Health Systems in Transition

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Switzerland:

Summary 2015

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Abstract

This analysis of the Swiss health system reviews recent developments in organization and governance, health financing, health care provision, health reforms and health system performance.

The Swiss health system is highly complex, combining aspects of managed competition and "corporatism" (the integration of interest groups in the policy process) in a decentralized regulatory framework shaped by the influences of direct democracy. The health system performs very well with regard to a broad range of indicators. Life expectancy in Switzerland (82.8 years) is the highest in Europe after Iceland, and healthy life expectancy is several years above the European Union (EU) average. Coverage is ensured through mandatory health insurance (MHI), with subsidies for people on low incomes. The system offers a high degree of choice and direct access to all levels of care with virtually no waiting times, though managed care type insurance plans that include gatekeeping restrictions are becoming increasingly important. Public satisfaction with the system is high and quality is generally viewed to be good or very good.

Reforms since the year 2000 have improved the MHI system, changed the financing of hospitals, strengthened regulations in the area of pharmaceuticals and the control of epidemics, and harmonized regulation of human resources across the country. In addition, there has been a slow (and not always linear) process towards more centralization of national health policy-making.

Nevertheless, a number of challenges remain. The costs of the health care system are well above the EU average, in particular in absolute terms but also as a percentage of gross domestic product (GDP) (11.5%). MHI premiums have increased more quickly than incomes since 2003. By European standards, the share of out-of-pocket payments is exceptionally high at 26% of total health expenditure (compared to the EU average of 16%). Low- and middle-income households contribute a greater share of their income to the financing of the health system than higher-income households. Flawed financial incentives exist at different levels of the health system, potentially distorting the allocation of resources to different providers. Furthermore, the system remains highly fragmented as regards both organization and planning as well as health care provision.

European Observatory on Health Systems and Policies
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Summary

Switzerland

1 Introduction

Switzerland is a small Alpine country, with a population of about 8.1 million people and four official languages (German, French, Italian and Romansh). Switzerland has a highly decentralized administrative and political structure, organized around three levels of government: the federal level (the "Confederation"), 26 cantons and 2352 municipalities. The country has a unique political system, arguably the closest in the world to a direct democracy with almost all issues of importance being decided upon through public referendum.

Switzerland is a wealthy country; its GDP per head is among the highest in Europe, and indeed the world. It attracts highly skilled migrants (principally from other OECD countries), leading to a particularly high proportion (27%) of foreign-born nationals living in the country. Switzerland has a thriving financial sector and is one of the world's top 20 exporters specializing in chemicals and high-technology products. It is home to many of the world's major international organizations, including the World Health Organization (WHO).

Like many western European countries, Switzerland faces an ageing population, with the ratio of older people to people of working age having risen to 26.1 per 100 (although this is still below the EU average of 28.1). Both life expectancy and healthy life expectancy are among the highest in Europe and well above the averages for the EU. Although life expectancy is higher for women (84.9 years compared to 80.7 for men), unlike for the EU, Swiss women have fewer healthy life years to look forward to than men (67.6 compared to 68.6). Similarly to many of its neighbours, Switzerland's two most important causes of mortality are cardiovascular diseases (CVD) and cancers, despite drops in mortality rates for both in recent decades. The incidence of some infectious diseases, including for HIV, is higher in Switzerland than the EU average.

Table 1
Key population, economic and health indicators of Switzerland, 1995 to 2013 (selected years)

	1995	2000	2005	2010	2013	EU average (2013)
Total population (in million)	7.0	7.2	7.4	7.8	8.1	506.8
Population aged 65 and above (% of total)	14.7	15.9	15.8	16.9	17.4	17.82
GDP per capita, in thousands Int USD (Purchasing Power Parity)	28,9	34.5	39.2	51.3	56.9	35.3
Public (Central Government) debt, total (% of GDP)	21.4	n/a	40.5	23.8	n/a	n/a
Life expectancy at birth, total	78.4	79.7	81.2	82.3	82.8	80.5
Infant mortality rate	5.2	4.6	4.3	3.8	3.7*	3.9
Under-five mortality rate	6.4	5.6	5.1	4.5	4.3*	4.7
Maternal mortality rate	8.5	6.4	5.5	3.7	8.5*	5.1
DALY	n/a	70.1	n/a	n/a	72.3	70.4

Source: Worldbank 2015, WHO HFA 2015, Eurostat 2015a.
Note: *are 2012 data.

2 Organization and Governance

The Swiss health system is highly complex, combining aspects of managed competition and "corporatism" (the integration of interest groups in the policy process) in a decentralized regulatory framework shaped by the influences of direct democracy. This explains the sharing (and some would say fragmentation) of decision-making powers between:

(1) the three different levels of government (the federal level, the cantons, and for social services the municipalities);

(2) recognized civil society organizations ("corporatist bodies"), such as associations of health insurers and health care providers; and

(3) the Swiss people, who can veto or demand reform through public referenda.

