

European **Observatory**
on Health Care Systems



Health Care Systems in Transition

Switzerland



The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine

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By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.
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Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Norway and Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) health data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at <http://www.observatory.dk>.

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The Health Care Systems in Transition profile on Switzerland was written by a team comprising Andreas Minder, Hans Schoenholzer and Marianne Amiet of the Swiss Conference of the Cantonal Ministers of Public Health in collaboration with the Swiss Federal Statistical Office, the Swiss Federal Office for Public Health and the Federal Office for Social Insurance. The editor for the Swiss HiT was Anna Dixon, European Observatory on Health Care Systems and the Research Director Elias Mossialos.

The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems. The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

The Observatory team is led by Josep Figueras, Head of the Secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. Administrative support, design and production of the HiTs has been undertaken by a team led by Phyllis Dahl and comprising Myriam Andersen, Sue Gammerman and Anna Maresso. Special thanks are extended to the WHO Regional Office for Europe health for all database from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European (CEE) countries. Thanks are also due to national statistical offices that have provided national data.

Introduction and historical background

Introductory overview

Physical and human geography

Switzerland, officially known as the Swiss Confederation, is a federal republic made up of 23 cantons. It lies in central Europe and is bordered by France to the west and northwest, Germany to the north, Austria and Liechtenstein to the east and Italy to the south. It covers an area of 41 287 km². Major cities include Berne (the capital), Zurich, Basle and Geneva. The country is dominated by the Jura mountains in the northwest and the spectacular Alps in the south, which together occupy about 70% of the country's area. The Rhine and Rhône rivers both rise in Switzerland, and there are many lakes, including Lake Geneva and Lake Constance.

Most of the population of just over 7 million (1997) lives in the Swiss Plateau, a narrow, hilly region between the two mountain ranges. Switzerland has a temperate climate with conditions that vary with relief and altitude.

The population is made up of four principle language communities: Germans account for 65% of the population, the French for 18%, the Italians for 10% and the Romansch for 1%. Switzerland has four national languages: German, French, Italian and Romansch (a Rhaeto-Roman dialect). About 48% of the population are Roman Catholic and 44% Protestant.

Economy

Despite few natural resources (hydroelectric power is a notable exception) and a largely barren soil, Switzerland has attained prosperity mainly through technological expertise and export manufacturing. Tourism and international finance are important sources of income. Principal products are machinery,

Fig. 1. Map of Switzerland¹

Source: Central Intelligence Agency, The World Factbook, 1999.

precision instruments, chemicals, pharmaceuticals, watches, jewellery, textiles and foodstuffs (notably cheese and chocolate).

Switzerland's economy has grown in recent years: gross domestic product (GDP) grew at an annual rate of 1.6% in 1996/1997. The total labour force in 1997 was nearly four million and the unemployment rate was 5.2%, which declined to 3.4% in 1999. The dependency ratio² was 59.4 in 1995, which is low compared with the countries of the European Union.

Health indicators

Life expectancy at birth in 1994 was 78.8 years. The infant mortality rate was 5.1 per 1000 live births in 1994. The leading causes of death are malignant neoplasms (standardized death rate per 10 000 population (SDR) was 182.0), followed by ischaemic heart disease (SDR 100.4) and cerebrovascular disease (SDR 48.8). External causes accounted for 57.8 deaths per 10 000 of which only 8.4 resulted from motor vehicle accidents.

¹ The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

² The dependency ratio is the number of people 19 years of age or younger or 65 years old and older divided by the number of people 20–64 years old.

Political and administrative structure

The Swiss Confederation

The senior executive body is the Federal Council, which consists of seven ministers of equal rank. The Parliament elects them individually for a four-year term, and each year one of them is elected to be President of the Confederation. This does not give the holder any additional power except to chair meetings of the Federal Council and to carry out certain representative duties. Since 1959 the Federal Council has been composed of two representatives of the Radical Free Democratic Party, two of the Christian Democratic People's Party, two of the Social Democratic Party and one of the Democratic Union of the Centre, which supports the interests of farmers and the business community.

In Switzerland, executive bodies at all levels of authority are based on a collegial system. Although the members are from different political parties, they do not form a coalition. Members of the executive bodies vote according to their convictions, but the decisions they take must be upheld by all the members collectively.

The Parliament consists of two chambers.

- The National Council represents the population as a whole. Its 200 members are elected for a term of four years, and the seats are distributed according to the number of votes received by each party.
- The Council of States, with 46 members, represents the cantons. Each canton, regardless of size, elects two members according to its own electoral system. Demi-cantons, which are entities with the same autonomy as cantons into which three cantons are divided for historical reasons, each have one member in the Council of States.

Cantonal sovereignty

Since 1979, Switzerland has been made up of 23 cantons, three of which are divided into demi-cantons. Thus, Switzerland today is composed of 26 entities that are sovereign in all matters that are not specifically designated the responsibility of the Swiss Confederation by the federal constitution. Each canton and demi-canton has its own constitution and a comprehensive body of legislation stemming from its constitution. The legislative authority is a unicameral parliament that, in most cantons, is elected by proportional representation. Like the Swiss Confederation, the cantons have an executive body that is a collegial group of between five and nine members. In contrast to

the Federal Council, the members of the cantonal executives are directly elected by popular vote. Like the Federal Council, the individual members of a cantonal executive participate in the collective decisions of the cantonal government and also take responsibility for one or more administrative departments, usually called departments or directorates. Each canton organizes its administration in its own way. The cantons finance the activities of their administration primarily through income tax and property tax on individuals and corporations in the cantons.

The people have the right to call referenda and organize popular petitions at the cantonal level. Some cantons even allow petitions relating to laws and a financial referendum in which expenditure decisions made by the cantonal parliament have to be approved by popular vote.

The cantons are also responsible for civil and criminal court matters in the first instance as well as for the administration of the judicial system.

Municipal autonomy

Switzerland has about 2900 municipalities that constitute the level of authority closest to the people within the federal structure. The rights and duties of municipalities are not always identical but are laid down in the different cantonal laws applying to municipalities. The most obvious sign of autonomy is the tax sovereignty of the municipalities. Like the Confederation and the cantons, the municipalities are entitled to levy income tax and property tax on individuals and corporations in the municipality. They are also free to set the rate of tax. Swiss municipalities vary greatly in size, and their organization also differs. In many small municipalities, especially in the part of Switzerland in which German speakers predominate, all citizens with the right to vote can take part in the municipal assembly, which is the highest legislative body, whereas the larger municipalities have municipal parliaments. In most places, the executive authority is the district or town council, which is directly elected and functions as a collegial authority. The municipalities can formulate policies in many areas. Depending on the rules laid down by the canton, these can include policies on nurseries, schools, energy supplies, refuse collection, building regulations, transport, social care, cultural activities, adult education and sport. Numerous tasks of political leadership in many smaller and medium-sized municipalities are carried out on a voluntary basis or in return for merely symbolic compensation.

Elections

All Swiss citizens 18 years and older are eligible to vote in the elections to the National Council. People eligible to vote are also eligible to stand for election.

Petitions, ballots and referenda

In Switzerland the population is involved in the process of political decision-making more directly than in most countries. Through popular petitions the population can seek to make changes to the constitution. This requires the signatures of 100 000 voters to be collected within a period of 18 months. These may either be presented in the form of a general proposal or contain the exact amended text of the constitution. Cantons and Members of Parliament have a similar, although less binding, right to make proposals (a so-called state petition). Any amendments to the Federal Constitution must be passed by popular ballot (i.e. a ballot of the whole population). For an amendment to pass, it must have the support of the majority of valid votes cast (known as a popular majority) and of the majority in more than half of the total number of cantons (known as the majority of states). Popular ballots must also be held for decisions about accession to certain international organizations (also known as a compulsory referendum) and may be held on laws and federal decrees passed by parliament if requested by 50 000 electors who give their signatures within 90 days (a so-called optional referendum). Eight cantons acting together may also seek a referendum.

Historical background

Switzerland has an extremely well developed health care system. The entire system underwent massive expansion after the Second World War. Inpatient health care was expanded by the cantons and developed in a largely uncoordinated fashion. For a long time there has been excess capacity in various areas of health care service provision; however it was not until the early 1990s that a substantial effort was made to limit capacity and coordinate health care nationally.

Until the early 1970s, there were shortages of certain health professionals especially dentists and hospital-based doctors. Health care in some rural areas was also inadequate. These shortages have been eliminated, and today the number of doctors is considered to be too high.

In the first half of the twentieth century, the health policy of the cantons and the Swiss Confederation mainly focused on prevention at the population level. This population-based approach was probably the most effective means of improving health at a time when there were low levels of economic prosperity and the epidemiological profile featured high levels of infectious diseases. After the Second World War, increasing emphasis was placed on the individual and on curative medicine. At the end of the 1960s, the growth in health care

expenditure led experts to question the curative orientation of the system for the first time. Discussion of new approaches focused on concepts such as disease prevention based on the individual person and health promotion. Despite continuous efforts to alter the system's orientation towards population health, overall preventive strategies have remained selective and suffered from a lack of coordination.

At an institutional level, the cantons and municipalities were almost exclusively responsible for health and welfare. At its inception in 1848, the Swiss Confederation had practically no legislative powers in this area. This situation changed gradually. In 1877 the qualifying examinations for doctors, pharmacists and veterinarians were standardized throughout Switzerland. In 1886 a federal law to combat epidemic diseases came into force. At the end of the nineteenth century, the federal government was given a constitutional mandate to implement legislation on food and consumer safety; legislation based on this mandate came into force in 1909. A law on narcotic substances came into force in 1925 and a law on tuberculosis in 1928. The federal government has been responsible for monitoring sera and vaccines since 1931. The federal law on trade in poisons entered into force in 1972.

In 1890 the federal government was given a constitutional mandate to legislate on sickness and accident insurance. An attempt to introduce a system of health insurance in Switzerland was made as early as 1899 with the tabling of a health and accident insurance law. The proposed system was modelled on the German system of health insurance. The first proposal was rejected by referendum so the proposals were changed and resubmitted. The legislation was passed by referendum in 1911. The health insurance law required health insurance funds that wished to take advantage of federal subsidies to register with the Federal Office for Social Insurance and to abide by its rules. These rules included the obligation to provide a defined package of benefits, which included ambulatory care, drugs and hospital stays of limited duration, and to allow people a certain degree of freedom to change funds. People were able to change funds under certain conditions defined in the law such as change of residence, as many funds were regional funds, or change of job, as funds were often related to a specific company or professional association. It also imposed a limit of 10% on the difference in contribution rates for men and women and prohibited funds from making a profit. The funds were subsidized by the federal government according to the number of people they insured. The law left it to the cantons to declare whether the insurance was compulsory. The financial situation of the funds rapidly deteriorated as a result of miscalculations regarding projected demand for services.

Several attempts were made to completely overhaul the system, but they all failed at referendum, so from 1958 efforts were restricted to a partial reform of the health insurance system. This was completed successfully in 1964 and led primarily to improvements in the financial position of the health insurance funds. The reforms included a revised system of subsidies to the funds, based on age and gender, and the introduction of compulsory user charges in the statutory health insurance system. These direct charges to patients included a deductible for those over the age of 20 years and a coinsurance for all patients on all services. The subsidies were calculated on the basis of a fund's expenditure in the previous year and amounted to 30% of average total expenditure. The financial problems, which began as early as 1911 and continued until the partial reforms in 1964, did not result in any funds going formally bankrupt, but the number of funds declined significantly.

The task of reforming the system was tackled again as soon as the partial modification had come into effect. The dominant theme of the discussions at the time was the sharp rate at which expenditure was rising in the health system. There were several further attempts at reform, including two referenda in 1974 and 1987, but both failed. One reason was that both reforms contained a complex mix of reform proposals relating to cost control, the benefit package, maternity insurance and compulsory insurance. Each component had significant opposition, and the accumulation of this opposition contributed to the failure of the referenda. The revised health insurance law, which was passed by the parliament on 18 March 1994, was approved by referendum on 4 December 1994 and came into force on 1 January 1996. It pursued two fundamental objectives: to strengthen solidarity and to contain costs. See the section on *Health care reforms*.

Organizational structure and management

The political system in Switzerland is characterized by both liberalism and federalism. This is also reflected in how the health care system is organized.

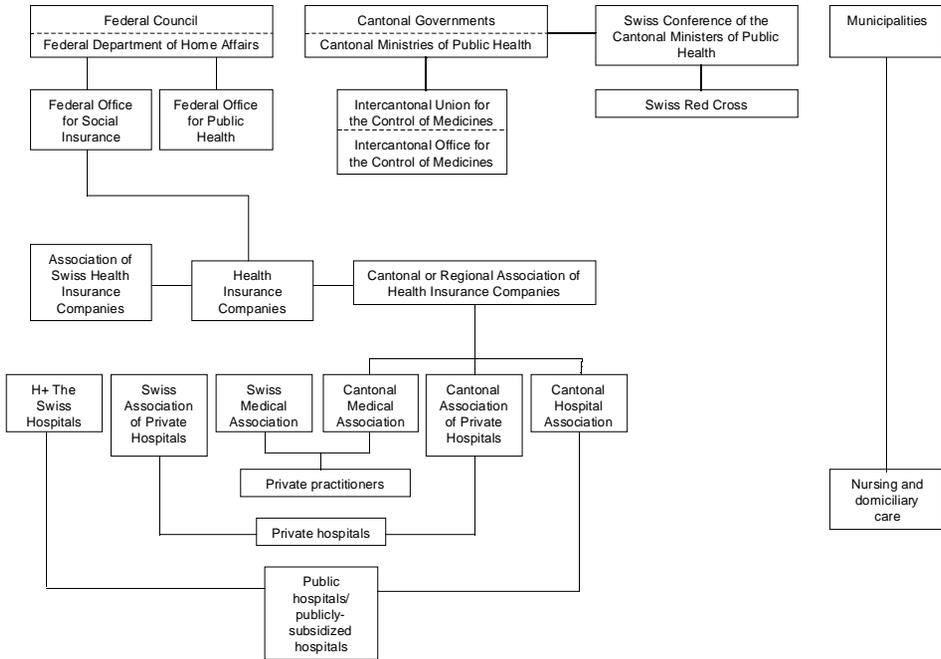
- The liberal orientation of the state is reflected in the constitutions of the Swiss Confederation and the cantons. The state basically only intervenes when private initiative fails to produce satisfactory results, i.e. it acts only as a safety net or provider of last resort. This explains the relatively major role that actors outside the public sector play in Switzerland's health care system.
- The principle of federalism is anchored in the federal constitution. The Swiss Confederation can legislate only when expressly empowered to do so by the constitution. The constitution only grants limited powers to the Confederation over the health care system. In addition, the cantons may delegate tasks to the municipalities.

These principles result in a complicated system in which many different actors are involved.

The most fundamental changes in recent decades have come about following the enactment of the health insurance law that entered into force on 1 January 1996. This law is still being implemented and is being continually adjusted by further ordinances and revisions passed by Parliament (see the section on *Health care reforms*).

Organizational structure of the health care system

This section describes the responsibilities of the public authorities and the most important private actors. The main functions and interrelationships of these actors are outlined briefly below and shown in Fig. 2.

Fig. 2. Organizational chart of the Swiss health care system

The federal government

The federal constitution lists in full the legally defined responsibilities of the federal government. Those areas that relate principally to health are:

Eradication of communicable or very widespread or virulent diseases of humans and animals

- This constitutional duty is further elaborated through several acts of legislation known as federal laws, ordinances and decrees;³

³ Federal laws are passed by parliament (i.e. National Council and the Council of States) and must then be passed by referendum if requested by 50 000 electors before they become legislation. Ordinances which elaborate the laws, are passed by the government (i.e. Federal Council). Federal decrees also further elaborate laws and can be passed by either parliament (in which case they must be approved by referendum if requested by 50 000 electors), or Federal Council.

- epidemics law: Federal law on combating communicable diseases in humans (18 December 1970);⁴
- immunobiological products ordinance: Ordinance on immunobiological products (23 August 1989);
- blood, blood products and transplant material decree: Federal decree on the control of blood, blood products and transplant material (22 March 1996);
- foodstuffs law: Federal law on food and consumer safety (9 October 1992);
- narcotic substances law: Federal law on narcotic substances and psychotropic substances (3 October 1951);
- poisons law: Federal law on trade in poisons (21 March 1969);
- the federal government's activities aimed at preventing AIDS and addiction (embodied in several ordinances).

The Swiss Federal Office for Public Health is the section of the Federal Department of Home Affairs with the greatest responsibility for these areas. Its work is supported by a large number of special commissions.⁵ The task of implementing these laws has largely been delegated to the cantons.

Promotion of exercise and sport

The Federal law on exercise and sport (17 March 1972) empowered the federal government to issue further legislation in support of the following areas of activity:

- physical exercise and sport in schools
- gymnastics and sports clubs as well as sports events
- research on sports science
- the building of national sports facilities
- a gymnastic and sports school.

Besides these responsibilities the federal state runs the Organization for Youth and Sport, which aims to encourage young people (aged 10–20 years old) to undertake further sports training and to lead healthier lifestyles.

⁴ In Switzerland, each law, decree or ordinance is referred to either by a shorthand name for the law or its full title which includes the date on which it was passed by parliament. Both are given here but the laws will be referred to only by their shorthand name throughout the remainder of the report.

⁵ These include advisory commissions such as the Federal Commission on Poisons, the Codex Alimentarius Commission, which produces a food manual, the Federal Commission on the Question of AIDS, the Federal Commission on the Question of Alcohol, the Federal Commission on the Question of Immunization. There are also authority commissions which have greater powers of decision-making and are appointed either by the federal government, a minister or the Chancellor of the Confederation. There are also some other less official commissions which are mainly composed of members of the administration and/or treat questions in a more informal way.

Social insurance provision

The constitutionally defined duty of the federal government with regard to the provision of social insurance cover is further elaborated through other acts of legislation, including:

- the health insurance law: Federal law on health insurance (18 March 1994)
- the accident insurance law: Federal law on accident insurance (20 March 1981)
- the disability insurance law: Federal law on disability insurance (29 June 1959)
- the military insurance law: Federal law on military insurance (19 June 1992).

The Federal Office for Social Insurance is responsible for all these social insurance policies mentioned above. The only exception to this is military insurance, which is the responsibility of the Federal Office for Military Insurance. Military insurance covers damage to health sustained during military service or peacetime duties for the federal government, such as civil defence duties, emergency relief and peacekeeping duties.

