the ambulatory sector in Switzerland, doctors below the age of 45 work on average 4.1 days per week whereas those aged 45 and more work 4.4 days per week (FMH, 2011). Young doctors also tend to favour group practice more than their predecessors (OFSP, 2010). Group practice allows more flexibility for doctors, especially in terms of working time, and is also a good way to address the issue of professional isolation that some doctors in independent practice may face.

Expectations of the new generations of doctors also make it important to address issues related to working conditions. The worsening working conditions, notably for family physicians, have attracted increasing attention. Loss of prestige and professional autonomy, and even lower income, are among the issues regularly raised by family doctors (Buddeberg-Fischer *et al.,* 2006; Waeber *et al*., 2009). The issue of income differences between medical generalists and specialists, in particular of those specialists performing complex treatment procedures, is well recognised. The introduction of TARMED in 2004, a unified tariff system for the payment of doctors in independent practice, aimed to narrow this income differential. However, while some improvements have been achieved, differences in income remain significant (OFSP, 2010). The worsening of working conditions is also a contributory factor to the increasing burnout rates of doctors. Arigoni *et al*. (2010) found that the burnout level among Swiss doctors has increased throughout the country over the past decade. Overall, general practitioners are considered to be at increased risk of experiencing stress-related suffering compared to other medical specialists. In particular, Goehring *et al*. (2005) found that moderate burnout for Swiss general practitioners was associated with being male and being in the age group 45 to 55 years old. It was also found that the risk of burnout was higher for family doctors practicing in non-urban areas.

Working conditions are also a serious concern for the nursing workforce. The NEXT Study, which comprises 11 European countries (but not Switzerland), is investigating the reasons, circumstances and consequences surrounding premature departure from the nursing profession. It found an obvious relationship between job satisfaction and intention to leave the profession (Hasselhorn *et al.,* 2004). While nurse workforce retention is not well documented in Switzerland, preliminary results of the RN4CAST studies indicate that close to 28% of nurses intend to leave their current occupation, and that among those who intend to leave, 46% would seek to work as a nurse in another hospital, 30% would want to continue to work as a nurse but not in a hospital, and finally, 24% would want to leave the nursing profession entirely (RN4CAST, 2011). In a context of high turnover, the inability to recruit and retain the right staff is likely to have some adverse effects on the delivery of health services, particularly on quality of care and costs due to the loss of work group efficiency and diminishing organisational performance (OECD, 2008).

In Switzerland, some evidence suggests a worsening of working conditions for nurses. According to the RICH nursing study,[4] strategies that nurses use to prioritise the care and to distribute scarce resources among their patients can result in a rationing of nursing care which impacts negatively on nursing working conditions. It was found that higher levels of

rationing were also related to higher rates of emotional exhaustion and job dissatisfaction among nurses.

3.3. Education

A changing landscape…

Health professional education has witnessed major reforms and changes over the past decades. These reforms notably aim to improve the quality and attractiveness of education programmes, providing a better response to the new realities of health personnel daily work, and facilitating transfers across education programmes. The adoption of federal laws such as the Law on University-based Medical Professions (LPMed), the Law on Non-university Based Professional Education (LFPr), and the Law on Highly Specialised Schools (LHES) are illustrations of these changes. In addition, some revisions or drafts of federal laws are also under consideration, such as the Law on Non-university Based Health Professions.

In terms of medical education, the introduction of the LPMéd[5] in 2007, which replaced the Federal Law on Medical Professions of 1877, has contributed to the strengthening of medical education. For example, under this law, continuous medical education is now compulsory. While this law is considered a positive step towards better medical education in Switzerland, co-ordination among stakeholders involved in medical education such as the confederation, cantons, universities, hospitals, FMH, etc. remains a challenge (OFSP, 2010). The implementation of the Bologna process (see Box 3.3) in Switzerland also led to a significant transformation in the structure of the curricula and is also likely to have an impact on the health workforce. The Bologna reform has been now successfully introduced in all medical faculties of Switzerland (Banz *et al.,* 2011) and has led to more flexibility in medical education (CSST, 2006). The bachelor in medicine is obtained after three years, and then the master in medicine after three years (two years in university and one year in practical training). The Swiss experience, although limited, already suggests that the bachelor is not only seen as a path towards becoming a medical doctor, but also a key step to other careers like biomedical science or public health (Banz *et al*., 2011). It may actually contribute to building better bridges between health professions (CSST, 2006).

Box 3.3. **The Bologna reform**

The aim of the Bologna reform is to create a European Higher Education Area (EHEA) by making academic degree standards and quality assurance standards more comparable and compatible throughout Europe, and hence to also facilitate the mobility of students and academics. There is also a willingness to commit to enhance the competitiveness of the EHEA. The Bologna reform was initiated in 1999 and became a reality following the Budapest-Vienna Declaration of March 2010. A total of 47 countries are current members of this process. The core aspects of the Bologna reform include a three tiered system for higher education qualifications (*i.e.* bachelor, master and doctorate) and the introduction of the European Credit Transfer System (ECTS), which is used to calculate, transfer and accumulate study content. However, not all countries have implemented the Bologna process regarding medical education.

Source: Adapted from the European Higher Education Area website (*www.ehea.info/*).

Some other changes are also raising concerns. The introduction of the new hospital financing mode, with the introduction of DRGs, is perceived by some as potentially negative for the training of junior doctors (Rindlibascher, 2010). It is feared that due to the increasing pressure on hospital costs and the relative opacity of post-graduate training costs, this might lead to a decrease in the quality and/or number of junior doctors in hospitals. While it is still too early to assess the exact nature of the impact of this new financial mechanism on postgraduate training programmes in hospitals, these issues are being taken seriously and were discussed in the context of the recent platform "Avenir de la Formation Médicale" which facilitates regular exchanges between health cantonal directors and federal authorities.

There have also been substantial changes in Switzerland regarding health professions not requiring a university title. In terms of governance, competencies were transferred from the cantons to the confederation regarding the regulation of these professions as a result of the Federal Law on Non-university Based Professional Education (LFPr) implemented in 2004. The law was conceived as a general framework to help better address health labour market demands. This law is notably encouraging and facilitating transfers from one training programme to another, and more generally within the health education system as a whole. As a result, some training schemes have been revised and some new titles/cadres have been established (*e.g.*, primary health care assistant (Assistant de Soins de Santé Communautaire). While the confederation has a greater role and voice regarding these professions, the financing and determination of the number of students remain essentially the responsibility of the cantons.

The scope and complexity of these changes can be illustrated with nursing education. Unlike in a number of OECD countries, nurses do not require a university degree to practice in Switzerland. Various education paths have been established for professional nursing in Switzerland. A first path is represented by the nursing programmes of the Colleges of Vocational Education and Training (Écoles Supérieures). With more than 5 000 enrolled students, the new education path proposed by the Colleges of Vocational Education and Training comprises the largest number of nursing students (OFFT, 2010). While nursing reforms aimed to attract more students, the number of students enrolled in Colleges of Vocational Education and Training is actually below expectations (OFFT, 2010). Anecdotal evidence suggests that this situation could be partially explained by the fact that the level of remuneration during nurse internships is not sufficient to attract more students. Another education path for nursing is represented by the nursing programmes of the Universities of Applies Sciences (Hautes Etudes Spécialisées). There are seven such schools in Switzerland which function like "regional training schools" for training nurses, midwives and other allied health professions.

The evolution of these two education paths is quite contrasted between the Swiss German-speaking part of Switzerland and both the Swiss Italian- and French-speaking parts of Switzerland. In the Swiss French and Italian parts of Switzerland, the Universities of Applies Sciences serve as the main nursing education path[6] and the number of new students enrolling has increased in past years. In contrast, in the Swiss German-speaking part of Switzerland, the Colleges of Vocational Education and Training provide the main education path.[7] Moreover, the model of the Universities of Applies Sciences seems to have had difficulties establishing themselves in the Swiss German part of Switzerland. In this context, one may wonder if this could lead to two main geographical nursing education systems, one in the French- and Italian-speaking parts of Switzerland, with the

Universities of Applies Sciences, and another one in the Swiss German part of Switzerland, with the Colleges of Vocational Education and Training. Moreover, although these two education paths did not aim to create different types of nurses, some confusion has persisted largely due to the fact that the entry requirements are not the same between the different HES schools themselves and also because of a lack of harmonisation in the curricula (OFFT, 2010). Finally, master and Ph.D. programmes in nursing science have also been recently established.[8] This evolution is important as it contributes to the strengthening of research on nursing issues in Switzerland and hence can also play an important role in the training of nursing faculty members.

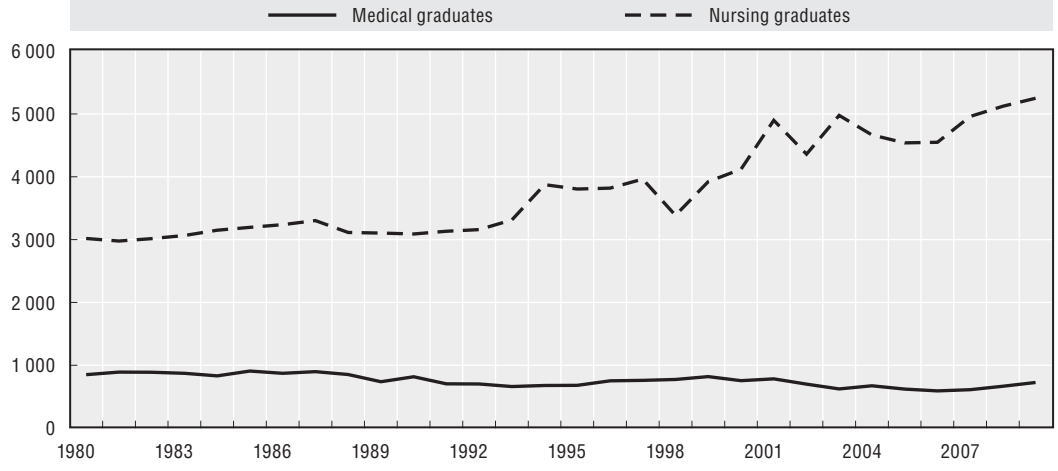
In the light of these complex and numerous reforms, a "Master plan" has been jointly developed by the confederation, cantons and the umbrella organisation related to labour in the health sector for non-university based health professions (OdaSanté). This "Master plan" aims to improve collaboration and co-ordination between the key stakeholders in the field of health education. It also aims to clarify the situation between nursing programmes of the Colleges of Vocational Education and Training and those of Universities of Applies Sciences as well as facilitate the creation of an adequate number of training places aligned with needs and ensure uniform requirements across all nursing programmes of Universities of Applies Sciences exist in Switzerland.

Does Switzerland train enough health personnel?

Different patterns can be observed in the evolution of medical and nursing graduates between 1980 and 2009, as is illustrated in Figure 3.9. The number of medical graduates has decreased over time. While the average number of yearly medical graduates reached 860 in the 1980s, it only amounted to 676 in the 2000s. However, one can observe a slight increase in recent years.

In addition, in light of projected health workforce shortages, measures to increase the number of medical and nursing students have been adopted. The Universities of Zurich, Bern and Basel have relaxed their *numerus clausus*[9] for first year medical students. As a result, the number of first year medical students increased from 937 in 2005 to 1 160 in 2010 (Personal communication with OFS, 2011).

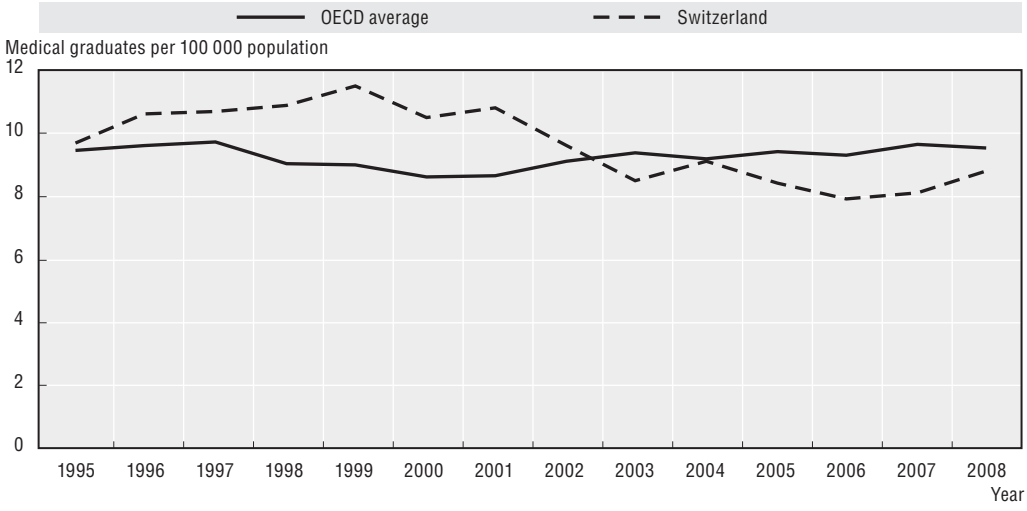
Figure 3.9. **Number of medical and nursing graduates in Switzerland, 1980-2009**



Source: Personal communication with OFS (2011).

Yet, the number of medical graduates per 1,000 in Switzerland has decreased over time, as is illustrated in Figure 3.10. This evolution contrasts with the general evolution in OECD countries. Although Switzerland was above the OECD average of yearly number of medical graduates between 1995 and 2002, since 2003, the number of yearly medical graduates in Switzerland has been below the OECD average.

Figure 3.10. **Number of medical graduates per 100 000 population, 1995-2008, OECD average and Switzerland**



Source: OECD Health Data 2010.

For nursing graduates (professional and associate professional degrees), there has been a strong upward trend in numbers between 1980 and 2009, as depicted in Figure 3.9. The yearly number of nursing graduates increased from 3 018 in 1980 to 5 250 in 2009, corresponding to an increase of more than 50%. Moreover, in contrast to medical graduates, the number of nursing graduates per 1 000 population in Switzerland is one of the highest among OECD countries.

While measures have been adopted to increase the number of medical and nursing graduates, these appear to be insufficient to eliminate projected health workforce shortages. For example, the current numbers of yearly nursing graduates is clearly below the level required to meet future needs as depicted in Table 3.1. While the average number of yearly new graduate nurses over the past years has been of 2 279 for professional nursing and 2 320 for associate professional nursing, respectively, this remains below the 2 415 additional professional nurses and 2 103 associate professional nurses who would need to be trained on a yearly basis by 2020 to match future nursing workforce needs (CDS and OdASanté, 2009[10]).

Table 3.1. **Yearly number of nursing graduates and projected needs**

	Average yearly number of graduates	Projected yearly needs	Difference between needs and average yearly number of graduates
Professional nursing	2 279	4 694	–2 415
Associate professional nursing	2 320	4 423	–2 103

Source: CDS and OdASanté (2009).

Strengthening education capacity in hopes of increasing the number of health workers is therefore a serious and attractive option to be considered. Nonetheless, feasibility and sustainability issues are to be seriously taken into consideration. Cost implications are likely to be significant, especially for medical students whose education costs are very high. Any decision to significantly increase the number students in the field of health care will have cantonal budget implications as the cantons are the main funders for the education of health personnel. Moreover, a significant increase in the number of students could have some adverse impacts on the quality of education if the faculty is not sufficiently staffed or specialty training facilities in institutions are lacking or inadequate.

While financial and organisational constraints can represent a major challenge to successfully scaling-up the number of students enrolled, one should also consider the ability to attract more students, particularly in light of the demographic projections which forecast a continuous decline in the age group 15-24 (OECD, 2008). As a result, competition to attract young people into different employment sectors will likely increase. However, this does not seem like too much of a problem for medical students, as the number of applicants is largely superior to the number of seats available in Swiss faculties of medicine[11] (see Table 3.2) and the image and prestige surrounding the medical professions remains high (Portenier *et al.*, 2007). However, this is not necessarily true for all fields of medicine, in particular for general medicine, as the latter seems to have lost some of its attractiveness among medical students and young doctors. For instance, a study undertaken at the medical faculty of Basel University found that only 10% of medicine students wanted to go into general medicine (IHAMB, 2005). Other studies also found that only a small proportion of current medical students or young doctors are planning to practice general medicine (Buddeberg-Fischer *et al.*, 2006; Waeber *et al.*, 2009; Jeannin *et al.*, 2007).

For nursing, the demographic projections appear to pose a bigger challenge to attracting a significantly higher number of students. Indeed, unlike for medical studies, the number of applicants in nursing studies does not exceed current capacity, suggesting that under the current circumstances, the actual pool of potential additional nursing students might not be so important. Also, as previously mentioned, nursing programmes at Colleges of Vocational Education and Training already face some difficulties in filling available places in their schools. Moreover, the lower social status image of nurses in comparison to doctors is also likely to make it more difficult to attract students into nursing (Hutmacher, 2004). However, the reforms and changes in nursing education, notably the success of new

Table 3.2. **Medical studies: number of applicants and capacity in universities, academic year 2010/11**

University	Applicants	Capacity
Basel	618	130
Bern	581	180
Fribourg	179	103
Geneva	537	187
Lausanne	548	197
Neuchâtel	88	47
Zurich	1 273	240
Total	**3 824**	**1 084**

Source: Conférence Universitaire Suisse (2010).

professions like the primary health care assistant (ASSC) (Lehman *et al*., 2011), and the regular increase over the past years in the number of nursing students suggest that there is a real potential for increasing in the number of nursing students.

