Analytical support on social protection reforms and their socio-economic impact

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Pensions, health and long-term care

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1 Executive Summary

Pensions, health care and long term care have been at the centre of political debates over the last few years in Switzerland. Several reforms have been adopted, but a few have failed to gain final approval. On occasions, reforms have been rejected in referendums that the constitution allows on any act passed by parliament at the request of at least 50,000 citizens.

In the field of pensions, the main issues have been the financial sustainability of the basic pension in the context of population ageing and the adaptation of second pillar pension legislation to longer life expectancy and lower returns of invested funds. Reforms attempts to deal with both these issues failed in the late 2000s, and in 2013 the government announced plans for a comprehensive reform of the pension system, known as "*Reform des Altersvorsorge 2020*". The reform is expected to include some moderate cuts, additional funds for the basic pension and adjustments to the occupational pension low that should be neutral in terms of benefit levels but that will increase contributions.

In the field of healthcare, most debates have actually revolved around the issue of cost containment. Various tools have been used or discussed to that effect, such as plans to strengthen the managed care system in ambulatory care, intending to achieve more efficiency, better quality and lower costs. The corresponding law, however, was rejected in a referendum. Another important reform was the change in the cost calculation method in hospitals. The new payment system is based on "diagnose-related groups".

Another contentious issue has been a temporary regulation of the number of licences for specialised doctors. This was abandoned in 2011, only to be re-installed in July 2013 in order to avoid a surplus offer of such doctors in the system. Since 2011 the federal government has also the right to intervene into the tariff structure of payments of insurers for providers if associations (insurers, hospitals, medical doctors) do not find an agreement. Finally, in order to discourage risk-picking by health insurers, the number of days in hospital of patients was added as a third criterion next to gender and age in order to calculate re-distribution payments in risk equalisation.

Finally, with regard to long term care, the system is rather fragmented and requires substantial contributions by service users. Recent debates have revolved around cost containment. Some political actors have proposed the introduction of a long term care insurance scheme, either a s a social insurance scheme (the left) or as a compulsory private insurance (the right). However, there does not seem to be sufficient support for either idea for them to be turned in to law any time soon.

2 Pensions

The Swiss pension system is often praised for its capacity to combine effective needs-coverage with a solid financial basis (see e.g. Quiesser and Vittas 2000). This combination of what are sometimes conflicting goals is achieved thanks to a system structured around three pillars of provision and a means-tested pension supplement. The first pillar is universal and provides all retirees with a minimum income. Together with the means-tested pension supplement this guarantees an income at or above the official poverty line. The second pillar is compulsory for most employees, is fully funded, and provides earnings related benefits. The third pillar is a voluntary top-up encouraged by generous tax concessions. The multipillar character of the system and the inclusion of both pay-as-you-go (PAYG) and funded financing are its key strengths.

Praise notwithstanding, the Swiss pension system is not immune from the effects of developments like population ageing or the transformation of labor markets which put pressure on pension systems throughout the industrial world. Expenditure on its pay-as-you-go first pillar is expected to increase over the next several decades at a much higher rate than receipts, and a key objective of current reform initiatives is to guarantee the medium and long term solvency of the scheme. Population aging, however, does not affect the basic pension alone. Second pillar occupational pensions have to deal with the issue of higher life expectancy at retirement age. Longer life expectancy increases the cost of annuities, or put another way, with the same amount of accumulated capital, pensioners will obtain an increasingly lower annuity.

2.1 System description

2.1.1 Major reforms that shaped the current system

1948: Adoption of the first nationwide pension scheme (AHV-AVS)
Switzerland is a latecomer to social insurance. In the first half of the 20th century a few attempts at setting up a national old age insurance scheme failed. After World War II, however, demands for a national pension scheme became stronger. This was facilitated by development during the war. Between 1939 and 1945 the government introduced a system of compensation for lost earnings due to military service which resembled Bismarckian social insurance. In 1948 the scheme was converted into the first national old age and survivors pension scheme. Its main features were a universal pension scheme with earnings-related benefits and contributions, the latter being equally split between employers and employees. There was no contribution ceiling, whereas benefits varied within a 1 to 3 range. This was later reduced to 1 to 2 (Bernstein 1986).

In the following years the basic pension was reformed several times (to date there have been 10 revisions of the initial law). Until the 1970s, reforms aimed at improving coverage and strengthening the finance of the scheme. In more recent years, reforms are instead aimed at containing expenditure but also at adapting the pension systems to changes economic and social circumstances, like the emergence of atypical employment or gender equality.

1971: Adoption of a constitutional article on the three pillar pension system
An important expansionist reform was the adoption, in 1971, of a constitutional article establishing the principle of a three pillar system with mandatory occupational coverage. It defined the division of labor between the three pillars and established the legal principle of compulsory occupational pensions (DFI 1995; Bonoli 2007).

1982: Adoption of the law on occupational pensions (BVG-LPP, in force since 1985)
Occupational pensions were made compulsory for employees earning above a given threshold. The law also specifies minimum requirements for compulsory coverage. Employers and pension funds are free to provide better coverage (see below for details).