Figure 1 gives an overview of the Swiss health system. The federal setup of the country gives all power to the cantons except in areas where the constitution has explicitly assigned competences to the federal level. Historically, the federal level had very little legislative power in the area of health. This led to the emergence of different patterns of financing and health care provision across the country. Today, as the result of a slow but steady process of greater centralization over recent decades, the federal level plays an important role in regulating most areas of the health system, including:

(1) the financing of the system (mandatory health insurance (MHI) and other social insurances);

(2) the quality and safety of pharmaceuticals and medical devices;

(3) public health (control of infectious diseases, food safety, some areas of health promotion); and

(4) research and training (tertiary education, training of non-physician health professionals).

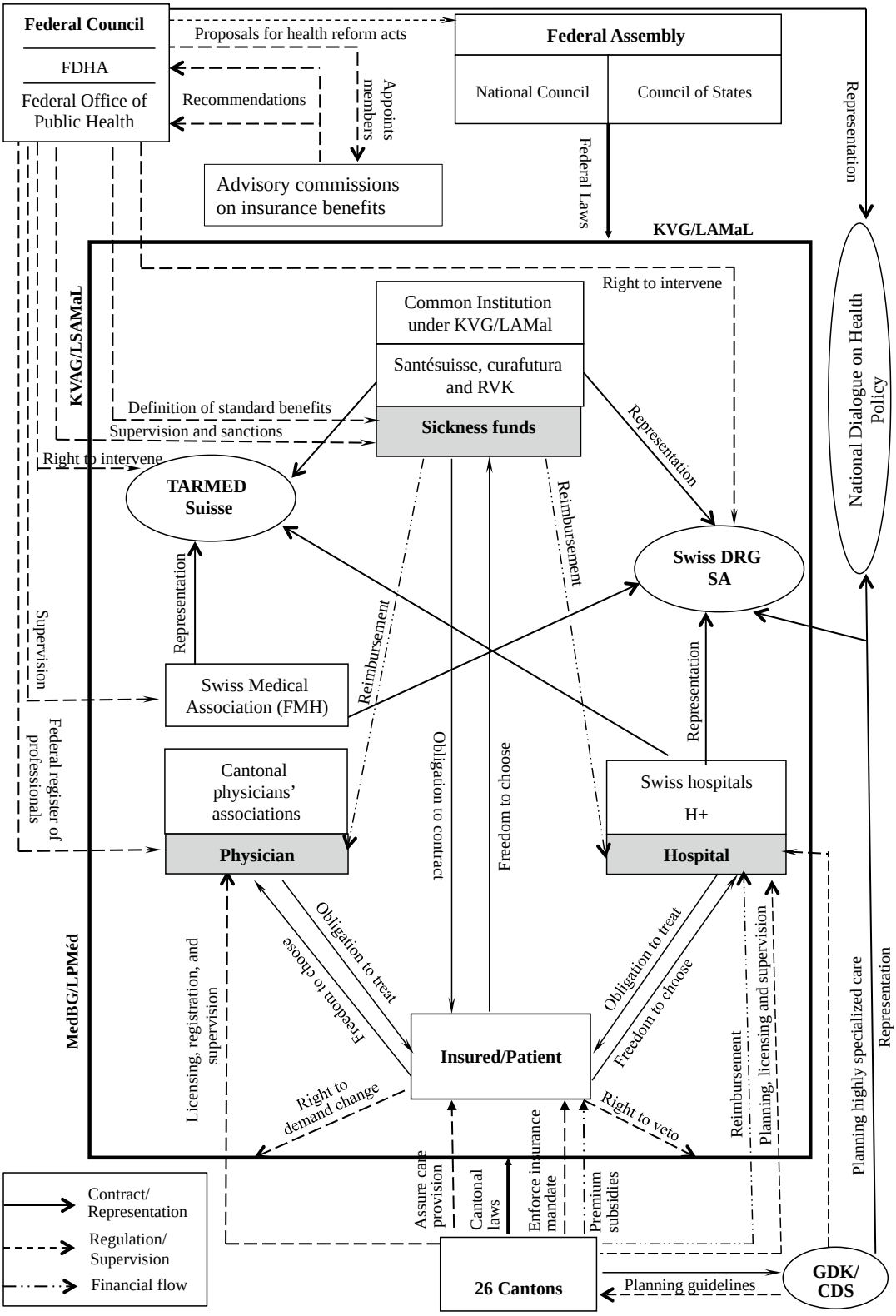
Switzerland ensures access to health care through a system of MHI, which has been compulsory for all residents since 1996 (although some cantons had compulsory insurance as early as 1914). Citizens who want to purchase MHI cannot be turned down by insurers, and cantons provide subsidies for people on low incomes (although the nature and level of these vary widely by canton). The standard benefits package is regulated by federal legislation and includes most general practitioner (GP) and specialist services, as well as inpatient care and services provided by other health professionals if prescribed by a physician.

