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Guest Editorial

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In this issue, we publish two articles on Switzerland [1,2], and we take the opportunity to look back at nine further papers on Swiss health care reforms, processes, and outcomes published since 2014 [3–11]. Switzerland is a fascinating small country (population 8.4 million) – not only because of its wealth (GDP per capita of US$ PPP 65 096) [12], its beautiful Alpine landscape, its four official languages (German, French, Italian and Romansh), its exceptionally high degree of decentralization (with 26 cantons and 2352 municipalities), its unique consensus-oriented political system with frequent referenda, and because trains in Switzerland always arrive on time [13]. Switzerland is fascinating also because it has an extremely complex yet well-functioning health system.

The complexity of the Swiss health system is related to its historic development, which explains its high degree of sharing (or fragmentation) of decision-making powers between three main groups of actors:

1) the three different levels of government (the federal level, the cantons, and for social services the municipalities);
2) recognized civil society organizations ("corporatist bodies"), such as associations of health insurers and health care providers; and
3) the Swiss people, who can veto or demand reform through public referenda.

All residents in Switzerland have to purchase health insurance from competing mandatory health insurance (MHI) companies, which are not allowed to make a profit from their MHI activities. Cantons are responsible for securing health care provision for their populations; they own most larger hospitals and nursing homes in the country; and they finance an important share of inpatient care. In fact, a particularity of the Swiss health system is that it is financed in almost equal shares through taxes, community-rated MHI premiums, and household out-of-pocket (OOP) payments. Yet, an important part of tax resources is spent on subsidies enabling lower and lower-middle income households to purchase MHI. Consequently, MHI companies are the most important purchasers and payers in the system, negotiating through their associations (santésuisse, curafutura) with associations of physicians and hospitals about contracts and reimbursement schedules. Finally, popular initiatives and referenda are often at the origin of federal legislative activity, responding to citizens' demands for change – as has been described in two recent papers published in this journal [4,7].

Despite the complexity of the Swiss health system, it performs very well with regard to a broad range of indicators. Life expectancy in Switzerland (82.8 years) is the highest in Europe after Iceland, and healthy life expectancy is several years above the European Union (EU) average. Almost the entire population is covered by health insurance, which secures access to a broad range of services. The system offers a high degree of choice and direct access to all levels of care with virtually no waiting times. Furthermore, easy geographic access is ensured by a wide network of hospitals, very high numbers of physicians (4.2 per 1 000 population), the highest number of nurses in Europe (18.0 per 1 000 population), and excellent public transport infrastructure. Public satisfaction with the system is high and quality is generally viewed to be good or very good [13].

In view of these achievements, it may be surprising that popular initiatives have repeatedly demanded to completely overhaul the health system through public referendum [7]. As described by De Pietro and Crivelli in this journal, three popular initiatives in the past 15 years (2003, 2007, and 2014) aimed at replacing the market-based health insurance system with one single public insurance fund. Although the last initiative was rejected at the ballot with 61% in September 2014, the arguments of the proponents of the initiative are interesting because they draw attention to several deficiencies of the Swiss system [7].

First, the health system is very expensive. Health expenditures in Switzerland are now the highest in Europe, both in absolute terms (US$PPP 7 919) and as a percentage of GDP (12.4%) [14]; and there is considerable variation in spending levels across cantons. From a scientific perspective, this large variation is very interesting, because it allows cross-sectional analyses of the determinants of cantonal spending levels. In fact, two recent papers published in Health Policy combined cantonal level analyses of expenditure data with panel data analyses for different time periods [5,8]. Schleiniger found that expenditure growth in the period 2004–2010 was mostly (more than 60% of the increase) driven by an increase in the quantities of health care services provided, and only to a relatively small degree by an increase of prices [8]. In addition, the considerable differences in cantonal expenditure levels could only partially be explained by socio-economic factors,

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which – according to the author – gave rise to efficiency concerns in service utilization. Braendle and Colombier found that per capita income, the unemployment rate and the share of foreigners, as well as the share of women elected to parliament were positively related to cantonal public health care expenditure growth in the period 1970–2012–and they, too, suggested that spending growth is likely to reflect inefficiencies [5].