The federal government is the sole provider of disability insurance and military insurance. This contrasts with compulsory health insurance and compulsory accident insurance, which are provided by a variety of insurance funds under the supervision of the Federal Office for Social Insurance.

In 1945 the federal government was given a constitutional mandate to establish a system of maternity insurance, to cover women for loss of pay during pregnancy and childbirth. All attempts to do so in the past have failed to pass in public referenda (1984, 1987 and 1999).

Medical examinations and qualifications

Since as long ago as 1877, when the Federal law on the freedom of medical personnel in the Swiss Confederation (19 December 1877) was enacted, the federal government has been responsible for the accreditation of “scientific professions”. This term covers doctors, dentists, veterinarians and pharmacists. They are all required to pass a federal examination, and having done so are awarded a diploma that guarantees them freedom to practice anywhere in Switzerland, providing they also apply for a licence to practice from the cantonal authorities (see below). Specialist medical training is regulated by the Swiss Medical Association (see below).

Promotion of science, research and tertiary education

The Federal law on research activities (7 October 1983) empowers the federal government to promote scientific research. The Federal Council determines

the objectives of Switzerland's research policy and ensures that federal resources are coordinated and deployed effectively.

The Federal law on the promotion of tertiary education (22 March 1991) empowers the federal government to promote the operation and expansion of cantonal universities and recognized institutions of tertiary education. The aim of this legislation is to achieve a coordinated tertiary education policy that enables international recognition.

Genetic engineering, reproductive medicine, transplant medicine and medical research

There is a public consensus that the federal government should have the main responsibility for genetic engineering, reproductive medicine, transplant medicine and medical research. These activities, however, are the subject of intense controversy. Since 1992 the federal government has had a constitutional mandate to legislate on reproductive and genetic technology. The parliament passed a law on reproductive medicine in autumn 1998. A federal law on genetic investigations in humans has been drafted. The federal government has had a constitutional mandate to regulate transplant medicine since 7 February 1999. The Federal Expert Commission for Biological Safety advises the federal government and cantons on genetic engineering and biotechnology.

Statistics

The statistics law (Federal statistics law (9 October 1992)) requires the federal government to compile data on health and the health care system. The health insurance law contains additional regulations that empower the Federal Council to collect statistical data necessary to implement the law such as expenditure data, utilization data, etc.

Labour laws

The legislation on labour and the protection of workers (Federal law on labour in industry and trade (13 March 1964)) empowers the federal government to compel employers to take the necessary measures to protect the health and safety of the workforce.

Environmental protection

The responsibilities of the federal government to protect the environment are embodied in several laws that are significant for health:

- waterways protection law: Federal law on the protection of the waterways (24 January 1991)
- environmental protection law: Federal law on environmental protection (7 October 1983)

- radiation protection law (22 March 1991)
- safety of technical facilities and equipment law: Federal law on the safety of technical facilities and equipment (19 March 1976).

International relations

As part of its remit to promote international cooperation, the Swiss Federal Office for Public Health collaborates with the World Health Organization (WHO) and the Council of Europe. Other federal bodies and the Swiss Conference of the Cantonal Ministers of Public Health are also active in this field.

The cantons

The health service is one of the areas of government activity in which the cantons have a declining but still relatively high degree of independence. The cantonal activities can be divided into the following four areas, which are described in more detail below:

- regulation of health matters
- provision of health care
- disease prevention and health education
- implementation of federal laws.

Regulation of health matters

Licensing of the health professions

The cantons determine the conditions under which individuals in health professions may receive a licence to practice.

Authorization to open a medical practice or pharmacy

Market authorization and control of medicines

The need for national standardization in registering and controlling medicines led to an intercantonal agreement on this matter as long ago as 1900. The cantons established the Intercantonal Union for the Control of Medicines for this purpose (see the section on *Pharmaceuticals*).

Provision of health care

Inpatient care (hospitals and residential nursing homes)

Most cantons operate their own hospitals; some also subsidize private hospitals. There are also private clinics that do not receive any state support. The revised

health insurance law requires the cantons to draw up plans for providing hospital care according to need and to produce a list of hospitals and nursing homes that are eligible for reimbursement under compulsory health insurance. This list includes public and publicly subsidized hospitals but may also include private providers.

Global budgets for public and publicly subsidised hospitals were introduced in five cantons in 1994 and have since been introduced in other cantons. The exact way in which these budgets operate varies between cantons. For more detail see the section on *Payment of hospitals*. Objections to cantonal decisions regarding hospital lists and global budgets can be lodged with the Federal Council.

Nursing and home care⁶

The cantons can provide nursing and home care or delegate this responsibility. Most cantons delegate at least some of these tasks to the municipalities. The canton is responsible in any case for licensing providers of nursing and home care services.

Fees

The cantonal government endorses the fee schedules negotiated and agreed between service providers and associations of health insurance funds in each canton. If the parties are unable to agree, the cantonal government determines the fee schedule. Objections to decisions made by cantonal governments on fees can be lodged with the Federal Council (see the section on *Planning, regulation and management*).

Emergency, rescue and disaster-aid services

Emergency, rescue and disaster-aid services include emergency transport and ambulance services.

Basic and specialty medical training

Basic and specialty medical training is provided at seven cantonal universities and public hospitals and clinics. Training follows the federal regulations on medical examinations and qualifications (see above). The Swiss Medical Association (Foedaratio Medicorum Helveticorum) regulates postgraduate training for doctors.

Training in paramedical occupations

The cantons regulate all major health-related occupations. Training is delegated to the Swiss Red Cross (see the section on *Human resources and training*).

⁶ This is referred to as Spitex in Switzerland, an abbreviation of “Spitalexterne Krankenpflege”, which translates as “out-of-hospital care”.

Disease prevention and health education

The cantons' activities in disease prevention, health promotion and health education vary widely both in scope and nature. Numerous diverse projects and activities aim primarily to prevent disease. Nevertheless, there are no strategic cantonal objectives covering the whole of Switzerland and no means for implementing such national projects. In 1989 the federal government and the Association of Swiss Health Insurance Companies set up the Swiss Foundation for Health Promotion, partly with the aim of remedying this situation. In mid-1996 the Foundation was designated as the national institution responsible for initiating, coordinating and evaluating measures designed to promote health and prevent disease in accordance with Article 19 (§ 19) of the health insurance law 1994 (see the section on *Public health services*). The Foundation is supervised by the Federal Office for Social Insurance, but the management body of the Foundation includes representation from the cantons.

Implementation of federal laws

In most of its areas of responsibility, the federal government has delegated powers of implementation to the cantons.

The municipalities

The cantonal health laws confer responsibility for health policy on the municipalities. The responsibility for providing nursing care for certain vulnerable groups is usually delegated to the municipalities, with the emphasis on home care, residential and nursing homes for elderly people and community-based mental health services.

The municipalities have delegated responsibility to independent organizations for most home care services. Larger municipalities and associations of municipalities often run their own residential and nursing homes for elderly people. Municipalities run nursing homes and hospitals either alone or in conjunction with other municipalities (through hospital associations) or are represented on the boards of such facilities. The municipalities are also responsible for supporting and counselling pregnant women and mothers, providing obstetric services and health and dental care in schools.

Health insurance companies

In 1999, there were 109 insurance companies that offered compulsory health insurance policies in Switzerland (this compares to 207 companies offering statutory health insurance in 1993). Only those insurance providers who comply with the requirements of the health insurance law and are registered with the

Federal Office for Social Insurance may provide compulsory health insurance (CHI). The main requirement being that no profit should be made from compulsory health insurance activities.

There are many insurance companies active in providing insurance policies of different types, including occupational and non-occupational accident insurance, old age and disability insurance, and maternity insurance.

The registered health insurance companies that offer compulsory health insurance also dominate the market for supplementary health insurance policies⁷ whereas the non-registered insurance companies provide other types of insurance and have a small share in the market for supplementary health insurance policies. In 1998 there were 63 registered insurance companies offering supplementary health insurance policies, compared with 61 non-registered companies.

The registered insurance companies that are allowed to offer compulsory health insurance have developed historically and may be regional, federal, religious or occupational based. They are not allowed for any reason to refuse an individual's application for compulsory health insurance coverage. Since the revised health insurance law was enacted in 1996, compulsory health insurance policies are uniform, i.e. covering the same package of benefits.

Table 1 shows the size and market share of different insurance companies in Switzerland. Seventy-one per cent of all insurance companies cover less than 10 000 people; these insure only 3.2% of the total insured population. The insurance companies covering less than 10 000 people insure 2500 people each on average. The insurance companies that cover between 100 001 and 1 million people cover 68.4% of all insured people. The largest company covers over 1 million people, which represents 16.8% of the total insured population.

The regulation of the insurance companies in relation to administration, accounting and premium calculations intensified substantially in 1996 when the revised health insurance law came into force; many small insurance companies could no longer participate in this drive for professionalism and withdrew or merged with larger insurance companies. This has not yet resulted in any action on monopolies by the Swiss Competition Commission as 109 companies are still active in the CHI market in 1999 (see Table 2).

⁷ The main supplementary health insurance policies known as "private" and "semi-private" cover additional benefits not covered by compulsory health insurance, i.e. free choice of hospital doctor and superior levels of hospital accommodation.

Table 1. Number and size of compulsory health insurance (CHI) providers, 1997

Insured persons per CHI provider	Number of CHI providers	Number of insured persons	Percentage of total
<1 000	32	16 677	0.2
1 001–10 000	60	213 142	3.0
10 001–100 000	23	832 613	11.6
100 001–1 000 000	14	4 909 494	68.4
>1 000 000	1	1 210 566	16.8
Total	130	7 182 492	100

Source: Association of Swiss Health Insurance Companies (1)

Table 2. Trend in total number of compulsory health insurance (CHI) providers, 1993–1998

Year	Number of CHI providers	Annual change
1993	207	–
1994	178	-29
1995	166	-12
1996	145	-21
1997	130	-15
1998	119	-11
1999	109	-10

Source: Association of Swiss Health Insurance Companies (1)

The health insurance companies have banded together to form cantonal and intercantonal associations that negotiate fees with service providers. Registered insurance companies can request the canton to set a global budget for financing hospitals and nursing homes as a one-off temporary measure to contain an excessive increase in expenditure. This provision has never been exercised.

All health insurance companies in Switzerland are members of the Association of Swiss Health Insurance Companies. The main functions of the Association are:

- public relations;
- representing the interests of the members to political bodies, including influencing the legislation process, influencing the work on reforming the fee schedule and representing the insurance companies in federal commissions;
- compiling statistics, including collecting extensive data on expenditure and utilization from its members which is primarily used for the fee negotiations;

- negotiating with service providers at the national level on fee schedules, quality assurance and other matters;
- supporting the cantonal associations when they appeal against the decision of a cantonal government to the Federal Council;
- training in areas of health insurance accounting, administration and management.

On 1 January 1996 when the revised health insurance law came into force, the registered insurance companies established a joint organization, known as Foundation 18. Its responsibilities are to meet the financial obligations of insurance companies in financial difficulty, to be responsible for risk adjustment between the registered insurance companies and to meet international obligations for reimbursing health care services.⁸

Professional associations

The doctors are organized into cantonal medical associations. These negotiate fee levels with the cantonal associations of health insurance companies. Membership of the cantonal medical associations is not compulsory but everyone who is a member of the Swiss Medical Association has to be member of a cantonal association.

The Swiss Medical Association regulates and accredits postgraduate medical training for doctors. The Association only confers qualifications for postgraduate medical training on doctors who are members.

The Swiss Dental Association, like the Swiss Medical Association, is a professional and representative organization as well as a scientific society for dental medicine. The Swiss Dental Association collaborates with universities and specialist colleges to find ways to incorporate new concepts and methods of prevention and therapy into practice. As a representative organization, the Swiss Dental Association pursues a number of other functions, including legal advice, political representation and public relations and assistance in establishing and developing dental practices.

Pharmacists are members of the Swiss Pharmacists' Association. Its main functions are similar to the other professional associations and include provision of scientific information for pharmacies.

⁸ At present this concerns people insured by a sickness fund in Germany who use health care services in Switzerland. The joint organization pays the service provider and is later reimbursed by the German fund. For people insured in Switzerland and using health care services in Germany, the joint organization reimburses the German funds based on a special agreement between Germany and Switzerland. As soon as the bilateral agreement between the European Union and Switzerland comes into force (earliest possible date 1 January 2001), the joint organization will extend its activities to all 15 European Union countries.

Practitioners of health-related professions other than doctors are represented by organizations specific to their occupation. These organizations represent the interests of their members in dealing with employers and are involved in drawing up the training guidelines issued by the Swiss Red Cross and in the ongoing development of the training system. Various occupational organizations also offer courses of advanced and specialist training.

Most of the occupational organizations are represented by an umbrella organization, the Swiss Federation of Healthcare Professional Associations, which represents its members' interests at the national level. It has a seat on the federal government's advisory committee that considers proposals for extending the package of compulsory health insurance benefits.

Hospital associations

The Swiss Association of Hospitals is called "H+ The Swiss Hospitals". Its main tasks are to represent the interests of all hospitals, provide in-service training for managers, develop management tools (such as cost accounting) and compile comparative statistics. It collects both administrative statistics such as wage costs and input costs as well as medical statistics about length of stay and service intensity. The private hospitals are also members of the Swiss Association of Private Hospitals. The Association's main functions are public relations, legal advice, information provision and political representation.

At the cantonal level, the public and publicly subsidized hospitals have formed hospital associations that negotiate fees with the health insurance companies. Private hospitals are often also members of the cantonal hospital associations.

Voluntary and consumer organizations

A large number of organizations concentrate on specific diseases, such as the Swiss Cancer League, the Swiss League against Rheumatism, the Swiss Lung Association and support organizations for people with AIDS. They fulfil major functions, including prevention, public relations, counselling and liaison with patients.

Patient organizations work on various committees to represent the interests of the insured population. They have the right to be consulted in the process of negotiating fee schedules between insurance companies and service providers. In general, however, the recipients of services, including insured people, patients and relatives, tend to be in a weak position.

The responsibilities of the various actors described above have developed over time, and in some instances there is no clear or objective demarcation of

responsibility. This leaves room for interpretation and, together with the coexistence of cantonal and federal regulations, produces a great need for consultation if inconsistencies and contradictions are to be avoided.

Planning, regulation and management

Switzerland's health care system is a liberal and decentralized system. Providers are free to choose where to locate and patients are free to choose providers within a canton.

Planning health care services

Federal and cantonal authorities have no direct planning controls over ambulatory services but have significant controls over hospitals and residential nursing homes. Hospitals and nursing homes can only be reimbursed for services under compulsory health insurance if they are included in the canton's official list of hospitals and nursing homes.

These lists are drawn up as part of the canton's planning exercise. In most cantons the criteria used as the basis for planning are limited to bed requirements. The target in relation to the number of acute beds per 1000 inhabitants varies considerably between cantons: for example, between 2.6 and 3.5 beds per 1000 population for 2005. The basic objectives of the planning process are not explicit and may vary between cantons. Planning objectives might include maximising efficiency, containing inpatient expenditure, providing sufficient high-quality inpatient health care, or meeting the needs of patients, and may contradict each other. The main aim of planning at present is to reduce or avoid excess capacity and thus excessive costs.

The canton is usually responsible for planning, but some cantons collaborate on planning. Nevertheless, a supraregional or even nationwide consensus about hospital planning does not exist at present.

The cantons' decisions on hospital planning and lists can be challenged by submission to the Federal Council. Appeals are usually lodged by hospitals or nursing homes that have been excluded from the cantonal list or by an insurance fund that considers the list to be too comprehensive. The initial publication of the cantonal hospital lists led to numerous complaints being made to the Federal Council by hospitals and nursing homes that were omitted. The Federal Council's decisions have mostly found in favour of the complainant and thus have resulted in extension of the hospital and nursing home lists. Most complaints focused on the lists, but objections were also raised about the fees charged

by the hospitals, nursing homes, Spitex organizations⁹ and other providers of ambulatory services (such as doctors and midwives). It appears that the number of complaints regarding the lists is falling as there is greater convergence between the opinion of the federal state and the cantons. Many of these initial difficulties with the planning process can be attributed to start-up troubles with a new planning instrument.

Regulation of health care services

The basic benefits package and therefore the services covered by the compulsory health insurance are defined in law (see the section on *Health care benefits and rationing*). The insurance provider will reimburse service providers if the services are clinically effective, appropriate and cost-effective. These criteria also apply to pharmaceuticals and to medical devices and medical aids (see below). The service providers or their associations are also required to develop and implement methods of assuring and improving quality. The National Association for Promoting Quality in Health Care is the main body responsible for developments in quality management and is attempting to monitor, coordinate and support work in this area on a national basis. It is an independent network made up of representatives of many of the key actors in the health sector discussed in this section.

So far, the requirement that services should be clinically effective, appropriate and cost effective to qualify for reimbursement has only been applied to considerations of services which are to be added to the benefits package. Existing services have not been subjected to scrutiny under these criteria. The development of measures to promote quality assurance and improvements varies greatly between cantons and health care sectors. Outline agreements have been reached between insurance companies and service providers in the hospital sector, but work has only just started on implementing measures of this kind in ambulatory care.

Regulation of health care facilities and personnel

The cantons of Basle, Berne, Freiburg and Zurich do have the legal basis to introduce a *numerus clausus* at their universities. Due to the over-supply of doctors, a *numerus clausus* has been implemented at those universities through a test measuring aptitude to study medicine (since 1998). More stringent selection criteria were adopted in the preliminary medical examinations at the

⁹ Spitex is the term used to describe organizations which provide nursing and home care.

universities in Geneva, Lausanne and Neuchâtel (Neuenburg) for the same reason.

Neither the health insurance law of 1911 nor the revised law of 1994 provided for any state influence in the ambulatory care sector. Doctors are free to set up a practice in a location of his/her choosing. The only requirement is that the doctor must hold a recognized diploma and fulfil certain other criteria (such as character reference, minimum period of residence in the canton, postgraduate training) in order to obtain a cantonal licence to practise medicine. In theory a doctor can establish an independent practice without further specialist qualifications.

The lack of regulation governing where doctors set up practice results in large variation in the density of doctors per inhabitant. In urban cantons like Basle or Geneva the number of inhabitants per doctor in independent practice is much lower than in rural cantons like Appenzell or Obwalden (see the section on *Human resources and training*). As with doctors, there are no restrictions on pharmacists who want to open a pharmacy.