2.1.2 System characteristics

The Swiss pension system is best described as a three-pillar system. The first pillar (AHV/AVS) covers the basic needs of retirees. It is moderately earnings-related and includes a means-tested pension supplement (EL-PC). The second pillar aims to guarantee to retirees a standard of living close to the one they experienced in employment and consists of mandatory occupational pensions. Finally, the third pillar allows people to tailor pension coverage to their individual needs, through non-compulsory personal pensions supported by tax-concessions. The functional division between three levels of pension provision is upheld by the federal Constitution, and is widely regarded as an important constraint to policy change in the area of pensions. Most pensioners receive income from a combination of these different pillars

The First Pillar
The first pillar (AHV/AVS) provides universal coverage and is a fairly redistributive scheme, since there is no contribution ceiling but the amount of the benefit can vary between a floor and a ceiling that is twice as high as the floor. In 2013 the limits are set at CHF 1,170 (€ 950) and CHF 2,340 (€1,900) per month respectively, corresponding to approximately 20% and 40% of the average wage. Within these limits, the amount of the benefit is related to contributions paid during employment, with about a third of retirees receiving the maximum amount. Benefits are adjusted every two years according to a so-called "mixed index" derived from the arithmetic average between inflation and wage increases. A full pension is paid at the age 64 for women and 65 for men.

With regard to financing, the basic pension operates on a pay-as-you-go basis. As in Bismarckian systems, the AHV/AVS has a separate budget, and it has a reserve fund roughly equal to one year's worth of outlays. The scheme is financed by contributions (4.2% of salary each for employees and employers; up to 7.8% for self-employed), and receives a subsidy equal to 19% of outlays. In addition, since 1999, one percentage point of VAT is assigned to AHV/AVS. The social partners participate in the management of the scheme by running some branch-related funds. The central fund, however, is managed by the federal administration. The rules governing entitlement, benefit and contribution levels are set by legislation. As a result their modification can be subjected to a referendum and must go through lengthy law-making process which involves the consultation of all relevant actors.

The Second Pillar

The second pillar of the Swiss pension system, occupational pensions, were first granted tax-concessions in 1916 and became compulsory in 1985 for all employees earning at least twice the minimum AHV/AVS pension (Bonoli 2007; Leimgruber 2008). In the 1990s coverage was virtually universal among male employees but reached only about 80% of women (OFAS 1995: 10). A full occupational pension is granted to employees with a contribution record of 39 years for women and 40 for men. When membership in an occupational pension scheme became

compulsory, many employees were already covered by voluntary arrangements. The situation was such that legislation needed to take into account the existence of a relatively developed system of occupational pension provision. As a result, it was decided to introduce a compulsory minimum level of provision (known as the *Obligatorium*) calculated on the basis of notional contributions (see table 1.1), leaving existing pension funds a relatively high degree of autonomy over how to deliver and finance that minimum level of provision. Many pension funds (especially in the public sector, or those sponsored by large employers) offer better conditions than the *Obligatorium* (Bonoli and Gay-des-Combes 2003; Vontobel 2000).

The occupational pension law also prescribes a government-set minimum nominal interest rate for second pillar pension funds covered by the *Obligatorium*. In recent years the rate has been rather low, prompting concerns about the contribution that returns on investment will make to financing pensions (see table 1.2).

Table 1: Notional contribution rates applied to 2nd pillar occupational pensions (applied to earnings between the lower and upper threshold)

Age	Rate
25-34	7%
35-44	10%
45-54	15%
55-64	18%

Notional contribution = *Altersgutschriften/Bonification de vieillesse*

Table 2: Minimum interest rate applied to assets of pension funds (only to the compulsory portion)

Year	Minimum interest rate
1985-2002	4%
2003	3.25%
2004	2.25%
2005-2007	2.5%
2008	2.75%
2009-2011	2%
2012-2013	1.5

A final important parameter defining second pillar pension benefits is the annuity rate (*Umwandlungsatz/taux de conversion*) which converts the accumulated capital into an annuity. It is

set by legislation, currently at 6.8%. In 1985, when the law came into force, it was set at 7.2%. The pension industry and the government consider it to be currently too high.

The objective of the system is a combined (AHV/AVS + Obligatorium) replacement rate of 60% of gross earnings up to a ceiling equal to three times the maximum AHV/AVS benefit. Minimum compulsory benefits are calculated on the basis of notional contributions.

The Third Pillar

The third pillar consists in voluntary private individual pensions. These are encouraged through tax deductions. Employees can deduct payment to a third pillar pension of up to CHF 6,739 (€ 5,434; figure for 2013) per year. The self-employed, who are not covered by compulsory occupational pensions, can deduct 20% of their earnings. Funds invested in a third pillar pensions can be withdrawn earlier to buy accommodation to be occupied by the insured person. As a result it is unclear what role third pillar pensions play in the pension system. Often, they are marketed with tax efficiency argument rather than as solid investments for old age.

2.1.3 Details on recent reforms

Over the last few years, pension policy has been characterised by the successive failure of the government to push reforms through. The last reform successfully adopted goes back to 2003 (Bonoli 2007). On that occasion, the law on occupational pensions was subjected to a number of changes, the most important of which were:

- Lowering the access threshold of compulsory coverage for employees from approximately 40% to approx. 30% of average earnings.
- Increase in the portion of salary to which notional contributions are applied
- Reduction of the annuity rate from 7.2% to 6.8%

In 2004 a reform (known as the 11th AHV/AVS revision) which contained some moderate elements of retrenchment (e.g. increase of women's age of retirement) was rejected in a referendum. A second version of the same reform with minimal changes was subsequently voted down in parliament in 2011.