Cantons are responsible for securing health care provision for their populations, although they may also include hospitals from other cantons on their lists of providers, and they finance about half of inpatient care. Cantons are also in charge of issuing and implementing a large proportion of health-related legislation, and they carry out prevention and health promotion activities. In order to coordinate their activities, in particular for highly specialized medical care, the cantons work together in the Conference of the Cantonal Ministers of Public Health (GDK/CDS).

Corporatist actors, in particular associations of MHI companies and providers (associations of physicians and hospitals) play an important role in the Swiss health system. They are charged with determining tariffs for the reimbursement of services, they negotiate contracts and they oversee their members at the cantonal level.

Popular initiatives and referenda have a pervasive influence in shaping health policy-making. Certain reforms of the health care system require a positive referendum by the Swiss population, in particular when concerning the reallocation of responsibilities between the three levels of governance. In addition, popular initiatives often drive legislative activity, responding to citizens' demands for change.

Figure 1
Organisation of the Swiss health system



Source: Authors' own compilation.
Notes: FDHA = Federal Department of Home Affairs; GDK/CDS = Conference of the Cantonal Ministers of Public HealthM; KVG/LAMal = Federal Health Insurance Law; KVAG/LSAMal = Federal Law on the Supervision of MHI; MedBG/LPMéd = Law on Medical Professions.

3 Financing

In 2013, total health expenditure (THE) in Switzerland was 11.5% of GDP, one of the highest shares in Europe and well above the EU average of 9.5%. In Europe, only the Netherlands and France spent an even larger proportion of GDP on health. When looking at per capita spending on health, Switzerland spends US$ 6187 (when measured in purchasing power parities, PPP) approaching double the EU average of US$ 3379; in Europe, only Luxembourg and Norway spend more.

Table 2
Trends in health expenditure in country, 1995 to latest available year (selected years)

	1995	2000	2005	2010	2013	EU average (2013)
Total health expenditure per capita in Int USD (Purchasing Power Parity)	2567.8	3233.9	4027.3	5319.1	6186.7	3378.5
Total health expenditure as % of GDP	9.3	9.9	10.9	10.9	11.5	9.5
Public expenditure on health as % of total expenditure on health (WHO estimates)	53.6	55.4	59.5	65.2	66.0	76.0
Private expenditure on health as % of total expenditure on health	n/a	n/a	n/a	34.8	33.2	16.2
General government expenditure on health as % of general government expenditure	n/a	14.4	15.4	21.0	22.1	15.2
Government health spending as % of GDP*	5.00	5.49	6.46	7.12	7.57	n/a
OOP payments as % of total expenditure on health	33.1	32.9	30.6	25.1	25.9	16.1
OOP payments as % of private expenditure on health	71.3	74.0	75.6	72.3	76.1	66.3
Private insurance as % of private expenditure on health*	26.65	23.81	22.16	24.88	21.03	n/a

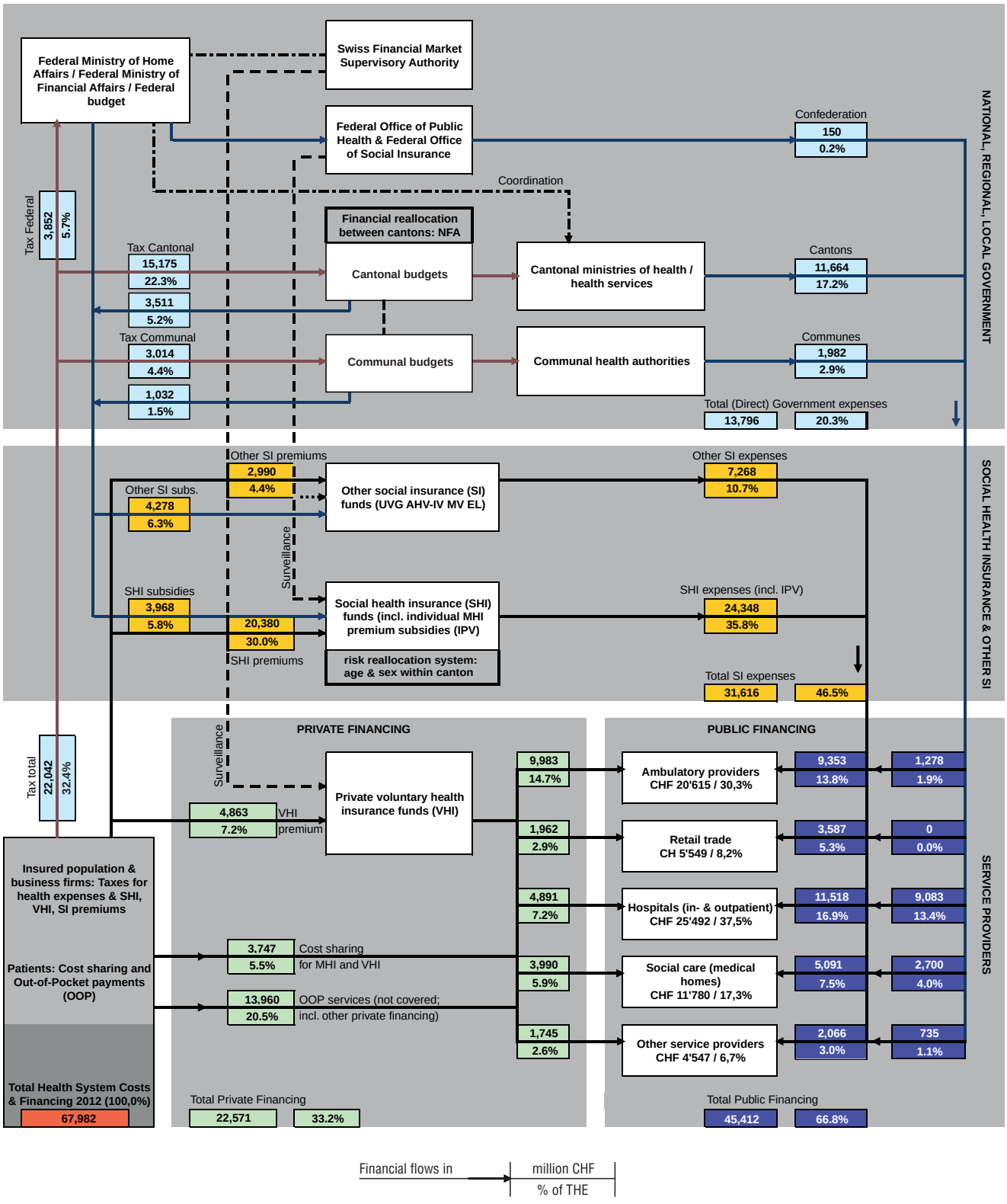
Source: WHO Regional Office for Europe (2015), *WHO (2015)