Dentists, chiropractors and midwives are also reimbursed under the compulsory health insurance (to the extent that their services are included in the benefits package) provided that they have completed a recognized course of training. Physiotherapists, ergotherapists, nurses, speech therapists and dieticians working on a self-employed basis need a recognized qualification and a prescription from a doctor for any services carried out under the compulsory health insurance system.

Spitex organizations must meet certain requirements as defined in the health insurance law and its ordinances, such as appropriate facilities and personnel with recognized qualifications. These apply to all institutions that must be licensed by the canton before they can work under the compulsory health insurance system.

Regulation of pharmaceuticals and technology

The Federal Department of Home Affairs decides which medicines are covered by compulsory health insurance and at what price they should be sold. It also determines which laboratory analyses and investigations or medical devices and medical aids are covered by the compulsory health insurance.

The Federal Department of Home Affairs consults five different commissions: four of which are specialist commissions, such as the Federal Commission for Pharmaceuticals, and the fifth is the Federal Commission for Fundamental

Questions of Health Insurance, which has greater authority than the other four but is still only advisory. It has 17 members including representatives from each of the other four commissions, the Federal Office for Public Health, the Data Protection Agency, Intercantonal Office for the Control of Medicines, the Swiss Competition Commission and the cantons. It attempts to unify practice and ethical considerations related to defining the benefits package. The other commissions have to comply with the decisions of this Commission. (See the section on *Pharmaceuticals* for more detail on pharmaceutical policy and regulation.)

Health policy

Many of the attempts by the federal government, cantons and other actors to achieve a common health policy have failed. A new attempt is currently being made. Health policy is understood here in its broadest sense. It covers not only organizing the provision of health services but also health promotion and the prevention and control of diseases. Health policy defined in this way encompasses not only policy on health care but also all policy areas that affect the health of the population, including economic policy, environmental policy and social policy. This concept of health policy is substantially influenced by the WHO policy framework for health for all (see the subsection on *Health for all policy* in the section on *Proposed reforms*). A prominent element in the new health policy currently under discussion is the creation of a Swiss Health Observatory to eliminate the notorious information deficits that hamper the development of strategies on health policy.

(De)centralization of the health care system

The regulatory powers of the federal government over the health care system have increased considerably in recent decades, in particular with the changes to the statutory health insurance, which have fundamentally affected the development of structures for delivering health care and how the cantons finance health care services. The health insurance law compels the cantons to plan hospital provision and to limit the range of providers who will be reimbursed. It also defines the general conditions by which all services will be assessed for reimbursement. In these ways we can see some centralization of power at the federal level.

Reform proposals in several other areas illustrate quite clearly that this process is intended to continue. The new federal constitution adopted on

18 April 1999 lays down the responsibility of the federal government for the training of health-related professionals other than doctors.

Further measures for transferring responsibility to the federal government are under discussion. At the same time, however, proposals have been put forward for increasing the power of the cantons to intervene, as well as proposals to shift from state regulation to market regulation of health care provision (see the section on *Health care reforms*).

Health care finance and expenditure

Main system of finance and coverage

Switzerland's health care system is largely financed through compulsory health insurance premiums. Since the revised health insurance law came into force in 1996 all permanent residents in Switzerland are legally obliged to purchase compulsory health insurance policies. Individuals or their legal representatives purchase insurance policies for which the premiums are community rated (i.e. the same for each person taking out insurance with a particular company within a canton or subregion of a canton regardless of individual risk rating).

Prior to 1996 premiums were risk-related and resulted in certain individuals who were classed as high-risk by the health insurance companies, such as the elderly and chronically ill, finding health insurance unaffordable.

Permanent residents exempted from purchasing compulsory insurance under the new system are:

- public employees covered by military insurance;
- non-Swiss citizens residing for more than three months in Switzerland who are already insured for services in Switzerland equivalent to those covered by Swiss compulsory health insurance, either through a non-Swiss insurance company or their employer, and who have received written notice of exemption.

Non-Swiss citizens are always treated in an emergency; the issue of who pays for the service only arises afterwards. The cantons are obligated to inform residents that they must purchase compulsory health insurance and to enforce this policy. Residents of a canton are obliged to obtain insurance within three months of their arrival in the canton, including non-Swiss citizens residing in Switzerland for more than three months. For individuals who do not respect this time limit, a surcharge is calculated based on the premiums for a period twice as long as the time by which the time limit is exceeded. For example, if

a resident only purchases compulsory health insurance after four months s/he will pay a surcharge equivalent to two months' premiums. The only exception to this is if the person is eligible for premium subsidies in which case the municipality or cantonal authority purchases the insurance. In this case no surcharge is imposed. Individuals who refuse to take out compulsory health insurance are forcibly assigned to a health insurance company by the cantonal authority.

Compulsory health insurance can be purchased from a limited number of insurance companies, both public and private, which are registered with the Federal Office for Social Insurance. These insurance companies are not allowed to make profits from their compulsory health insurance activities and the Federal Office to whom they must submit accounts monitors their activities.

The entire resident population is guaranteed a free choice of insurance provider for compulsory health insurance, and insurance companies offering compulsory health insurance are not allowed for any reason to refuse an individual's application for a compulsory health insurance policy. People are allowed to change their compulsory health insurance company twice a year. The insurance companies compete within each canton based on the level of the premium. There is no premium fixing by the state instead price competition appears to work, with many people changing companies on an annual basis depending on the premiums offered. Nevertheless, they are not allowed to compete on the basis of benefits offered, as a package of health care benefits is defined which all companies must offer. Opportunities for competing based on the quality of care are very limited. Managed care and quality competition are allowed under compulsory health insurance but are still not very common in Switzerland.

Compulsory health insurance contributions are community rated, i.e. all subscribers to a particular insurance company within a canton or subregion of a canton pay the same rate. The insurance companies calculate their premiums based on estimates of health care expenditure in a canton or subregion of a canton. These premiums are audited annually by the Federal Office for Social Insurance before they are introduced. If the premiums are too high, the federal government can force the insurance company to reduce them before they are introduced. In order to enforce this system of auditing the Swiss cantons have a right to access information held by the insurance companies about the calculation of these premiums. They have access to both information about the method of calculation and also the cost data used in the calculations of the premiums.

To reduce the social impact of per capita premiums, both the Swiss Confederation and the cantons subsidize compulsory health insurance premiums through tax-financed allocations. In accordance with the revised health insurance law

these public transfers must be used to provide a means-tested subsidy which varies according to the income and wealth of the insured person. Prior to 1996, the transfers were paid directly to the insurance companies, which reduced the level of the premiums for all subscribers rather than targeting the subsidies.

The cantons have some autonomy to define the principles on which premium subsidies are based. They are also free, within limits imposed by the Confederation, to choose the level at which to fix the total cantonal (and federal) budget available for premium subsidy. In some cantons, the premiums paid by individuals or families cannot exceed a certain percentage of their total income (for example, 10%). In other cantons, premium subsidies vary according to income and are phased out at a defined upper limit of income. For people on very low incomes the entire premium or a cantonal “reference price” which ever is smaller, is paid directly by the municipal or cantonal authorities.

Compulsory health insurance covers a broad range of services as defined in the revised health insurance law. The services not covered by compulsory health insurance can be funded by supplementary health insurance (estimates suggest about one in four people in Switzerland have one of the major supplementary health insurance policies known as private or semi-private), or direct payments (see the section on *Health care benefits and rationing*). In contrast to the community-rated premiums, which are levied for compulsory health insurance, supplementary health insurance premiums are usually risk-related.

Per capita premiums for compulsory health insurance require some risk adjustment between health insurance companies in order that those companies with high-risk enrollees are not penalized. With the enactment of the revised health insurance law, new mechanisms for risk adjustment have been created. The risk adjustment formula is based on the age and the sex of the insured people. Some health insurance companies are currently proposing a revised formula that would also take account of the number of hospital treatments in the past year. Foundation 18 is responsible for calculating and making the transfer between insurance companies.

The structure of health care expenditure has changed considerably in the past 20 years as shown in Table 3.

- Tax financing has decreased since 1980 from 31.7% of total expenditure in 1980 to 24.9% in 1997;
- Health insurance financing (the sum of compulsory (2) and not-for-profit supplementary health insurance (6)) has increased since 1980 from 33.4% of total expenditure in 1980 to 37.5% (27.5% + 10.0%) in 1997;
- Direct payments (the sum of cost sharing in the compulsory health insurance (4) and for profit supplementary health insurance (5)) have decreased since

1980 from 32.4% of total expenditure in 1980 to 28.8% (27.6% + 1.2%) in 1997.

Table 3. Main sources of finance (%)

Source of finance	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997
Public	65.1	63.3	65.2	65.8	66.3	67.9	57.8	57.4	58.8	59.1
Taxes ¹	31.7	27.4	27.4	28.6	27.7	26.7	25.6	25.2	24.9	24.9
Compulsory health insurance ^{2,6}	33.4	29.7	31.8	31.0	32.0	34.2	25.5	25.5	27.2	27.5
Other statutory insurance schemes ³	–	6.3	6.0	6.2	6.6	7.0	6.7	6.7	6.7	6.7
Private	32.4	33.6	32.4	31.8	31.4	30.4	40.3	40.7	39.5	38.7
Out-of-pocket ^{4,5}	32.4	33.6	32.4	31.8	30.1	29.1	28.8	28.8	27.4	27.6
Supplementary health insurance (for profit) ⁵	–	–	–	–	1.3	1.3	1.3	1.0	1.2	1.2
Supplementary health insurance (not for profit) ⁶	–	–	–	–	–	–	10.2	10.9	10.9	10.0
Other payments ⁷	2.5	3.1	2.4	2.4	2.3	1.7	1.8	1.9	1.7	2.1

Source: Swiss Federal Statistical Office 1999

¹ Financing from central, regional and local public authorities as subsidies to hospitals, nursing homes and home care, to compulsory (until 1996 statutory) health insurance, military insurance and public health expenditures (such as prevention and administration).

² Compulsory health insurance since 1996, statutory health insurance before 1996.

³ Occupational and non-occupational accident insurance, old age and disability insurance.

⁴ Direct payments from households to health care providers for services not covered by any compulsory or supplementary private health insurance and cost sharing in the compulsory health insurance system.

⁵ Insurance companies (for profit) offering only supplementary private health insurance. Before 1992, data included in "out-of-pocket".

⁶ Not-for-profit companies offering supplementary private insurance and also statutory health insurance until 1996 and since 1996 also compulsory insurance. Data not available before 1994.

⁷ Payments from residents of other countries.

Complementary sources of finance

Federal, cantonal and municipal tax revenues are another source of financing. These cover the following:

- cantonal subsidies to both private and public hospitals
- cantonal and municipal subsidies to nursing homes and home care providers
- cantonal and federal subsidies for compulsory health insurance premiums
- premiums for military health insurance paid by the federal government
- public health expenditures (such as disease prevention and health care administration).

In 1997 these subsidies paid for out of taxation accounted for 24.9% of total health care expenditure (see Table 3) whereas compulsory health insurance

financed 27.5% of total health care expenditure. Before 1996 this insurance was statutory (but not compulsory) and up until 1994 also included expenditure by supplementary health insurance. Occupational and non-occupational accident insurance, old age and disability insurance financed 6.7% of total health care expenditure in 1997.¹⁰

Out-of-pocket payments

Table 3 shows that direct payments amounted to 27.6% of total health care expenditure in 1997.¹¹ This results from a combination of high levels of copayment under compulsory health insurance (previously statutory health insurance) and direct out-of-pocket payments for services not covered by the benefits package.

Most insurance policies require that insured people pay a fixed part of the costs covered by compulsory health insurance in the form of a deductible. This is set annually and varies between compulsory health insurance policies. The minimum is Sw.fr. 230 and the maximum is Sw.fr. 1500 per year. The standard deductible for adults is Sw.fr. 230 whereas there is usually no deductible for children up to the age of 18 (this is extended up to 25 years by some insurance companies). However insurance companies are allowed to offer higher deductible rates (up to Sw.fr.1500 for adults and Sw.fr. 375 for children). The individual may choose the level of deductible that he or she wishes to pay but his/her premium will clearly be less if a higher level of deductible is chosen.

In addition, to the deductible there is a 10% co-insurance on the price of all services covered by compulsory health insurance which has to be paid by patients in the form of a direct payment. The upper limit for co-insurance is Sw.fr. 600 for adults and Sw.fr. 300 for children (1999). The co-insurance may apply to a standardized price for one item of service or it may apply to the price of a specified number of treatments (i.e. an episode of care). In some cases, part of the cost is only reimbursed if the frequency of utilization of services is

¹⁰ Explanation of other insurance policies which are or have been involved in the financing of health services: **Occupational and non-occupational accident insurance:** employers are obliged to insure their employees for compulsory accident insurance. Accident insurance can also be purchased on a supplementary basis by those people not in employment. Accident insurance covers ambulatory and inpatient treatment costs and transportation costs incurred as a result of occupational and leisure accidents. Payments are made to people who as a result of an accident are actually unable to work, are handicapped and to the survivors.

Military insurance is paid by the Swiss Confederation (through federal taxes). Swiss military insurance insures all soldiers that are currently serving in the Swiss army. It covers health care, accident and transportation costs.

Old age and disability insurance contributions are paid by employers and employees. These contributions finance pensions and health care costs of the elderly and payments for people handicapped since birth.

¹¹ Until 1992 these figures also included expenditure by for-profit private insurance companies that did not offer statutory health insurance.

within specified limits, otherwise the full cost of the service will have to be borne by the patient. For example compulsory health insurance covers Sw.fr. 200 every year up to the age of 15, and Sw.fr. 200 every five years thereafter for the replacement of spectacles. Other co-payments include:

- transportation costs – half of the costs have to be paid by the patient
- inpatient treatment – single people (without children) have to pay Sw.fr. 10 per day.

If several children in one family are insured for compulsory health insurance by the same health insurance company, the total amount of direct payments must not exceed twice the maximum amount for one child for both deductible and co-insurance (i.e. Sw.fr. 375 + Sw.fr. 300 x 2 = 1350).

Services that are excluded from compulsory health insurance cover must be financed by direct payment by the patient (unless they are covered by supplementary health insurance). These are detailed in the section below on *Health care benefits and rationing*.

Supplementary health insurance

In 1997 supplementary health care insurance financed 11.2 % of total health care expenditure. Until 1992 the expenditure by insurance companies which did not offer statutory health insurance was included under the expenditure category out-of-pocket payments. Until 1994 expenditure by registered insurance companies offering both statutory/compulsory health insurance and supplementary health insurance was included under compulsory health insurance in Table 3.

Different supplementary health insurance policies exist in Switzerland. The most popular supplementary health insurance policies are those that allow free choice of doctor and cover for superior inpatient accommodation.¹² About one quarter of the population has one of these main forms of supplementary health insurance. Other supplementary insurance policies that are much less popular cover treatments and repatriations for people temporarily leaving Swiss territory, complementary medicine, dental care and drugs which are not expressly mentioned in the lists of medications and pharmaceutical products. There is only one example of a company that offers a supplementary health insurance policy to cover user charges under compulsory health insurance. The company does not actively promote this product. It is not currently illegal, however the first partial revision of the health insurance law includes the prohibition of

¹² In Switzerland supplementary health insurance policies offer two levels of inpatient care cover: private and semi-private. The entitlements for these are identical except private entitles the patient to an individual room, semi-private entitles the patient to a room shared with another person.

such insurance schemes. It is uncontested and is likely to be passed (see the section on *Proposed reforms*).

The insurance companies that provide compulsory health insurance are also the main providers of supplementary health insurance (see the subsection on *Health insurance companies* under the section on *Organizational structure of the health care system*). There is a current debate about the future of the distinction between private and semi-private health insurance cover. A number of patients are only interested in better “hotel” facilities, the others are only interested in having a free choice of hospital doctor. There are discussions about whether to maintain the status quo or to offer two different insurance policies: one to cover hotel facilities and the other a free choice of doctor. This will allow greater choice for the consumer.

There are currently no tax incentives to encourage people to take out supplementary insurance. The number of people with supplementary health insurance is actually declining due to the rising level of premiums charged and the expansion of the compulsory health insurance benefits package which makes supplementary insurance less attractive. It is nevertheless difficult to tell how this trend will continue due to the many changes taking place.

External sources of funding

Other external sources of funding include money from the residents of other countries coming to Switzerland for treatment (usually as inpatients). In 1997, this financed 2.1% of total health care expenditure.

Health care benefits and rationing

The revised health insurance law and associated regulations define the basic package of health care services covered by compulsory health insurance. The law enlarged the package of services previously covered by statutory health insurance.

The main additions to the basic package of care were unlimited stay in nursing homes, home care, unlimited stay in hospitals, accidents (if not covered by accident insurance), diagnostic and therapeutic equipment, transport, limited dental treatment¹³ and disease prevention and health promotion activities such

¹³ Dental treatment is covered by the compulsory health insurance only in the case of very severe and unavoidable diseases. As a result, most dental services are funded privately either by the patient or through supplementary health insurance. The amount of dental treatment received varies between socioeconomic groups.

as mammography, screening for newborn babies and hepatitis vaccination. The package has also been enlarged to include alternative therapy or complementary medicine from 1 July 1999 on the condition that the latter is offered by doctors. Acupuncture will definitely be covered by compulsory health insurance. Anthroposophic medicine, homeopathy, neural therapy, phytotherapy and Chinese medicine will be covered on a provisional basis until 30 June 2005 when a final decision will be taken.

The following services are not included in the compulsory health insurance package:

- routine dental care such as dental check-ups (except those provided for children in schools), fillings and extraction, dentures not related to congenital malformation or special diseases;
- psychotherapy provided by non-medically qualified practitioners and hypnosis (only psychiatric services are paid);
- medicines not mentioned in the approved lists of medicines and pharmaceutical products;
- non-essential interventions such as plastic surgery not related to accidents, disease or congenital malformation;
- in vitro fertilization.

The following services are only partly financed by compulsory health insurance according to certain restrictions:

- spectacles
- therapies in thermal baths
- medical aids
- transportation and emergency rescue services.

Rationing has again become a theme of public discussion in response to the recent use of new and extremely expensive orphan drugs (i.e. drugs developed to treat rare diseases) in university hospitals, which have to be financed by some cantons which own the university hospitals.

