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Chapter 5

Reforms and Governance of the Swiss Health System

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

Introduction

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

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

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

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

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

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

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

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

5.1. Main issues in health system governance identified in 2006

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

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

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

- The debate over the health reforms that are needed to address the system's shortcomings is taking place in an environment where data are most often inadequate to make evidence-informed decisions. Setting appropriate regulations and standards to widen and deepen available data sets would help improve governance, particularly if they are combined with improved transparency, accountability and performance management. Publicly available statistics are often limited by the absence of comprehensive national reporting requirements. Existing data collection by cantons is not always standardised. Privately collected and owned statistics (*e.g.* insurers' databases) are not always publicly disclosed or openly available to the statistical authorities.

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

5.2. Governance traditions and principles

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

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

As the capacity of individual cantons to undertake health activities can vary greatly, a political co-ordination body – the Swiss Conference of the Cantonal Ministers of Public Health (CDS) – was established in 1919 to promote co-operation and common policies primarily between cantons and, in some cases also with the confederation. Through regular meetings, the CDS facilitates the development of common policies between cantons and the confederation. However, this process does not result in binding decisions on all cantons, rather it facilitates consensus building. Only when cantons agree to make a formal agreement does a decision taken through the CDS become legally binding on all parties (OECD 2006). More generally, a key feature of the Swiss governance system is the political tradition which permits groups of citizens to contest legislation and the constitution. In practice, only 4% of legislation is contested. But it has, nonetheless, created

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

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

5.3. Dynamic governance or the political capacity for reform

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Enabling citizen participation and patient choice

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

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

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

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

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

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

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

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

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

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

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

Transparency, accountability and performance management

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

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

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

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

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

Generating and using evidence for policy

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

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

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

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

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

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

5.5. Looking at health system objectives through the governance lens

Increasing the effectiveness and quality of health provision

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

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

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

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

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

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

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

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

Increased efficiency and sustainability

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

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

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

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

5.6. Conclusion

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

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

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

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

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

Notes

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

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

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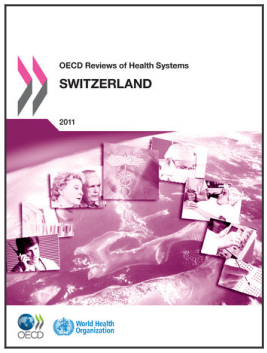

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