In view of the above elements, developing and strengthening education capacity in Switzerland in order to train more health workers appears as a solid option. The strength of this argument is even further reinforced when looking at the importance of health worker migration in Switzerland.

3.4. International health worker migration and Switzerland

The issue of international health worker migration has gained increased visibility over the past decades. Migration flows have grown in number and complexity (OECD and WHO, 2010). Through its nature and magnitude, international health workforce migration can have various impacts. On one hand, health worker immigration can strengthen the health workforce in destination countries; while, on the other hand, health worker emigration can further weaken already fragile health systems in source countries (OECD and WHO, 2010).

International migration is playing an important role in OECD countries as, on average, 18% of doctors and 11% of nurses are migrant health workers, as is depicted in Table 3.3 (OECD, 2007). However, this proportion is even more important in Switzerland, as the share of migrant doctors and nurses is estimated to be around 30% (OECD, 2007).

Table 3.3. **Percentage of migrant practicing doctors and nurses in OECD countries (foreign-born)**

	Nurses (%)	Doctors (%)
New Zealand	23.2	46.9
Australia	24.8	42.9
Ireland	14.3	35.3
Canada	17.2	35.1
United Kingdom	15.2	33.7
Luxembourg	25.8	30.2
Switzerland	**28.6**	**28.1**
United States	11.9	24.4
Sweden	8.9	22.9
Portugal	13.9	19.7
France	5.5	16.9
Netherlands	6.9	16.7
Norway	6.1	16.6
Austria	14.5	14.6
Belgium	6.6	11.8
Germany	10.4	11.1
Hungary	3.1	11.0
Denmark	4.1	10.9
Greece	9.7	8.6
Spain	3.4	7.5
Turkey		6.2
Finland	0.8	4.0
Poland	0.4	3.2
Mexico	0.2	1.5
OECD average	**10.7**	**18.2**

Source: OECD (2007).

In their study, Jaccard-Ruedin and Widmer (2010) provide a detailed analysis of migrant health workers in Switzerland. The share of migrant health workers is particularly important in hospitals. It is estimated that 39% of ancillary health personnel, 38% of professional health care givers (non-university based professions), and 35% of doctors and other university-based health professions are migrant health workers (*op. cit.*). There has also been a recent increase in international migration flows to Switzerland as, on average, the share of migrant health workers increased from 33% in 2002 to 36% in 2008. For doctors, the increase has been starker, as this ratio rose from 29% to 35%. In terms of demographic characteristics, a comparison across health professions in Swiss hospitals shows that the share of women tends to be lower among migrant health workers for all professions with the exception of doctors and other university-based professions (*op. cit.*). Differences are also prevailing in terms of geographical locations, as the share of international migrant health workers is more important in hospitals in the French and Italian parts of Switzerland than in the Swiss German part of Switzerland (*op. cit.*). Information regarding the duration of stay in Switzerland of international health worker migrants is very limited. However, in a qualitative study on migrant health personnel recruitment practices in Switzerland, Huber and Mariéthoz (2010) found that most interviewed persons wished to stay in Switzerland. Overall, the large majority of migrant workers come from neighbouring countries. Indeed, in 2008 around 77% of all migrant doctors from neighbouring countries came from Germany (Jaccard-Ruedin and Widmer, 2010). While the migration of health personnel from lower-income countries is very limited in Switzerland, Switzerland is also indirectly exacerbating the acuteness of the health workforce crisis in some countries through the "domino effect".[12]

The importance of migration for Switzerland is also illustrated by the fact that in recent years the yearly inflows of migrant doctors has been very similar to the number of yearly medical graduates in Switzerland (Jaccard-Ruedin and Widmer, 2010). In fact, in 2008, the inflow of medical migrants was even superior to the number of yearly medical graduates (*op. cit.*). Questions are certainly being raised about the desirability and sustainability of this reliance on migrant health workers.

Of particular concern is Switzerland's dependence on Germany which could lead to a delicate situation if a significant decline in doctors' migration towards Switzerland was to take place in a short time. Recent changes to reimbursement in Germany have led to an increase in self-employed doctors' incomes (GKV, 2011), particularly in underserved areas. Additionally, the planned measures to keep more young doctors in the country (Bundesgesundheitsministerium, 2011) suggest that the flow of German doctors to Switzerland might diminish in the coming years. In addition, the current situation is also giving rise to debates in Germany, as some perceive that Switzerland is benefiting from the emigration of German doctors without having to support educational costs. Buschle and Hänsel (2010) estimated that for Germany the education and training costs of the 3 300 German doctors living in Switzerland amounts to EUR 917 million. Notably, public debate has recently emerged in cities such as Zurich and Basel about the impact of the migration of German doctors in Swiss hospitals, in particular at the level of interaction with patients and health personnel.

On a more general scale, the issue of costs and benefits of the international migration of health workers for both source and destination countries has raised many discussions in the international arena, and the ethics of the international recruitment of health personnel have also become an important issue. All these elements contributed to the

Box 3.4. **The WHO Global Code of Practice on the international recruitment of health personnel**

The 2006 World Health Report highlighted a global shortage of almost 4.3 million health personnel and identified 57 countries, most of them in Africa and Asia, facing a severe shortage of health personnel. One significant contributing factor to these shortages is that health personnel continue to leave their homes in search of better career opportunities and living conditions elsewhere. Indeed, the numbers of migrating health personnel have significantly increased in recent years and patterns of migration have become increasingly complicated and involve more countries. While all countries can be affected by the international and national migration of their health workforce, it is particularly challenging for those with already fragile health systems. In countries like Tanzania, Mozambique, Haiti, and Sierra Leone, outmigration rates for doctors are above 50% (OECD and WHO, 2010).

In order to provide a global response to health workforce migration concerns, the 2004 World Health Assembly requested WHO to develop a code of practice on the international recruitment of health personnel. In response, the WHO Secretariat initiated a programme of work and a global consultation process in order to produce a draft code. Following discussions in numerous international and national fora, the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by the 193 Member States of the 63rd World Health Assembly on 21 May 2010.

The Code is voluntary in nature and aims to establish and promote principles and practices for the ethical international recruitment of health personnel and to facilitate the strengthening of health systems. It was designed by member states to serve as a continuous and dynamic framework for global dialogue and co-operation.

The Code is based on several key principles, such as the right of all people to the highest attainable standard of health; the right for any individual, including health personnel, to leave any country and to migrate to any other country that wishes to admit and employ them; ethical international recruitment practices; health workforce development and health systems sustainability; fair treatment of migrant health personnel; encouragement of international co-operation and providing support to developing countries.

Member states are expected to provide their national data on issues related to health personnel and health systems, and measures taken to implement the Code in a single national report to the WHO Secretariat every three years, beginning in 2012. These reports will form the core of the WHO Director General's global report on the implementation of the Code, due to the World Health Assembly in 2013 and every three years thereafter.

Source: Extracted from WHO (2010).

development and adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel in May 2010 by the World Health Assembly.

In an effort to strengthen policy coherence between national and international health policy, Switzerland has integrated the issue of international migration of health workers into its foreign health policy (OFSP, 2006). Among other interests and objectives, Swiss health foreign policy aims to "manage the migration of health professionals so as to ensure that the needs of labour markets in industrialised countries and emerging economies are satisfied, without depriving developing countries of the health workforce they need" (*op. cit.*). Therefore the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel represents a positive development for Swiss health

foreign policy. Moreover, three studies were published in the context of this Swiss foreign health policy with the intention to document the role of Switzerland in the global health worker shortage (*op. cit.*); these are the studies by Jaccard-Ruedin and Widmer (2010), Huber and Mariethoz (2010) and Wyss *et al.* (2010).

The WHO Global Code of Practice provides guidance to Switzerland on the issue of international recruitment of health personnel. One of the Code's recommendations, increasing the number of domestically trained health personnel (Article 5.5), is certainly of particular significance in the current Swiss context.

3.5. Not only a question of numbers

While there is growing consensus on the importance of increasing the number of domestically-trained health workers in Switzerland, it has also been recognised that addressing these shortages is not only about numbers. Indeed, the benefit of training additional health workers could be, to a large extent, offset by student choices. For example, students may continue not to choose the professions or specialties that are the most in need or may continue to settle in regions where there is already an excess of health workers. Moreover, reducing health workforce attrition or improving productivity can also lead to significant gains in terms of health personnel. In this context, ensuring a better use of the existing workforce is also essential and policies focusing on occupational status and working conditions are gaining increasing attention at the international level (OECD, 2010).

In terms of working conditions for nurses, health workplace strategies such as flexible work arrangements, family friendly initiatives (notably the development of more day care centres), leave and compensation benefits, and safety practices are perceived to have a positive impact on nursing retention (OECD, 2008). The case of the Magnet Hospitals may also provide interesting insight into various possible strategies to better attract and retain staff (see Box 3.5). To reduce nurse turnover, improving remuneration is among the most common approaches, and although evaluations of such policies are scarce in Switzerland, international studies show that financial incentives have produced mixed results (OECD, 2008).

Box 3.5. **Magnet hospitals**

It has been observed that some hospitals are more successful in recruiting and retaining health care staff than others. Those hospitals have been designated as "magnet hospitals". Research shows superior outcomes for magnet hospitals, such as lower risk-adjusted hospital mortality, higher ratings of quality of care, higher patient satisfaction, lower rates of nurse burnout and higher rates of nurse job satisfaction. In terms of workforce, these hospitals are characterised by such qualities as strong nursing leadership, a flat organisational structure, a participatory management style, flexibility in scheduling, and promoting work autonomy. The number of hospitals having achieved the Magnet Recognition Programme suggests that positive changes have been achieved in the nurse workforce environment (Aiken and Cheung, 2008). The Magnet Recognition Programme was initiated in the United States in the 1990s by the American Nursing Credentialing Center. Now, more than 100 hospitals in the United States and abroad have been designated as magnet hospitals.

In light of the loss of attractiveness for a career as a general practitioner, various measures have been adopted such as favouring post-graduate training in medical practices and better remuneration for the provision of emergency medical services (OFSP, 2010b). However, given the anticipated looming shortage of health workers, stakeholders share the view that more should be done to increase the number of general practitioners. As a result, a popular initiative to make family medicine more attractive was initiated and will be the object of a vote by the Swiss population. This initiative proposes constitutional changes to strengthen the role of family medicine and make the general practitioner profession more attractive. In particular, the role of the confederation would be reinforced, notably in the fields of educating and training family doctors. The confederation would also have more regulatory power to improve family doctors' remuneration and image, as well as facilitate the practice of the profession, for instance through the ease of administrative work. This initiative, however, was followed by a counter-initiative of the Federal Council which, while recognising the importance of the role of the general practitioner, considers that the focus should not be on a specific profession, but more on the enhancement of primary health care and inter-professional collaboration (Arrêté Fédéral, 2011). Therefore, the counter-initiative proposes to incorporate other professions involved in primary health care, notably nurses. The role of the confederation would also be less prominent, although, for instance, it is proposed that it could intervene if the level of primary health care services went below a yet to be defined specific threshold (OFSP, 2011).

In terms of task shifting, the development of master and Ph.D. programmes for nursing science in Switzerland could increase the potential for the role of advanced practice nurses in Switzerland and might contribute to facilitating task shifting between doctors and nurses. Advanced nurse roles such as nurse practitioners are already important actors in many countries (see Box 3.6).

Box 3.6. **Nurse practitioner/advanced practice nurse**

"A nurse practitioner/advanced practice nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level" (ICN, 2008).

Advanced nurse roles such as nurse practitioners, advanced practice nurses and clinical nurse specialists have been a recognised cadre in some countries for many years such as Canada and the United States. Numbers and demand for this profession vary considerably across countries. For example, over 2 000 clinical nurse specialists were registered in Canada in 2008, where there were over 59 000 of the same category registered in the United States in the same year. The scope of practice for this cadre also differs from country to country. For example, certain categories of advanced practice nurses in England have been authorised to prescribe drugs for many years, whereas Finland only proposed legislation allowing nurses to prescribe a limited number of drugs in 2010. Similarly, the level of education required for an advanced nurse role varies across countries from a Bachelor's degree with appropriate professional experience to a master's level qualification.

There have been various different motivations for creating this cadre of health professionals, including improving access to care, especially in countries with a shortage of doctors, and reducing demands on doctors' time through task-shifting. Nurse

Box 3.6. **Nurse practitioner/advanced practice nurse** *(cont.)*

practitioners have also been presented as a cadre that can cut-costs as they are often less expensive than doctors.

A comprehensive evaluation of advanced practice nurses was conducted in 12 countries by the OECD in 2010.The report concluded that,

> "In general, the available evaluations show that the use of advanced practice nurses can improve access to services and reduce waiting times for the set of services they provide. There is also a large body of evidence showing that advanced practice nurses are able to deliver the same quality of care as doctors for a range of services transferred to them (*e.g.* routine follow-up of patients with chronic conditions, first contact for people with minor illnesses), provided they have received proper education and training" (Delamaire and Lafortune, 2010).

However, as with introducing any other new cadre of health professional, each country has to consider its own health and policy context before deciding to introduce advanced roles for nurses. It is important that their scope of practice and training requirements are well defined and agreed upon in advance with a broad array of relevant stakeholders, including representatives of the health professions, various ministries, employer and regulatory bodies.

Source: Adapted from Delamaire and Lafortune (2010).

Finally, enhancing integration into the health workforce, notably by recruiting back health workers, can also make a difference. For instance, in the United States, according to the findings from the 2008 National Sample Survey of Registered Nurses, about 15% of registered nurses with active licenses were found to not be employed in nursing. In Switzerland data are very scarce on this issue, but the preliminary results of the RN4CAST study suggest that there could be a pool of nurses who left nursing as up to 24% of currently employed nurses who intend to leave their job said they would not want to work as a nurse (RN4CAST, 2011). This impression is reinforced by the experience undertaken in the Canton of Vaud by the "Centre d'Information des Professions Santé-Social" which succeeded to reintegrate over 270 nurses into the health sector since 2004 (see Box 3.7).

Box 3.7. **Reintegrating nurses in the workforce, the experience of the Canton of Vaud**

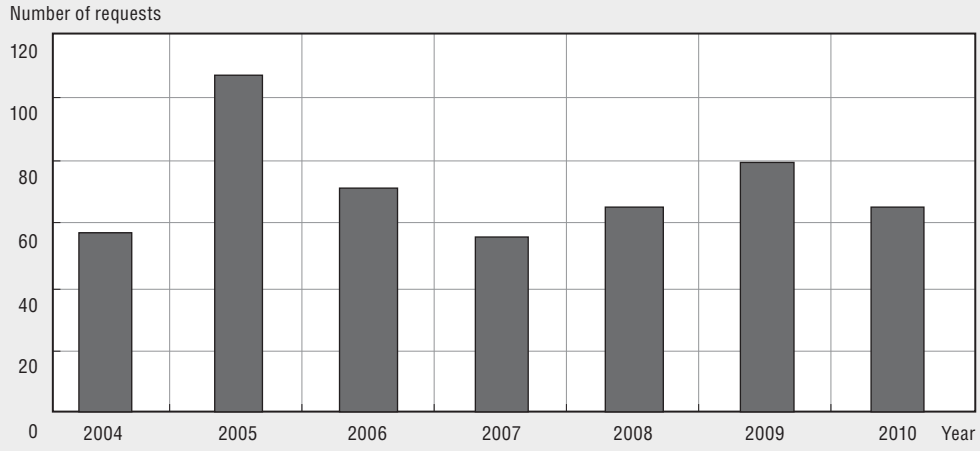
Faced with concerning statistics, such as the need to replace significant numbers of health professionals in the future, the Canton of Vaud decided to launch a series of programmes in 2004 to promote and strengthen the health workforce in Vaud. As part of this initiative, the "Centre d'Information des Professions Santé-Social" (CiPS) concentrates most of its efforts on facilitating nurses who wish to return to work after a long period of absence or wish to strengthen their competencies in a specific area of the health service. For each nurse, the process begins with an individual interview during which CiPS staff can learn about their intentions, previous experience, competencies and specific interests for their future work within the health sector. Following this interview, CiPS then offers different professional projects according to their specific needs, such as a skills assessment or modules for updating/expanding professional knowledge or competencies.

Box 3.7. **Reintegrating nurses in the workforce, the experience of the Canton of Vaud** *(cont.)*

If a nurse is interested in trying out a different area of health care services that they are unfamiliar with or has been out of the health workforce for a longer period of time, CiPS can also organise a short period of practical training in various different health service providers throughout the Canton of Vaud.