Financial flows are fragmented and split between different government levels and different social insurance schemes (see Figure 2). Resources are collected mostly through taxes (32.4% of THE in 2012) and MHI premiums (30.0% of THE) but a considerable part of tax resources are subsequently allocated to the different social insurance schemes, in particular as subsidies to lower- and lower middle-income households for the purchase of MHI. As a result of this reallocation, MHI companies are the largest purchasers and payers in the system, financing 35.8% of THE. The next largest components are out-of-pocket (OOP) payments, amounting to 26.0% of THE, and government spending (mostly from the cantons) covering 20.3% of THE. By European standards, the share of public spending is relatively low at 66% of THE (compared to the EU average of 76%), while the share of OOP payments is exceptionally high at 26% of THE (compared to the EU average of 16%) (see Table 2). Private financing is the main source of funding for dental care, and is also substantial in ambulatory care and long-term institutional care; public financing is predominant for hospital services.

MHI premiums are community-rated, i.e. they are the same for every person enrolled with a particular insurance company within a given region (meaning a canton or part of a canton) independent of gender or health status. Progressively higher premiums apply to three different age classes: (1) from 0 to less than 19 years; (2) from 19 to less than 26 years; (3) 26 years and above. In 2012, 29% of the Swiss population had to pay a reduced premium only, or no premium at all. MHI premiums are collected by MHI companies and are subsequently reallocated between the MHI companies, based on an increasingly refined risk-equalization mechanism that takes account of age, gender, prior hospitalization and (from 2017) pharmaceutical expenditure. Additional voluntary health insurance (VHI) plays a rather small and declining role, financing about 7.2% of THE in 2012.

MHI companies offer different types of MHI policy, which vary with regard to the size of deductible (the amount that people have to pay themselves before their MHI coverage kicks in) and restrictions on their choice of provider. The minimum annual deductible is Sw.fr.300 (around €275) for adults, while the maximum deductible is Sw.fr.2500 (around €2300). In addition, a 10% co-payment rate applies to all services (which can not be covered by voluntary insurance). However, total user charges (deductible plus co-payment) are capped at Sw.fr.1000 (around €920) or Sw.fr.3200 (around €2945), depending on the size of deductible chosen. Insurance plans with some restriction of choice of provider (e.g. managed care-style insurance) have gradually become the dominant form of insurance in Switzerland, with more than 60% of insured opting for these plans in 2013; this proportion was below 10% in 2003. MHI cannot be profit-making, but the same companies may also offer VHI, which is allowed to make profits; many MHI companies offer such products as well.

Figure 2
Financial flows in the Swiss health care system, 2012 (in million CHF)



Source: Authors' own compilation based on FSO (2014).

Fee-for-service is the dominant method of provider payment in Switzerland. The tariffs for ambulatory care and, since 2012, also for acute inpatient care, are based on national frameworks developed jointly by associations of insurers and providers. For inpatient rehabilitation and inpatient psychiatry, work on developing national tariff frameworks is ongoing. For long-term care, MHI pays a contribution that depends on the care needs of the patient; the patient pays a contribution capped at 20% of the MHI contribution; and the canton covers the remaining costs.