In 2010 a reform of the law on occupational pension that would have reduced the annuity rate applied to occupational pensions from 6.8 to 6.4 was rejected in a referendum by 72.7% of voters.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Overall, the pension system can be considered as rather successful in guaranteeing adequate benefits to the retired population. Eurostat publishes a very high at-risk-of-poverty figure for Switzerland (28.3%) that does not reflect the general perception in the country. One reason for this may be the fact that many new pensioners decide to withdraw their second pillar pension as a lump sum (which can by fiscally more convenient than an annuity). As a result they are income poor but asset-rich. Using fiscal data that include information on both incomes and assets, Wanner et al (2008) find an at-risk-of-poverty rate of around 10% for the 65-69 age group, rising to 17% for the

80+[1]. Single women have slightly higher at-risk-of-poverty rates, reaching up to 20%. In general, Swiss studies of income distribution have shown that older people are less exposed to the risk of poverty than other groups, such as single parent families and large families, although they tend to be more exposed than other working age people (Wanner et al 2008). Means-tested pension supplements are probably a rather effective tool in combating poverty in old age even though there might be a non-negligible non-take up rate.

Turning to the composition of older people's income, as can be seen in table 1.3, the basic pension still plays the biggest role (39% overall). The role of occupational pensions is still limited but can be expected to increase in the following years, as maturation is not completed (law is in force only since 1985, and 39/40 contribution years are required for a full occupations pensions).

Table 3: Aggregate composition of the income of older people (2003)

Source of income	Proportion of aggregate pensioners' income
Basic pension (AHV/AVS)	39.1%
Other social transfers	2.9%
Occupational pensions	21.8%
Income from work	9.0%
Income from assets	26%
Other income	1.2

Source: Wanner et al 2008

2.2.2 Sustainability

Sustainability issues concern both the first and the second pillar, though they translate into rather different actual problems. With regard to the basic pension, which is pay-as-you-go financed, the main issue is how to keep a balance between receipts and outlays in spite of population ageing. In relation to second pillar pensions, the key challenge is how to respect the parameters imposed by legislation, in particular the annuity rate, in spite of rising life expectancy and lower returns of invested assets.

Projections of the budget of the basic pension have been published more or less regularly since the 1990s. In general, they have turned out to be too pessimistic, as the emergence of regular budget deficits has been postponed by successive projections. In the most recent projections, the basic pension is expected to enter into stable negative territory around 2020. The scheme has a "small" reserve fund that will make up for the shortfall for about 6 to 10 years thereafter (OFAS 2013).

[1] In the study, 5% of liquid assets (cash) is considered as income.

According to the projections, the basic pensions in order to have a balanced budget in 2030 will need additional funds. Depending on the various scenarios, these are expected to be in the range of between 1.6 to 3.4 percentage points of VAT. Considering the fact that the current VAT rate is at 8%, this increase may be considered as manageable.

It should be noted that the main reason why early projections proved too pessimistic, is the fact that they underestimated migration into the country, and the ensuing expansion of employment. Since 2005, immigration has been more or less constantly high, and many newcomers are highly skilled professionals, making thus a significant contribution to the basic scheme. Of course, by paying contributions, these immigrants obtain rights to future payments, suggesting that this development has simply delayed the emergence of budgetary problems.

Note also that current projections provide estimates of receipts and outlays until 2030, but pension expenditure is likely to peak after 2035, when the large cohorts born in the late 1960s will be over 65.

Sustainability issues concern also funded second pillar pensions, though in a different way. Increases in life expectancy and the reduction in the returns on invested assets since the early 2000s, make it difficult for most funds to apply the annuity rate of 6.8% currently in force. As a result, many pension funds use contributions made by the current active generation to finance a small part of the pensions that are being currently paid out, introducing in this way a small pay-as-you-go component in a scheme that was meant to be entirely funded. In 2010, the federal government estimated the size of this transfer at 600 m CHF per year, or 0.1 % of GDP (DFI 2010: 14). For this reason in 2010, the government tried to push through a reduction in the annuity rate from 6.8 to 6.4 %, which was rejected in a referendum by an overwhelming 72.7% of voters.

It should be noted that while the pension industry pushed strongly for a reduction of the annuity rate, it also argued that the appropriate value of this important parameter had to be lower, below 6%.

The sustainability of 2nd pillar pensions was also called into question as a result of the stock market crashes of 2001-2 and 2008-9. In response, many funds had to increase contributions to make up for the funds lost. The situation, however, has improved in 2012, when on average, pension funds had returns of 6.3% (well above the minimum rate in applicable for that year, set at 1.5%). During the first three months of 2013, pension funds obtained an average rate of return of 2.9% (ASIP 2013).