Cost-containment measures undertaken since the introduction of the revised health insurance law include:

- reducing the number of public and publicly subsidized hospitals and hospital beds;
- merging public and publicly subsidized hospitals;
- global budgeting for cantonal subsidies of hospitals;

- regulating the retail price of drugs¹⁴ and health services by setting maximum limits;
- introduction of fixed allowances and budgets;
- managed care policies such as establishment of health maintenance organizations (HMOs) and referral through general practitioners.

Future cost containment policies are more likely to focus on improving efficiency rather than, as the insurance companies would like, a reduction in the benefits package. In order to maintain the quality of all services covered by compulsory health insurance, the revised health insurance law enables the Federal Council to conduct systematic and scientific quality controls. Scientific evaluation of such social policy issues as accessibility to health care and the burden of financing for low-income households is also expected.

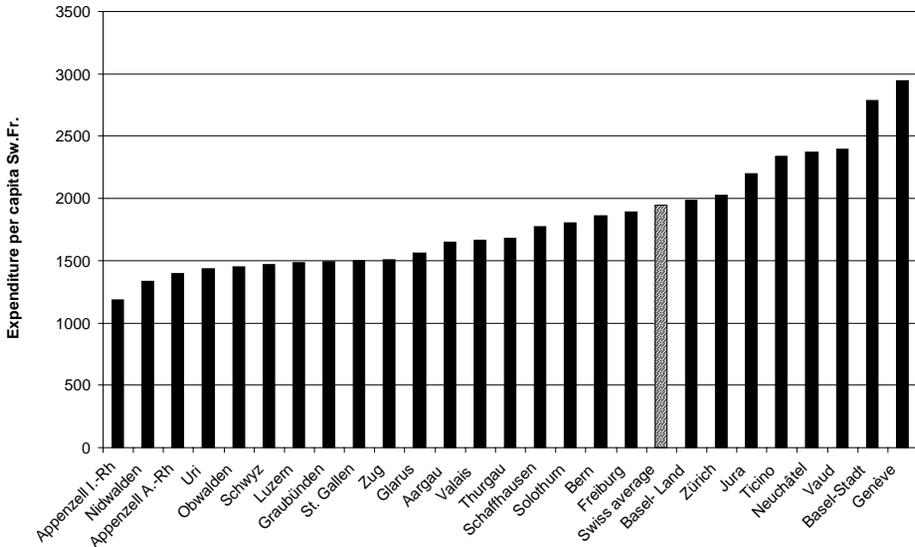
These controls are intended to maintain the very high quality and accessibility of care in Switzerland while meeting the general requirements of the new law to promote efficient cost management.

Health care expenditure

Health expenditure as a share of GDP has continued to grow over the last two decades (see Table 4) with spending in 1996 reaching 10.1% of GDP. This is most likely a result of the high levels of supply (Switzerland has the highest hospital density, concentration of high-technology equipment and one of the highest doctor to population ratios in Europe) and utilization. In addition to the level of provision, culture and tradition have an influence on consumption (see Fig. 3). French-speaking and German-speaking cantons exhibit different patterns of expenditure as do the rural and urban areas. Variation in expenditure is partly a result of cultural difference in utilization rates with the predominantly French speaking cantons consuming more services. It also relates to the density of providers which is greater in urban areas.

The percentage of Swiss GDP devoted to health is seen in a wider European context in Fig. 4 and Fig. 5. Switzerland spends more on health care than most countries in the European Region with only Germany spending more (10.7% of GDP). In 1970 Switzerland spent a smaller proportion of its GDP on health care than France, Italy or Germany. By the mid-1980s it had outstripped Italy, yet it was not until the mid 1990s that it overtook France.

¹⁴ Prices for medicines are fixed by the Federal Office for Social Insurance.

Fig. 3. Expenditure per person by canton under Compulsory Health Insurance, 1998¹⁵

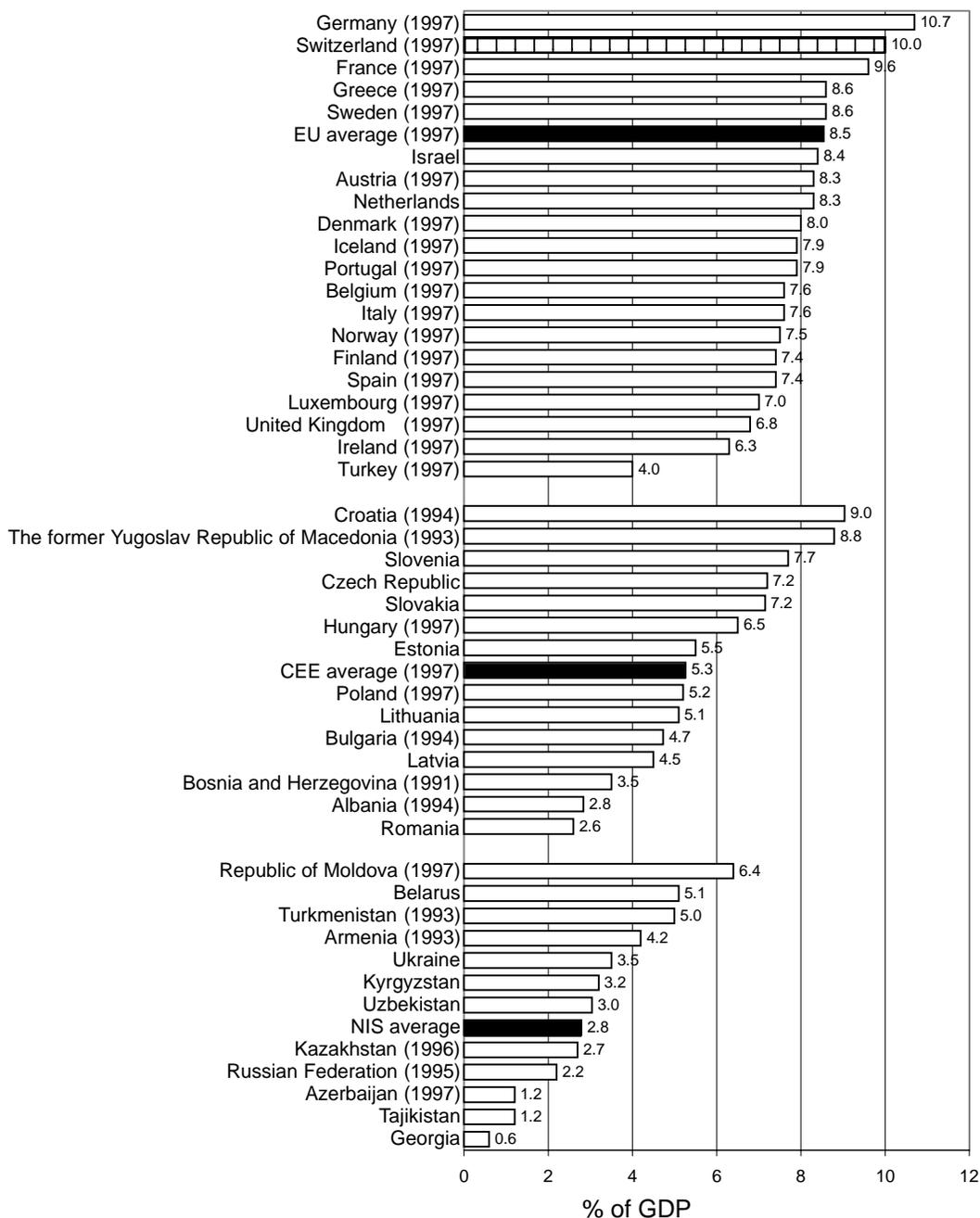
Source: Association of Swiss Health Insurance Companies (2)

The level of health care expenditure in US \$PPP is shown in Fig. 6 and amounts to US\$ PPP 2611 in Switzerland, well over the European Union (EU) average of US \$PPP 1771. Switzerland tops all European countries' health care expenditure when calculated as per capita expenditure in US \$PPP, exceeding the amount in both Germany (2364) and Luxembourg (2303).

Fig. 7 shows the proportion of total health expenditure from government or public sources. Switzerland appears to be one of the lowest in the Region with 70% of total health expenditure from public sources. This is higher than the figure of 58.8% for the same year shown in Table 4 from data provided by the Swiss Federal Statistical Office. This would mean that Switzerland had one of the lowest proportions of public expenditure on health in the European Region, lower even than Portugal (60%). The proportion of health care expenditure funded through public financing is low relative to other western European countries because a large proportion of health care is financed directly by patients and by supplementary insurance.

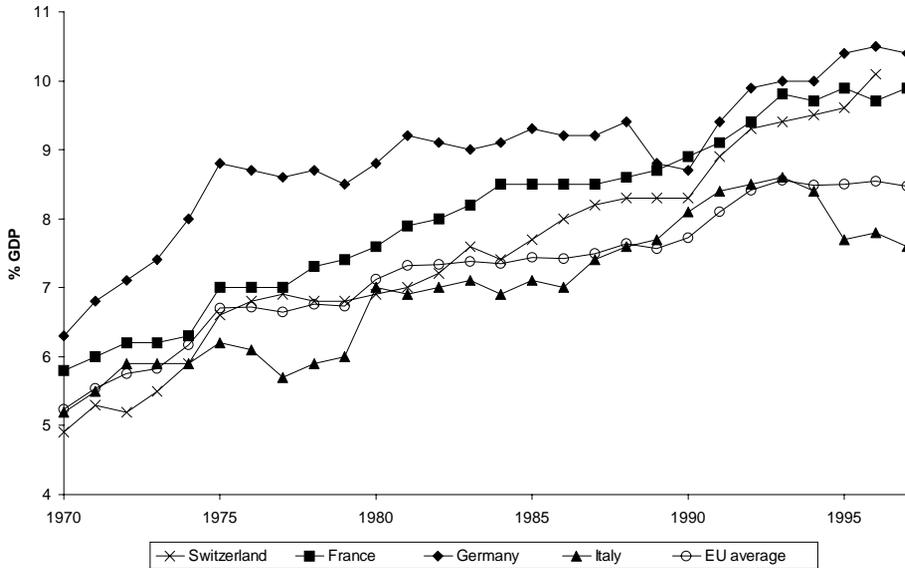
¹⁵ Geneva, Neuchâtel (Neuenburg), Vaud and Jura are predominantly French speaking cantons, Ticino is predominantly Italian speaking, Berne, Freiburg (Fribourg) and Wallis (Valais) are bilingual (German/ French) cantons and Graubünden is part Romansch and part Italian but is usually considered to be a German speaking canton.

Fig. 4. Total expenditure on health as a % of GDP in the WHO European Region, 1998 (or latest year)



Source: WHO Regional Office for Europe health for all database.

Fig. 5 Trends in health care expenditure as a % of GDP in Switzerland and selected countries, 1970–1996



Source: WHO Regional Office for Europe health for all database; Swiss Federal Statistical Office 1999

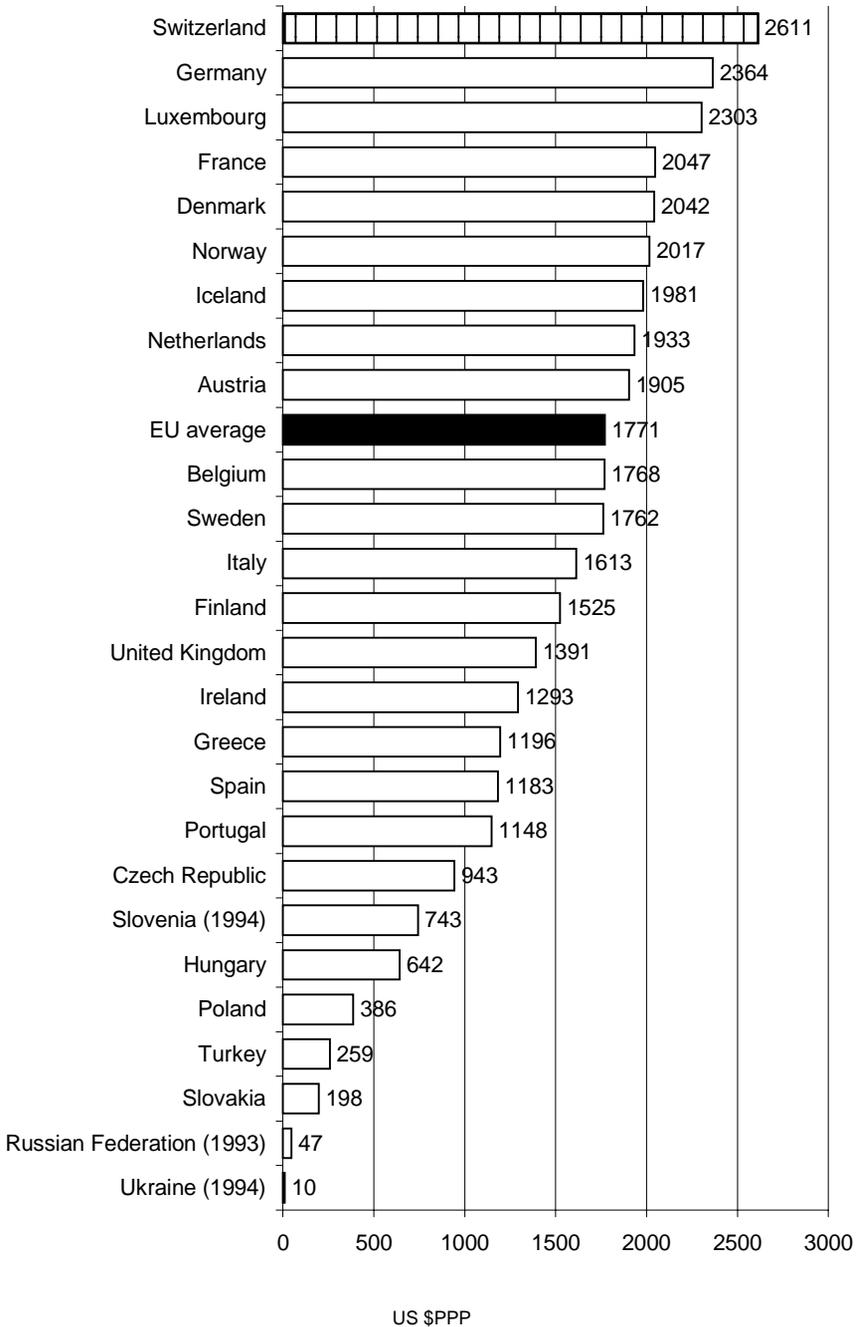
Table 4. Trends in health care expenditure, 1970–1997

Total expenditure on health care	1970	1975	1980	1985	1990	1994	1995	1996	1997
Value in current prices (million Sw.fr.)	4 697	9 810	12 373	18 383	26 308	33 817	35 050	36 940	37 200
Value in constant prices 1990 (million Sw.fr.)	14 651	17 537	18 445	21 196	26 308	28 538	29 039	30 033	30 024
Value in current prices, per capita (US \$PPP)	252	483	801	1 250	1 760	2 288	2 403	2 499	2 547
Share of GDP (%)	5.7	7.3	7.3	7.8	8.3	9.5	9.6	10.1	–
Public as share of total expenditure on health care (%) ¹	–	–	65.1	63.3	65.2	57.8	57.4	58.8	–

Source: WHO Regional Office for Europe health for all database; OECD Health Data 1998; Swiss Federal Statistical Office 1999

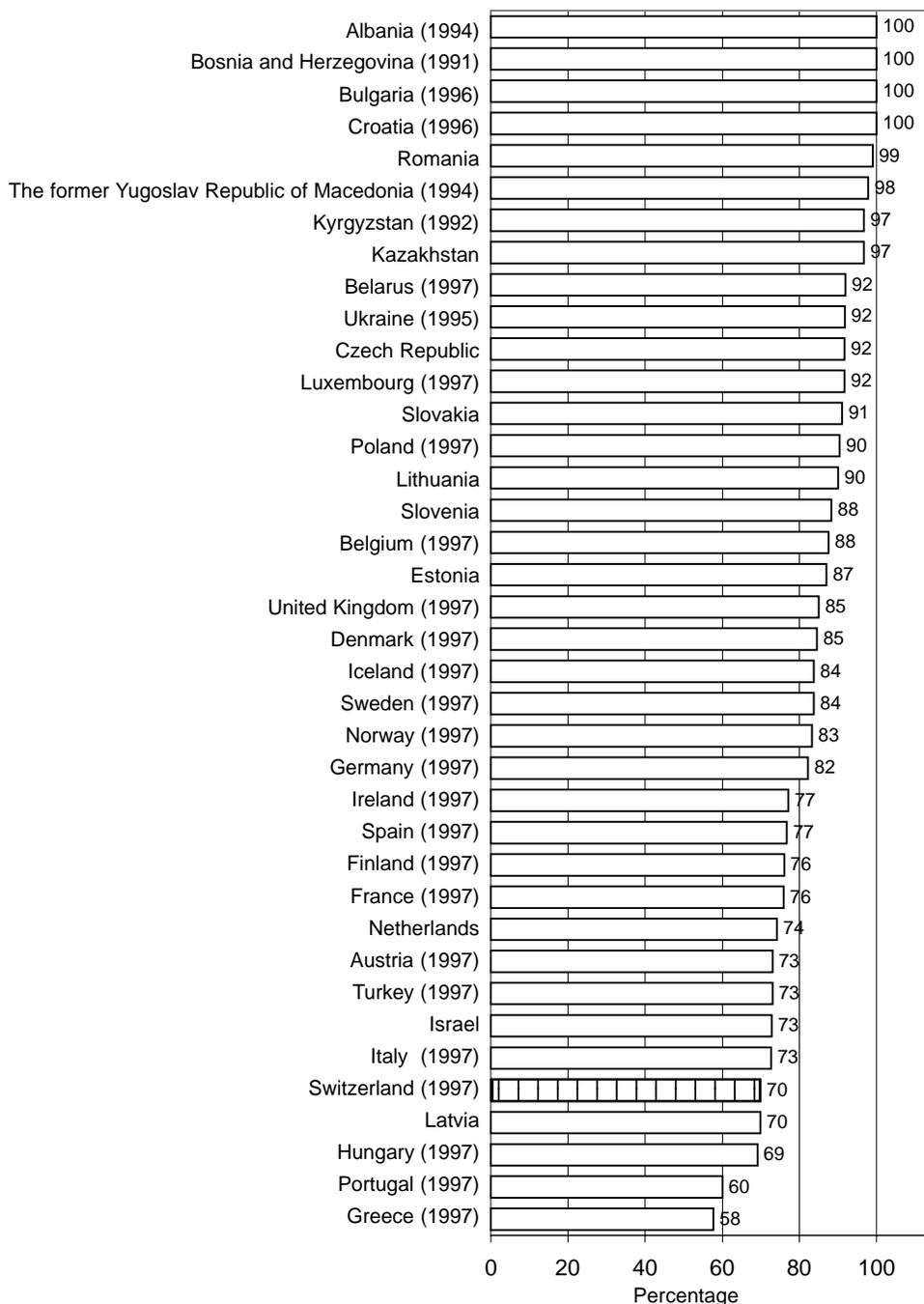
¹ Public health expenditure since 1994 excludes supplementary health insurance offered by companies who also offer compulsory health insurance, and cost sharing for compulsory health insurance. The figures from 1994 onwards include statutory/ compulsory health insurance, taxes and other statutory insurance schemes such as professional and non-professional accident insurance, old age and disability insurance.