4 Physical and human resources

There are 293 hospitals in Switzerland, which can vary greatly in size from those with 2–3 beds to more than 2000 beds. On average, hospitals are rather small when compared with other countries, but the number of hospitals per population is comparatively high. About 21% of hospitals are publicly owned and managed either as part of the administration or as public companies; 25% are run by a non-profit organization, which can be a foundation, an association or a cooperative; and more than half of all hospitals are privately owned (including stock companies, limited liability companies and individuals). Nevertheless, almost two thirds (about 65%) of all beds are in public or non-profit hospitals.

The number of acute care hospitals decreased by about 50% between 2000 and 2013 and the number of beds in acute care hospitals was reduced by about 20% over the same period of time. There were 2.9 beds in acute care hospitals per 1000 people in Switzerland in 2013, which was below the EU average of 3.6 beds per 1000 people. Average length of stay in acute care hospitals fell by 37% since 2000 to 5.9 days in 2013, which was also below the EU average of 6.3 days.

Owners of health care institutions are responsible for managing capital investments and, since the introduction of payment based on diagnosis-related groups in 2012, hospital investments are – at least in theory – also financed from revenues received for services. However, cantons sometimes still have dedicated budgets for investment as they did before the introduction of this system. Switzerland also has one of the highest densities of medical imaging technologies in Europe, alhough this varies considerably across cantons.

The number of physicians and nurses has increased relatively strongly over the past two decades, while the number of dentists, pharmacists and midwives has remained more or less stable. With 4.1 physicians and 17.7 nurses (including midwives) per 1000 people in 2013, Switzerland had the highest number of nurses and the second highest combined number of physicians and nurses in the entire European Region after Monaco; for comparison, the EU averages are 3.5 physicians and 9.1 nurses per 1000 people. In contrast, the number of dentists, pharmacists and midwifes per 1000 people are low in comparison to EU averages. The composition of the medical workforce is changing noticeably, with older male physicians being increasingly replaced by younger female physicians. There is a high reliance on foreign-trained health workers; almost 30% of all active physicians in Switzerland held a diploma from a foreign medical university in 2013, mostly from Germany.

Table 3
Selected health care resources per 1000 population and health care utilization, 1995 to 2013 (selected years)

	1995	2000	2005	2010	2013	EU average (2013)
Acute care hospital beds	n/a	4.11	3.65	3.13	2.91	3.6
Average length of stay, acute care hospitals only	12.0	9.3	8.5	6.6	5.9	6.34
Bed occupancy rate (%), acute care hospitals only	n/a	84.8	86.1	89.1	83.6	76.6*
Physicians	n/a	2.4	2.71	2.96	3.3	3.5
Nurses	n/a	13.2	14.3	16.3	17.7	8.5

Source: WHO Regional Office for Europe (2015).
Note: *are 2012 data.

5 Provision of Services

Responsibilities for the legislation, implementation and supervision of public health services are split between the federal level and the cantons. Consequently, public health activities are not well coordinated and vary greatly across cantons.

Ambulatory care is provided mostly by self-employed physicians working in independent single practices offering both primary care and specialized care. In general, patients have a very large degree of freedom concerning choice of physician and hospital. Easy access to all levels of care, including inpatient care, without need for a referral, has been a key characteristic of the Swiss health care system. However, the past decade has seen a rise in physician networks and health maintenance organizations (HMOs), which contract with insurers to provide care. In 2012, about 20.8% of all insured were estimated to be insured by either an HMO plan or a physician network plan. Such plans include gatekeeping by a GP.

Acute care hospitals provide inpatient care and play an increasingly important role for the provision of ambulatory and day care services. Traditionally, choice of hospital was somewhat restricted by cantonal borders. However, since the implementation of a hospital financing reform in 2012, patients can choose any hospital located outside the canton of residence as long as the hospital is included on the hospital list of the canton of treatment. Nevertheless, reimbursement follows the rules of the canton of residence, which means that it is limited to the level of costs that would have had to be paid if the patient had been treated in the canton of residence.

Cantons are responsible for the organization of long-term care, rehabilitation care, palliative care and psychiatric care, but may delegate responsibility to municipalities. In addition, informal carers play a substantial role; about 4.7% of the population are estimated to provide informal help on a daily basis, and an additional 9.6% are estimated to provide informal help about once a week. Better integration of care across different institutions and providers has been under discussion for some years, especially for mental health care activities, but progress in this direction remains limited.

Expenditure on pharmaceuticals was €652 per head in 2012 – the highest of all European countries for which data are available. Considerable efforts have been made in recent years to reduce the relatively high retail prices in Switzerland and to increase the use of generics. The market share of generics as a proportion of all reimbursed pharmaceuticals in terms of volume rose from 6.1% in the year 2000 to 23.9% in 2013, but remains far below the share of generics in other countries, such as Germany (78.2% in 2012) or Austria (48.5% in 2012). A Swiss particularity is that pharmaceuticals are not only distributed by pharmacies but – in some cantons – also by so-called self-dispensing doctors, who sell about 24% of all sold pharmaceuticals in Switzerland (in terms of value) through their in-practice pharmacies.