The work of CiPS is evaluated every four years and so far the results have been encouraging. Over 500 nurses have sought the assistance of CiPS since 2004 and over 270 have since been reintegrated/reemployed in the health sector in the Canton of Vaud. An economic evaluation of the programme in 2009 found that the average cost for each nurse reemployed was CHF 8 800, which is undoubtedly less than the cost of training and recruiting a new professional. Interestingly, the programmes and assistance provided by CiPS have proven to be particularly popular with middle-aged nurses and even nurses approaching the end of their working lives.

Figure 3.11. **Requests for assistance for reintegration into the profession (nurse) per year**



Source: Personnal communication, J. Rouge, CiPS, Lausanne, 2011. Information available at: *www.cips-vd.ch*.

3.6. The challenge of developing a national and long-term vision on health workforce issues

On a more general scale, addressing health workforce issues in Switzerland is also challenging due to the difficulties in developing a national and long-term vision. This is notably due to the fragmentation of responsibilities, especially between the cantons and the confederation, and to the lack of co-ordination among stakeholders. Indeed, the cantons, the confederation, hospitals, universities, professional schools, professional associations, health insurance providers, etc., are all key actors involved in health workforce issues. While various platforms and co-ordination mechanisms have been established in Switzerland, each tends to focus solely on a set of professions or education level or sector, *i.e.,* education or health sector. In addition, the lack of strategic long-term planning does not facilitate the development of more comprehensive policies across stakeholders. In this context, health workforce strategic developments such as the

determination of skill mix requirements to meet future health needs or inter-professional strengthening is likely to be more challenging.

Finally, while knowledge on health personnel has improved over the past years in Switzerland, particularly thanks to the studies undertaken by the Swiss Observatory on Health (Obsan), information systems on health workforce remain relatively weak, especially for nursing and other allied health professions. National data bases and regular health personnel surveys are very limited (see Box 3.8 for the experience of another federal state). This weakness of the information system represents a serious obstacle to the development of evidence-based policy making.

Box 3.8. **Pan-Canadian Health Human Resource Planning Initiative**

The Pan-Canadian Health Human Resource Planning Initiative aims to enhance and strengthen the evidence base and capacity for co-ordinated health workforce planning to better support federal/provincial/territorial, jurisdictional and nationwide activities as well as create a culture in which key health workforce issues can be identified and addressed. Identified implementation challenges include a lack of high quality, consistent data on all major health disciplines, a lack of national data standards or consistent information on health workforce productivity, utilisation and demand, and poor information on educational facilities and their capacity. A number of collaborative challenges have also been identified, including the balance between inter-jurisdictional collaboration and jurisdictional flexibility, determining which activities are shared and which are specific to jurisdictions, how to avoid duplication of efforts with existing structures and how to involve other key players outside of governments.

A successful project example from the Pan-Canadian Health Human Resource Planning Initiative was the development of a national supply-based database for five regulated health professions (pharmacists, occupational therapists, physiotherapists, medical laboratory technologists and medical radiation technologists) to provide evidence for health and human resource research and planning activities. This database replaced previous separate, provincially-held databases for these professions. Data was added to the existing health professions database administered by the Canadian Institutes for Health Information (CIHI) and included information such as total numbers of professionals, age and gender distribution, and graduates numbers nationwide and by jurisdiction. Also, a number of papers were published on human resources for health issues.

Overall, it would appear that the existence of a national advisory committee working towards an objective of strengthening the evidence and capacity for co-ordinated health workforce planning across all levels of a federated government is necessary. Since its establishment in 2002, the Pan-Canadian Health Human Resource Planning Initiative contributed to provide national data, programmes and literature which compare trends in health human resources across Canada and efforts to address issues of health human resource inequalities.

Notes

1. Belgium, Chile, Czech Republic, Ireland, Italy, Portugal, Slovak Republic, Sweden and Turkey are not included.
2. In the context of this study, general practitioners, medical generalists, and family doctors are considered as equivalent. They include doctors specialised in internal medicine and medical practitioners.
3. The RN4CAST study includes a consortium of 11 European countries, three international co-operation partners, and the United States. The Institute of Nursing Science from the University of Basel is the lead institution for Switzerland.
4. The aim of the Rationing of Nursing Care in Switzerland Study (RICH Nursing Study) was to study the issue of prioritising and rationing nursing care and to assess the associations between rationing and patient and nurse outcomes.
5. This law regulates the following professions: physician, dentist, veterinarian, pharmacist and chiropractor.
6. In May 2004, the CDS proposed that in the French-speaking part of Switzerland, nursing education will be only offered in the Universities of Applies Sciences.
7. Even colleges of vocational education and training have difficulties filling all their available places. For instance, in 2009, out of 450 places available at the Berner Bildungszentrum Pflege, a College of Vocational Education and Training, only 274 were filled (OFFT, 2011).
8. Masters are proposed both by the Universities of Applies Sciences, and the University of Basel, whereas only the University of Basel and Lausanne have a Ph.D. in nursing programme.
9. There has also been an increase in the number of first year students in the University of Geneva, Lausanne and Neuchatel which do not have a *numerus clausus*.
10. The projections do not include the ambulatory sector.
11. The Universities of Basel, Bern and Zurich have a *numerus clausus*.
12. The "domino effect" largely reflects the interdependency of health systems and the globalisation of the health labour market, as a country recruiting heath personnel in another country may induce the latter to recruit in a third country in order to compensate for the outmigration of health workers.

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Chapter 4

Recent Health System Reforms and Progress since the 2006 Review

This chapter examines recent progress on public health and prevention, quality of care, hospital financing and pharmaceuticals. Despite some encouraging developments in recent years, public health and health promotion in Switzerland remains largely uncoordinated and varies in line with cantonal policies and capacities. As debate has continued over a new prevention law, progress has been slow in promoting cost-effective health prevention policies or expanding coverage of successful prevention measures – such as breast cancer screening. Similarly, while recent efforts to expand collection of quality of care data are worthwhile, there remains a need for nationally consistent data collection to determine whether Swiss people are indeed receiving best practice health care. Switzerland's move to a case-based financing of inpatient hospital services is a positive move that should help improve efficiency. The extent to which it does so will critically depend on how individual cantons implement these reforms. Pharmaceutical policies have met some success, though more could be done to increase value for money.

The 2006 *OECD/WHO Review of the Swiss Health System* contained policy recommendations for improving the Swiss health system in both the short and the long term. The preceding chapters examine recent policies relating to insurance and the health workforce – the subjects of many of the recommendations of the 2006 review. This chapter provides an update on other areas that were the subject of the 2006 review's recommendations or where considerable changes have occurred over past years: public health and prevention, quality of care, hospital financing, and pharmaceuticals.

4.1. Public health and prevention

Health protection

Co-ordination over health protection has improved

Switzerland has made considerable progress in strengthening its policy framework for health protection. A clear legal mandate exists to allow federal employees (co-ordinated by the Federal Office of Public Health) to lead on protecting the country from communicable diseases and chemical or radiological contamination. The federal level issues guidance and the cantons are responsible for detailed plans and implementation. There are clear lines of accountability and working relationships between dedicated federal leaders and relevant canton level officials. For communicable disease control, the cantonal level officials are the Chief Medical Officers and for chemical incidents, the Chief Professional Chemists.

Even in this well developed part of the system, co-ordination issues can emerge in implementing policy, as recently demonstrated in the Swiss response to the 2009 H1N1 outbreak. With a considerable amount of service delivery relating to health protection devolved to cantons, major variations in population, health needs, and cantonal resources can often translate into substantial variations in responses to public health threats across Switzerland. The lack of central level guidance on Tamiflu coverage levels for different population groups at initial stages of the pandemic left it to cantonal health directors to decide, resulting in different coverage decisions. An evaluation of Switzerland's H1N1 immunisation strategy found that response plans across cantons were not standardised and harmonised to minimum standards, there was a lack of co-ordination on the distribution of vaccines to cantons and that there was a need for leadership in communication (Ernst and Young, 2010).

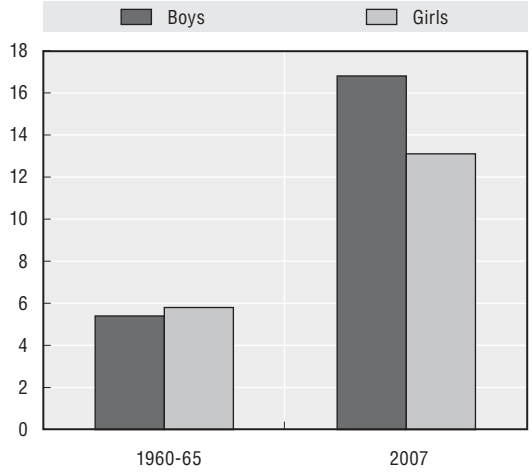
A further potential area for improvement is deepening links between Switzerland and European Union so as to generate early warnings of public health threats. Given the irrelevance of national borders in the face of serious outbreaks or contamination, this is an area that requires urgent attention. In addition there would be mutual benefit from a greater degree of co-operation more generally between Swiss experts and those at the European Centre for Disease Control. Relationships with the World Health Organization are already good.

Prevention of (non-communicable) diseases and health promotion

Though there have been noteworthy developments, prevention and health promotion remains uncoordinated

As with other OECD countries, non-communicable diseases are the most significant risks to health in Switzerland. It is estimated that smoking caused 9 201 deaths in 2007 – 15% of the total number of deaths, making it the leading preventable cause of death in Switzerland (OFS, 2009). As illustrated in Figure 4.1 below, the proportion of overweight and obese individuals has been increasing, particularly amongst children aged 6 to 13 where it has risen to 16.8% from 5.4% for boys between 1960/65 and 2007 and to 13.1% from 5.8% for girls over the same period (Schneider *et al.*, 2009). Studies sponsored by federal government have demonstrated that major prevention measures that have been undertaken across tobacco, harmful alcohol use and road accidents can deliver good value for money in Switzerland (Wieser *et al.*, 2009). Similarly, a recent OECD study analysed a range of interventions for tackling obesity, to help governments select the portfolio of investments that would best deliver value of money for the resources they could make available (Box 4.1).

Figure 4.1. **Prevalence of overweight and obesity amongst Swiss children aged 6 years to 12/13 years**



Source: Schneider *et al.* (2009).

Switzerland has made some progress towards tackling these major risk factors. A new ban on smoking in enclosed public spaces came into force in May 2010. This ban combined nationally legislated minimum standards with local delivery, with cantons holding the responsibility for enforcement and the ability to enact tougher provisions where they choose to. According to Swiss authorities, 14 cantons had legislation that exceeded requirements set by federal law by January 2010 (OFSP, 2011). The smoking ban provides an example of Switzerland's ability to use its highly devolved federal structure to allow variation in policy underpinned by national minimum standards.

There have also been attempts to co-ordinate the direction of efforts relating to alcohol related health risks through a National Alcohol Programme (2008-12) and the National Programme on Diet and Physical Activity 2008-12. These programmes seek to build a broad consensus amongst different levels of government, not-for-profit

Box 4.1. **Tackling obesity: the cost-effectiveness of prevention**

Overweight and obesity rates have been increasing relentlessly over recent decades in all industrialised countries. Governments across the world have been implementing interventions at the national and local level to address rising rates of obesity without a strong body of evidence on the effectiveness or distributional impact of these various interventions. The OECD, in collaboration with the WHO, sought to analyse a range of interventions to prevent chronic disease by improving diet and increasing physical activity. The purpose of this research was to help Governments choose the portfolio of investments that would make the best use of the resources they could make available.

At a general level, interventions aimed at tackling individual determinants or that are targeted at one group of individuals will not significantly reduce the scale of the obesity problem. More than a single preventative intervention is required to tackle the multiple and complex risk factors for obesity. To be most effective, these interventions should be pursued with multiple stakeholders – such as governments, industry and professional bodies – as no one party is in a position to meaningfully reduce the size of the obesity problem.

In arriving at these conclusions, the OECD modelled the efficiency and distributional impact of interventions to prevent chronic disease linked to unhealthy diets and sedentary lifestyles. This involved modelling health outcomes arising from lifestyle risk factors typically associated with obesity. The model used in this analysis was able to simulate the dynamics of a European population. While recently published OECD research applies this model to England and Italy, the broad conclusions could be similar for Switzerland.

Key findings include:

- Interventions to address obesity can deliver significant gains to health – ranging from 39 000 DALYs per year (mass media campaigns) to 490 000 DALYs per year (intensive counseling in primary care) in the European region – and are highly cost-effective relative to treating diseases once they emerge.
- The most efficient interventions are outside the health sector (*e.g.* food labelling, fiscal measures).
- Counselling individuals at risk in primary care is the single intervention with the largest impact on obesity and related chronic conditions, but is also the most expensive intervention.
- Interventions targeting younger age groups are likely to take several decades before they have an impact and deliver good cost-effectiveness ratios.
- Strategies combining multiple interventions may increase population coverage by targeting different age groups and so exploit synergies between intervention, with analysis showing that multi-pronged approaches may be up to twice as effective as the single most effective intervention, at a comparable levels of cost-effectiveness.
- Interventions aimed at tackling obesity by improving diets and increasing physical activity in at least three areas, including health education and promotion, regulation and fiscal measures, and counseling in primary care, have favourable cost-effectiveness ratios.
- In the European region, all the interventions show larger health effects on individuals in poorer socio-economic circumstances than on their better-off counterparts.

In general, most of the interventions considered required additional resources to be made available upfront, with returns in improvements to health being significant but often delayed over a longer period of time. Nonetheless, prevention policies remain very cost-effective in comparison to treating diseases as they emerge.

Source: OECD (2010b).

organisations and other interests on what priority areas for action ought to be. They demonstrate progress in building a coalition of support – an important step in the Swiss policy development process. However, apart from the recently introduced smoking ban, no population-wide prevention measures (where the greatest gains to health are likely to exist) have been introduced in the last years. In this environment, public health and prevention actions have been directed towards funding a range of smaller-scale health promotion programmes which are generally undertaken by not-for-profit organisations and foundations.

While the Swiss public health system shows real excellence in parts, it requires further resources and remains fragmented in general. Establishing a legal framework to facilitate national public health policies was highlighted as a priority action in the 2006 review. Since then there has been considerable debate and discussion, culminating recently in a new proposed law on prevention (see Box 4.2 below) that is currently (at the time of publication) being discussed by the parliament.

While the proposed law (as drafted), contains a range of initiatives that will help support co-ordination on public health issues, its lack of formal mechanisms for assuring the delivery of national public health policies could curtail its influence. Under this law, cantons continue to exercise a high degree of autonomy about the extent to which they implement measures to address agreed national prevention priorities. However, many

Box 4.2. **Progress on establishing a legal framework for prevention**

The 2006 OECD/WHO review argued that defining a common purpose and clearly delineating responsibilities between different levels of government was required to help mount effective policies against population wide health risks. While the decentralised structure of Switzerland's health system can allow cantons to develop and deliver locally relevant prevention activities, it also makes it more difficult to co-ordinate broad public health and prevention programmes.

Though there has been considerable debate and discussion over the proposed law on prevention, there is currently no clear legal mandate for federal leadership in health promotion and prevention. A draft bill is currently before the Swiss Parliament. This bill seeks to:

- Clarify the confederation's role in prevention and early intervention for chronic disease, that will see the confederation deal in areas where a concerted national approach is required, such as information campaigns, incentives for research and development and granting financial assistance to not-for-profit organisations with a national remit.
- Prescribe that national targets on prevention and health promotion should be set every eight years and strategic priorities every four years to help co-ordinate measures from different levels of government and private organisations.
- Prescribe that the implementation of measures for prevention, health promotion and early detection is still primarily the responsibility of cantons, and that cantons will bear the cost of measures in their jurisdiction.
- Provide responsibility to an organisation for distributing revenues raised from prevention charges and smoking taxes, noting that a portion of proceeds should be directed to grants for cantonal programmes in line with national priorities.

Source: Adapted from "Loi fédérale sur la prévention et la promotion de la santé", Office Fédéral de la Santé Publique (September 2009)

cantons – who already have considerable responsibilities and financial pressures in financing and operating their acute health care services – do not seem to be staffed in a way that would allow them to lead in prevention. There has been considerable discussion over whether a new body is needed at the Federal level as a centre of excellence for prevention and health promotion. With the contents of this proposed law currently under consideration, it remains to be seen whether Switzerland will be able to deliver a reform that is capable of directing resources towards supporting co-ordinated national action on measures that have a proven evidence base.

Whether through the prevention law or by other means, it would be beneficial to improve co-ordination in public health in Switzerland. The strongly local and participative nature of civic governance in Switzerland is a strength in developing locally relevant public health solutions. However, the challenge remains in better working out exactly who should do what at each level of government, and how these efforts are to be effectively co-ordinated. This is not an insignificant task and could benefit from a focused examination.

Switzerland also faces challenges in developing the human resources needed to embed a focus on public health in the health system. There appears to be a lack of further formal training for both medically qualified and non-medically qualified public health graduates. At the same time, there exists considerable scope for both federal and cantonal levels of government to proactively develop roles for public health professionals within their organisational structures. This could help support a much needed focus on broad-based improvements to existing health systems, structures and policies, which is difficult to achieve within the current model characterised by cantons seeking to contract for specific (and often small scale) public health programmes.