Fig. 6. Health care expenditure in US \$PPP per capita in the WHO European Region, 1997 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Fig. 7. Proportion of total health expenditure from government (public) sources in the WHO European Region, 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Switzerland

Percentage

Switzerland's health care system consumes significant resources but offers broad and high-quality health care services. Nevertheless, just as in other European countries, the problem of increasing health expenditure and controlling it is one of the main concerns of government.

Table 5 shows the proportion of total health expenditure that is spent on different aspects of health care. The proportion of total health expenditure on pharmaceuticals has slightly decreased from 1975 to 1996. The proportion spent on inpatient care was relatively stable over the same period. The decline in pharmaceutical expenditure relative to other areas of expenditure is not particularly significant in policy terms and has been caused by several factors:

- the amount spent on inpatient care increased relative to pharmaceuticals
- pharmaceuticals were more expensive in 1975 than in 1996 relative to other European countries
- the heavy regulation of the pharmaceutical industry by the Federal Office for Social Insurance, such as through revisions to the drug lists and reduction in the retail prices.

Table 5. Health care expenditure by categories (as percentage of total expenditure on health care), 1970–1996

Total expenditure on	1970	1975	1980	1985	1990	1994	1995	1996
Inpatient care (%)	44.5	47.9	47.9	47.1	48.4	49.6	48.4	48.1
Pharmaceuticals (%)	17.3	12.9	13.6	12.6	11.5	11.0	11.2	11.1
Public investment (%)	–	5.8	3.3	2.6	3.3	3.3	3.2	2.8

Source: WHO Regional Office for Europe health for all database; OECD Health data 1998.

Health care delivery system

Ambulatory health care

Doctors in independent practice provide most ambulatory health care in Switzerland. Most doctor contacts take place in office-based practices; most are individual practices, although some group practices exist. Most doctors work with medical practice assistants. Of the 23 679 active doctors in Switzerland in 1998, 13 357 (56%) are private office-based doctors (3). About 36% of these are general practitioners and 46% specialists (4).

Patients are free to choose any doctor although most have a regular doctor. Patients also have direct access to specialists in an ambulatory care setting. However most patients are referred to hospital-based specialists. Certain hospitals, however, such as university teaching hospitals, run polyclinics which offer direct access to outpatient services and offer consultations for which patients can register themselves.

Ambulatory care is mainly financed by statutory/compulsory health insurance (around two thirds according to (4)) with the rest being financed by other statutory insurance schemes (accident insurance, maternity insurance, etc.), supplementary health insurance and direct out-of-pocket payments.

The revised health insurance law allows people to purchase insurance policies that cover benefits from a limited range of suppliers (similar to health maintenance organizations (HMOs) or a general practitioner system). HMOs are group practices that mainly employ general practitioners and specialists in internal medicine plus other health care personnel, such as public health nurses, physiotherapists and practice assistants. A few HMOs employ gynaecologists and paediatricians. The doctors in HMOs and general practitioner systems refer patients to particular specialists and hospitals, but the patient still has a free choice. An estimated 140 doctors are working in HMOs covering about 98 400 insured people. As many as 3792 doctors are in the system of general practice covering 350 000 people (5).

Dentists in independent practice provide most dental services. Exceptions are the polyclinics at university teaching hospitals and dental check-ups and oral health education provided in schools.

Fig. 8 shows that Switzerland has the highest number of outpatient contacts in western Europe with 11 contacts per person in 1992. This exceeds the European average of 6.1 contacts per person.

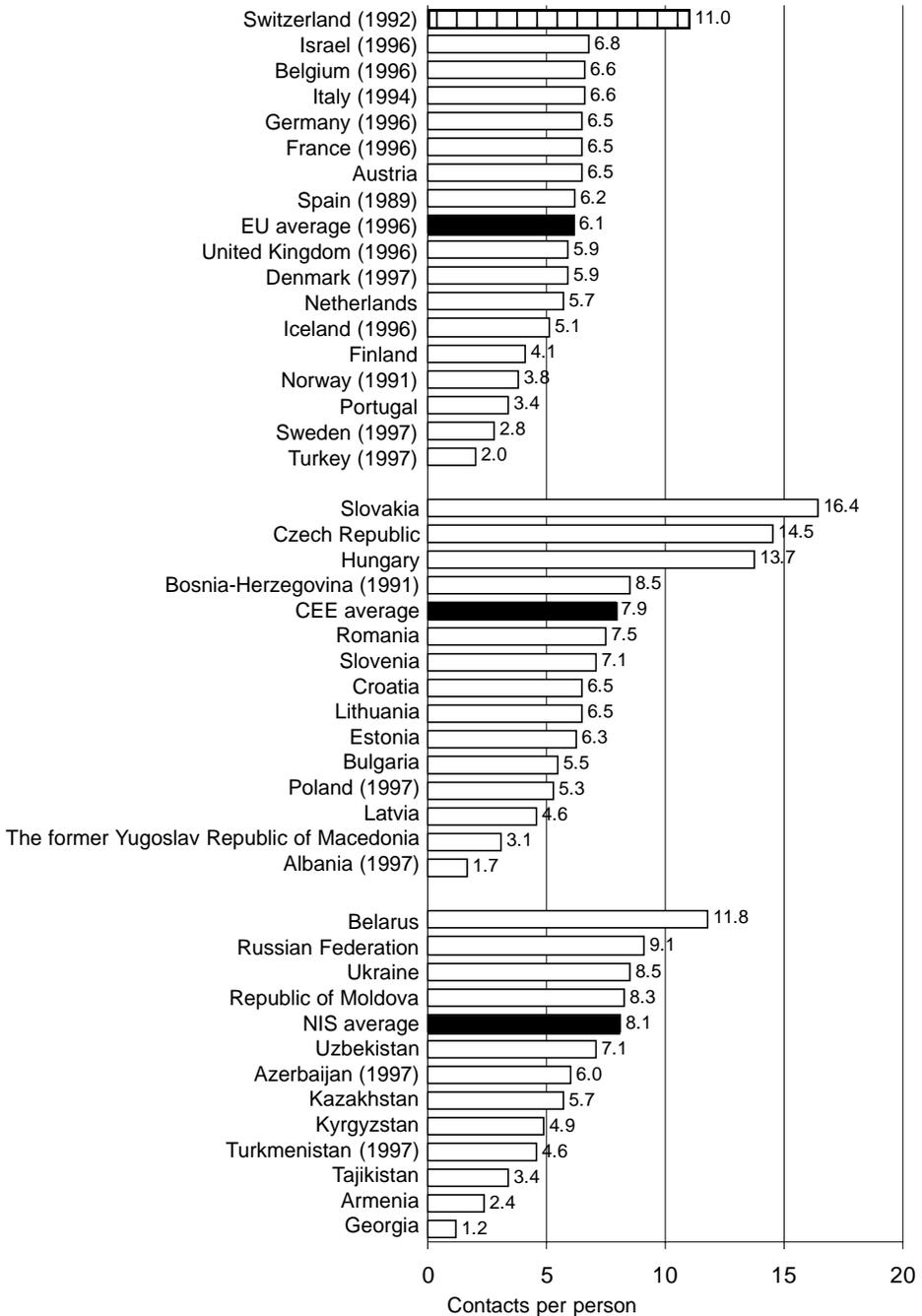
The following factors contribute to the exceptionally high number of doctor consultations per person:

- a high density of doctors and free choice of doctor
- fee-for-service payment system
- a relatively limited range of non-doctor providers of primary health care, such as nurses
- a culture that emphasizes a high level of utilization of health services
- a lack of negative financial incentives for individuals to reduce utilization.

There is little evidence in Switzerland as to whether the freedom of choice and high levels of utilization detailed above actually lead to high levels of satisfaction among the population. A study carried out in 1993/1994 (6), focusing on the regions of Basle and Zurich aimed to compare the satisfaction of patients covered by HMOs and those covered by normal insurance policies. A total of 2040 persons (of which 1040 were enrolled in HMOs) were asked to fill in a questionnaire and to answer questions over the telephone. The study used a slightly adapted version of the patient satisfaction questionnaire of Ware et al. (7). The study concluded that there was a high level of satisfaction and almost no significant differences between those insured by HMOs and those enrolled in traditional policies (6). Another study of public attitudes to the health care system showed that in general 13.1% of the population were “very satisfied”, 45.2% were “quite satisfied”, 23.3% dissatisfied and 18.2% were indifferent (8).

Managed care systems in general and the gatekeeper system in particular are very much in vogue. Many people believe that they are a good method of controlling costs. It is difficult to predict how the system of primary care provision will develop in future, as expansion of managed care systems will depend on consumer choice. Considerable expansion of managed care systems is however likely in the coming years as cost control continues to be an important factor in the organization of health care services.

Fig. 8. Outpatient contacts per person in the WHO European Region, 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Public health services

The federal government is responsible for controlling communicable diseases in accordance with the epidemics law described in the section on *Organizational structure* of the health care system. The obligations and legal duties of the government in this respect are defined clearly. The situation regarding disease prevention and health promotion is less clear and the responsibilities more diverse. The state and many NGOs are involved in this field.

Communicable diseases

Doctors and laboratories are legally obliged¹⁶ to report the incidence of certain diseases which are contained in a definitive list to the appropriate cantonal medical officer. The medical officer passes on these reports each week to the Swiss Federal Office for Public Health, which processes incoming reports, publishes weekly statistics and instigates measures to control a disease outbreak where necessary. The Federal Department of Home Affairs who established the compulsory reporting system defines the reporting criteria and reporting periods used in the collection of data. The Federal Office for Public Health checks the reports once a year to ensure that the information being collected remains appropriate, and when necessary consults with cantonal doctors and the medical associations about the data collection.

A voluntary reporting system came into being in 1986. Sentinella is a joint project run by the Swiss Federal Office for Public Health and the University of Berne in collaboration with the Swiss Medical Association and the Swiss Society for General Medicine. Between 150 and 250 general practitioners, specialists in internal medicine, paediatricians and a few gynaecologists supply data to the Swiss Federal Office for Public Health every week. In 1998, for example, the Sentinella reporting system required data on the incidence of influenza, measles, rubella, mumps, pneumonia and sexually transmitted diseases. Through this reporting system in the ambulatory sector, infectious diseases can be identified early and tackled promptly.

The Federal Department of Home Affairs and the Swiss Federal Office for Public Health are responsible for measures to prevent communicable diseases from entering from other countries. The measures decreed by the government are implemented (as described below) by the Swiss Federal Office for Public Health, and by its Frontier Medical Service in particular, with the assistance of the federal and cantonal frontier control bodies.

¹⁶ This obligation is embodied in the Ordinance on the reporting of communicable diseases in humans (13 January 1999)

People entering the country to take up residence are examined for pulmonary tuberculosis and, in certain cases, for other communicable diseases. The Swiss Federal Office for Public Health can recommend or order people entering the country to be immunized against certain communicable diseases. Examination by the Frontier Medical Service is mandatory for non-Swiss citizens entering Switzerland to take up employment for the first time and for refugees and asylum-seekers.

There is no general requirement for immunization in Switzerland though compulsory health insurance covers many immunizations.¹⁷ The Swiss Federal Office for Public Health and the Federal Commission on the Question of Immunization publish a routine immunization schedule that is updated occasionally. Immunization against diphtheria or tetanus is mandatory in some cantons.

Switzerland is in line with the average measles immunization rate for western European of over 80% (Fig. 9). The financial resources and infrastructure available would allow for a higher level of immunization, but there is relatively widespread and controversial discussion about the need for universal immunization. There is a certain degree of scepticism, especially towards immunization against diseases of childhood (measles, mumps and rubella). The educational level of the mother and the immunization rate for these diseases are negatively correlated: the higher the educational level of the mother, the lower the immunization rate (8).

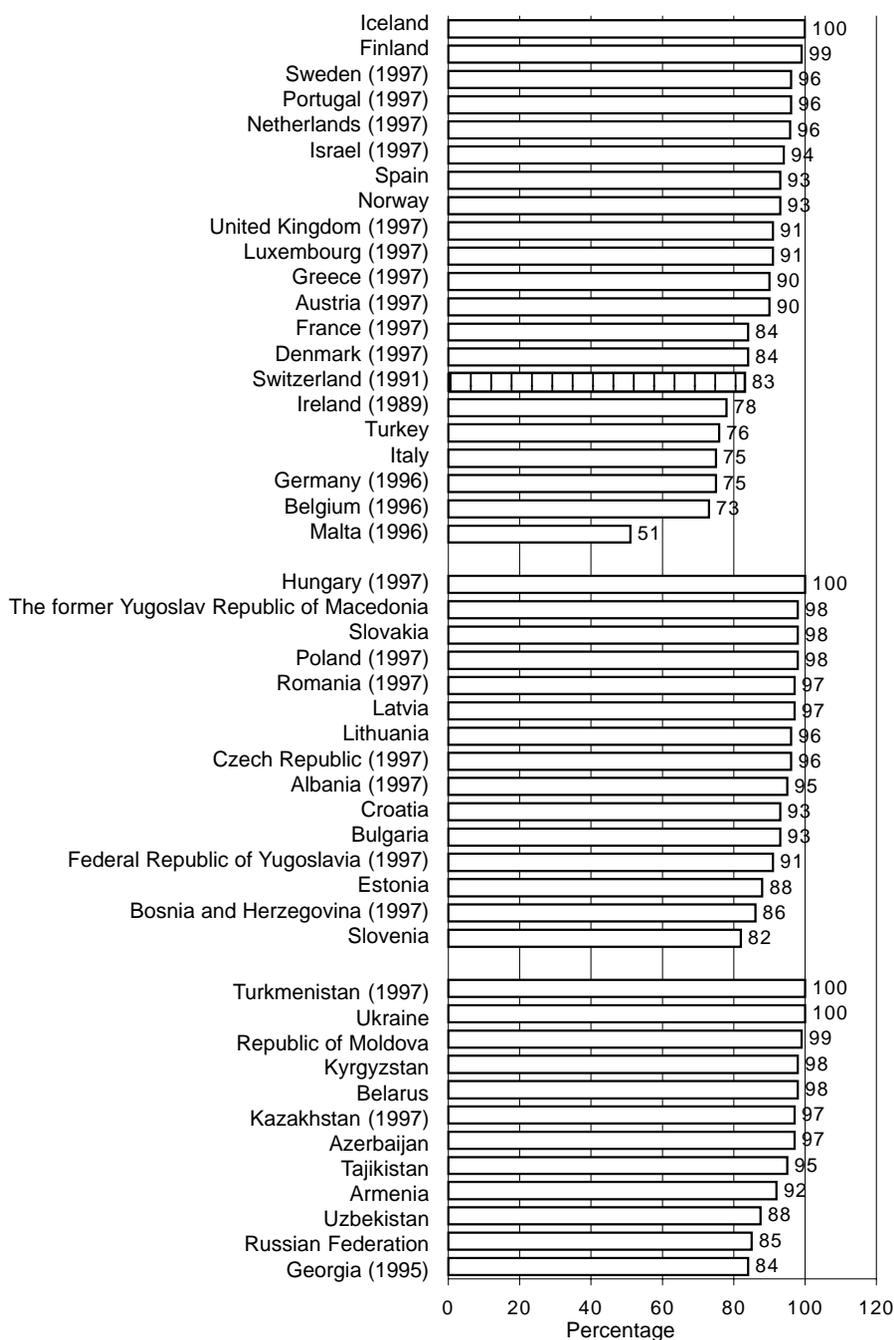
Table 6. Rates of immunization, 1998

Disease	Percentage
Diphtheria	94.3
Tetanus	93.3
Poliomyelitis	92.1
Pertussis	88.1
Measles	81.4
Mumps	78.9
Rubella	78.7
Haemophilus influenza	76.9
Tuberculosis	20.6
Hepatitis B	4.7

Source: Swiss Federal Office for Public Health (8)

¹⁷ Immunizations against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps and rubella are given to children up to the age of 16 years. Measles vaccine is also given to women of child-bearing age who have not been immunized previously. Boosters against diphtheria and tetanus are given to adults every 10 years. Haemophilus influenzae vaccine is given to children under 5 years old. Influenza vaccine is given to severely ill people for whom influenza would lead to severe complications and to people over 65 years of age. In accordance with the recommendation of the Swiss Federal Office for Public Health and the Federal Commission on the Question of Immunization, hepatitis B immunization is given to newborn babies of hepatitis-positive mothers and to those with a high risk of infection. Tetanus boosters are given after an injury.

Fig. 9. Levels of immunization for measles in the WHO European Region, 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Switzerland

Accident prevention

The Federal law on labour compels all employers to protect the health of their workforce. Employers should take all measures that experience has shown to be necessary, that are possible given the state of technology and that are appropriate to the situation in the workplace. The cantons, under the supervision of the federal government, are responsible for ensuring that this requirement is observed. They collaborate with the Federal Labour Inspectorate and the Swiss National Fund for Accident Insurance.

The Swiss National Fund for Accident Insurance is an independent public body. Until the accident insurance law was revised in 1981, it had sole responsibility for compulsory accident insurance. Since then additional insurance companies have been granted a license to offer accident insurance. The Fund continues to be the most important provider of compulsory accident insurance by far. It also has other duties under the terms of the accident insurance law. In conjunction with the occupational safety organizations in each canton, the Fund enforces the regulations governing the prevention of accidents at work.

Together with the other providers of accident insurance, the Fund also promotes the prevention of non-work-related accidents. A joint institution has been established, the Swiss Council for Accident Prevention, which is responsible for preventing road traffic accidents, accidents in the home and garden and injuries from sport and leisure activities. It also coordinates the accident prevention activities of other organizations with similar objectives. The Council is financed by an additional premium levied on the net premiums paid by employers for compulsory insurance against non-work-related accidents.