6 Principal Health Reforms

Since the year 2000, numerous reforms have been made, which have optimized the MHI system, changed the financing of hospitals, improved regulations in the area of pharmaceuticals, strengthened the control of epidemics, and harmonized regulation of human resources across the country. As KVG/LAMal is the most important federal law outlining the basic characteristics of the health system, most reforms are, in fact, revisions of KVG/LAMal and the related ordinances (see Table 4 for an overview).

Making health reforms in Switzerland is difficult as a broad consensus of the main stakeholders is required. Reaching such a consensus is complicated, sometimes impossible, and almost always takes a very long time. Yet, the complex political and institutional structure of the country is very successful at negotiating compromises that are supported (or at least not opposed) by all relevant stakeholders. This leads to lengthy reform processes but also to solid reforms, which are – once implemented – almost never reversed. This characteristic feature of policy-making in Switzerland is also supported by a high degree of political and personal continuity within political institutions.

One important trend across all reforms since 2000 (and even before that) has been a tendency towards more harmonization of national health policy-making. Many reforms have strengthened the role of the federal government, which has obtained more influence over hospital inpatient care provision, insurance supervision and public health. In addition, cantons are increasingly coordinating their activities, and this has led to a stronger role for the Conference of the Cantonal Ministers of Public Health, in particular in the area of highly specialized medical care. Nevertheless, reforms strengthening the federal level are often highly contested as cantons are reluctant to allow more federal intervention in health care, as they perceive this to be one of their core areas of responsibility; other stakeholders exploit and support this cantonal attitude. A consensus seems to be emerging that a greater role for the federal level is necessary, at least for coordination of activities. Most current reform proposals confirm this trend towards more influence for the federal level, although the constitutional distribution of competences will likely remain untouched.

Future reforms are guided by the federal government's Health 2020 strategy paper, which outlines the reform priorities for the coming years. Three particularly important areas of reform are: (1) improving the use of information; (2) improving planning of ambulatory care; and (3) improving health care provision for people with specific needs. Given the lengthy process of making health reforms, most of these areas have already been on the political agenda for quite some time, but it will still be several years before institutional or legislative changes materialize.

Table 4
Major health reforms and other significant development in the health system, 2000–2014

Reforms of the hospital sector	Contents	Year passed	Year implemented
Hospital Financing Reform (Revision of KVG/LAMal)	Adoption of Swiss DRGs for payment of inpatient care. Co-funding of inpatient care by cantons (55%) and Insurers (45%). Inter-cantonal portability of the insurance coverage for inpatient care (with limitations). Inter-cantonal hospital planning for the highly specialised medicine.	2007	2012
Inter-Cantonal Agreement on Highly Specialised Medical Services	Organisation of the inter-cantonal planning of the highly specialized medicine	2008	since 1.1.2009
Creation of the National Association for Quality Improvement in Hospitals and Clinics (ANQ)	Hospitals, cantons, and insurers agree on merging two previously existing quality initiatives into one national association.		2009
Adoption of the «Zurich model» of hospital planning by most cantons	The Zurich model defines groups of hospital services and specifies quality criteria that hospitals have to fulfil in order to be allowed to provide these services.		2015
Reforms of the MHI system	**Contents**	**Year passed**	**Year implemented**
Parliamentary rejection of the second revision of KVG/LAMal	The reform package included different measures concerning risk-adjustment, long-term care financing, hospital financing, and better coordination of care across providers.	Rejected in 2003	–
New Federal Law on Fiscal Equalisation (FiLaG/PFCC)	The system of co-financing of premium subsidies by the federal government and cantons was changed.	2003	2005
Improvement of risk adjustment (Revision of KVG/LAMal)	The criterion of "hospitalization of three or more days in the previous year" has been added to the previous age and sex.	2007	2012
Parliamentary approval of Managed Care Reform Law (Revision of KVG/LAMal)	The proposed reform aimed to improve the coordination of care across providers by promoting and financially incentivizing insurance contracts, where patients agree to a restriction of choice in exchange for lower premiums.	2011, Rejected by popular referendum in 2012	–
Improvement of risk adjustment (Revision of KVG/LAMal)	The criterion of "expenditures for pharmaceuticals exceeding CHF5 000 in the previous year reimbursed by the MHI" has been added to previous criteria.	2014	2017
Federal Law on the Supervision of MHI (KVAG/LSAMal)	Stronger monitoring by the FOPH of premiums proposed by insurers. Clearer separation between the MHI and the voluntary health insurance schemes issued by the same insurer.	2014	To be determined by the Federal Council
Popular initiative "For a Public Sickness Fund" rejected in referendum	The initiative proposed to replace the multiple competing MHI companies with a single, public sickness fund.	September 2014	–
Reforms in public health	**Contents**	**Year passed**	**Year implemented**
Establishment of the foundation "Health Promotion Switzerland"	Cantons and insurers create the foundation to promote the coordination and evaluation of prevention activities.		1989
Federal Law on the Prevention of Passive Smoking	Indoor smoking ban in public buildings or workplaces, including public administrative buildings, hospitals, restaurants, public transport, etc.	2008	2010
Parliamentary rejection of the proposed Federal Law on Disease Prevention and Health Promotion	The proposal aimed at better coordination of prevention activities and a stronger role for the Confederation.	Rejected in 2012	–
Revision of the Epidemics Act (EpG/LEp)	Improvement of early detection and effective action in a crisis. Development of national programs in the area of antibiotic resistance and hospital-acquired infections. Clarification and restriction of the situations in which cantons can introduce mandatory vaccination.	2012 Confirmed by popular referendum in 2013	2016
Other reforms	**Contents**	**Year passed**	**Year implemented**
Federal Law on Therapeutic Products (HMG/LPTh)	Harmonization of the procedures for marketing authorization and surveillance of pharmaceuticals and medical devices, establishment of Swissmedic.	2000	2002
Establishment of the foundation Patient Safety Switzerland	The federal government, the SAMW/ASSM and many professional associations create the foundation with the aim of improving patient safety.	2003	2004
Federal Law on University Medical Professions (MedBG/LPMéd)	New harmonized regulation of university education and professional practice of medical doctors, dentists, pharmacists, chiropractors, and veterinary surgeons.	2006	2007