Breast cancer screening is a clear example of co-ordination difficulties

The challenge of implementing national prevention and public health programmes within Switzerland's current arrangements is demonstrated by the slow progress in implementing the OECD/WHO 2006 recommendation to establish a nationwide breast cancer screening programme. While there is ongoing discussion about the appropriate frequency and age, screening through mammography is a cost-effective method for ensuring early detection and improved patient outcomes. The majority of OECD countries have national programmes for breast cancer screening which are executed as part of a strategy to reach the large majority of the female population. Earlier studies have suggested that the introduction of screening in some cantons have demonstrated decreases in mortality amongst women aged 55-74 (NICER, 2010). Another Swiss specific study suggests that organised mammography screening with high participation would be more cost-effective than opportunistic screening (Gelder *et al.*, 2008). Studies have also suggested that providing easy and cheap access to breast cancer screening could help address the disparities in uptake of breast cancer prevention measures amongst immigrant and low income women (Fontana and Bischoff, 2008).

While cancer organisations in Switzerland have been seeking nationally consistent adoption of organised mammography screening, approaches vary substantially across cantons. Currently, routine mammography for target population groups in Switzerland is only paid for by the insurer (and free of charge for patients) in the six cantons where there is a prevention programme run by the canton. A recent decision by the Swiss Parliament clarified that insurance funds are obliged to support the cost of mammography screening where undertaken as part of a broader cantonal programme. While this is an important

step, cantonal action (and investment) is still required to deliver more comprehensive coverage. While cantons are moving to introduce mammography screening programmes – with St Gallen, Graubünden and Bern doing so over the past year – progress towards a co-ordinated national approach has been slow.

Health inequalities

A national minimum health data set is needed to determine the extent of health inequities

Switzerland appears to accept a greater tolerance of variations in wealth and wellbeing across communes and cantons than many other countries. Political initiatives in the area of health inequities have often focused on select topics, such as the recent Strategy on Migration and Health which aims to improve health monitoring of the migrant population. While it is plausible that Switzerland may not have health inequities that are as pronounced as other OECD countries, there is a lack of information on health outcomes for specific population groups. An overwhelming body of evidence has shown that disparities in health status and health care outcomes are often related to social class and deprivation – this has been demonstrated in comprehensive national studies such as the recent Marmot Review in the United Kingdom and in cross country comparisons (Mackenbach *et al*., 2008). Comprehensive and nationally consistent data on health status and outcomes across socio-economic and geographical cross sections of Swiss citizens are limited. While data is available on health outcomes and mortality related to income and education levels, there does not appear to be a systematic interest in identifying groups within Switzerland that experience systemic inequalities that are often related to, for example, early childhood development, the receipt of government benefits, employment and family structures. Swiss policy makers could consider *OECD Health Data* and the World Health Organization Europe's *Health for All* databases as a starting point for the indicators it would be worthwhile to collect.

4.2. Quality of care

More information is needed to monitor quality of care. Encouraging but limited steps have been taken towards addressing the 2006 review's recommendation that Switzerland develop a national framework for assessing quality of care in health services. The 2006 review highlighted that the Swiss health system combined a high degree of reliance on clinician self regulation combined with a series of institutional level initiatives to improve quality of care and patient safety. Since then, gradual steps have been taken to improve the range and consistency of data on the quality of care. From 2009, the Federal Office of Public Health has been publishing case numbers and mortality rates for 30 different diagnosis groups. A new organisation – the "Association Nationale pour le Développement de la Qualité dans les Hôpitaux et les Cliniques (ANQ)" – has been made responsible for developing and measuring quality indicators at hospitals and clinics around the country. The ANQ programme has sought to measure a series of quality of care indicators including rehospitalisation rates, reoperation rates, surgical site inflection rates, falls, ulcers and patient satisfaction. While participation under this programme has so far been voluntary under a pilot project, it is intended that the collection and publication of results for all hospitals will become mandatory.

The recent establishment of an insurance card is also a useful foundation for developing health information systems that can support better monitoring of patient

outcomes (and experiences) to drive improvements to the quality of care. While the insurance card will only store administrative data initially, trials are underway in some cantons to provide an opportunity to use the card to store medical data that can be shared amongst multiple health professionals. Such a system has the potential to directly improve the accuracy of diagnosis and reduce duplication of tests and diagnostics. It also holds the potential to collect data that can help policy makers assess the quality of care delivered by health service providers.

In general, health data remains collected in a fragmented way in Switzerland. In addition to the ANQ's role described above, the Federal Office of Public Health collects national data related to communicable disease control. The federal agency for statistics collects mortality data and also undertakes the Swiss Health Survey. Much of the remaining data collection – and the use of such data to improve quality of care – is only undertaken in local and specific ways for particular providers or cantons. For example, error reporting systems that exist in some hospitals are led by institutions and insurers, and individual projects are often not interconnected or comparable. There is a need for governments, health professionals and statisticians to develop shared objectives in order to help Switzerland overcome the gaps in current data collection. Switzerland would benefit from the specification of a national minimum health data set, ideally covering health outcomes across the population and the quality of care across the full spectrum of health services. While this could be collected and reported by different agencies and organisations as Swiss policy makers saw appropriate, co-ordination and a national focus will be critical to building a long term resource that can inform future improvements to the Swiss health system.

More effort is needed to align providers, insurers and cantons

As at the time of the last review, while there have been positive initiatives being undertaken, it remains to be seen whether the recent Swiss National Quality Strategy will deliver a systematic national framework to measure the quality of care, and whether this is then usefully deployed to ensure that Swiss residents receive best practice care. The challenge remains that cantons, as both owners and quality assurers of hospitals, may have mixed incentives to look assiduously for quality shortfalls. This is perhaps particularly a risk if the viability of their local service is under threat. Similarly, cantonal-level quality programmes that have occurred to date often focused on hospitals, and little information is available on the quality of primary care or outpatient activity.

For these reasons, efforts to assure the quality of care in Switzerland should be nationally consistent and co-ordinated. Policy development needs to be cognisant that cantons currently hold considerable financial and operational influence over health services and individual service providers. Swiss authorities are best placed to judge what institutional architecture and co-operation mechanisms could give effect to monitoring health outcomes and the performance of providers, but shifting away from self regulation (by service providers) would be a constructive guiding principle. This is an area that should be a major priority for a country that invests as much in its health services as Switzerland. Worthwhile improvements can help patients make informed choices and provide health insurers and governments with the tools to better assess value for money in financing health services.

Box 4.3. **Quality of care and progress on cancer registries in Switzerland**

Cancer registries are a particular example of the limited progress that has been made on establishing the nationally consistent (or co-ordinated) data systems needed to help improve quality of care in Switzerland. With many cantons running their unique cancer screening programmes and having individual arrangements with regional cancer registries, there is little recent and nationally consistent data on cancer survival and screening rates across Switzerland. There are currently some 11 cancer registries covering 22 cantons (OFSP, 3 Dec. 2010).

As a rare event affecting a fraction of the population, cancer registries require scale to produce meaningful data for analysis and surveillance, making Switzerland's cancer registry arrangements potentially inefficient for a country with a small population and area relative to other OECD countries. It is estimated that around 68% of the Swiss population is covered by cancer registries (NICER, 2010), a level that may limit the ability of registries to interpret variations in prevalence observed across time and geographical areas. Patients are likely to cross the jurisdictions and monitoring regimes of several registries in the process of travelling to receive specialist services in capital cities (such as Bern and Zurich). Often funded by cantons, universities and research groupings, there are also concerns about the capacity of registries to collect ongoing data (OFSP, 3 Dec. 2010).

It is likely that this combination of limited coverage and comparability issues constrains the potential value of cancer surveillance to drive the identification of trends and improvements in treatment outcomes. In light of this situation, the federal government's intentions to develop a new law to harmonise cantonal laws and regulate cancer registration by 2012 is a positive step, particularly if it is not limited to epidemiological surveillance and also facilitates the evaluation of medical services that deliver cancer care. It is, however, an overdue development when compared to OECD countries at similar levels of economic development – such as the Netherlands, France and Australia – that have each managed to deliver comprehensive coverage for cancer registries within regional (or federal) systems.

4.3. Hospital financing

The move towards DRG-based pricing and financing of hospital services should help drive efficiency…

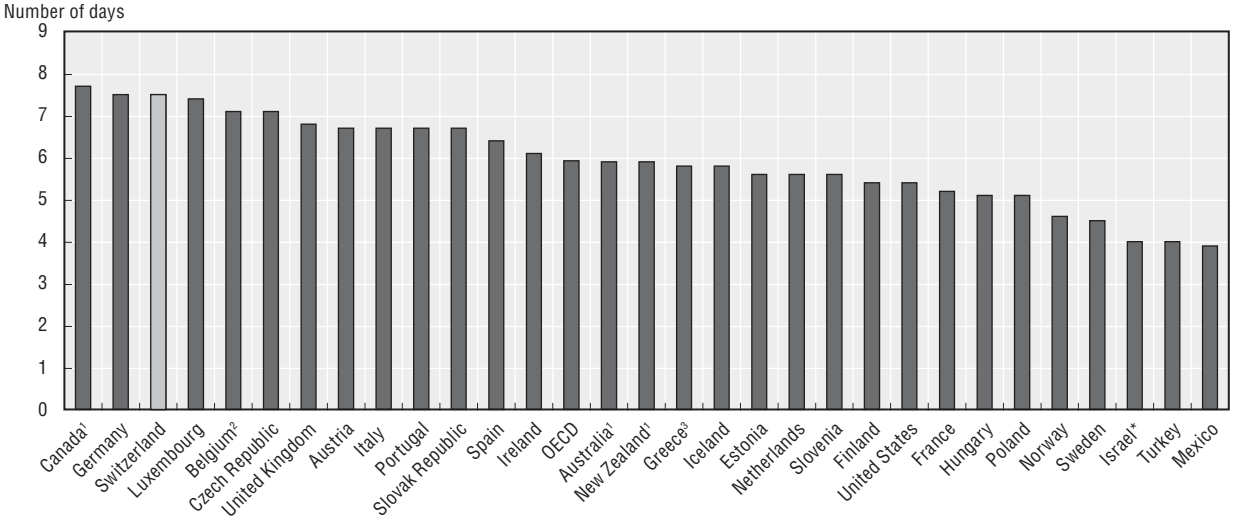
There has been considerable progress on reforms to hospital financing using Diagnostic Related Group (DRG) based payments, a key recommendation of the 2006 OECD/WHO review. A new organisation, Swiss DRG SA, has been established to develop and maintain a national schedule of Swiss Diagnostic Related Groups, initially based on a German DRG model (Swiss DRG, 2005). Once fully implemented throughout Switzerland by 2012, this national schedule will govern payments for compulsory social insurance schemes (health, accident, military and disability) to all hospitals (including private hospitals). Scales will be computed based on 42 hospitals that delivered data to Swiss DRG. The split of funding will see insurers provide a maximum 45% of the price of a service and cantons providing 55% of the price of a service.

The shift to DRG-based case payments for inpatient services should result in Swiss hospitals delivering care more efficiently. Currently, hospital financing varies across cantons, with per diem and DRG payments used across Switzerland.[1] The use of per diem payments for hospitals can create incentives for oversupply as it rewards providers for doing more

(OECD and WHO, 2006). Several cantons also supplement per diem payments by providing subsidies to cover hospital deficits at the end of the financial year; fostering an environment where loose budgetary controls may lead to services being undertaken when they could be delivered more cost-effectively in ambulatory care or outpatient settings. By moving to paying a benchmark "price" for diagnostically similar services, more efficient hospitals stand to financially benefit while less efficient hospitals will face economic pressures to improve efficiency. This has been demonstrated to help reduce costs and average lengths of stay across several OECD countries (Böcking, *et al.*, 2005). Early evidence from the introduction of DRG-based payments in some Swiss cantons suggests it can deliver a relocation of resources to outpatient care (Busato and Below, 2010). While they have been gradually decreasing over the past decade, average lengths of stay in Switzerland remain above the OECD average (see Figure 4.2) and indicators also show that Switzerland has fewer day cases as a proportion of total cases compared to other OECD countries (see Figure 4.3). This suggests that there is considerable potential for efficiency improvements.

The introduction of new hospital "lists" in conjunction with changes in financing should help drive competition between hospitals by guaranteeing an equal treatment of private and public hospitals. To date, cantons have selected which hospitals have received subsidies. Along with DRG reforms, a hospital "list" will be established, specifying those hospitals which will be able to receive the canton's funding of 55% of each service delivered. Furthermore, investment costs will be included in the case-based payment system, removing the uneven playing field that formerly existed where hospitals receiving subsidies for investment costs had a lower marginal cost per service compared to those hospitals that did not receive subsidies. The combination of discontinuing subsidies and paying hospitals for the cost of each inpatient case on the basis of a uniform tariff structure, should, in principle, drive activity towards the most efficient hospitals, whether public or private. The establishment of hospital lists enhances the ability to build a long

Figure 4.2. **Average length of stay for acute care across OECD countries, 2009**

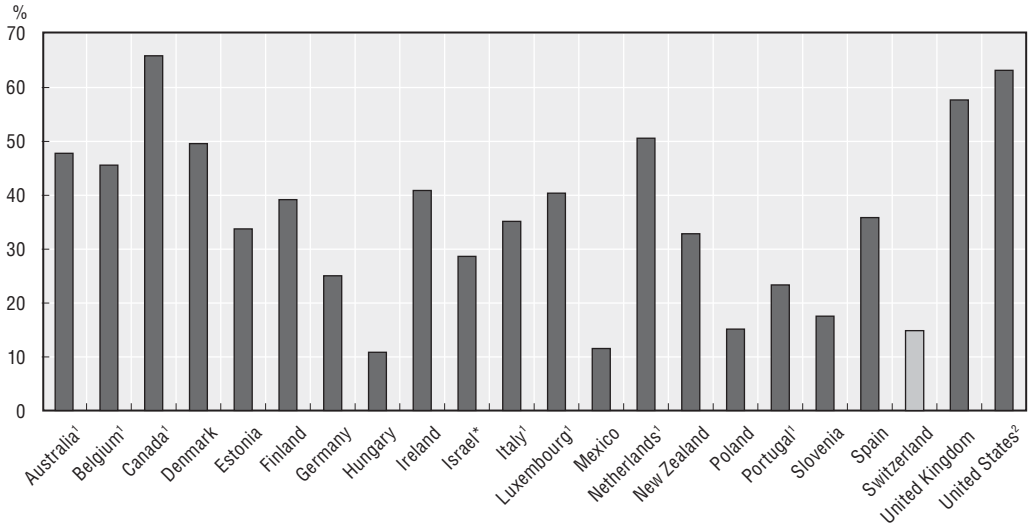


1. 2008 data.
2. 2007 data.
3. 2006 data.

* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD Health Data 2010.

Figure 4.3. **Day cases as a proportion of total surgical procedures delivered in hospitals, 2008**



1. 2007 data.
2. 2006 data.

* Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Source: OECD Health Data 2010.

term link between payments for services and meeting quality and safety standards (such as hospital accreditation or obligations to report certain data).

Establishing a case-based payment system will also provide a platform for innovation and future reform. The shift to payment on the basis of a nationally standardised system of DRGs will help provide information on performance, by encouraging hospitals to improve disclosure on levels of activity and costs of delivery. The classification of services is also likely to improve data on the major morbidities (and co-morbidities) dealt with by Swiss hospitals. This information could see DRGs becoming a useful tool to enhance links between payments and performance in the future.

… but the way DRGs are implemented will influence the extent of potential efficiency gains

The challenge of implementing the DRG-based payment system to maximise efficiency will predominately rest with cantons, who both own and operate many hospitals and pay for more than half of the services they deliver. While they generally encourage providers to reduce the cost of each service delivered, DRG-based payment systems can also encourage hospitals to increase the volume of treatments they deliver (OECD, 2010a). This could particularly be a concern for cantons that are moving to DRG-based payments at the same time as moving to a national tariff structure. For this reason, best practice models of introducing DRGs across OECD countries have incorporated explicit strategies for dealing with the potential for an increase in volumes and admissions. For example, when first implementing DRGs for Medicare, the United States initially introduced surveillance and warnings to impose sanctions if the number of admissions was to increase dramatically (Böcking *et al.*, 2005). In France, DRG tariffs are adjusted downwards if the health insurance spending target for hospital care is exceeded (Ministère de la Santé et des Sports, 2010).

Under the Swiss approach, while the schedule of diagnostically similar groups (DRGs) is set on a national basis, the actual prices associated with this schedule will be negotiated at a cantonal level by hospitals and insurer associations. Many cantons are likely to play a significant role in these negotiations as a result of their hospital ownership. Some cantons have developed expertise in estimating and projecting DRG costs and payment prices. Other cantons are likely to be less experienced. Minimising the potential for volume increases will require careful management at the cantonal level.