2.2.3 Private pensions

The Swiss pension system relies on private pensions to a substantial extent, essentially because the mandatory character of occupational pensions. The “market” for occupational pensions is heavily regulated, but at the same time huge. In 2009 the total assets of Swiss pension funds were estimated at CHF 700 billion, or 126% of GDP (OFAS 2011). The regulation of such a vast market poses a number of challenges, in addition to those that concern sustainability discussed above. These include:

Governance and transparency

According to law, occupational pensions must be governed in compliance with the parity principle, i.e. decisions must be taken by committees comprising the same number of representatives of employers and employees. Over the last few years it has appeared that this principle has not always been followed scrupulously. This has been the case in particular for smaller companies. The law on occupational pensions makes it mandatory for employers to arrange second pillar coverage for their employees. Large companies tend to have their own pension funds. There are a few branch sector funds that cater for smaller employers within a sector. However, the vast majority of smaller employers turn to "collective foundations" for the provision of second pillar pension coverage for their employees. Collective foundations are set up by banks and insurance companies, and at the beginning of the 2000s representatives of employees had relatively little influence on the decisions taken by these collective foundations.

This issue came up in the aftermath of the stock market crash of 2001-2. Collective foundations were accused by the trade unions and the left to have unduly benefitted from investment returns well in excess of the 4% minimum rate in the previous years. An audit was requested by the federal parliament, which could neither confirm nor infirm these allegations (Bättig 2004). The audit raised the issue of pension funds governance to the centre stage of the political debate, as a result of which some measures were adopted so to improve the governance of collective foundations and in particular the effective involvement of representative of employees. The pension industry emerged nonetheless scathed by this scandal which became known as the "*Rentenklau*" (pension theft). The somewhat tarnished image of the pension industry was further damaged by the financial crisis of 2008. As a result, requests to lower the annuity rate tend to encounter public hostility.

Administrative costs

In 2011 the federal office of social insurance published a report which tried to estimate for the first time the total cost of managing second pillar pensions. In the past, administrative costs were published, but these concerned only the management of the pension fund itself and not the costs of the financial institutions that manage money on behalf of the pension funds. The result was that annual average administrative costs were around 0.56% of assets. However the report also found that there was a big variation across funds, and the correlation between administrative costs and returns on investment was negative. In other words, insured people that had to pay higher administrative fees were getting lower returns. In response to these findings, more transparency of administrative costs is now requested from pension funds.

Coverage of part-time / low wage workers

Switzerland, not being an EU member, does not apply the directive on part-time work. Access to compulsory pensions requires annual earnings to exceed a threshold which is the same for full-time and part-time employees (in 2013: 21,060 CHF or € 17,100). As a result, part-time workers are less likely to be covered by compulsory occupational pensions. It should be noted, that a reform adopted in 2003 which lowered this access threshold somewhat improved their situation. However, part-time workers, especially those on low earnings, are unlikely to receive significant 2nd pillar pensions even if their earnings exceed the access threshold.

On the other hand, the basic pension is quite favourable to part-time (and low wage) workers. The lower guarantees a (low) minimum pension regardless of the earnings obtained during the working

life. This amount is well below the poverty line, and in the absence of other income, recipients of the minimum pension must turn to means-tested pension supplements.

2.2.4 Summary

The Swiss pension system is generally considered as a rather effective machine to guarantee a decent income to the retired population while at the same time being financially sustainable. This analysis appears justified on the basis of the evidence reviewed above. However, it should be stressed that this good performance is to a large extent due to the good economic situation enjoyed by the country since the mid-2000s. Thanks to the free movement agreement with the European Union (in force since 2002), Switzerland has seen strong and sustained highly qualified immigration, which has contributed to improve the budget of the PAYG basic pension scheme. This development is delaying the emergence of budgetary problems, and has somewhat reduced the pressure on policy makers to intervene in the field of pensions. On the other hand, lower returns and increasing life expectancy mean that pension funds are sometimes relying on current contributions to finance current benefit (in a limited way). Many see this development as a departure from the principle of full funding that must be redressed urgently, by adapting the annuity rate. To sum up, one can mention the following strengths of the Swiss pension system:

- Balanced combination of PAYG and pre-funding as funding mechanisms
- Relatively good protection against poverty in old age, thanks to a compressed benefit structure in the universal first pillar and to means-tested pension supplements. The high poverty rates found on the basis of income data are not a reliable source, since many new pensioners withdraw their second pillar pension as a lump sum.
- The system seems broadly sustainable. Some adjustment will arguably be needed, but these seem feasible
- System is compatible with high employment rates among the older population

And among its key weaknesses, one can mention:

- Lack of trust in the pension industry (i.e. private providers of occupational pensions). In the context of Switzerland's direct democracy, this prevents the adoption of reforms that are probably needed to secure occupational pensions in the long run.
- Complex governance and difficulties in ensuring accountability and transparency in 2nd pillar pensions
- Financial imbalances in the PAYG basic pension

2.3 Reform debates

Old age pensions have featured prominently in political debates since the early 1990s. After the policy failures of the 2000s discussed above, politicians have been extremely cautious in dealing with this issue. The Ministry of the Interior, responsible for old age pensions, was traditionally held by the liberal party (FDP-PRD). Since January 2012, however, a new Socialist Minister has been appointed (Alain Berset). Less than a year after taking up office, the new Minister announced a

new course in pension policy, based on a number of key principles. First, the next reform will be a combined reform of the 1st and if the 2nd pillar. Given the stalemate observed in reforms attempted in both pillars, it seems that the government thought that joining two reforms would open up the way for new consensus building opportunities. Second, the Minister adopted a reassuring tone, promising that there will be no reduction in benefits.