Creation of the Swiss Medical Board	Canton of Zurich creates the Medical Board with the aim of promoting HTA and economic evaluations. The organisation was joined by the GDK/CDS in 2009, and by FMH and SAMW/ASSM in 2010.		2008
Federal Law on new long-term care financing arrangements	Clearer responsibilities of MHI insurers, cantons, other social insurance, and patients and their families. Equal reimbursement for services provided by public and private home care organisations.	2008	2011 (2011–2013 transition period)
Federal law on psychological professions (PsyG/LPsy)	Regulation of university education and professional practice of psychologists.	2011	2013
New article on primary care added to the Federal Constitution (Art. 117a)	The new article assigns co-responsibility to the Confederation and the cantons for providing the entire population with high quality primary care, as well as for promoting family medicine. For the first time the Swiss Constitution provides for an explicit right to health care and for a federal role in health care provision.	2013 Confirmed by popular referendum in 2014	2014

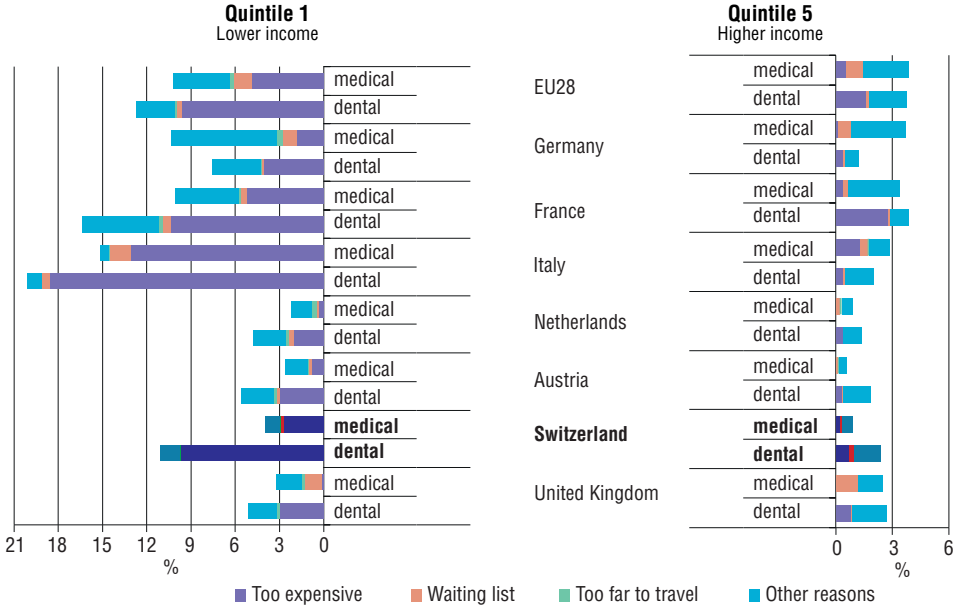
Source: Authors' own compilation

7 Assessment of the Health System

Population health indicators are very good in Switzerland. Patients are highly satisfied with the health system, perceive quality to be good or very good, and there are virtually no waiting times. Avoidable hospital admissions are relatively low and OECD quality indicators confirm that health care quality is high – although not exceptional.

Nevertheless, there is room for improvement, in particular concerning the health care financing system. Financial protection of Swiss households from the costs of medical care is good – and better than in many European countries when all forms of social protection are taken into account. However, the very high share of OOP payments – related to the exclusion of certain services from coverage (notably dental care) and to the relatively high user charges – means that financial protection is more limited than, for example, in Austria, Germany or the Netherlands. Surveys indicate that almost 3% of the poorest income quintile have an unmet need for medical examination or treatment because of costs – a share that is considerably higher than in Austria, Germany or the Netherlands (see Figure 3).