Cantonal governments will also hold an influential role in regulating prices negotiated at a cantonal level, with substantial implications for levels of funding provided to hospitals. Under current plans, cantonal governments will act as the approving authority for rates negotiated within a canton. Cantons will also intervene in setting tariffs if interested parties do not reach an agreement. As part of this process, the Swiss "price surveillance authority" has indicated that it may provide recommendations on appropriate base rates to be used to calculate prices for services (Surveillant des prix, 2011). If cantons approve rates higher than those suggested by the price surveillance authority, they will be obliged to make their reasons known. While this provides a transparent architecture to help cantons contain cost pressures, potential efficiency gains could be compromised by the extent to which some cantons might be willing to approve rates that do not reflect the cost structure in a particular location. In light of the previous practice of cantons' providing deficit funding of hospitals, there may be a risk that efficiency gains might also be compromised by the extent to which cantonal governments provide funding to hospitals outside the DRG-based system which can be used by hospital administrators to supplement the cost of delivering inpatient services (*e.g.* funds for research or other activities that are used by hospitals to deliver services rather than their specified purpose).

Structural characteristics of the Swiss health system are likely to remain constraints in making the most of financing reforms…

More broadly, the full extent of efficiency gains from hospital financing reform could be limited by the market structure within which DRG-based payments are provided. Other than Austria and Japan, Switzerland is unique amongst OECD countries with insurance-based health systems in that government is major partner in directly financing hospitals (see Table 4.1). As discussed in the previous review, dual financing reduces incentives to cut hospital costs, with cantons potentially facing conflicts of interest and weak incentives to control costs as a result of their multiple roles as owners, financiers and providers (OECD and WHO, 2006). Under these new financing arrangements, cantonal hospitals will continue to receive more than half of their funding from cantonal governments. At the same time, hospitals providing basic care are generally obliged to provide a minimum set of services (which may vary across cantons). This financing structure, combined with regulation on the range of services provided by hospitals, can reduce scope for hospital managers to make autonomous decisions on the mix of services they choose to provide (such as choosing to specialise in certain services or reduce other types of services), particularly when decisions conflict with the priorities of their cantonal owners. This could constrain the extent to which the new price signals introduced through a DRG-based system will help deliver improved efficiency within hospitals.

Similarly, the small size of cantons – and their centrality to defining the boundaries of hospital markets – may continue to provide a constraint on maximising efficiency for hospital spending. Twelve cantons have only one or two general (*i.e.* non-specialist) public

Table 4.1. **Hospital financing amongst OECD countries with insurance-based systems, 2007**

Percentages

	Government	Social insurance	PHI	Other private
Austria	44.5	45.8	7.2	2.6
Belgium	0.0	73.8	8.8	17.4
Czech Republic	2.8	95.4	0.5	1.3
Estonia	2.4	91.6	0.5	5.5
France	1.3	91.5	4.5	2.6
Germany	6.2	82.2	9.4	2.2
Japan	23.5	63.8	4.1	8.6
Korea	14.8	46.7	5.6	33.0
Netherlands	4.1	90.1	0.0	5.8
Slovenia	0.3	87.7	8.2	3.8
Switzerland	**34.2**	**44.0**	**11.2**	**10.5**

Note: Government spending data in Switzerland may be slightly higher as it includes depreciation costs. However, including capital costs in other countries would not substantially change this data.
Source: OECD Health Data 2010.

hospitals (OFS, 2011). With prices negotiated at a cantonal level, hospitals in these smaller cantons could hold considerable bargaining power in negotiation. A recent study estimates that the general level of prices for hospital services may currently vary by as much as 60% across cantons (Schleiniger, 2008). Current changes to open cantonal boundaries will provide patients with considerably more freedom to choose hospitals in other cantons, and will encourage hospitals to compete on quality across cantons. However, inter-cantonal cost competition is likely to be harder to achieve. It is difficult to see how lower prices in one canton could drive competitive pressures for hospitals in other cantons, and it is possible that negotiations for hospital prices in each canton could entrench variations in the cost of delivering services across cantons (beyond reasonable variations related to the cost of living). In effect, the existence of multiple small markets could limit the potential gains from activity-based funding to improving efficiency *within* a particular canton. While this will benefit those cantons with a high density of hospitals, it may not be very effective in addressing variations in costs throughout Switzerland.

Finally, the introduction of DRG-based payments will provide Switzerland with the opportunity to harvest new efficiency information (alongside information on quality) for future hospital planning. Switzerland's hospital financing reforms will shift all hospitals to DRG-based payments for all their inpatient caseload. Switzerland currently has uniquely high levels of access to hospital services, with more than 41 hospitals per million persons compared to an OECD average of 30 hospitals per million persons. After excluding 185 specialist centers and 40 major hospitals from Switzerland's 314 hospitals, there remain a significant number of hospitals which are likely to have small case loads and high availability requirements (for example, to maintain emergency services). The experience of other OECD countries in implementing DRG-based funding – such as the United States, Australia and Canada – have generally seen small and regional hospitals receiving supplementary payments to help underwrite their availability for access reasons. As funding will be linked to the number and complexity of services they deliver, this may raise questions on whether certain hospitals receive sufficient volumes to finance their ongoing operational requirements. As mentioned earlier, potentially insufficient funding in some hospitals may be addressed through cantonal governments permitting the higher tariff structures to

underwrite hospital availability. But importantly, the new financial information available from financing reforms may also help highlight those small hospitals that operate inefficiently and allow cantons to better assess whether the financial cost of the high degree of access to hospitals currently provided in Switzerland is a spending priority.

4.4. Pharmaceuticals

The OECD's analysis of Switzerland's pharmaceutical policies published in 2007 suggested that the prices of patented drugs were excessively high, generic markets were not efficient enough, and that decision making for pricing and reimbursement decisions lacked transparency (key findings of this study are summarised in Box 4.4). Since then, the Swiss authorities have taken actions to lower prices and boost generic markets, whose impact is assessed in the paragraphs below. Less progress has been made on the pricing and reimbursement decision-making processes.

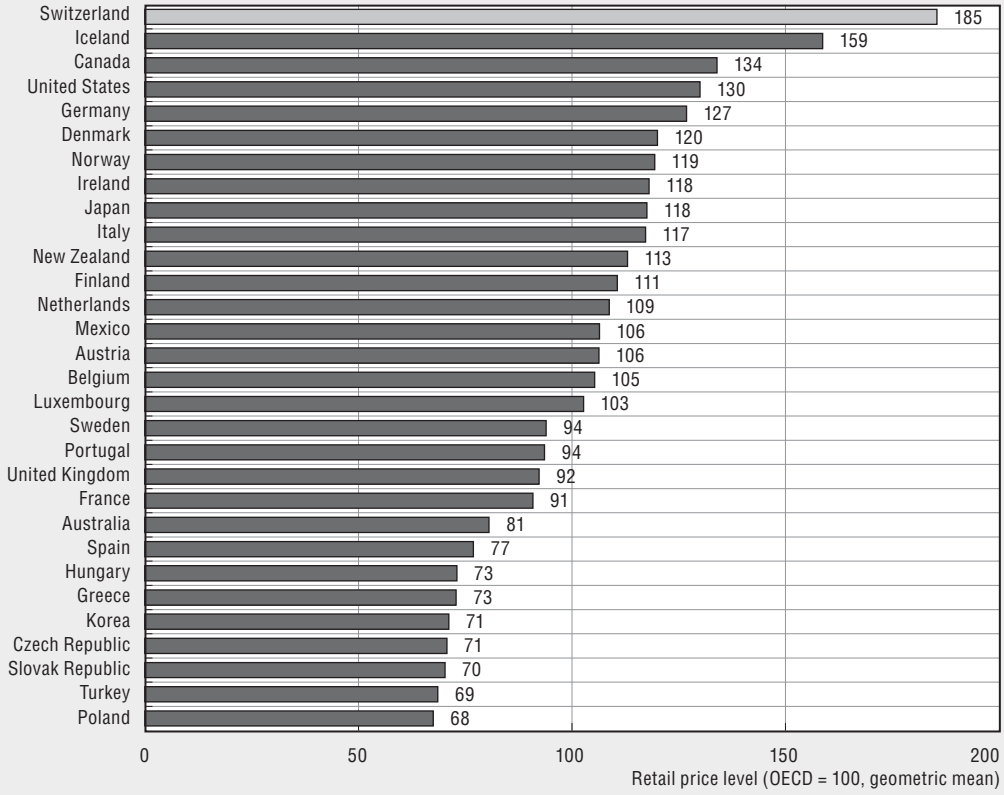
Box 4.4. **Switzerland's pharmaceutical pricing policies in a global context**

More so than many other areas of health policy, pharmaceutical policy operates in a distinctly global market place. The OECD report *Pharmaceutical Pricing Policy in a Global Market*, released in 2008, examined the national and cross-border impact of national pricing policies. Switzerland was one of the six case-studies. The project provided a number of key findings about Switzerland, which are briefly outlined below (with updated information where possible).

1. The Swiss population enjoys quick and affordable access to medicines:
   - Despite the small population it serves, the Swiss market is still attractive for companies, who tend to apply early to the Swiss drug agency (Swissmedic) to obtain market authorisation. Though Swissmedic does not always comply with treatment delays for granting market authorisation, the backlog in applications observed in 2008 has been reduced and was expected to be absorbed in 2010 (Swissmedic, 2010). Swissmedic now approves more medicines that have already been approved abroad without duplicating scientific assessment conducted by drug agencies it recognises.
   - The delay for market access after marketing authorisation in Switzerland is lower than delays in other European countries with pricing and reimbursement processes, except Denmark and Austria (140 delays, according to the Patients "Waiting to Access Innovative Therapies" indicator of EFPIA).
2. Swiss retail prices for pharmaceuticals were relatively high:
   - According to data collected by the OECD to compute Purchasing Power Parities, Switzerland's retail pharmaceutical price levels were particularly high in 2005: they were at 185% of the OECD average, the highest level amongst OECD countries (see chart below). The price level for original products was 74% greater than the OECD average in Switzerland, whereas that for generics was 125% greater than the OECD average.
   - Even after considering that the economy-wide price level in Switzerland is 140% of the OECD average, pharmaceutical price levels were still relatively high in Switzerland.
   - Switzerland's high retail pharmaceutical price level is likely to be explained by relatively high ex-manufacturer prices combined with relatively high distribution costs (pharmacy and wholesale mark-ups), despite lower value added taxes on pharmaceuticals than other OECD countries.

Box 4.4. **Switzerland's pharmaceutical pricing policies in a global context** *(cont.)*

Figure 4.4. **Relative retail pharmaceutical price levels in OECD countries, 2005**



Note: Prices were converted to a common currency (USD) using the 2005 average exchange rate.

Source: Eurostat-OECD Purchasing Power Parity Programme, 2007.

3. The pharmaceutical industry is a major asset to the Swiss economy

- Switzerland is home to two of the top ten global pharmaceutical firms. Pharmaceutical production represented 3.1% of GDP in 2004 and contributed significantly to Swiss economic growth during the 1990s.
- Industry financed R&D is more important to Switzerland than any other OECD country. In 2004, corporate expenditures on pharmaceutical R&D were USD 2 billion in Switzerland, accounting for around 0.8% of GDP in that year.
- Switzerland and Ireland were the biggest net exporters of pharmaceuticals in 2006, exporting USD 29.5 billion and USD 28.7 billion respectively.

Source: OECD (2008); Paris and Docteur (2007); *OECD Health Data 2011*, Swissmedic (2010); EFPIA (2009); *OECD Stan Bilateral Trade Database 2011*.

The prices of patented drugs have been lowered

In recent years, the pricing of new patented drugs has been reformed slightly to obtain better prices. As with many OECD countries, Switzerland continues to use international benchmarking to negotiate drug prices with industry. The group of comparator countries was expanded in 2006, when France and Austria were added to the initial group of four: Denmark, Germany, the Netherlands and the United Kingdom. Since 2006, Swiss

authorities have undertaken three waves of price revisions[2], the last one being a revision of prices for all drugs launched between 1955 and 2006, based on benchmarking with prices in the six comparator countries (IMS, 2011). This may have contributed to the Swiss pharmaceutical market declining by 1.3% in 2010 – the first decline in its history. From now on, prices will be reviewed (and revised) every three years or when a new indication has been approved.

Between 2006 and 2010, the gap between Swiss prices and prices in the six comparator countries has decreased from 38% to 6% (Gnägi, 2010). In 2010, both Germany and Denmark had higher prices than Switzerland for original preparations (respectively 17% and 13% higher). Since then, however, the gap between Switzerland and the six comparator countries may have widened again due to currency fluctuations.

Looking ahead, Swiss authorities should anticipate changes that will take place in several of their comparator countries. Both Germany and the United Kingdom announced their intention to regulate reimbursement prices of new products using cost-effectiveness assessment and value-based pricing. France has similarly announced better use of economic evaluation for pricing and reimbursement. In a best case scenario, these changes will increase value-for-money in pharmaceutical spending in comparator countries and Switzerland will benefit from the flow on effects of their international benchmarking. However, economic evaluation is in principle highly context-dependent and assessment made by other countries may not reflect the value of new products in the Swiss health system.

After a few years of expansion, the generic market is stagnating

Switzerland has implemented policies to promote the use of generics and drive further price competition for off-patent drugs (see Box 4.5).

These policies have had positive impacts on the development of the Swiss generic market from 2003 to 2006, with average growth of 42% a year. However, since 2006, growth in the generics market has slowed and penetration has stagnated at about 10% of total pharmaceutical market value at ex-manufacturers' prices (Interpharma, 2010). Part of this stagnation is explained by originators lowering the price of their products to compete, which has made generics less attractive for consumers, without affecting health insurance spending.

The Swiss generics market has the potential to be more efficient. Firstly, it remains highly concentrated, with two manufacturers (Sandoz and Mepha) holding 70% of the market (Sandoz, 2011). Secondly, generics prices are still very high. Generics prices in Switzerland are almost twice as high as the average generic price observed in the six international comparator countries. They are more than three times higher than Dutch generic prices, two and a half times higher than Danish prices and two times higher than German and British prices. By contrast, prices of off-patent originators are comparable to those observed in other countries and even lower than German and Danish listed[3] prices (Krause, 2010). The small size of Switzerland may not be attractive for generics manufacturers, but the relatively high prices of originators should partly compensate. Other factors may also explain the low take up of generics in the Swiss market that Swiss authorities should seek to identify and remove.

Box 4.5. **Policy actions to promote generics penetration in Switzerland**

Swiss authorities have undertaken a range of actions to promote the take up of generics over the last five years. These include:

1. Financial incentives for consumers

Swiss patients generally contribute 10% towards the cost of medicines (after paying a deductible on their insurance policy). In late 2005, this contribution was increased to 20% for brand name drugs for which less expensive and interchangeable generics were available (which applies up to an annual cap of CHF 933). Since the end of 2006, manufacturers of originator products were provided with the opportunity to "buy" an entitlement to lower (10%) cost-sharing by patients if they reduce their prices in line with generics, and many of them did.

From July 2011, this system will become even more dynamic. From two years after a generic's entry, the differentiated copayment will be automatically re-introduced as soon as the price of any interchangeable drug exceeds the average price of the cheapest third of products with the same active ingredient by 20%.

2. Pricing regulation for generics

On market entry in Switzerland, generics must be priced below the reference price of the original drug. In the past, the price of a generic was set 40% below the originator's price. Since 2008, in order to encourage generic entry in the Swiss market, generic price discounts have been defined in relation to originators' market shares: the larger the market share, the higher the discount (see the table below). In January 2012, five categories of market shares will be defined and generic price discounts will range from 10% (which is very low) from 60%.

January 2008		October 2009		January 2012	
Market value[1]	Generic price discount (%)	Market value[1]	Generic price discount (%)	Market value[1]	Generic price discount (%)
< 4 Mio.	20			< 4 Mio.	10
> 4 Mio.	40	< 8 Mio.	20	4 – 8 Mio.	20
		8 – 16 Mio.	40	8-16 Mio.	40
		> 16 Mio.	50	16-25 Mio	50
				> 25 Mio.	60

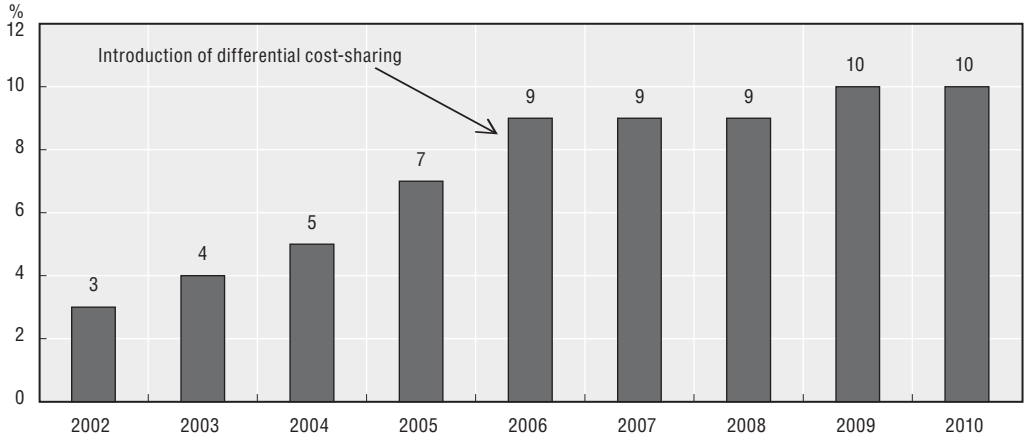
1. Originator's market value at patent expiry.