The new combined 1st and 2nd pillar reform, known as "Altersvorsorge 2020" was announced in December 2012. Its main features were then made public in June 2013 (DFI 2013). They include the following points:

For the first pillar:

- Equalisation of retirement age at 65

This is a rather controversial measure, since it reduces provision without any compensation. The trade unions and the left are against it, unless some compensations are also legislated. The Socialist party has proposed the coupling of the increase in women's age of retirement with reductions in the gender wage gap. Increases will only be effective when given thresholds in the reduction of the gender wage gap will be attained (see Fehr 2013).

- Early retirement with no or educed loss possible for those who have started paying contributions before 20

Contributions to AHV-AVS must be paid by all resident citizen after the age of 20. However, those who are in employment at an earlier age, start paying contributions at age 18. The two extra contribution years paid by those who start their working life earlier are then disregarded in the determination of pension rights (both pension level and age of retirement) unless the insured person has some contribution gaps later on, in which case the two additional years can be used to fill that gap. The proposal is to consider the contributions paid before age 20 and facilitate access to early retirement for the insured persons concerned. This measure may be subjected to and income test. The result will be that people who have started their career early and have remained on a comparatively low income will be able to take early retirement at age 62 or 63 without reductions or with less than the full actuarial reduction. Given the fact that this new entitlement is based on contributions that have been paid, it is possible that its adoption may be less controversial than previous attempts at facilitating early retirement. However, it probably concerns a small number of retirees.

- Part-time basic pension

This is a rather uncontroversial measure. Part-time retirement is Switzerland is possible only through the second pillar pension, provided that the individual pension fund allow this. The basic pension, instead, must be claimed in full. The reform would introduce the possibility of claiming a 50% basic pension while continuing to work and contribute to the remaining 50%.

- 1 or 2 extra percentage points of VAT

In order to make up for the financial shortfall expected around the government proposes to increase by 1 or 2 percentage point the standard VAT rate (currently of 8%). The government does not specify when (it is only mentioned around 2020 and 2030) these increases may become effective, but considers 2 percentage points as the maximum increase (DFI 2013: 6).

- Automatic cuts if the reserve funds is lower than a given threshold

The basic pension has a reserve fund which is supposed to amount to one year of pension expenditure (situation in the current legislation). The reform envisages an automatic mechanism in two stages:

- Stage 1: when official projections expect the fund to go below 70% of yearly expenditure, the government is required to adopt measures that will bring the fund back above the threshold.
- Stage 2: if the reserve fund is lower than 70% during two consecutive years and if the negative imbalance between receipts and expenses if bigger than 3% of yearly expenses also during two consecutive years, then the following measures are adopted: an additional percentage point of VAT and a slowdown in the indexation of benefits.

For the second pillar:

The government proposes the reduction of the annuity rate from the current 6.8% to 6.0%. This is a much bolder reduction than the one rejected by voters in 2010, which aimed for 6.4%. However, unlike in the 2010 reform, the government now proposes some compensation measures that will reduce or eliminate the negative impact of this decision on the actual amount of second pillar pensions. The document released in June 2013 is not very precise with regard to the form the compensation will take, however three possible avenues are mentioned:

- *Lowering of the earnings threshold above which contributions must be paid.* Currently contributions to 2nd pillar pensions are compulsory only for the portion of earnings comprised between CHF 24,570 (€ 19,810) and 84,240 (€ 67,935; figures for 2013). It is planned to replace the lower threshold with a percentage of earnings (25%). This will increase the portion of the salary on which contributions are paid, especially for low income workers.

- *Increase in the notional contribution rates.* The government proposes an increase in the notional contribution rates that are used to calculate the minimum occupational pension (reproduced in table 1.1). The increase will concern only workers aged between 35 and 44, for whom the rate will go from 10% to 11.5% and those aged between 45 and 54, for whom the rate will go from 15% to 17.5%.

- *Adoption of a lower starting age for contributing to a 2nd pillar pension*. Current legislation makes provision for compulsory 2nd pillar pension coverage for employees aged between 25 and 64.The government proposes to explore the possibility of lowering the age of the entry into the system.

Additional compensation measures are also planned for older workers, for whom the remaining time until retirement is not sufficient to make up for the shortfall in benefit due to the reduction in the annuity rate, in spite of the compensation measure discussed above.

The timeline of the reform

The reform has been announced in late 2012, and elements reported above were presented in June 2013. A detailed plan is expected for end 2013. Then, following the usual decision making process, such a detailed plan will be subjected to a very broad consultation procedure, were each relevant actor will be able to express their position. On the basis of the results of the consultation procedure, the government will decide how to craft the pension reform bill. This should then be approved by parliament, possibly in a revised form. After parliamentary approval, voters have a 90 days period during which a referendum on the reform can be called. For that to happen, 50,000 signatures of voters are requested. Considering the potential for controversy involved in such a big reform, it is quite likely that it will be subjected to a referendum.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

The health care system in operation today is based on the health insurance law adopted in 1994 and valid since 1996 (LAMal; "Loi fédérale sur l'assurance maladie"), which replaced the initial law of 1911. The reform in 1994 signified the change from a voluntary health insurance system to a universal and mandatory health insurance system (Uhlmann and Braun 2011). The reason for the reform was on the one hand an attempt to reduce the continuing increase in the costs of the health care system and on the other hand the wish to reduce inequalities by strengthening the solidarity among all premium payers. The fundamental structure and philosophy of the LAMal have not been changed since then though there have been incremental adaptations.