Disease prevention and health promotion

Compulsory health insurance pays for certain investigations for the early detection of diseases in defined risk groups and for examinations carried out in connection with pregnancy and childbirth.

The federal government has taken on an important role in preventing disease and promoting public health. The central function of the Swiss Federal Office for Public Health is to develop, manage, coordinate and ensure the quality of disease prevention and health promotion programmes. It also ensures financial backing for related projects.

These programmes follow the recommendations and principles of WHO (in particular, the Ottawa Charter for Health Promotion) and UNAIDS (the Joint United Nations Programme on HIV/AIDS), which are based on the principle of promoting health. People should be able to take responsibility for maintaining and improving their own health. The appropriate social, political

and economic framework needs to be created to ensure that people are in a position to take responsibility for their health. The cantons, municipalities and nongovernmental organizations implement these programmes at the regional and local level.

There are many other projects in addition to those connected with programmes run by the federal government. The Swiss Foundation for Health Promotion proposes measures to promote public health and prevent disease and coordinates and evaluates them. It is funded out of revenue from compulsory health insurance premiums and contributions from its founders and other interested parties. As a coordinating body, the Foundation aims to record all the preventive and health-promoting activities carried out in Switzerland, to identify shortfalls and to define objectives, measures and activities for Switzerland as a whole (see section on *Organizational structure of the health care system*).

The municipalities

Many municipalities have healthy living centres offering a variety of health-promoting activities that vary from one municipality to the next. Some offer family planning services and others women's health clinics or other services for which municipalities are responsible (see the section on *Organizational structure of the health care system*). They are staffed by a variety of professionals depending on the main function of the health centre: providing information or services. They are run by either the municipalities or nongovernmental organizations with public subsidies.

Secondary and tertiary care

There are public, publicly subsidized and private hospitals in Switzerland. The public hospitals may be operated by the canton in which they are located, associations of municipalities, individual municipalities or independent foundations.

The private hospitals do not receive any financial subsidies but are financed solely by payments made by health insurance companies and patients (see the section on *Payment of hospitals*). Private hospitals included in the cantons' hospital list can be reimbursed for services under compulsory health insurance (see the section on *Planning, regulation and management*).

Since 1997, the Swiss Federal Statistical Office has collected data on hospital activity and services. Previously the Swiss Association of Hospitals collected

these data concerning its members, which meant that nursing homes and the hospitals that were not members of the Swiss Association of Hospitals, were not taken into account. The statistical data collected by the Swiss Federal Statistical Office, despite being more comprehensive, is less reliable than that previously collected because many institutions simply do not respond, whilst others give data which is not accurate. This is a problem of transition and it is predicted that the data collected will improve in time. The most recent data indicate that there were 406 hospitals in Switzerland in 1997. Of these, 272 were public or publicly subsidized hospitals (10).

Table 7 shows the number of hospitals by type. There are five university hospitals in Zurich, Berne, Basle, Lausanne and Geneva.

Table 7. Number and type of hospitals, 1997

Type of hospital	Number of hospitals
General hospitals	
University hospitals	5
Non-university hospitals	221
Total	226
Specialist Hospitals	
Psychiatric clinics	61
Rehabilitation clinics	46
Surgical clinics	19
Other specialist hospitals	53
Total	180
Total	406

Source: Swiss Federal Statistical Office (9)

Secondary care

Switzerland has a very well developed infrastructure of hospital care.

For the purposes of planning and funding, secondary care can be divided into two parts, each of which is governed by different regulatory principles. The federal government has no planning authority for outpatient and short-stay inpatient care (one night or less) nor does it provide subsidies for it. In contrast, inpatient hospital care (of more than one night) is subject to state planning and receives public subsidies (see the sections on *Planning, regulation and management* and *Main system of finance and coverage*).

This results in a system that does not always provide incentives for treatment that is optimal for health and economically efficient. Health insurance providers, for example, will tend to favour inpatient treatment since some of the cost is borne by the state. The incentive structure affecting hospitals and

doctors is complex. Their preference for either inpatient or for short-stay or outpatient treatment is determined by many different factors such as hospital capacity and occupancy rates. Treatment decisions are not always based solely on health considerations. The Federal Council has proposed revising the health insurance law to attempt to remove the perverse incentives (see the section on *Health care reforms*).

Table 8 shows trends in the utilization and performance of inpatient services in Switzerland. The occupancy rate has fluctuated since 1980. Occupancy rates dropped from an average of nearly 85% of beds to about 82% in 1990 before rising again to nearer 86% in 1997. The average length of stay has been reduced dramatically from 26 bed days in 1970 to only 13 bed days in 1997. This has been paralleled by a small increase in admission rates, but overall the capacity utilization has improved.

Table 8. Hospital inpatient facilities utilization and performance, 1970–1996

Inpatient	1970	1975	1980	1985	1990	1994	1995	1996	1997
Admissions per 100 population	13.1	11.4	12.6	13.1	13.9	15.0	–	–	–
Average length of stay in days	26.0	25.8	24.7	24.4	19.7	17.4	17.0	–	13.0
Occupancy rate (%)	–	–	84.6	85.2	82.4	83.5	84.7	84.4	85.8

Source: OECD health data 1998; Swiss Federal Statistical Office 1999.

Note: The 1997 data are from the new statistics produced by the Swiss Federal Statistical Office. The older data are from The Swiss Association of Hospitals. The underlying definitions and institutions are not exactly the same. Includes psychiatric and rehabilitation but not long-term care facilities.

Switzerland has one of the longest average length of stay in acute hospitals in western Europe (see Table 9), even though the duration has dropped continuously since the mid-1980s from around 25 to around 13 days (see Table 8). This above-average figure is slightly compensated by a below-average number of hospital admissions, giving a capacity utilization which lies around the mid-range in the ranking of western European countries.

Fig. 10 shows that the number of acute beds per 1000 population in 1990 in Switzerland (6.1) was above the European average (5.0). The latest figure available shows that Switzerland has followed the trend in bed reduction seen in most other western European countries including France and Italy. The main reason for the reduction in bed numbers throughout Europe is the decline in the length of stay in hospital. This is a result of technological development and the political desire to increase efficiency through a reduction in excessively long stays.

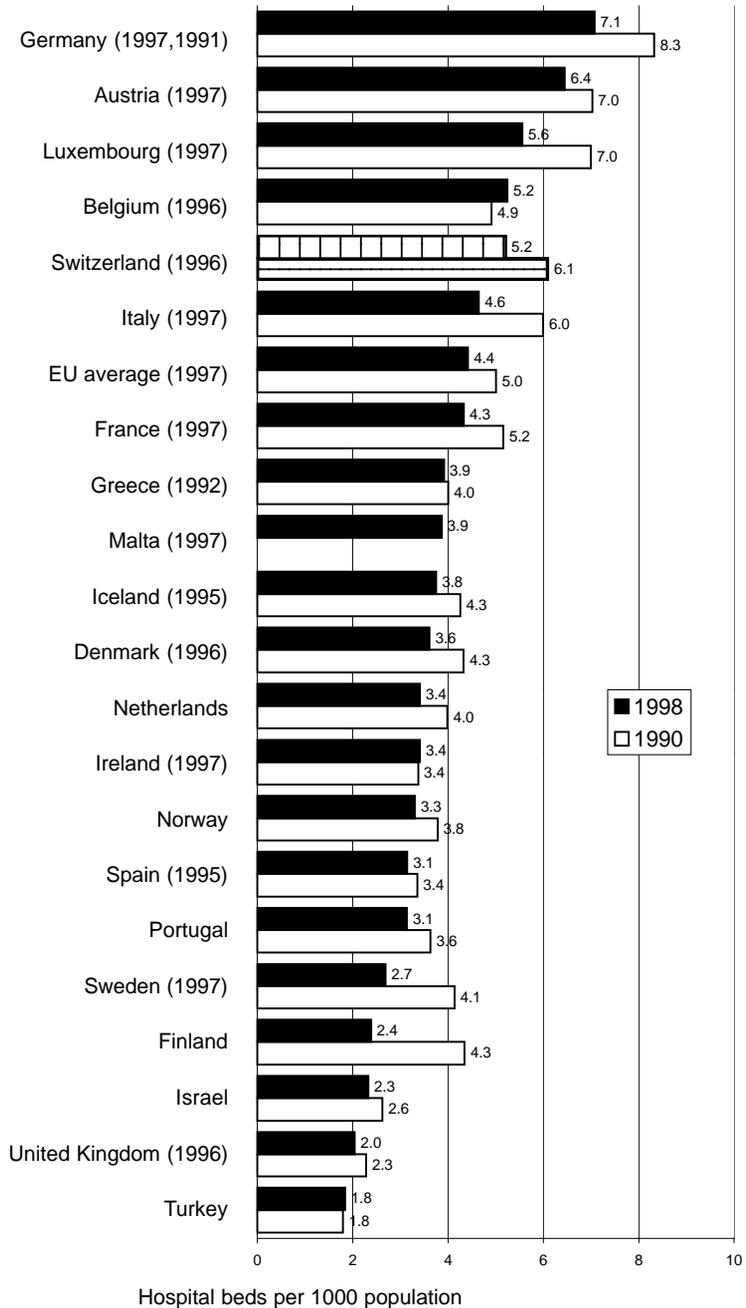
Table 9. Inpatient utilization and performance in acute hospitals in the WHO European Region, 1998 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	6.4 ^a	24.7 ^a	7.1 ^a	74.0 ^a
Belgium	5.2 ^b	18.0 ^b	7.5 ^b	80.6 ^c
Denmark	3.6 ^b	18.8 ^b	5.6 ^b	81.0 ^b
Finland	2.4	20.5	4.7	74.0 ^c
France	4.3 ^a	20.3 ^c	6.0 ^b	75.7 ^a
Germany	7.1 ^a	19.6 ^a	11.0 ^a	76.6 ^a
Greece	3.9 ^f	—	—	—
Iceland	3.8 ^c	18.1 ^c	6.8 ^c	—
Ireland	3.4 ^a	14.9 ^b	6.7 ^b	82.3 ^b
Israel	2.3	18.4	4.2	94.0
Italy	4.6 ^a	16.5 ^a	7.0 ^a	76.0 ^a
Luxembourg	5.6 ^a	18.4 ^d	9.8 ^b	74.3 ^d
Malta	3.9 ^a	—	4.5	72.2 ^a
Netherlands	3.4	9.2	8.3	61.3
Norway	3.3	14.7 ^b	6.5 ^b	81.1 ^b
Portugal	3.1	11.9	7.3	75.5
Spain	3.1 ^c	10.7 ^c	8.5 ^b	76.4 ^c
Sweden	2.7 ^a	16.0 ^b	5.1 ^b	77.5 ^b
Switzerland	5.2 ^b	14.2 ^e	11.0 ^a	84.0 ^a
Turkey	1.8	7.1	5.5	57.3
United Kingdom	2.0 ^b	21.4 ^b	4.8 ^b	—
CCEE				
Albania	2.8 ^a	—	—	—
Bosnia and Herzegovina	3.4 ^g	7.4 ^g	9.7 ^g	70.9 ^g
Bulgaria	7.6 ^b	14.8 ^b	10.7 ^b	64.1 ^b
Croatia	4.0	13.4	9.6	88.2
Czech Republic	6.5	18.4	8.8	70.8
Estonia	6.0	17.9	8.8	74.6
Hungary	5.8	21.7	8.5	75.8
Latvia	—	—	—	—
Lithuania	—	—	—	—
Poland	—	—	—	—
Romania	—	—	—	—
Slovakia	7.1	19.3	10.3	77.9
Slovenia	4.6	15.9	7.9	75.4
The former Yugoslav Republic of Macedonia	3.5 ^a	8.1	8.9	66.5
NIS				
Armenia	6.0	6.0	10.7	30.2
Azerbaijan	8.0	5.6	—	—
Belarus	—	—	—	88.7 ^d
Georgia	4.6 ^b	4.8 ^b	8.3 ^b	26.8 ^d
Kazakhstan	6.6	14.9	13.0	91.2
Kyrgyzstan	6.7	15.8	12.9	81.7
Republic of Moldova	9.1	16.9	15.4	77.6
Russian Federation	9.0	19.9	14.0	82.5
Tajikistan	6.2	9.7	13.0	59.9 ^b
Turkmenistan	6.0 ^a	12.4 ^a	11.1 ^a	72.1 ^a
Ukraine	7.4	17.9	13.4	88.1
Uzbekistan	—	—	—	—

Source: WHO Regional Office for Europe health for all database.

Note: ^a 1997, ^b 1996, ^c 1995, ^d 1994, ^e 1993, ^f 1992, ^g 1991, ^h 1990.

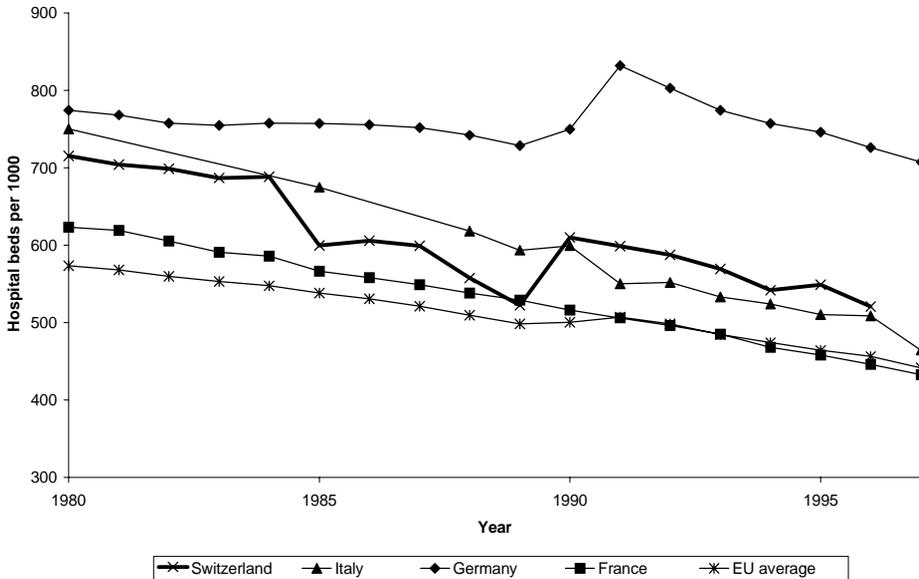
Fig. 10. Hospital beds in acute hospitals per 1000 population in western Europe, 1990 and 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Switzerland

Fig. 11. Number of acute hospital beds per 100 000 population in Switzerland and selected countries, 1980–1997



Source: WHO Regional Office for Europe health for all database.

Tertiary care

Highly complex and highly specialized treatment is provided by university hospitals, some large cantonal hospitals and, in certain areas, private clinics operating with or without subsidies. This situation has developed over time in a largely uncoordinated fashion, usually at the instigation of interested doctors and hospitals.

It is generally agreed that, in the near future, Switzerland will have to reduce excess capacity in high-technology medicine and specialized treatments and to concentrate this type of health care in a few centres of excellence. This will necessitate intercantonal and partly even national planning of delivery structures.

There is no agreement on how this type of planning should be implemented. Two basic alternatives are being discussed. Under the first alternative, the federal government would create the necessary regulation for intervening in the planning of high-technology health care and centres of excellence and would ensure that hospital planning is carried out at the federal level in these areas. The other version leaves responsibility for tertiary health care with the cantons, who would coordinate delivery structures throughout the country. This coordination could be enforced by means of a legally defined intercantonal agreement.

Social care

Although the organization of nursing care outside hospitals is currently being streamlined, making the services provided more comprehensive and accessible to the user, services are still inadequate in some cases. The revised health insurance law has brought about improvements by expanding cover for home nursing care and care in nursing homes. However, the providers of health insurance are not yet fully obligated to pay in full the cost of home nursing care. An unknown, but certainly large, proportion of people requiring nursing care are looked after by informal carers, with or without assistance from nursing and home care-organizations (known as “Spitex” services).

The formal nursing care network provides outpatient, short-term stay and inpatient services. There are two main categories of ambulatory service provider: practising doctors and Spitex services. The high density of doctors in Switzerland means the capacity exists to provide home medical care services throughout the country. Coverage by Spitex services is fairly comprehensive, although there is regional variation.

It is not yet possible to quantify the level of inpatient services provided for the disabled and elderly. Although the cantons generally subsidize the construction of nursing homes, many cantons keep no detailed statistics on the number of beds available. In most cantons, the municipalities are responsible for nursing homes and often commission private organizations to build and run such facilities.

Various indicators suggest that the capacity of the available inpatient services is sufficient – with regional variation – to meet current needs.

Table 10. Number and type of institutions for the disabled, elderly and others requiring care, 1997

Type of institution	Number
Residential facilities	
Nursing care homes	436
Old people's and nursing care homes	951
Old people's homes	222
Total	1609
Institutions for the care of the disabled and other institutions	
Institutions for the disabled	573
Institutions for addicts	144
Other social care institutions	149
Total	866
Total	2475

Source: Swiss Federal Statistical Office (9)

In recent decades there has been a massive shift in Switzerland from residential accommodation (i.e. without nursing care) to accommodation for people who require light to intensive nursing care in old people's homes. Despite this change, some elderly people requiring nursing care are probably still being admitted to hospital because not enough nursing beds are available. Before the revised health insurance law was introduced with extended cover to include reimbursement of nursing care, there was also a financial incentive to hospitalize patients requiring nursing care. In contrast to stays in nursing homes, the health insurance companies paid for hospital stays in full. In nursing homes, private households paid the largest share of the costs.

One of the most significant additions to the compulsory health insurance benefits package, introduced by the revised health insurance law, is cover for services provided in nursing homes and by home nursing organizations (Spitex services). Before insurance companies will pay nursing costs in full, a standardized cost accounting system has to be put in place by service providers. In recent years nursing homes and Spitex services have been the two areas in which expenditure by the health insurance companies has risen the most.

However, until the health insurance companies start paying for these services in full, the difference will continue to be funded by out-of-pocket payments, by other social insurance systems, including occupational accident insurance, old age and disability insurance, non-occupational accident insurance and supplementary benefits and, if this is not sufficient, by the welfare assistance system.

Disability insurance covers the cost of medical, nursing and rehabilitation services prescribed in the course of treatment following disability. Disability is defined in the disability insurance law as damage to health resulting in permanent or long-term incapacity to work.