3. Encouraging pharmacists to substitute to generics

For over a decade now, pharmacists have been allowed to substitute generic drugs for originals with the patient's agreement and when the doctor does not oppose it. By law, pharmacists must inform the patient's doctor on substitution, but in practice do not usually phone if they know the doctor usually agrees with substitution. In addition, pharmacists are paid a "substitution rate" for providing generic substitutes.

Source: Paris and Docteur (2007); Sandoz (2011).

Figure 4.5. **Trends in generic market share since 2002 (share of total market sales, at ex-factory prices)**



Source: IMS data, quoted in Sandoz (2011).

Could insurers reduce pharmaceutical costs through contracting with manufacturers?

Recent experiences in countries with competing insurers – the United States, Germany or the Netherlands – suggest that pharmaceutical prices can be substantially lowered by selective listing and tendering.

The United States model is the most liberal: each insurer defines the list of medicines covered (*formulary*) by a specific plan, as well as related copayments. Insurers usually have no regulatory constraint on the inclusion of drugs. In therapeutic classes where several drugs can reasonably be considered as alternatives, insurers can negotiate discounts or rebates with manufacturers in exchange for listing in their formulary. Such an approach, however, would not be compatible with principles set in LAMal of nation-wide definition of benefits covered. The Dutch and German approaches may be more compatible with the Swiss nation-wide positive list since selective listing and tendering are only (or mainly) used for generic drugs (see Box 4.6). Experiences in these countries allowed substantial savings for health insurance funds. They show nevertheless that tendering processes need to be carefully designed to guarantee both that winning companies will be able to supply adequately the market or otherwise risk enforceable penalties, and prevent excessive concentration in the generic market.

Could such a policy be adopted in Switzerland with some efficiency gains? In principle, selective contracting for generics does not conflict with a nation-wide uniform list of reimbursable drugs since generics are by definition interchangeable. The extent to which single insurers could get better prices by tendering than the government negotiating prices for the whole Switzerland is difficult to predict, but this is an area where competition between insurers could be exploited. However, this approach obviously constraints choice for patients, doctors and pharmacists. It thus belongs to stakeholders to weigh the potential savings against the cost of reduced choice.

Decision making for reimbursement could be more rational

While recent efforts to reduce prices of pharmaceuticals have been successful, as with many other OECD countries, greater attention could be given to assessing if drugs

Box 4.6. **Selective listing and tendering in countries with competing insurers: lessons from the United States, Germany and the Netherlands**

In the United States, private health insurers freely define the list of medicines they cover. Health insurers and pharmacy benefit managers have been contracting with pharmaceutical companies since the 1980s. They have obtained substantial discounts or confidential rebates for on-patent, off-patent and generic drugs from manufacturers in exchange for "listing", "preferred drug status", or even "exclusive listing" in their formularies for both patented and off-patent drugs sold to out-patients (US Federal Trade Commission, 2005).

In the Netherlands, health insurers are allowed to select one or more products, within a cluster of products with the same active ingredient, to be eligible for reimbursement. They contract with pharmaceutical companies to obtain discounts or rebates on prices in exchange for the exclusivity of the reimbursement status, for a given period of time. Patients have to pay out-of-pocket the full price of non-selected products, unless a doctor has confirmed a medical need for a specific product. Dutch health insurers have been using both collective and individual tendering. In 2005, seven private health insurers in the Netherlands, covering about 70% of the population, decided to tender jointly for the purchase of three high-selling off-patent active ingredients (simvastatin, pravastatin and omeprazole). Manufacturers offering the lowest price (or no more than 5% above) were selected and their drugs were supplied to patients free of charge, while other drugs were not reimbursed at all. Collective tendering has not been extended to other active ingredients but 33 substances were listed for potential tenders, led by individual health insurers. Insurers can use additional incentives: one insurer decided for instance to exempt patients who use preferred drugs from the annual deductible for out-patient pharmaceuticals (Maarse, 2009; Kanavos, 2009). The total initial savings of the tendering practices in the Netherlands were substantial (EUR 355 million): price reduction reached 90% in some cases and generic substitution increased. However, the government was obliged to increase pharmacists' fee to compensate losses incurred by pharmacists, reducing total savings by EUR 200 million (Kanavos, 2009).

In Germany, the 2007 Health Insurance Competition Enhancing Act designed a set of incentives to foster health insurance funds' contracting opportunities. According to the new law, when health insurance funds contract with a pharmaceutical company (in practice mainly generic companies) to obtain price reductions, pharmacists are obliged to substitute the "preferred" drug for the initial prescription, unless a doctor has formally excluded substitution. Health insurance funds tender for two types of contracts: contracts for the purchase of a specific active ingredient or contracts for a product portfolio. Contracts are confidential and thus actual prices unknown, but the largest insurer (AOK) announced savings of EUR 1.2 billion in 2010-11 thanks to these contracts (AOK, 2011).

Source: OECD (2010); Kanavos (2009); Maarse (2009); US Federal Trade Commission (2005); AOK (2011).

supported are effective and cost-effective. The Swiss positive list is considered to be quite comprehensive and decisions not to list a drug are rare.

Health insurers have increasingly become interested in promoting the cost-effective use of drugs, and have recently decided to restrict reimbursement of off-label use of very costly medicines in patients with serious diseases, following a court decision. In the short term, there exists considerable scope for the process of listing reimbursed services and pharmaceuticals to become more transparent and formalised. This move would foster a

more informed process. While building long term capacity for health technology assessment is difficult for a country as small as Switzerland, there is scope for Switzerland to further benefit from collaboration with European and international health technology assessment agencies such as the National Institute for Health and Clinical Excellence in the United Kingdom, the High Authority for Health in France, and the Institute of Medical Documentation and Information in Germany. Improvements in quality and transparency of the process can only come at the cost of increased funding for these activities, but expected benefits are high enough to justify the investment.

Perverse incentives remain in pharmaceutical distribution

Changes to pharmacists' remuneration, which link payments to services delivered and not to the volumes of medicines dispensed, are a positive move that should support improved quality of care. As the combination of rising multi-morbidities and health workforce shortages for medical professionals become more pronounced, pharmacists hold the potential to provide constructive support in medication management and co-ordination of care. Similarly, the introduction of "quality circles" provides an example of collaboration to improve physician prescribing behaviour towards evidence-based policies. Quality circles bring together five to eight physicians and pharmacists to develop collective, evidence-based guidelines and to put these recommendations into practice. While they have proven that they improve quality and efficiency, the effects on cost savings have been varied (OECD, 2007). While some insurers have already financially supported quality circles where they achieve savings, efforts to provide incentives for improved quality in prescribing and medication management are likely to become increasingly worthwhile to respond to changing health needs driven by an ageing population and rising chronic disease.

As efforts are made to re-orient pharmacy practice towards a focus on quality of care, policies in some cantons to allow doctors to dispense drugs continue to work against this – and create perverse incentives for over-prescription. While this is sometimes justified in terms of supporting health care in remote areas of Switzerland, it is likely the dispensing doctors make it more difficult for pharmacists to develop a sustainable business model to serve remote areas.

Notes

1. Current payments are based on an AP-DRG system, which will be replaced by the new SwissDRG system on January 1, 2012.
2. The first wave, in 2005-06, benchmarked the prices of all drugs marketed since 1955 to prices observed in the four initial comparator countries (Germany, Denmark, the United Kingdom and the Netherlands). The second wave, in 2007, revised the prices of drugs launched between 1993 and 2002 to prices in the same group of countries, allowing the price in Switzerland to be up to 8% higher than in comparator countries. These two waves allowed savings of (respectively) CHF 250 million and 150 million (Communication with Swiss Authorities).
3. Listed prices can differ from actual prices in countries in which negotiations between payers and manufacturers take place, as in Germany.

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Chapter 5

Reforms and Governance of the Swiss Health System

This chapter describes the governance of Switzerland's health system and the reform process. Governance in Switzerland is founded on decentralised approaches and consensus seeking. This can often curb the political capacity for reform, but it also provides opportunities for innovative policies at a municipal or cantonal level for sharing knowledge and best practices. In this context, improving governance will depend on the ability of the Swiss authorities and other stakeholders to develop and implement a strategic vision for the future of the Swiss health system. The ongoing discussions over a potential law on prevention and the national health strategy project are important initiatives in this direction. Better governance will also require development of nationwide information systems and generating better evidence to inform policy.

Introduction

As described in Chapter 1 of this report, the Swiss health system is characterised by three key features: the first is its federal structure and a complex system of powers and responsibilities by level of government; the second is a political tradition of direct democracy and governance through consensus; and the third is an emphasis on managed competition within the health system rather than state-run (*e.g. integrated* health care model) arrangements. As noted in Chapter 1, the finance of the health care system is, broadly speaking, governed at the Federal level while supply of health care services is the responsibility of the cantons.

Against this background, this chapter looks at some areas where strengthened governance might help improve the performance of the Swiss health care system. Good governance in health provision promotes effective delivery of health systems through the setting, amongst other things, of appropriate standards, incentives, information and accountabilities. Good governance in financing concerns ensuring that financial resources are collected and redistributed in ways that ensure that individuals have access to health care services as they need them without facing catastrophic household expenditure (Lewis and Musgrove, 2008).

Key features and instruments of governance evoked in this chapter include:

- Developing a vision for the future of the health system;
- Building consensus on how to achieve that vision, *inter alia* through greater participation of citizen/patient groups, health care professionals and other key actors.
- Greater transparency, accountability and performance management through enhanced data generation and information gathering for informing policy and evaluating progress; and,
- Ensuring appropriate standards and regulation.

Starting from the general discussion of the preceding paragraphs, this chapter first identifies major areas of weak governance and where and how the performance of the system might be improved, drawing on OECD and WHO (2006). In the light of the relatively limited progress in introducing reforms suggested in the 2006 review, governance-related factors that slow the pace of institutional change in Switzerland are briefly discussed. This chapter then looks at how those governance features and instruments constrain or support the achievement of health care system goals. The three goals of health care system as used in OECD and WHO (2006) are:

- Quality and effectiveness of health care provision;
- Access to care and financial protection; and
- Efficiency of provision and longer-run financial sustainability.

Each of these three sub-sections briefly identifies current problems, reviews any recent reforms that may affect governance capacity (including the concepts just described)

and suggests additional measures that might improve the situation. The key goal is to assess how governance features and instruments may help create conditions for high levels of health outcomes and, underlying this, adequate levels of health care, health promotion and disease prevention services and programmes. Finally, a short conclusion identifies some key areas where governance issues may be brought to bear in the future.

5.1. Main issues in health system governance identified in 2006

OECD and WHO (2006) identified several important areas where the current governance arrangements limit overall health system performance. Very briefly, these include:

- The fragmentation of responsibilities across different players (see previous chapters) means that none of them has overall responsibility for the performance of the system. The existence of 26 cantons holding primary responsibility for adequate health care provision raises the risk of policy incoherence or slowing the pace of reform (see Hurst, 2010).[1]
- Governance may also be weakened by conflicting incentives within the system. This is particularly the case at the level of the cantons where the authorities take on multiple roles as owners of hospitals, providers, financers and regulators of health care services, potentially resulting in conflicts of interest and weak incentives to control costs. This calls for better alignment of incentives, greater accountability and performance management, data collection, transparency and the use of data for policy making.
- This dispersion of responsibility and weak incentives also reflects the continuing absence of an overarching national framework or health law within which the Swiss authorities at all levels of government can define explicitly the overall objectives of the health system, set targets and standards and monitor their achievement. The continuing need for such a law on health policy is curbing the scope for health system reform in other areas – such as prevention (see Chapter 4). Seen from a governance perspective, changing this situation will require building coalitions for change.
- More attention also needs to be given to building cost-effective prevention programmes: there are only weak incentives within the system to promote prevention and health promotion policies and cost-effective interventions – as identified by the WHO – are under-utilised. For example, the WHO has identified increased "sin taxes" as a cost-effective means of reducing consumption of alcohol and tobacco. These taxes are generally lower in Switzerland when compared to other OECD countries.[2]
- While the federalist model can respond better to local needs and allows for innovative experiments, many of the 26 cantons are simply too small to achieve the minimum size needed for the spreading of health risks or to obtain efficient and high quality care for patients. Public awareness of such problems is increasing and inter-cantonal agreements to address common problems and to pool resources are becoming more and more common (CDS, 2009).[3] Governance would benefit from increased intelligence concerning quality and adequacy of care in the smaller cantons.
- Information on quality of care and efforts to improve quality are weak in Switzerland. International data (for example, the OECD Health Care Quality Indicators initiative) provide some comparative information on the quality of health care in Switzerland. There also exists a number of local programmes (see for example OECD and WHO, 2006,

Box 2.4) but these remain, for the most part, at a local level. The scope for improvement in this area appears large.

- 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 make evidence-informed decisions. Setting appropriate regulations and standards to widen and deepen available data sets would help improve governance, particularly if they are combined with improved transparency, accountability and performance management. Publicly available statistics are often limited by the absence of comprehensive national reporting requirements. Existing data collection by cantons is not always standardised. Privately collected and owned statistics (*e.g.* insurers' databases) are not always publicly disclosed or openly available to the statistical authorities.

As demonstrated below, many of those observations and recommendations in 2006 remain valid in 2011 and there has been only very limited progress. To understand this, it is worthwhile describing them against the background of governance traditions and principles (Section 5.4) which strongly affects the political capacity for reform but also provides ample opportunity for implementing innovative policies at a municipal or cantonal level, for cross-fertilisation and then dissemination through a bottom-up approach.

5.2. Governance traditions and principles

In Switzerland, governance takes place at three different levels: the confederation, cantons and municipalities.[4] The 26 cantons hold primary responsibility for ensuring adequate health care provision for its residents.

While it is often said that the greatest responsibility for the health system governance lies with the cantons, this is becoming less and less the case. The important role of the confederation in this regard is exemplified by LAMal which is the most important law governing the health care system, and goes well beyond the oversight of the basic health insurance system itself. Indeed, LAMal is now *ipso facto* the core legislation for the health care system (Kocher, 2009). Over the past few years the confederation has acquired new responsibilities both from the revision of federal laws and from the introduction of new federal legislation. The result has been that the confederation has become increasingly involved in a range of subject areas,[5] often in collaboration with the cantons either directly or indirectly via the CDS (see below).

As the capacity of 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 and common policies primarily between cantons and, in some cases also with the confederation. Through regular meetings, the CDS facilitates the development of common policies between cantons and the confederation. However, this process does not result in binding decisions on all cantons, 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 (OECD 2006). More generally, a key feature of the Swiss governance system is the political tradition which permits groups of citizens to contest legislation and the constitution. In practice, only 4% of legislation is contested. But it has, nonetheless, created

a culture in which the search for consensus is particularly strong.[6] Hence, the legislative process is Switzerland can be best defined as a bottom-up and consensual approach.

Overall, there is a constant tension between defenders of the market-based approach and those that support state-based arrangements. In practice, the Swiss health system makes considerable use of markets and competition in "regulating" the system. In the health sector, Switzerland along with Germany and the Netherlands make the greatest use of market forces among OECD countries while the degree of government regulation of health resources is assessed to be relatively weak (OECD, 2010). For example, managed competition in the basic health insurance system (LAMal) has aimed at maintaining a market-based approach while also achieving full coverage for the basic health insurance package by requiring all individuals to be covered by basic health care insurance. High user charges also discipline the individuals' demand for care. In addition, there are large areas of health care provision and insurance coverage where the state plays only a limited role.[7]

5.3. Dynamic governance or the political capacity for reform

Good governance of the health care system is also determined by whether reforms can be implemented. While the reforms in the health sector are, by nature, often contentious and slow to implement, this seems particularly so in Switzerland [see Box 6.1 in OECD and WHO (2006) and information from the Swiss authorities]. In practice, it would appear that the political system in Switzerland can make reforms more difficult to introduce at a national level and this may partly explain the limited extent of reforms since 2005 when the last survey of Switzerland was written. Some key reasons include:

- Switzerland comprises three main linguistic and cultural regions (German, French and Italian) so that there is no common ethnic or linguistic identity and cultural traditions. This may lead to very different attitudes, for example, in the demand for health care services and makes consensus building more difficult.
- The length of the legislative period is too short to get the legislation passed in parliament in a subject area that can be as contentious as health. The periods during which decisions are less subject to electoral cycles are relatively short.[8]
- The possibility (and threat) of popular initiatives and/or a referendum pushes legislators to find consensual policies in a country where there is a progressive polarisation in the system of political parties and a growing need for multi-party consensus. Final legislation after debate is sometimes voted down because the proposed legislation has lost too much of its substance in the legislative process.
- The division of sometimes overlapping responsibilities between the cantons and the confederation can mean that there is no single entity which co-ordinates activity in the area of health, leading in some cases, to an application of the legislation in ways that are not what was fully intended when the legislation was passed.
- The rather lengthy reform process may also reflect the length of the decision process and problems of introduction of complex legislation. Because of the need to ensure consensus a number of years may pass between the time that the policy is proposed by the Federal Council and when the legislation actually comes into effect on the ground.
- Finally, there are strong lobbies within parliament – the doctors; the health insurance industry and the pharmaceutical industry – that may be able to block or propose health care reforms in the interests of their members (Zeltner, 2010).