3.1.2 System characteristics

The health insurance system consists of three pillars: the *mandatory basic health insurance* with its three parts illness, accident, and maternity, covering most incidents of illness; the *complementary health insurance*, which is voluntary and covers costs like private or semi-private rooms in hospitals and specific treatments like for example dental care; and a voluntary insurance for *daily cash benefits*, compensating losses in income in the case of longer stays in the hospital.

These insurances are offered by private health insurance agencies. In the case of the basic health insurance, insurers are not allowed to make profits (they are part of the social insurance system), while they can in the case of the two other kinds of insurances. This means different access criteria: In mandatory health insurance, insurers are required, despite competition for insurance contracts, to accept all applications independent of gender, past incidences of illness, or age. Individuals, on the other side, are free to choose their doctor and even specialists (if they have not concluded specific premium contracts with lower premiums that limit this choice) and they can also choose their preferred insurance agency though this choice is limited to the canton, i.e. the federal member state, they are living in. Treatment outside the canton is, however, possible if patients are ready to pay for eventual price differences.

Insurance premiums in Switzerland are individual-based and not related to income, which makes the health insurance system a regressive system typical for a private insurance system while state-led and social insurance systems have progressive income systems for health premiums. Employers do not contribute to premium payments. Individuals pay directly to providers of health services and are reimbursed by their insurance companies.

Though insurers may not adapt premiums to gender, age, or past history of illness - an exception is only made for children and young adults in education who profit from a reduced premium level -, premiums may vary for other reasons: Together with the USA and the Netherlands, Switzerland is the only country offering "deductibles" on the basic insurance. They can vary between 350 and 2500 CHF. Deductibles are seen as a measure to reduce cost pressure on the system. About 60% of individuals use such deductibles (Kaufmann 2010). Furthermore, there is the possibility to choose for a lower premium insurance with restricted access to providers (e.g. by general physicians or

health maintenance organisations). Insurers can also offer a "bonus" for those who have not used any of the health care services during a year.

35% of the costs of health services and drugs were in 2010 financed by premium payments (BFS 2012: 90). In addition, private households contributed for about 25% in the form of out-of-pocket payments and deductibles and also paid about 9% for private health insurances. Political actors are contributing only for 19% to health expenditures, with cantons paying the lion share of 16%.

There is large variation in premium levels between cantons. In Switzerland - being a federal country - premium levels are calculated on the base of "cantonal risk" (incidences of illness; average provider costs) and are fixed for a canton and, eventually, again for up to three administrative sub-regions within one canton. This procedure has led to differences between cantons of 75% when comparing the highest and the lowest median premium level (OECD 2011: 37).

Households bear substantial additional costs in the form of "co-payments" and "out-of-pocket" payments respectively for drugs and medical services. However, these payments are fixed to 10% of the costs and 15 CHF per day in hospitals. A maximum amount per year holds: 700 CHF for adults and 300 CHF for children.

Taking into account the considerable costs this system generates for individuals, policy-makers have introduced *subsidies* for lower income groups. In 2009 a third of all premium payers profited from such subsidies. Eligibility criteria and amounts are defined by cantons and can therefore differ. The federal government offers to pay 50% of these subsidies if cantons match these payments.

In the case of *voluntary insurances*, the governance structure is different. Insurers (both commercial ones and those working under the rules of the social insurance system) cannot only make profits, they are also free to define eligibility and even exclusion criteria according to risk assessments.

Both private and public actors offer medical services. 186 public or subsidised and 128 private hospitals offer *stationary services* in 2009 (OECD 2011: 46). Private hospitals can be commercial or not-for-profit organisations. Cantons and municipalities finance public hospitals. Recent reforms inspired by new public management have led to a growing number of public hospitals with a legally independent status. Ambulatory services are mostly provided by doctors, dentists, psychotherapists and paramedical professionals in independent practices. Payments occur on a fee-for-service-basis. Fees are standardised by collective agreements between professional organisations and insurers within each canton.

The health care system, as defined by the health insurance law, is considered to be a market-oriented and competitive system but such competition is politically regulated. Involved in the governance of health care are first of all the two main federal actors, the federal government and the cantonal governments. The governance system is complex because of the many concurrent rights of both sides in health care. While the federal government, represented by the Department of Domestic Affairs and its main agency, the Federal Office of Public Health (OFSP), has the overall responsibility for the LAMal and treats system-wide aspects of regulation, cantons are in charge of the implementation of the LAMal but have also regulatory powers of hospitals (by also being the financing agency of public hospitals), control that all cantonal citizens have subscribed to health

insurance, define the criteria for premium subsidies and contribute, together with the federal government, to the financing of these subsidies, and have important powers in public health matters. Insurers and providers are also integrated in the governance system: the "weighting" of the resource-based tariff structure occurs in annual negotiations between the main organisations of these actors. The federal government can fix tariffs if no agreement is found. Some of the tasks are also delegated: risk equalisation for example (see below), is implemented - though not defined, which is the prerogative of federal government and parliament - by the "Common Institution", an organisation founded by insurance agencies. This institution fulfils also other tasks that encompass the capacities of individual insurers like the redistribution of reserve funds or take charge of payments for insurers that have gone bankrupt (Indra et al. 2010: 186).