Supplementary benefits are available to make up the shortfall (up to a fixed level) between the costs of care of old-age pensioners or recipients of a state disability pension and the money they have available. Since personal wealth/income and level of nursing care required both vary considerably from one person to the next, the amount paid in supplementary benefit also varies widely.

If supplementary benefits are not sufficient to make up the shortfall, the cantonal or municipal welfare assistance systems, which are funded out of taxation, come into play. The systems vary greatly between cantons, but there are two basic forms that welfare assistance takes. Under the first, it is the municipalities' responsibility to finance the costs of nursing care that cannot be covered either by the individual or supplementary benefits. Under the second, the cantons make top-up payments in addition to the supplementary benefits, either alone or in conjunction with the municipalities.

Human resources and training

Table 11. Health care personnel, 1970–1997

Number per 1000 population	1970	1975	1980	1985	1990	1995	1996	1997
Active doctors	1.4	1.8	2.4	2.7	2.9	3.2	3.2	3.3
Active dentists	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5
Certified nurses	5.1	–	9.9	–	13.8	–	–	–
Active pharmacists	0.3	–	0.4	–	0.5	–	–	–

Source: OECD Health data 1998; Swiss Federal Statistical Office 1999

Doctors

The training of doctors is generally considered to be of a good standard in Switzerland, although reform is needed in certain areas (see below). Medical training lasts a minimum of six years; divided into two years of basic training, three years of clinical training and an elective year. The entire course of study concludes with a standardized examination (the federal medical examination). The federal government is responsible for the examination of basic training.

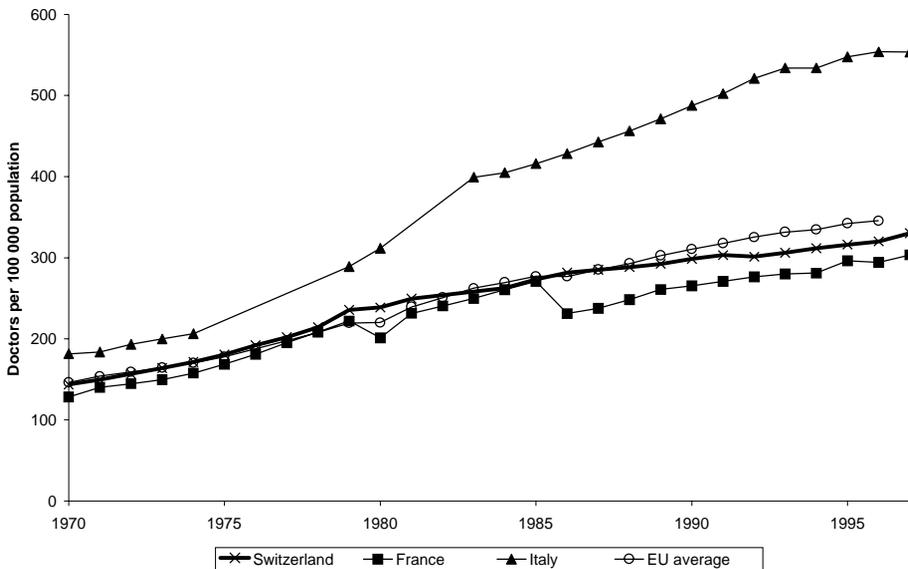
Doctors are then trained in a medical specialty. The length of postgraduate training varies between fields but generally lasts between five and seven years. The Swiss Medical Association, which awards specialist qualifications, recognizes about 50 specialties including training in general practice. The 13 357 general practitioners and internists comprise about 40% of all doctors. If paediatricians are included, this figure rises to 45% (3).

No training is currently provided for chiropractors; they have to pass an examination given by the Swiss Conference of the Cantonal Ministers of Public Health before they may work in Switzerland.

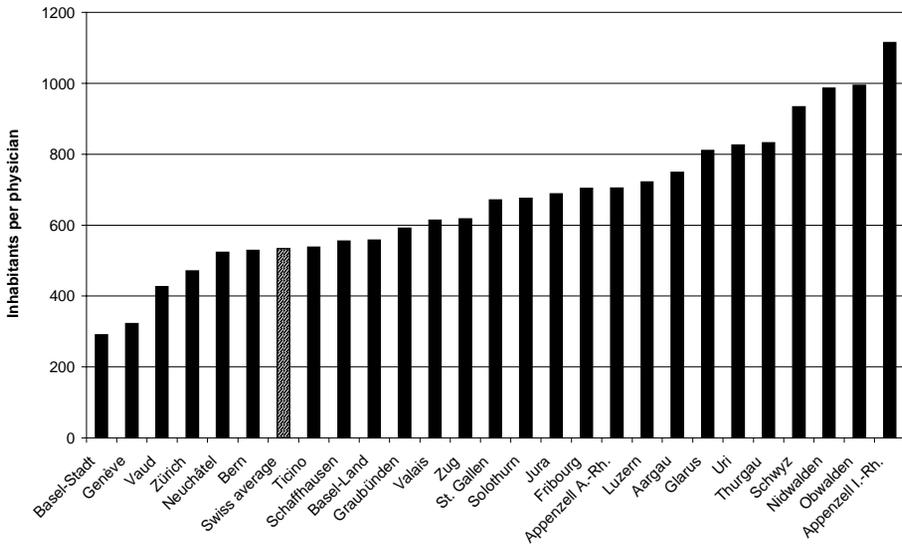
The number of doctors is in line with the EU average, but within Switzerland is considered to be very high. One particular problem is the fact that the number of doctors is still growing despite the high density (by 3% in 1996–1997). Moreover, the interest of young people in studying medicine has not declined. The number of students registering for medicine remained stable in the 1970s and 1980s but rose sharply in the 1990s. A test measuring aptitude to study medicine was introduced in 1998 at the universities in Basle, Berne, Fribourg (Freiburg) and Zurich, as the number of people applying to study medicine was far greater than the number of places available. More stringent selection criteria were adopted in the preliminary medical examinations at the universities in Geneva, Lausanne and Neuchâtel (Neuenburg). The number of places available to study medicine at these seven universities in 1999 was 923.

The number of doctors per person varies between regions. In 1998 the highest numbers of doctors were found in Basle, with one doctor for every 291 inhabitants, and Geneva, with one for every 322 inhabitants. Appenzell has the lowest density of doctors, one doctor for 1115 inhabitants, and Obwalden has one doctor for every 994 inhabitants (see Fig. 13). There appears to be a number of possible factors that cause the patterns of higher density of doctors in urban areas particularly specialists. Such as the concentration of doctors around university hospitals, higher rates of school matriculation necessary for entry to medical training, and finally higher numbers of specialists in ambulatory care where the market for such services is larger.

Fig. 12. Number of doctors per 100 000 population in Switzerland and selected countries, 1970–1997



Source: WHO Regional Office for Europe health for all database.

Fig. 13. Number of inhabitants per doctor in independent practice by canton.1998

Source: Swiss Medical Association (3)

Dentists and pharmacists

With regard to pharmacists and dentists there is no such problem of excess supply. The density of dentists in Switzerland is considered to be adequate (50 dentists per 100 000 inhabitants). In recent years however, the available places to study dentistry have consistently been under-subscribed. Some people fear that this might lead to a shortage of dentists in the future. This problem occurred in the past and was countered – as in the paramedical occupations today – by licensing more dentists from other countries.

Dental training lasts ten semesters and is completed at the faculty of medicine. During the first two years it is identical to the training for doctors. Further years of study are completed separately at one of the four dental schools at the universities of Basle, Berne, Geneva or Zurich. The federal examination forms the basic dental training qualification. After that there are different training options. The Swiss Dental Medical Association currently grants only one specialty title for dentofacial orthopaedics. Other specialist titles are planned in periodontology and prosthetics.

Training for pharmacists lasts five years (including a practical year in the third year) and is completed by passing the federal examination. Training takes place at the universities of Basle, Geneva, Lausanne and Zurich. At the universities of Berne, Fribourg (Freiburg) and Neuchâtel (Neuenburg), only the basic training is offered. The federal degree in pharmacy entitles the holder to be an independent pharmacist. There are also different training opportunities such as hospital pharmacist, medical laboratory technician, homeopath and food chemist.

Paramedical occupations

The Swiss Red Cross regulates the paramedical occupations on behalf of the cantons. In 1998, 5341 people got diplomas or certificates in three occupational categories (4355 in nursing, 344 in technical medical occupations and 642 in therapeutic medical occupations). The number of diplomas registered has increased since the early 1990s. This increase is due mainly to the greater number of diplomas awarded in Switzerland which rose from 3462 in 1991 to 4062 in 1998. In the same period, the number of professionals with equivalent qualifications obtained outside Switzerland registered to practice within Switzerland declined from 1912 in 1991 to 1279 in 1998.

Switzerland recruits many people qualified in paramedical occupations from other countries. More than 40% of registered therapists, such as physiotherapy, came from other countries in 1998. The percentage of those with registered diplomas and certificates in 1998 was 22% amongst nurses and 11% amongst medical technicians. Switzerland has high levels of pay, and employers can therefore meet their labour needs by recruiting personnel from other countries.

Health services management and public health training

Several universities (Berne, Basle, Zurich, Lausanne and Geneva) offer part-time postgraduate courses in health care management and public health. They target senior managers in the health service who need to function in an interdisciplinary environment. The courses are designed to help them cope more effectively with the enormous variety of tasks they confront in a rapidly changing health service.

Nursing

Since 1992 new regulations have been introduced governing nurse training in Switzerland. There are two levels of training for nurses: Level 1, which lasts three years, and Level 2 which lasts four years. The transition period for the

introduction of this reform lasts ten years until 2002 when all nurse training will follow this pattern. On completion of training, nurses are certified by and receive a diploma from the Swiss Red Cross. In addition specialization with further training is possible. Qualification as an auxiliary nurse on the other hand only requires one year of study in order to obtain a certificate in nursing from the Swiss Red Cross.

The exceptionally high numbers of nurses recorded in Switzerland result from a very broad statistical interpretation of the term “nurse” in Switzerland, which includes all nurses, whether or not they are certified. The large differences between Switzerland and other countries are therefore not very significant.

Reforms in health care professionals training

A law on basic, advanced and in-service training for medical and medical-related personnel (such as veterinarians, dentists, pharmacists and chiropractors) is expected to be introduced in the Parliament in 2001. It proposes to move the responsibility for specialty training from the Swiss Medical Association to the federal government. This is necessary in particular to ensure that these specialties are recognized internationally. The reorganization of advanced training will be accompanied by a reform of basic university courses, especially for doctors and pharmacists. The objective is to enhance the problem-oriented and interdisciplinary focus of training and to place greater emphasis on independent study. The quality of teaching will be monitored by regular evaluation.

Preparatory work on federal regulation for psychologists and psychotherapists is also in progress; the aim here is to draft a separate law covering these occupations.

Current training in the paramedical occupations is considered to be of a good standard in Switzerland. However, in the late 1980s it became clear that the generally increasing demands being made on people in these occupations would require the expansion of non-university tertiary training. The Swiss Conference of the Cantonal Ministers of Public Health carried out preliminary work, and the first university of applied science was opened in autumn 1998. A second is expected to be established in 2001.

The question of recognition of Swiss qualifications in Europe arose when the universities of applied science were being established and the entire vocational training system was being restructured. The intention is to provide three levels of practically oriented training in health care occupations: assistant level at the upper secondary stage of basic education, diploma level and polytechnic level. It is assumed that this kind of system will enable students to meet the demands of their professional environment.

The University of Basle will offer a course in nursing science from autumn 2000 that will establish nursing at the university level in Switzerland. A similar course is currently being planned at the University of Lausanne.

Pharmaceuticals

The Intercantonal Office for the Control of Medicines, which was established following an agreement between the cantonal governments, is responsible for registering drug products. Any company that wishes to bring a product onto the market must initiate and pay for the registration procedure. Pharmaceuticals are divided into several legal categories. Over-the-counter drugs are divided into three categories: those which can only be sold in pharmacies, those which can be sold in pharmacies and drugstores and those which can be sold anywhere.

The Federal Office for Social Insurance draws up a positive list of pharmaceuticals for which the compulsory health insurance system will pay (the specialty list). Maximum prices are also set for these products.

The price structure for pharmaceuticals is determined by the "Sanphar" pricing code which governs manufacturers' selling prices, wholesale prices and retail prices. Sanphar is an association representing manufacturers and wholesalers in the Swiss pharmaceutical sector. Pharmacists and dispensing doctors receive a regressive margin determined by the retail price (i.e. the higher the price, the smaller the relative margin). Nonetheless, pharmacists earn more from dispensing expensive pharmaceuticals than from lower cost pharmaceuticals.

About 62 % of medicines in Switzerland are sold through pharmacies. The other distribution channels are dispensing doctors (about 20 %), hospitals (about 12 %) and drugstores (about 6 %). The cantons decide whether doctors have the right to sell pharmaceuticals or not (so-called dispensing doctors). There are no restrictions on dispensing doctors in 13 of the cantons. There is a positive correlation between the number of dispensing doctors in a canton and the number of inhabitants per pharmacy.

A total of Sw.fr. 4.3 billion were spent on pharmaceuticals in Switzerland in 1997, which is 11.6% of total health expenditure. About 33% of all medicines were produced and sold in Switzerland. Of these, the firms Ares-Serono, Novartis and Roche (and their subsidiaries) account for two thirds or 19.8% of the total Swiss pharmaceutical market. 67% of pharmaceutical products are imported. The export market of pharmaceutical products amounted to about Sw.fr. 16.8 billion. This accounts for 16% of total Swiss exports. Switzerland

made an export surplus from pharmaceutical products of Sw.fr. 10.4 billion. More than 90% of pharmaceuticals manufactured in Switzerland are destined for export.

In recent years pharmaceutical expenditure has risen steeply. This is due at least in part to the current financial incentives to prescribe a lot of drugs and expensive products. It is against this background that consideration is being given in the first revision of the health insurance law to promote the sale of generic products. The pharmacist will be able to dispense a cheaper equivalent medicine instead of the brand product. In order to ensure that this does not adversely affect his or her income, the pharmacy margin will be replaced by a payment for services rendered (i.e. filling a prescription, providing information, advice and patient care).

There are plans to replace the existing intercantonal pharmaceutical agreement, which currently forms the basis of the work carried out by the Intercantonal Office for the Control of Medicines, with a federal law on pharmaceuticals in 2000. The Intercantonal Office for the Control of Medicines would be dissolved and replaced by the Swiss Pharmaceutical Institute which would exist as a separate federal legal entity. The aim of the federal law is to eliminate overlapping areas of responsibility which result from the present combination of cantonal, intercantonal and federal regulations that are not clearly defined.

Health care technology assessment

The health insurance law defines which medical aids and medical devices are covered by compulsory health insurance. In the schedule of benefits covered by compulsory health insurance there is a list of all aids and devices that are covered. The list also indicates the maximum price the insurance provider will pay for the aids and devices. The Federal Department of Home Affairs consults the Federal Commission on Medical Aids and Devices and then decides what specific aids and devices are to be covered by compulsory health insurance.

In general, services covered by compulsory health insurance must meet criteria of clinical effectiveness, appropriateness and cost-effectiveness. Article 56 of the health insurance law states that "The service provider must limit its services to the level that is in the best interest of patients and is necessary for the purposes of treatment. For services provided over and above this level, reimbursement may be denied". The service provider must also meet specific requirements, such as appropriate facilities and personnel with recognized qualifications.

Financial resource allocation

Providers are mostly financed by payments from insurance companies or by direct payments by patients (about 75% of total health expenditure in 1997). Federal, cantonal and municipal subsidies paid from tax revenue are used to fund hospitals, inpatient and outpatient care for elderly people and for physically and mentally handicapped people, and means-tested premium subsidies for compulsory health insurance (about 25% of total health expenditure in 1997) (see the section on *Main system of finance and coverage*).

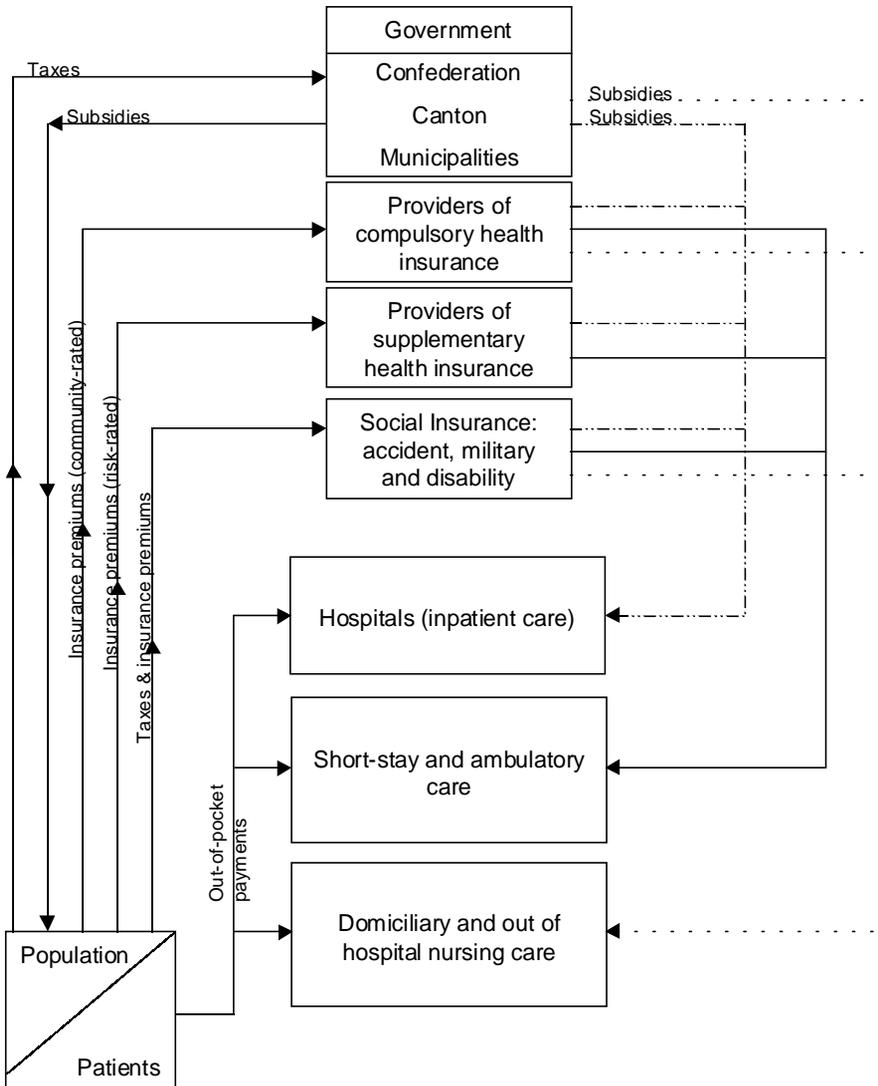
Third-party budget setting and resource allocation

The federal Parliament approves the budget for the federal contribution to subsidies for compulsory health insurance premiums every four years. It has an annual process of budget setting for federal disease prevention activities and health promotion programmes and for the federal health administration.