While many of these factors are found in other federal democracies, they are perhaps exacerbated in the Swiss case by the presence of direct democracy channels to contest legislation. At the same time, however, there may be some benefit to the extent that laws, once passed, may be better understood and accepted by the population at large. But once laws are passed it is also difficult to make subsequent modifications, as witnessed by the lengthy process in making changes to LAMal since it was passed in 1994. In sum, these features may limit the capacity of the authorities to govern the system.

From another perspective, with 26 cantons each holding significant responsibilities for health policy, there are as many opportunities to "test" policies on a smaller scale. In addition, cantons can also delegate tasks to the communes, who often undertake prevention work in schools, helping on early detection and on treatment. This gives rise to numerous opportunities for innovation at the local level. Successful practices might then rapidly be disseminated and copied in other cantons. The forthcoming European Health Policy of the WHO Regional Office for Europe (*Health 2020*) advocates for more collaboration in sharing and testing out policy experiences at international, national and local level. Consequently, *Health 2020* puts forward a stronger strategic role of international and national public health agencies in providing evidence and policy analysis (WHO, 2011).

In its report on governance in the 21st century, the OECD highlighted that new forms of leadership are emerging, continuously shifting the allocations of power and modifying centralised top down decision-making structures (OECD, 2001). The WHO Regional Office for Europe adopts a similar position in its European Health Policy (*Health 2020*) by recognising that today's governance for health is dispersed across sectors and society and that new health leaders will need to convince others through influence rather than control. Hence, policy decision making in Switzerland should build on the systems governance traditions and foster innovations in a participatory and upstream way, rather than opting for a total shift of responsibilities. This means strengthening frameworks, institutions and mechanisms to foster innovation, create consensus for common national health goals and objectives, align local policies with them, and facilitate their dissemination across cantons. As highlighted above, it requires, among others, platforms for structuring policy learning, disseminating know-how and experiences of policy developments at the local level.

5.4. Key features and instruments of governance of the Swiss health system

Developing and building a consensus on a strategic vision and longer-term policies

Governance can also be defined as "the attempts of governments and other actors to steer communities, whole countries, or even group of countries in the pursuit of collective goals" (Bell and Hindmoor, 2009). Therefore, good governance encourages the development of plans and policies that, through decision making, assist the constituents of the system in working collaboratively towards the achievement of higher health outcomes.

As noted elsewhere in this report, Switzerland's health system traditionally relies on decentralised decision-making structures, competition and private health care provision and health insurance. The devolution of decision making to the cantons, combined with canton variations in population size, health needs, and in the resources available to canton administrations, translates into substantial variation in health policies across cantons and further differences in access to services, benefit coverage and premium levels. Devolved government and autonomous provider and insurer units, may tend to give higher priority to their specific interests than to the broader social and national interest. This has made it

more difficult to orient the system towards social goals and population health outcomes at the national level.

This dispersion in policy has also meant that there is only limited overall vision for the health system beyond the health financing system as embodied in LAMal. In other words, there is no national health care system; rather, there is a national health insurance law. Taken from this perspective, current efforts to build wider laws on prevention are of particular importance for building a common vision for overall health policy. A new law on prevention was drafted by the federal government and then passed over to parliament for debate. The draft law, if passed, should permit the setting of national goals on disease prevention to be formulated by the federal government in close collaboration with the cantons and NGOs.[9] The law also stresses the need for consensus building at the canton level and strengthening the role of citizen groups and NGOs so as to draw on existing experience in this area. There is a risk, however, that the end result will be limited to setting of some national-level objectives, with few resources and institutional capacity.[10] Careful consideration needs to be given to building capacity for implementation at all levels of government.

Indeed, some scepticism has been voiced as to whether the proposed law would really be fit for its purpose even if passed, as a degree of watering down has occurred during consultation. In addition, very few cantons seem to be staffed in a way which would allow them to lead in these areas without some supporting central resource. Chief Medical Officers in the cantons often focus on communicable disease to push for public health initiatives in this domain. A diversity of often local and single issue non-governmental organisations seek to address non-communicable disease but comprehensiveness and co-ordination are lacking.

In practice, recent federal efforts to build consensus on prevention since OECD and WHO (2006) have focused on disease or risk related programmes for: AIDS and other sexually transmitted disease; substance abuse (alcohol, tobacco and narcotics); and, diet and physical activity with programmes generally running over the period 2008 to 2012. More recently, efforts have been made to build consensus among the cantons and with civil-society organisations to ensure that these programmes benefit from wider Swiss and international experience in this area. To this end, the federal authorities have been disseminating increasing amounts of information through the internet.

At a more practical policy level, organisations such as the CDS play an important role by bringing together ministers of health at the canton and federal levels. This institution – which is essentially a consultative body – has also taken on more operational roles – for example, by contributing to establishing principles of hospital planning on a canton as well as an inter-canton basis. It has also contributed to the recent construction of health policy platforms aimed at increasing the focus on longer term and foreign policy issues and encouraging strategic thinking at the level of the administration on prevention policies.[11, 12]

While the federal government has significant responsibilities for regulating managed competition, it does not have the levers to drive system-wide improvements. Small and highly decentralised cantonal governments are usually both payers and service providers, which dilutes their incentives to develop highly accountable and responsive arrangements. Swiss health insurers operate in an environment where they are regulated by one level of

government and co-finance hospital inpatient services with another level of government. This constrains their capacity to use their financial influence to drive change.

In such circumstances, measures and institutions to enhance governance through alignment and consensus building appear particularly important for Switzerland. This might be achieved through formal mechanisms such as an overarching framework law for health, as suggested in the 2006 report. Such a law would clearly specify objectives and priorities to ensure that cantons and insurers meet agreed outcomes while recognising diverse approaches on how to meet those, to reflect the diversity in resources, needs and preferences across cantons. Apart from considering an adaptation of the Swiss health constitution (*i.e.* in the form, for example of the framework law on health), the confederation and the cantons are considering institutionalising the existing co-operation and co-ordination between the two levels. But there is still a considerable way to go in determining what should be the most appropriate balance of powers and responsibilities. The national strategy on health care is an important step in this regard. This project is currently led by the permanent platform of the confederation and cantons "National dialog on health policy" (*Dialogue National de la Politique de Santé*) with the objective of optimising co-ordination and definition of responsibilities between cantons and the confederation in a number of domains to be jointly defined. The progress towards a potential Law on Prevention is also an important milestone to develop a common vision for health with a greater emphasis on health promotion. The draft law contains articles on national goals and on disease prevention to be formulated by the federal government in close collaboration with the cantons and NGOs. If passed, this law could come into effect in 2013 at the earliest.

Enabling citizen participation and patient choice

A key strength of the Swiss governance arrangements and democracy is that citizens can, in principle, drive decision making at all levels of government – municipal, cantonal and national – and experience shows that there is a relatively high degree of political involvement. The strongly local and participative nature of civic governance in Switzerland can be seen as a considerable strength in facilitating locally relevant public health solutions. However, citizen participation and patient choice is constrained by poor dissemination of data or lack of evidence. For example, there is only limited data in the public domain on health status, health determinants, health care quality, or on the effectiveness of interventions. Thus, citizen engagement in policy needs to be buttressed by efforts to gather information and inform the general public.

There is a strong emphasis on individual consumer choice when it comes to opting for individual insurers and providers. With regards to providers, consumer choice within a canton focuses on ease of access to care within their community, which may be perceived by the population as a proxy for quality. The widening of consumer choice by allowing individuals to have access to hospital care outside the canton where they live has recently been agreed, although obstacles to completely free movement apparently remain. In the health insurance market, patient choice has started to show up as a force for change with about 15% of the insured changing their insurer in recent years, mostly made up of the young and healthy. However, in the absence of transparent information, widespread competition on the basis of price and quality seems unlikely to happen, and decisions may be influenced by the limited degree of risk adjustment in the insurance market and the scope for "cream skimming" the best risks. In this context, a patient's charter might also help increase the flow of information to all of the parties to the health care system where

it clearly defines the information that should be available to all citizens as well as patient rights and responsibilities.

Health literacy also needs to be strengthened to inform the population. For example, safety and quality issues arising from the risks associated with low volumes of medical interventions or the importance of co-ordination of care for enhanced outcomes. In the absence of such awareness by the population (which supposes that data is translated and made available in a format understandable to the general public), the electorate may contest and reject many important policy proposals. Such interventions include, for instance, closing of small hospitals, consolidation of tertiary or quaternary care services and, introduction of referral systems, as well as strengthening of network and managed care approaches. Currently, patients very often use hospital as their primary entry point for most of their health needs, with the assumption that better care would be provided at secondary or tertiary care services. This reinforces a hospital-centric system.

Similarly, efforts would be needed to bring additional focus on prevention. Despite the increase in the burden of non-communicable disease over time, prevention does not have a high profile from a political point of view and effective prevention methods are often politically controversial *e.g.* behaviour prevention activities.

There are plenty of organisations representing consumers and patients interests, but very little is done to improve the level of awareness of, for example, provider performance in relation to quality of care and inequalities in service access and outcomes. In practice, a range of civil-society organisations aim at counselling and informing patients, providing legal protection where needed and more generally supporting patient interests.[13] While the institution of patients' rights was an area of major achievement in the 1970s, progress in this area has slowed substantially and other countries have by-passed Switzerland in the meantime. Such organisations provide important services at the level of the individual and as co-ordination mechanisms. Yet they are often fragmented and need to be set into a wider framework for health policy. Some efforts are being made in this direction to the extent that the existing prevention policies (*e.g.* AIDS and sexually transmitted disease or substance abuse) have drawn on the experience at the canton level and among the NGO sector to smooth their introduction.

Reach out and build coalitions with other sectors: Health in All Policies

There is increasing understanding that, overall, health outcomes reflects multiple determinants of health which extend across the whole of society. This, combined with the responsibility of governments for improving overall health outcomes, has led to a greater focus on the health impacts of other policies. This has come to be called "Health in All Policies" (HiAP). Many policies relevant to health lie outside the remit of the health ministry. In practice, policies governing most social determinants are the responsibility of non-health sectors or ministries. Policies on agriculture, education, housing, labour, transport, taxation and welfare, for example, shape and affect the social determinants of health and patterns of health inequities in society. Yet the consequences (often unintentional) of other sectors on health subsequently become the responsibility of ministries of health. HiAP therefore involves putting health on society's and government's wider agenda as an asset for development via integrating common objectives, targets and indicators that seek to enhance and sustain health and health equity into the policies of other ministries and sectors.

Such horizontal governance recognises that actors across and outside the government may contribute to policy making on issues for which they have shared responsibility (Philips, 2006). Horizontal governance is also defined as working though networks in place of hierarchies; through interdependence rather than power relationships; negotiation rather than control; and enablement rather than management (Philips, 2004). As described above, many of those features are prominent in the governance of the Swiss health system because they are intrinsically linked to the governance tradition and principles in Switzerland – *i.e.* consensus building. Within the public health sector, a high degree of co-ordination can be observed and some collaboration but there are opportunities for strengthening these further and creating alliances with the private sector.

While the Commission on Social Determinants of Health (WHO CSDH, 2008) considers the reduction of inequity in health as lying at the heart of governance, Switzerland does not seem to accord this a similarly high priority as there is no regular surveillance of health inequalities at the national level. Health inequalities are mostly considered from the limited perspective of equity of access to health care services and the focus is on migrant population and gender. For instance, through the National Programme "Migration and Public Health", the OFSP has been working since 2002 towards strengthening the migrant population's health literacy and developing the public health care system that accords with their needs. Currently, there is a federal strategy on migration and health for the period 2008 to 2013 (see *www.bag.admin.ch/themen/gesundheitspolitik/07685/07688/index.html?lang=fr*). As the OFSP is currently investigating the need for a specific policy to tackle health inequalities in Switzerland, further evidence on the nature and scope of the issue seems likely to be needed.[14]

A number of collaborations with other sectors exist – for example, in the field of urban traffic and spatial development. But while such collaborations are running smoothly on small scale project basis thanks to individual attention and commitment, the programme still remains in an embryonic stage and is not considered a political priority. Decentralisation of responsibilities to the cantonal and communal levels brings an additional layer of complexity when it comes to collaboration with other sectors, such as for instance bringing together actors from 26 health systems and 26 education systems. Horizontal policies pertaining to migrant health and migration of health professions are two exceptions, since intensive collaboration exists between the OFSP and other federal offices (*e.g.* Federal Office for Migration, Federal Office for Statistics, Federal Office for Professional Education and Technology, State Secretariat for Economic Affairs and Federal Office for Spatial Development), that pave the way for outreach to other sectors in other domains.

Transparency, accountability and performance management

As highlighted above, increased public information is essential if the governance capacity of the Swiss health system is to improve. A number of initiatives certainly have gone in the right direction. The authorities – mainly the OFSP, the OFS and the Swiss Health Observatory – have made efforts to improve available data on health in a range of dimensions and to enhance their quality. However, critical information (*e.g.* national registry data for cancer) is not yet available on a consistent basis (legislation is expected in 2012 and registries for other illnesses such as heart attacks and diabetes are also planned – see previous chapters). Geographical variations in quality, prices and cost are thought to be considerable but there is no solid evidence to support this hypothesis. Such

variations ought to be detected, and if confirmed, brought to the public attention for transparency and accountability.

Cantons have multiple – and sometimes conflicting roles in the governance of health care supply. They own and partly finance hospitals, play a planning role and control which hospitals are on the hospital lists and which can, therefore, be (partly) paid by the canton. The multiplicity of roles on the side of the cantons may distort incentives. The new law on hospital financing (*i.e.* payment per case) aims at improving transparency and reducing the potential conflicts between financers and providers.

Governance also needs reinforcement from a move towards greater professionalism and accountability amongst health care providers. Areas requiring particular attention are the development of best practice guidelines, improved disclosures of medical errors and the introduction of clinical governance mechanisms such as peer review processes, internal rewards, and sanctions. Monitoring of the situation in each of these areas is continuing but it is still too early to see any results. In the absence of an empowered national quality agency, cantons as both owners and quality assurers of hospitals could at least in theory be tempted to gloss over deficiencies or to fail to look assiduously for quality shortfalls. This is perhaps particularly at risk if the viability of their local services is under threat, recognising that the public pressure is often towards greater proximity rather than better quality of care.

Similarly, more transparency and accountability of health insurers would be desirable. Once again, some progress has already been achieved. In February 2011, the Federal Council introduced a new law for discussion concerning the health insurance system. This new law foresees, amongst other things, increased controls and more powers to protect the insured and stronger sanctions where the law is broken.

Generating and using evidence for policy

The OECD and WHO 2006 report stressed that governance and associated quality improvements were unlikely to be forthcoming without better statistical information on which to base decision making. But while the competency for data collection and diffusion is in the hands of the confederation, the actual production and collection of data depends on the good will of the cantons to provide the necessary information and continuing efforts to improve data collection is likely to be needed.

An additional factor constraining evidence for informed policy relates to the limited awareness of citizens on health care issues, where relatively weak patient organisations face strong lobbies. As a result, emotional debates continue to drive much of the policy discussion. For instance (and as illustrated above) quality of care is a complicated thing to disseminate and citizens often prefer to judge quality on proximity to care.

Additional governance issues concern whether the scope of services covered by LAMal is well suited to the Swiss burden of disease, and whether these covered services are cost-effective. Currently, all medical *procedures* are automatically covered under LAMal unless specifically excluded following a challenge by health care providers, sickness funds, health authorities or patient organisations as to their effectiveness, appropriateness or efficiency. In contrast, prevention, drugs and laboratory analysis require evaluation before being included in the accepted list. Although the coverage under the positive list is already wide, there remains a medium and longer term need to improve the transparency by putting in place evidence-based procedures for identifying the benefit package and ensuring that the

current coverage is effective and in line with the existing burden of disease. Such issues are of particular importance in a system where health care costs and health premiums are increasing steadily, partly because of the continued introduction of new technology.

While there are clear constraints – both in terms of time and necessary information – methods such as health technology assessment (HTA) are increasingly needed for the evaluation of clinical practice. Such evaluations are needed at the very least for decisions to include new products and interventions in the basic package of LAMal, particularly where new drugs or procedures add substantially to the cost of care. A recent example is, as noted above, the referendum requiring reimbursement of selected areas of alternative medicine under LAMal (anthroposophic medicine, homeopathy, neural therapy, herbal medicine and Chinese traditional medicine), an area where the evidence base on effectiveness is particularly weak. These alternative medicines were included in the benefit package for a limited period of five years under the "coverage with evidence development" scheme available under LAMal for the introduction of new technologies.