A system of "risk equalisation" has been established that is supposed to equalise asymmetries in the member composition of insurers within cantons but also between cantons that can nevertheless occur. Such equalisation serves to reduce any incentive to search for low risks by insurance agencies. The criteria applied to calculate the sums of money to be redistributed among insurers were since the beginning the membership composition based on age and gender. Since 2012 the duration of hospital days is added to the list.

Further regulation is taking place with regard to the right of insurers and providers to conclude contracts - free contracting is not allowed -, but also with regard to price setting for pharmaceutical products. The federal government is responsible for selecting drugs that will be reimbursed within the framework of the LAMal. New drugs must pass a test by the "Federal Drug Committee", after it has been registered by Swissmedic, the "Agency for Therapeutic Products", on the base of their cost effectiveness and their appropriateness for the kind of illness they are addressing. A comparison of prices with a selected number of other countries is taken as one of the criteria. The federal government does, moreover, also regulate different aspects within the LAMal, for example, the definition of deductible thresholds. Most importantly, any increase in premiums must be approved by the federal government, a procedure that is taking place each year.

3.1.3 Details on recent reforms

During the last years a number of successful and unsuccessful reforms have taken place:

Cost control and quality enhancement

- Political actors planned to strengthen the managed care system in ambulatory care, intending to achieve more efficiency, better quality and lower costs. The corresponding law was rejected in a referendum (18.6.2012).
- In order to further reduce the costs of the system, any payments for visual aids were excluded from the basic insurance in 2012.
- On the 1st of January 2012 cost calculation in hospitals was changed. The new payment system is based on "diagnose-related groups". "SwissDRG", a newly created organisation (representatives from cantons, insurers and providers), is entitled to define the details for DRGs. 55% of the costs are paid by cantons and 45% by insurance agencies.

Benefits

Initiated by a referendum in 2009, five treatments in the tradition of complementary medicine have been re-integrated (after having been discarded in 2003) into the benefit scheme of the LAMal. The integration is temporary for a period of six years, in which the efficacy of the treatments is tested.

Regulation

- A temporary regulation of the number of licences for specialised doctors was abandoned in 2011, only to be re-installed in July 2013 in order to avoid a surplus offer of such doctors in the system.
- Since 2011 the federal government has the right to intervene into the tariff structure of payments of insurers for providers if associations (insurers, hospitals, medical doctors) do not find an agreement.
- Since 2012 insurance agencies are obliged to hold minimum reserves of money in order to avoid bankruptcy. In addition they have to undergo an "insolvency test".

Risk-based selection of insured people

The number of days in hospital of patients was added as a third criterion next to gender and age in order to calculate distribution payments in risk equalisation.

Governance and Coordination

The OECD had criticised Switzerland already in 2006 for its lack of coordination (OECD 2006). This has led to more efforts, for example in the form of federal programmes for better disease control. A new "law on epidemic diseases" has been accepted in September 2013, granting - among other things - the federal government a more leading role and more coordination capacity in the combat of such diseases. By contrast, a new "law on health promotion and prevention", with similar intentions, was rejected in parliament in 2013.

3.2 Assessments of strengths and weaknesses/challenges requiring reforms

3.2.1 Coverage and access to service

Switzerland offers universal coverage in health care. Medical services are non-discriminatory and accessible for all persons having paid their insurance premiums. Benefits under the basic insurance scheme are generally considered as being very comprehensive, with the notable exception of dental care and visual aids, which are excluded from reimbursements.

The health care system supplies also high comfort measured in waiting time for medical treatment. Waiting lines seem to be very small. More than 75% of participating persons claim, according to a survey, that they have been treated almost always directly or the next day (CommonwealthFund 2011).

Corresponding to this is the fact that Switzerland has seen a continuous increase in health professional density. Switzerland compares favourably here with 68.4 persons per 1000 population

against an OECD average of 48.6 (OECD 2011: 88). The number of practicing doctors rose from 2.4 to 3.9 per 1000 population between 1980 and 2008, a figure which is also above the OECD average (OECD 2011: 47). The density of physicians in independent practices grew significantly between 1980 and 2009 from 1.2 to 2.0 physicians per 1000 population (OECD 2011: 89).

Health inequalities

The main discussion about health inequalities in Switzerland concerns unequal distribution of financial costs among income groups with possible consequences for the access to medical services. Such inequalities are due to the regressive character of health premiums and other financial contributions of private households. The health system redistributes between the healthy and ill, young and old, and men and women but not between rich and poor (Rosenbrock and Gerlinger 2006: 291). The following points can demonstrate this:

- Premium levels are regressive. The burden, expressed as a share of household income, is higher for lower incomes than for higher incomes (11.8% in 2008 for the lowest income quartile against 3.4% for the highest income quartile) (OECD 2011: 66).
- Subsidies compensate these differences to some extent but not sufficiently, among others because premiums are rising more rapidly than subsidies (ibid.: 68).
- The share of out-of-pocket payments is the highest for private households in the OECD (three times the average of the OECD; ibid.: 69). If these payments are added to premium payments, the inequality between households becomes again visible, even after reduction of premium subsidies (22% of disposable household income for the lowest income quartile against 11% for the highest income quartile; ibid.: 70).