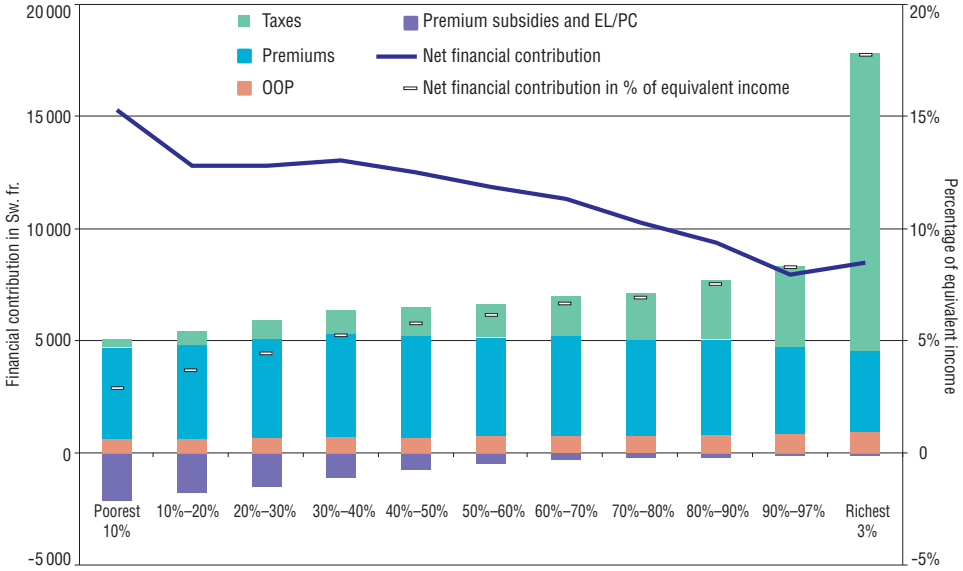
Figure 3
Unmet needs for medical or dental examination or treatment by income quintile and type of reason, 2013



Source: Eurostat, 2015b.

Low income households contribute a greater share of their income to the financing of the health system than higher income households (as shown in Figure 4). In addition, individuals and households at the same level of income often contribute very different shares of their income depending on their place of residence. The cantonal mechanisms of premium subsidies do not sufficiently reduce the financial burden on lower-income households and they contribute to the variation in financial burden depending on the place of residence.

Figure 4
Financial contributions to health of different income groups by type of contribution and in percent of equivalent income, 2010



Source: Ecoplan (2013), with modifications.

In view of escalating costs, it is very likely that resources could be used more efficiently. Research indicates that the variation in expenditures across cantons is at least partially related to supplier-induced demand, resulting from flawed incentives of (unlimited) fee-for-service reimbursement, subsidized hospital investments and fragmentation of provision. So far, there is limited use of independent health technology assessments (HTA) to inform coverage decisions and to limit expenditures on existing and new services of uncertain benefit. The use of medical guidelines could be strengthened to help professionals "choose wisely" when examining and treating patients.

In addition, the large number and the small size of hospitals in Switzerland implies that there is considerable room for efficiency improvement by exploiting economies of scale. Furthermore, prices of pharmaceuticals remain higher than in Austria, the Netherlands or France, while the share of generics remains relatively small. Finally, efficiency and quality could be increased by systematically addressing patient safety issues and by improving coordination of care.

8 Conclusion

The Swiss health system is highly valued by patients and scores very well on a broad range of indicators. However, financial protection and fairness of financing could be further improved and achieving greater effectiveness and efficiency of the system remains an important challenge. Controlling the high and rising costs of MHI premiums, which increase more quickly than incomes, is likely to require a more systematic and more stringent process of HTA, which could assess products and services for both inclusion in and removal from the MHI benefits basket. Greater use of medical guidelines, investments in patient safety, and the reduction of waste by improving coordination within and between different levels of care would further improve efficiency. The trend towards more managed care type insurance can contribute to realigning the incentives of insurers and providers and current reform plans for better planning of ambulatory care might eventually lead to a more needs-based distribution of providers.

Improving financial protection and fairness of financing is becoming more important because rising premiums and OOP payments place an increasingly large financial burden on households with lower and middleincomes. Current discussions about possible financing and payment reforms aiming to change the way how cantons and MHI companies split the bill of health care provision[1] could potentially address not only the distortion of incentives resulting from the current system of financing but also improve horizontal and vertical equity. However, given the tradition of slow and incremental reforms in Switzerland, more radical changes are very unlikely.

Finally, strengthening disease prevention and health promotion with a focus on non-communicable diseases (NCDs) remains an issue. Favourable living conditions in Switzerland, such as good housing conditions, a high quality education system, and low rates of unemployment contribute to healthy living conditions. However, prevention of NCDs, in particular through health promotion and health education, could potentially have a large impact on further improving the very good health status of the population, while avoiding the costs associated with the treatment of these preventable diseases.

[1] dual versus monistic financing of inpatient care versus dual financing of all levels of care

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