Further pressure for HTA also derives from 1999 federal legislation which requires that the cost-efficiency of important federal measures are evaluated in some form (*e.g.* by performance management/controlling, monitoring and/or evaluation). But with no overview of the range of services to be assessed and a lack of incentives for providers and insurance companies, only a fraction of the services covered by mandatory health insurance are evaluated. The Federal Council is committed to establishing an HTA structure and the OFSP is actively involved in international HTA networks (such as the European Network for Health Technology assessment and the International Network of Agencies for Health Technology Assessment), represented either by own staff members or by other national experts. Though, because of the high cost of undertaking HTA and the small size of the country, an international organisation might be given the mandate to perform HTA studies. In the meantime, a Swiss parliamentary commission concluded that the current approach where all medical procedures are automatically covered under LAMal unless challenged by one stakeholder ought to be maintained, but proposed several measures to improve the current process, which are being implemented.[15]

5.5. Looking at health system objectives through the governance lens

Increasing the effectiveness and quality of health provision

The division of responsibilities and different financial flows at the local level also hinders the development of solid networks of care and the organisation of care around patient pathways and across institutional settings (ambulatory care, hospital care and home care). For instance, an increase in hospital expenditures is partly borne by the cantonal budget; while an increase in ambulatory care expenditures is borne by health insurance. Local investments in prevention or home care will not directly benefit the authority which made the investment. Also, the Swiss population seems reluctant to limit its choice of provider and access to health care services. The modest uptake of HMO type is illustrative of this reluctance.

Effectiveness of health care systems also depends on ensuring that the distribution of resources going to health care is in line with the Swiss burden of disease. Mental health is a particular area that illustrates many of the governance related issues in Switzerland. In terms of the prevalence of mental illness, little has changed. Suicide rates in 2008 are the eighth highest in Europe, and above the European average.[16] While the cost of medical

psychotherapy is now covered by the mandatory health insurance from mid-2009, scope for further action at the federal level is probably limited to encouraging interested cantons to create new alliances at the canton level, potentially leading to different policy approaches to this area of morbidity. The current split in competencies impedes the creation of more coherent national policies.

The last survey of Switzerland (OECD and WHO, 2006) emphasized a backlog on countrywide health promotion and clinical prevention strategies along with a lack of evidence on cost effectiveness of interventions to prevent premature mortality and morbidity. Progress has been slow to date. For instance, screening against breast, cervix, colon and other cancers is still left to the discretion of cantons and in effect is not systematically rolled out to cover the respective population groups at risk. National regulation for some fields of health promotion is another area that was recommended for potential improvement in the 2006 review. For instance, smoking bans and increases in tobacco and alcohol taxation have been successfully adopted elsewhere to discourage tobacco and alcohol consumption and this experience lends itself to potential national and inter-cantonal review and collaboration.

As regards quality of care, self-regulation continues to be the main mechanism through which Switzerland has ensured clinical quality and, until recently, efforts at quality improvement have largely reliant on uncoordinated local initiatives led by individual providers, groups or associations. (OECD and WHO, 2006, Box 2.4). Recent Swiss measures in this area are aimed at increasing the transparency and fostering competition on the basis of quality:

- *Regulation/registration of health sector professionals*: one of the first moves away from self regulation has been the creation of a public register comprising all the physicians, chemists, dentists, chiropractors and veterinarians with detailed information about their specialisations. This register is now serving as a means to ensure quality and patient protection by making transparent which canton is responsible for supervision of a particular medical professional. It will also provide further information on health professional demography and progressively integrate all other health professionals.
- *Hospital effectiveness and care quality data* are now being collected on a more systematic basis. Starting from 2009, the OFSP has been publishing case numbers and mortality rates for 30 different diagnosis groups on an aggregate basis. From 2011, these data will be published for individual acute care hospitals. At the same time, the Swiss association for quality measurement (ANQ) is measuring five quality-related variables, within the context of the introduction of the Swiss DRG.[17] The number of indicators where Switzerland provides data in the OECD health care quality indicators project has also increased to around 30, thereby increasing the scope for international bench-marking.[18] Finally, the Federal Council has adopted a patient safety programme, the "National Quality Strategy for Swiss Healthcare".[19]

Thus, the authorities have begun to put in place a national information/intelligence system on the quality of health care and on the responsiveness of the system to patient needs. There have also been some modest developments in collecting data that should permit the authorities to gauge performance better both across cantons and internationally and to identify areas where health outcomes would benefit from further resources. However, this largely relates to the hospital sector and there remains a dearth of information on quality in the ambulatory sector.

Shortfalls in co-ordinating responses to recent public health concerns illustrated gaps in clear mandates for decision making. For example, there was a lack of central level guidance on antiviral coverage levels for different population groups at the initial stages of planning preparedness for a potential influenza pandemic in 2009. This meant that it was left to cantonal health directors to decide, and resulted in different coverage decisions.

Increased efficiency and sustainability

As a share of GDP, health related spending in 2009 for Switzerland was the seventh highest in the OECD area (11.4%). Although this outcome partly reflects the sluggish growth in Swiss GDP rather than rapid growth in health care spending *per se*, it has nonetheless led to levels of health insurance premiums that keep the issue of the cost of the health care system high on the political agenda. Projections of health spending (Vuilleumier *et al.*, 2007) suggest further cost pressure such that health care spending is – depending on the scenario assumptions – estimated to increase further to around 15% of GDP by 2030.

The coexistence of private and public funding sources and providers has enabled the diversification of funding and supply. Insurers and providers still enjoy a fair amount of autonomy through self-governance arrangements; although the federal level has gradually evolved towards tighter oversight on quality of care and registration of health professionals (see above). Concern in this context arises from problems in regulating and managing both the health insurance and provider markets, leading to high administrative costs. In addition, devolved government and autonomous provider and insurer units may tend to give higher priority to their own specific interests than to social and national objectives and this may have further compromised a system that is, in principle, targeted towards improving population health outcomes.

As regards the pricing of care, the TARMED and the Swiss DRG have increased transparency in pricing health care services but continue to encourage increased supply. From the beginning of 2012, the DRG should also encourage hospitals to search efficiency gains (see Chapter 4 for further details). Switzerland may also consider scenarios alternative to the current dual financing of hospitals to increase insurers purchasing power and lessen the risk of cost shifting between ambulatory and inpatient sectors. Moves to other contractual arrangements between insurers and providers through managed care policies may also help in constraining spending (see Chapter 2).

On the supply side, stronger governance will need to address the difficult issue of hospitals planning. In this context, planning would be improved if this also took into account the growing need for housing for the elderly on the one hand and the increased patient choice of provider on the other. From a governance point of view, greater choice in this area should increase patient voice and exit by placing some additional competitive pressure on providers. But it will also mean that the process of hospital planning will become a multi-cantonal and, possibly, a national issue. Cantonal hospital planning should be adapted to new requirements and environment by the end of 2014.

5.6. Conclusion

In sum, this chapter has examined selected governance issues and summarised some areas where the achievement of health system goals might be enhanced through better governance practices. A number of such problems were already raised in the OECD and WHO (2006) report. However, these issues have not changed appreciably since then.

Achieving better governance will also depend on the ability of the Swiss authorities to develop and align health actors around a common vision; which might – as discussed in the last report – be translated into an overarching law for health. In respect to the governance traditions in Switzerland (bottom-up) and the international trends towards new forms of governance (horizontal and participatory), the preferred solution might not be a major shift in responsibilities with substantial re-centralisation. The challenge is to build mechanisms to align health actors so that they strive towards a common vision through better alignment of incentives, increased dialogue, strengthened information systems, improved analytical capacity and accountability and transparency for public health outcomes. In undertaking this, it is important to acknowledge that solutions at the local level will vary depending on the needs, preferences and resources. The law on prevention and the national health strategy project are important milestones in this direction. Further progress could be achieved in mapping and aligning incentives for citizens, providers, municipalities, cantons and insurers. In particular, financial and organisational incentives for prevention and ambulatory care could be revised, *e.g.* through joint responsibilisation at the local level.

Progress towards better governance in this context will continue to be hampered by insufficient data to inform evidence-based decisions. There is only limited data, for example, on health status and determinants, or on health care quality, or other information that is needed for an assessment of system performance.

Policies for health promotion and disease prevention will also need strengthening. While progress has been made in some areas of prevention (*e.g.* the partial smoking bans) and public health programmes to prevent AIDS and substance abuse, the budget for prevention continues to fall due to lack of effective pro-prevention lobbies and strong public support. There remain a number of prevention areas which are cost-effective but have not yet been exploited.

Finally, the authorities will need to slow the growth of health care spending. This should benefit from greater transparency in ambulatory care prices (TARMED) and for hospitalisation (the Swiss DRG) and possibly from greater competition among providers. But cost control will inevitably require reductions in the supply of hospitals, and inter-cantonal collaboration in the area of hospital and residential care is needed. A move towards health care regions or groupings – as suggested in OECD and WHO 2006 – could enhance efficiency of health care supply. In this context, it would appear that a significant number of cross cantonal agreements for care already exist or are under study (CDS, 2009; and information provided by Swiss authorities) raising the potential for cross-cantonal hospital rationalisation in the future.

Notes

1. A wide range of governance concerns can be raised at this level, including: the need to improve system efficiency and effectiveness in view of policy overlaps (for instance federal and cantonal level responsibilities for policies to promote disease prevention), gaps in decision making (and fragmented approaches and attitudes of policy makers across the country as regards the need to improve access to standard quality services and responsiveness to patient needs.
2. See OECD and WHO (2006), Box 2.3 for references.
3. CDS (2009), "Coopération inter-cantonale en soins hospitaliers: Évaluation de l'enquête sur la collaboration inter-cantonale et résumé des caractéristiques de cooperation", CDS website available at *www.gdk-cds.ch/fileadmin/pdf/Aktuelles/Empfehlungen/EM_Spitalplanung_20090514-f.pdf*.

4. There are nearly 2 900 municipalities and in the area of health policy they are largely under the control of the cantons. Given the difficulty in generalising, their role in governance will not be discussed further.
5. Including high-tech medicine, pharmaceuticals and para-medical and post-graduate education.
6. *www.telegraph.co.uk/news/1435383/How-direct-democracy-makes-Switzerland-a-better-place.html*.
7. See Kocher (2009), Table 5. Key health sector areas where the influence of the state is limited include: ambulatory care of all kinds; hospitals and medical homes, laboratories, radiology clinics, pharmacies and pharmaceutical producers, complementary insurance, research.
8. For example, Braun and Uhlmann (2009) argue that the introduction of the LAMal in 1996 was the result of a very peculiar configuration of political parties which is not likely to be replicated.
9. One key novelty in the present legislation is that the goals would be specified every eight years with a "road map" of how to meet the goals laid out every four years.
10. Indeed, spending on prevention has tended to fall and the funding for prevention was reduced by an additional 8% in the most recent spending cuts.
11. In this context, an intranet platform has recently been introduced for health related issues, within the administration. This platform allows the exchange and joint storage of information and the elaboration and consultation of negotiation positions *e.g.* on major global health negotiations. The platform has been integrated into the general intranet platform CHa WORLD of the Federal Department of Foreign Affairs which is in use across the entire administration for the majority of foreign policy issues.
12. In addition, the Swiss National Dialogue on Health ("Dialogue Politique National Suisse de la Santé") permits the cantons and the confederation to debate periodically key challenges facing and to co-ordinate their action. For a list of subjects discussed in this forum see *www.nationalegesundheit.ch/%20fr/projets/themes-traites/index.html*.
13. For example, the *Patientenstelle* and the *Organisation Suisse des Patients et Assurés* informs patients, organises their protection and represents their rights where needed. At the level of individual illnesses, the "leagues" (*e.g.* for cancer) provide primary and secondary prevention services and where private resources are available, they can also provide support for research. There are also networks of NGOs providing support for groups such as the immigrant population as well as self help groups for individuals suffering from specific illnesses or medical conditions. Certain of these groups are totally or partly financed by governments, with the exception of those representing patient in legal conflicts and where there is a risk of conflict of interest.
14. Studies from the Swiss National Cohort show a systematic gap between level of education and mortality rates.
15. "Détermination et contrôle des prestations médicales dans l'assurance obligatoire des soins", Rapport du Contrôle Parlementaire de l'Administration à l'attention de la Commission de Gestion du Conseil National du 21 août 2008.
16. The number of psychiatric in-patient and out-patient treatments in Switzerland has continued to increase for a number of years. Nevertheless, there are people, in particular the socially disadvantaged, whose mental problems are not being treated (*www.obsan.admin.ch/bfs/obsan/en/index/02.html*).
17. The dimensions are rehospitalisation rates, reoperation rates, surgical site infection rates, falls, ulcers and patient satisfaction. These are intended to ensure that the use of DRGs does not have a negative effect on health care quality at the hospital level.
18. This is having knock-on effects with a number of hospitals now collecting information that goes beyond the data series just mentioned (Switzerland, questionnaire replies).
19. For further information on the quality programme see *www.bag.admin.ch/themen/krankenversicherung/00300/00304/index.html?lang=fr*.

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Acronyms

AVS-AI	Assurance Vieillesse – Assurance Invalidité (Old-Age Pensions, Disability Insurance)
AI	Assurance Invalidité (Disability Insurance)
AM	Assurance Maladie (Sickness Insurance)
AP-DRG	All-patients Diagnosis-related Group Classification
BMI	Body Mass Index
CDS	Conférence des Directeurs et Directrices Cantonaux de la Santé (Conference of the Cantonal Ministers of Public Health)
DALY	Disability Adjusted Life Years
DRG	Diagnosis-related Group
EU	European Union
FINMA	Autorité Fédérale de Surveillance des Marchés Financiers (Swiss Financial Market Supervisory Authority)
FMH	Fédération des médecins suisses (Swiss Medical Association)
GDP	Gross Domestic Product
HMO	Health Maintenance Organisation
HTA	Health Technology Assessment
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 Fédérale 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)
LPMed	Law on University-based Medical Professions
OFS	Office Fédéral de la Statistique (Federal Office of Statistics)
OFAP	Office Fédéral des Assurances Privées (Federal Office of Private Insurance)
OFAS	Office Fédéral des Assurances Sociales (Federal Office for Social Security)
OFSP	Office Fédéral de la Santé Publique (Federal Office of Public Health)
PPO	Preferred Provider Organisation
PPP	Purchasing Power Parity
RBP	Rémunération Basée sur les Prestations (Fee-for-Service)
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 Organization

Canton Abbreviations

CH	Schweiz/Switzerland
AI	Appenzell Innerrhoden/Appenzell Inner-Rhodes
AR	Appenzell Ausserrhoden/Appenzell Outer-Rhodes
AG	Aargau
BE	Bern
BL	Basel-Landschaft/Basel-Land
BS	Basel-Stadt/Basel-City
FR	Freibourg/Fribourg
GE	Geneva
GL	Glarus
GR	Graubünden
JU	Jura
LU	Luzern/Lucerne
NE	Neuenburg/Neuchâtel
NW	Nidwalden
OW	Obwalden
SG	St. Gallen
SH	Schaffhausen
SO	Solothurn
SZ	Schwyz
TG	Thurgau
TI	Ticino/Tessin
UR	Uri
VD	Waadt/Vaud
VS	Wallis/Valais
ZG	Zug
ZH	Zürich/Zurich

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

The OECD is a unique forum where governments work together to address the economic, social and environmental challenges of globalisation. The OECD is also at the forefront of efforts to understand and to help governments respond to new developments and concerns, such as corporate governance, the information economy and the challenges of an ageing population. The Organisation provides a setting where governments can compare policy experiences, seek answers to common problems, identify good practice and work to co-ordinate domestic and international policies.

The OECD member countries are: Australia, Austria, Belgium, Canada, Chile, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. The European Union takes part in the work of the OECD.

OECD Publishing disseminates widely the results of the Organisation's statistics gathering and research on economic, social and environmental issues, as well as the conventions, guidelines and standards agreed by its members.

WORLD HEALTH ORGANIZATION

The World Health Organization was established in 1948 as a specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health, a responsibility that it fulfils in part through its extensive programme of publications.

The Organization seeks through its publications to support national health strategies and address the most pressing public health concerns of populations around the world. To respond to the needs of Member States at all levels of development, WHO publishes practical manuals, handbooks and training material for specific categories of health workers; internationally applicable guidelines and standards; reviews and analyses of health policies, programmes and research; and state-of-the-art consensus reports that offer technical advice and recommendations for decision-makers. These books are closely tied to the Organization's priority activities, encompassing disease prevention and control, the development of equitable health systems based on primary health care, and health promotion for individuals and communities. Progress towards better health for all also demands the global dissemination and exchange of information that draws on the knowledge and experience of all WHO's Member countries and the collaboration of world leaders in public health and the biomedical sciences.

To ensure the widest possible availability of authoritative information and guidance on health matters, WHO secures the broad international distribution of its publications and encourages their translation and adaptation. By helping to promote and protect health and prevent and control disease throughout the world, WHO's books contribute to achieving the Organization's principal objective – the attainment by all people of the highest possible level of health.

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