Second, proponents of the initiative were concerned about the Diagnosis Related Group (DRG-)based inpatient payment system, which was introduced in Switzerland only in 2012 [7]. In fact, the (rather late) introduction of DRG-based payment in Switzerland has generated considerable scientific debate, and Fourie et al. published a paper in Health Policy proposing a matrix for a comprehensive evaluation of the effects of the reform on different aspects of health care delivery, such as cost-efficiency, quality, access, transparency, patient autonomy, and adherence to ethical standards [10]. Furthermore, in this issue Leu et al. show on the basis of interviews with hospital directors and managers that these experts were concerned about the effect of DRG-based payments on the treatment of vulnerable patient groups [1]. Hospitals report that these patients are financially unattractive under DRG-based payment, and that adjustments would be needed to avoid negative consequences for these patients – but data to quantify these problems remain unavailable [1]. Interestingly, payment reforms in Switzerland are taking place also at the cantonal level because cantons still determine the payment system for long-term care institutions – just as they did for acute care hospitals prior to the introduction of DRG-based payment. These payment reforms enable scientific analyses at the cantonal level as shown by an evaluation of the introduction of prospective global budgets for long-term care institutions in the canton of Ticino in 2006 [9].

A third major point of criticism was the high degree of fragmentation of the health system, which has only limited incentives for cooperation between health care providers [7]. However, in fact, Switzerland is interesting because managed care type insurance contracts – although generally with very weak gate-keeping, e.g. through teleconsultations – have grown rapidly since 2005 and now represent the vast majority of all insurance contracts [13]. In addition, the results of a national survey of integrated care initiatives in Switzerland published by Schusselé Filliettaz et al. in this issue show that the number of integrated care initiatives has increased considerably in recent years [2]. In fact, more than half of the 155 initiatives included in the survey started between 2010 and 2016. This includes nine physician networks, 52 initiatives for specific target groups of somatic patients (e.g. diabetic patients), 41 initiatives targeted at mental health conditions, and 25 initiatives to improve transition and coordination between several organization and levels of the health system. Furthermore, after a long process of discussions, Switzerland has finally enacted the federal law on electronic health records (EHR) and health information exchange (HIE) networks, which is expected to contributed to improved coordination of care over the coming years [3].

A fourth point of criticism of the Swiss health system has also been addressed by research published in Health Policy: Because of relatively poor risk-equalization between health insurers, in particular before 2012, it has been profitable for insurance companies to engage in risk-selection (cream skimming). As shown by Schmid and Beck in an empirical evaluation of different risk-equalization mechanisms, there have been high incentives for insurers to engage in risk-selection [6]. In addition, the authors argue that recent reforms to improve the system after 2012 have only partially solved the problem and that re-insurance could be more effective than improved risk-adjustment at mitigating incentives for risk-selection.

Last but not least, a major problem of the Swiss health system is that households face a considerable financial burden because they pay very high out-of-pocket (OOP) payments. In fact, the proportion of current health expenditures financed OOP in Switzerland (28.3%) is one of the highest in Europe, and financial protection is more limited than, for example, in Austria, Germany, or the Netherlands. Furthermore, 22% of the Swiss population have reported access problems due to costs in the 2016 Commonwealth Fund survey [15]. One important reason for the comparatively high level of out-of-pocket payments in Switzerland is that adult dental care is largely excluded from MHI coverage. However, as recently reported by Di Bella et al. in this journal, several popular initiatives at the cantonal level have aimed to change this by demanding the introduction of mandatory dental insurance [4]. Interestingly, the proposed dental insurance would be financed via an income-related contribution of 1% of gross salaries, which is different from the community-rated premiums of MHI insurance.

Finally, strengthening disease prevention and health promotion with a focus on non-communicable diseases remains an issue in Switzerland. For example, tobacco control policies remain relatively weak, and Switzerland has still not ratified WHO's Framework Convention on Tobacco Control. A particular case is tobacco control in prisons, which has been studied by Ritter and Elger [11]. Based on qualitative interviews with prisoners and prison staff, they showed that prisoners were satisfied new smoke-free regulations introduced in 2009 because it contributed to reduced smoking and better protection against passive smoking.

In conclusion, this brief overview of recent articles on Switzerland shows that papers published in Health Policy have addressed several of the major challenges and concerns facing the Swiss health system. More research on the country is certainly warranted as it exhibits several features that make it interesting from an international perspective: (1) the highly decentralized nature of the Swiss health system and ongoing cantonal reform processes (within a federal framework) provide the opportunity for quasi-experimental research to assess the effects of new policies; (2) the rather slow reform processes and considerable public debate may, at least in theory, enable research to influence and refine policies over time; and (3) often health reforms in Switzerland include demands for systematic evaluations of their effects. We would like to encourage researchers to submit these evaluations to Health Policy, as the journal would be happy to publish more articles on Switzerland in the future.

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