Cantonal parliaments approve budgets annually for the cantonal contribution to compulsory health insurance premium subsidies, prevention programmes, and subsidies to public and private cantonal hospitals. In some cantons budgets are also set for inpatient and outpatient care for the elderly and physically and mentally handicapped people within their canton. These budgets also include transfer payments for treatment provided for special reasons in cantons other than the one where the patient is registered.

Municipalities or associations of municipalities also approve budgets for subsidies to inpatient and outpatient care for the elderly and physically and mentally handicapped people and for disease prevention and health promotion programmes within their municipalities. All the above are indicative budgets rather than hard budgets.

Fig. 14. Financing flow chart



-----To providers of inpatient hospital care

—————To providers of short-stay inpatient (i.e. one night or less) and ambulatory medical care includes doctors, pharmacists, laboratory technicians, physiotherapists, chiropractors, dentists

-----To providers of domiciliary and out of hospital nursing care (Spitex services)

Fee negotiations

The new health insurance law allows several payment methods (particularly different kinds of fixed budgets). However, these are still rare. Services provided in the ambulatory sector and outpatient and short stay inpatient care (i.e. one night or less) in the hospital sector are therefore usually paid for under a fee-for-service payment system. Payment is based on a relative value scale similar to that in operation in Germany. The point values are agreed upon annually and appear in a national fee schedule which has to be approved by the Federal Council. The price attached to the point value is negotiated at cantonal level for compulsory health insurance but at the federal level for other types of insurance.

Negotiations take place at the federal level between the Swiss Association of Hospitals or professional associations and different insurance providers (e.g. health, accident, military and disability) to determine the fee schedule for those services which are to be consistent through out Switzerland. Within each canton negotiations take place between individual cantonal providers or associations of cantonal providers and individual cantonal insurance companies or associations of cantonal insurance companies about the price to assign to the nationally agreed fee schedule or to agree on a different payment system. The results of those negotiations must be approved by the representative cantonal government.

If health care providers and insurance companies cannot agree on the terms of a fee schedule, the government of the canton in which the provider is located fixes the level of fees. An appeal against the decision of the cantonal government can be made to the Federal Council. For health services not available within a canton or in the peripheral regions of a canton, fees for hospital inpatient care and residential and home care are fixed by the canton offering the service.

In a few cases, which fall outside the fee agreement, the government of the canton in which the health care provider is located has to fix the fees. Examples include:

- ambulatory treatment of an insured person outside the canton in which they are legally registered or the canton in which they work; and
- hospital inpatient or short-stay treatment of an insured person outside the canton in which they are legally registered.

Payment of hospitals

Insurance companies usually pay hospitals per diems. Usually the financial negotiations take place between cantonal associations of insurance companies

and the individual hospital or a group of hospitals. The agreements that result from the negotiations vary considerably between cantons. For inpatient services provided under compulsory health insurance the fee charged is a per diem rate (though different types of fixed allowances and budgets are being introduced since the enactment of the revised health insurance law in 1996). For those services covered by supplementary health insurance a higher per diem rate is charged for the “hotel” costs as well as the itemised charges for medical services.

Cantons are mainly involved in the financing of capital costs. Public hospitals, which are owned by the cantons or municipalities, and selected private hospitals which are subsidised by the cantons come under the control of the cantons. The capital investment costs for public hospitals are usually fully financed by cantonal tax revenues. The capital investment, education and research costs for public and publicly-subsidized hospitals are usually fully financed by cantonal tax revenues. The cantons also finance at least 50% of the running costs of these hospitals.

The revised health insurance law also allows the cantons to impose fixed budgets for the subsidies paid to public and publicly subsidized hospitals and nursing homes. Global budgets for public hospitals were introduced in five cantons in 1994 and have since been introduced in other cantons. The way in which these budgets operate varies between cantons. In some the deficit (profit) will be carried over to the next year. It also depends on who runs the hospital or nursing home as to how the budgets operate in practice and how strongly they are applied, i.e. with or without penalties for exceeding the allocation.

The financing of hospitals is the subject of controversial discussions in the context of a future revision of the health insurance law. The following questions are being discussed:

- Should the cantons subsidize all Swiss hospitals for inpatient treatment?
- Should the cantons instead channel all tax-financed subsidies towards reducing insurance premiums?
- Should the cantons also subsidize ambulatory and short-stay inpatient treatment?
- Should the insurance companies also pay part of the capital investment required?

Payment of health care professionals

Doctors working in an ambulatory setting are paid under a fee-for-service system. Doctors in ambulatory care itemize services on an invoice after completing an episode of care whereupon the third-party payer reimburses the doctor or the patient.

Dentists, chiropractors, midwives, physiotherapists, ergotherapists, nurses, speech therapists and nutrition advisers are principally paid by fee-for-service. The fees are determined through a point value system which is usually negotiated annually by associations of insurance funds and professional associations and is set out in a fee schedule. All medical and medical-related professions have a nationally agreed fee schedule, which is negotiated between the relevant professional association and the different insurance providers (e.g. health, accident, military and disability). For accident, military old age and disability insurance, not only is the fee schedule set nationally but also the actual price attached to the point value. Under compulsory health insurance, the price is negotiated on a cantonal level. In the private sector the actors are free to set prices themselves. However these prices are usually based on the nationally agreed fee schedule. Unlike doctors, dentists can only be reimbursed for a very small proportion of their services under compulsory health insurance.

Most hospital doctors are employed by the hospital and receive a salary. They also receive additional payments for services provided to people with supplementary health insurance but have to pay part of this income to the hospitals. The cantons recently proposed changing the system of paying doctors in hospitals. According to this proposal, the incomes of hospital doctors would be harmonized and restricted. The proposal is the subject of controversial debate at the moment.

The introduction of health maintenance organization (HMO) style insurance models similar to those in the USA, has changed the payment methods of some ambulatory doctors. The HMOs in Switzerland are mostly still insurance-owned group practices in which the doctors are employed on salary. In both of the first doctor-owned HMOs (MediX Zurich and Bubenbergr Berne) doctors receive performance-related payments as well as a guaranteed minimum income. A global budget (usually based on capitation) is agreed between the doctor-owned HMOs and their insurance partners which is adjusted for age, sex and other characteristics of the insured population.

Under the GP model of ambulatory care provision almost all the doctors are paid by fee-for-service. Some GPs also receive certain performance-related payments which depend on whether the savings target is met or not. For more information on managed care systems in primary care see the section on *Ambulatory health care*.

Reforming allocation and payment mechanisms

The fee schedule for the reimbursement of services is currently being totally revised. The revised schedule has to be agreed by 2001. The proposals will attempt to remove some of the perverse incentives which exist and that distort

the care settings used i.e. patient shifting between short-stay inpatient care or outpatient care and long-stay inpatient care, which shifts some of the costs from the insurance providers to the cantons. Also there are likely to be alterations in the payment structures for doctors to improve the relative position of general practitioners to specialists.

Health care reforms

Aims and objectives

The main reason health care reform was initiated in Switzerland was the significant increases in expenditure. This cost explosion has been the subject of concern and debate since the mid-1960s. The other problem in the health care system was that solidarity was being undermined by the possibility that insurance companies could discriminate based on risk. This problem became more and more important given constantly rising costs.

The main objectives of the revised health insurance law were to strengthen solidarity and to contain costs. The implementation of the law, however, has shown that the law has several shortcomings that are making achieving these objectives difficult.

The objectives as such are largely undisputed, especially the aim of containing costs. Consensus is less strong on the need to enhance solidarity. It is argued that the objective of compulsory health insurance, which provides as wide a range of benefits as possible, and the objective of containing costs are inherently contradictory.

There is far more controversy about the measures that need to be enacted to achieve the aims of the reform. The federal government feels that the fundamental mechanisms of the law must be retained and refined, whereas other actors are demanding more far-reaching reforms. The argument focuses on the relative roles of government and the market in regulating the provision of health care. Alternatives to the present mixed system of regulation are being put forward that more strongly emphasize the role played by either government or the market.

The situation is made more complex by the suggestions put forward by special interest groups; these groups are difficult to position on a continuum between government and the market.

Content of reforms

The legislative process in Switzerland is quite unique among democratic countries. It is fully described in the *Introductory overview*.

Health reform has been discussed more or less throughout the entire twentieth century. This stands in contrast to the legislation that has actually been passed. The health insurance law of 1911 has only been reformed once in 1964 and then been replaced by the health insurance law of 1994. Other ordinances and federal decrees have had a role in reforming the health care system.

Proposed reforms

The Federal Council, the Parliament and popular petitions have made proposals for reform that will directly affect the federal legislative framework for health care.

The Federal Council

The Federal Council has proposed to Parliament a partial revision of the health insurance law in two stages. The first partial revision is still being discussed by Parliament and did not enter into force on 1 January 2000 as envisaged by the Council. It would introduce a global budget also applicable to outpatient care, would promote generic dispensing and would increase the federal subsidies for compulsory health insurance premiums for the years 2000 to 2003. Parliament is currently discussing this partial revision. This attempt to introduce a global budget for outpatient care has been met with enormous resistance from many political parties; the other points remain largely unchallenged.

The second partial revision would affect hospital funding and would enter into force on 1 January 2001. The main changes proposed are as follows:

- The current health insurance law requires the cantons to pay at least half the costs of operating general wards in public and publicly subsidized hospitals, their capital expenditures in full and the costs of teaching and research. However, the hospitals do not receive any subsidies for areas covered by supplementary insurance. The provisions of the law covering fees also apply only to hospitalization in general wards. The revision would extend the cantons' responsibility to include subsidizing private hospitals on the cantonal hospital list. This would mean considerable extra expense for the cantons.
- The cantons' responsibility to subsidize inpatient treatment would be extended to cover short-stay treatment (one night or less). At the same time,

short-stay treatment would be included in hospital planning. This would mean that only hospitals or facilities on the hospital list would be able to provide short-stay services and be reimbursed under compulsory health insurance. This would impose the same planning and funding requirements on both inpatient and short-stay care. The intention of this reform is to eliminate some of the undesirable financial incentives inherent in the current system. A problem with this proposal is that the problems that occurred between the inpatient and the short-stay sector might just move to the interface with the ambulatory sector, where the cantons will not have any planning or funding functions. This proposal, too, would place a greater financial burden on the cantons.

- Until now, capital expenditures made by public and publicly subsidized hospitals have not had to be covered by fees and thus have not been taken into consideration when determining the amount to be charged in fees. The revision would change this. Capital expenditures would have to be covered through the income from fees and thus would need to be considered during the process of setting fee levels. Investments would then tend to be made in developing service provision rather than in acquiring further assets. Expenditure on teaching and research would be the only item still handled separately. This change would reduce the burden on the cantons, which currently fund capital investments, but increase the burden on health insurance companies and in turn could lead to increases in premiums.
- The federal government feels that the flat-rate payments (i.e. per diems) currently used to pay hospitals are not ideal. The revision would promote and standardize the use of per case payment (such as diagnosis-related groups) provided for in the present law, in which payment is determined by the services rendered. The law leaves it to the contractual partners to the fee schedule (i.e. the professional associations and the associations of insurance companies) to decide which payment system to use but requires structures to be standardized throughout Switzerland to enable comparisons to be made and to facilitate intercantonal payments.

This draft legislation has not yet been submitted to the Parliament. The content of the final version cannot be determined yet. The cantons have rejected the draft on the grounds that it would place an unacceptable financial burden on them.

Parliament

The proposals before Parliament are numerous and varied. These include:

- promoting competition of pharmaceuticals and promoting generic drugs;

- transferring cover for nursing care from compulsory health insurance to a separate insurance scheme;
- national planning of hospital structures and planning of high-technology medicine and centres of medical excellence at the federal level;
- removing responsibility for hospital financing from the cantons;
- instituting an official price freeze on health care services and health insurance premiums;
- reducing the benefits package covered by compulsory health insurance;
- revising risk adjustment formula used to balance payments between different insurance funds;
- allowing health insurance companies to make a profit on compulsory health insurance as well as setting insurance premiums according to the income and assets of subscribers.

Popular petitions

Four popular petitions have been submitted and will be the subject of referenda.

- Increasing the patients' free choice of doctors and hospitals for both out-patient and inpatient treatment by extending the cantonal lists to include all providers including private providers. The petition was proposed by representatives of the private clinics.
- A federal popular petition for lower hospital prices would limit the obligations of the insurance companies to fund inpatient care. The cantons should be required to provide an adequate number of beds. They would receive a per diem flat rate of Sw.fr. 250 for each patient from the insurance companies. This petition was proposed by a retail distributor.
- A federal popular petition for lower drug prices and automatic registering in Switzerland of drugs registered in countries adjacent to Switzerland. Generics should be used where available. This petition was proposed by the same retail distributor.
- A federal popular petition entitled "Health must remain affordable". This petition is based on the existing system. However, health insurance would be financed not by per capita premiums but by revenues from value-added tax and premiums which are set according to the income and assets of the insured individuals. High-technology medicine would be regulated at the federal level, and cantonal health planning would also be coordinated centrally. Maximum prices for the benefits provided under compulsory health insurance would be set centrally. The Swiss Social Democratic Party proposed this petition.

Signatures are currently being collected for a petition:

- A federal popular petition to ensure the provision of drugs that are safe and promote health calls for state regulation of the way drugs are marketed and dispensed. It was proposed by the Swiss Pharmacists' Association with the aim of ensuring that pharmaceutical products are primarily traded through pharmacies.

These petitions illustrate the breadth of the current discussion on health care reform.

Health for all policy

The WHO regional strategy for health for all attracted attention in Switzerland at a very early stage. The then director of the WHO Regional Office for Europe, Dr Leo A. Kaprio, was asked in 1984 to inform the members of the Swiss Conference of the Cantonal Ministers of Public Health about the European strategy for health for all, when the targets of this strategy were adopted. In 1986, the Swiss Society for Social and Preventive Medicine published a model based largely on the regional strategy and targets for health for all; this model can be considered as a draft programme. An intercantonal health indicator project was initiated in the late 1980s to formulate and implement health for all strategies. Awareness of HEALTH21, the new health for all policy framework for the WHO European Region, is widespread, and the policy framework has produced great interest.

In 1988, the Swiss Federal Office for Public Health produced its first evaluation report (*11*) on the implementation of the health for all strategy in Switzerland. Two further reports have appeared since then (*12,13*). These evaluations are extremely difficult to produce because no reliable data are available for many of the individual parameters in Switzerland. In general, however, the trend is a positive one and developments such as the introduction of compulsory health insurance will help to achieve some of the health for all objectives.

The economic recession in the 1990s and the rise in unemployment has, however, had a negative impact on the achievement of some goals. This applies specifically to the objectives concerning health and quality of life, better opportunities for the disabled, women's health and healthy living.

In terms of health care delivery, the difficult economic climate has, in contrast, encouraged more cost-effective and needs-oriented deployment of resources, and this is certainly in keeping with several of the targets for health for all. However, much still remains to be done in this area.

The concept of promoting health has become increasingly important in both the public and private sectors. Today a wide variety of actors are pursuing many activities based explicitly or implicitly on this concept. This is also the context for the creation of the Swiss Foundation for Health Promotion (see the section on the *Organizational structure of the health care system and Ambulatory health care*).

The conclusions of the third evaluation report on the ongoing development of the health for all strategy (12), however, are sobering. Current progress is practically restricted because the information needed to implement a health for all policy is lacking, and there is little activity in terms of formulating or implementing a health policy based explicitly on the concept and principles of health for all.

Thus, the situation in Switzerland is that there is a relatively high degree of awareness of the health for all policy; however verbal undertakings are not being matched by a satisfactory level of successful implementation.

Conclusions

Switzerland's health care system reflects its political system to a certain extent, that is one characterized by federalism and liberalism. State intervention in health care at the federal level has traditionally been kept to a minimum and much of the responsibility for financing, organizing and delivering health care has fallen to other actors including the cantons, municipalities, private insurance companies and private providers. The system of health care has historically undergone few major reforms. This is mainly a result of the political system of referenda which makes any comprehensive reforms difficult to pass into law. The system evolved in largely fragmented and uncoordinated fashion. Individuals were responsible for purchasing statutory health insurance from accredited insurance companies (as many as 98% of the population did have cover under this voluntary system). However rising health care costs combined with a lack of solidarity between insurance companies meant reform became necessary. In 1994 the most comprehensive change to the system was proposed and passed into law. The health insurance law made the purchasing of health insurance compulsory and made significant changes to the systems of subsidies within the system. It expanded the benefits package to include in particular nursing care. Premiums were changed from risk-rated to community-rated and cream skimming was eliminated by creating a legal obligation for insurance companies to accept anyone applying to them for compulsory health insurance. The problems associated with differential risk pools with some insurance companies attracting higher or lower risks are being dealt with through a sort of solidarity organization, Foundation 18, which is responsible for risk adjustment and transfers between companies.

Despite these changes there still remain some important questions which will have to be resolved by politicians and the people alike:

- The relative roles of the state and the market (How should hospitals be financed? How should other health care services be financed? Should the state withdraw from the planning process?)

- The extent of centralization (Should the planning of health care services be planned by the federal state? Should parts of the health care system (for example tertiary care) be planned by the federal state? If not, how can cantons achieve better coordination?)
- The relative importance of health and health care. (Should health policy be concerned only with health care and issues such as how many hospital beds to provide? Should health policy's primary concern be health per se?)
- Costs containment versus comprehensive health care benefits. (Can a comprehensive basic package be maintained? How is managed care going to develop? How can consumption of health services be reduced on both the supply and demand sides? Will rationing be necessary?)

Since 1996 Switzerland's revised health insurance law has set in motion several reforms however not all of the proposed reforms have been fully implemented. Some of the barriers to successful implementation include lack of information and the appropriate regulatory bodies (or at least with the necessary power). Issues needing to be tackled if implementation of the legislation is to progress further include:

- improvement of the statistical data
- full implementation of quality control and management
- improvement of management capacities of insurance funds and providers
- development of managed care.

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