All measures to avoid such income inequalities - expenditure ceilings; subsidies for low income households; or no cost-sharing for maternity related care - have until now been insufficient.

A survey indicates problems of parts of lower income groups to pay for medical services (9% against 2% in higher income groups)(CommonwealthFund 2010). On the other side, it is also indicated that low income groups in Switzerland get more rapid access to health care and even specialists once they get sick compared to most other countries.

Another topic is *regional inequalities* in premium payments. It has already been stated that premium levels can vary significantly between cantons. While this is linked to differences in the cost structure of health care systems in the cantons (OECD 2011: 65), another factor are differences in subsidy payments by cantonal governments. Cantons have a considerable discretion in defining eligibility criteria and levels of subsidy, which contributes to the large inter-cantonal differences in premium payments and, hence, to inequalities between citizens living in different regions.

3.2.2 Quality indicators

Switzerland had the highest life expectancy rates among OECD countries in 2011 (BFS 2012: 28), i.e. 82.8 years while the OECD average is 80.1. Men enjoy the highest life expectancy (80.2 years; ibid.) while women rank second among OECD countries with 84.6 years. Life expectancy with good health was 69.4 years for men and 70.3 years for women in 2011 (ibid.).

Corresponding these figures, surveys revealed that 87% of the population who lived in private households considered their health as being good or very good, which is in stark contrast to the OECD average of 69% (OECD 2011: 29).

Recently conducted surveys state that a large majority of the Swiss population is very satisfied with the health care system in general and medical services in particular (Neue Zürcher Zeitung, 25-6-13, p. 10) and has great trust in the effectiveness of the system (CommonwealthFund 2010). Medical doctors, both general physicians and specialists) are considered as being highly competent and well educated (80% agree; (CommonwealthFund 2011).

3.2.3 Sustainability

Health expenditures in Switzerland are high measured as a percentage of GDP. In 2011 they were 11% against an OECD average of 9.3%, giving Switzerland the seventh position among OECD states (OECD 2013). In per capita terms, the country ranks even second with 5643 USD in 2011 (ibid.). Growth rates in real terms of health expenditures between 1995 and 2010 were 4.8% per year on average (BFS 2012: 88). Overall, the increases were higher than GDP growth in this period. Premium increases have been for a long time the main preoccupation of citizens and remain one of the top priorities for citizens (Neue Zürcher Zeitung, 25-6-13). Though the average increase of premiums could be reduced since 1999 (OECD 2011), discussions about policy measures are continuing and can be regarded as the most important issue in reform debates. Angles of attack are, first, increasing pressure on the pharmaceutical industry to lower drug prices; second, a constant fine-tuning of risk equalisation schemes that were introduced as a temporary measure in order to force insurers to efficiency-enhancing strategies instead of search for low risks; third, a new base of hospital financing - the DRG - which should lead to more transparency, competition, and cost reduction. A fourth strategy, health maintenance organisations, which are supposed to work more efficiently as service providers, has failed to convince the Swiss people. The federal government has in its latest strategic paper - "Health Policy 2020" (EDI 2013) - underlined that it will pursue the struggle for an expansion of integrated care.

Though it cannot be denied that policymakers have endeavoured to tackle the problem, cost containment is by no means secured and further steps have to be taken. The more so, as one can expect future cost pressure because of an on-going structural shift in the provision of medical services away from stationary to ambulatory care, which are completely financed out of premium payments (Neue Zürcher Zeitung, 24-1-2013, p. 11). The struggle for cost containment is also necessary because the system is built on large inequalities between income groups. Premium rises tend to increase further such inequalities. All mitigating measures - like subsidies - have proven insufficient until now to overcome such inequalities. The federal government recognises this problem in its strategic paper and wants to increase solidarity by lowering premiums of low income households and families with children.

Health Workforce
In 2008 541800 persons were working in the health sector, which is 13.5% of overall employment. The growth of the health workforce has been increasing at a steadier pace than in the overall economy (3.8% since 1985 against 0.9%, with the highest growth in the pharmaceutical and medical technology industry; see Health Statistics 2012).

The major part of health personnel is working in hospital (163000), 15500 are employed in nursing homes (155000), 100000 in the ambulatory sector and about 61000 people in pharmaceutical and medical device industry (OECD 2011: 47).

Part-time work is particular strong in this sector (48% against 31%), which is linked to the high participation of women (72% in 2008) who are often choosing for part-time employment.

An important feature of the system is a migrant health personnel share of 25%. In hospitals, the share increased between 2002 and 2008 from 33% to 36%. 35% of doctors in hospitals are migrant health workers (OECD 2011: 102).

Sustainability is above all in question because of the high share of migrant health personnel. The rate of 35% of doctors in hospitals raises concerns that Switzerland could have serious difficulties if these doctors would return home or go to other countries. Switzerland is apparently not educating enough own health personnel. A discussion about a more sustainable strategy to increase the number of Swiss doctors has begun without visible outcomes until now.

3.2.4 Summary

One can mention five major concerns that not only seem to be weaknesses of the system but engender also questions about the sustainability of the Swiss health care system. All five points are not only raised by the OECD but figure prominently also in discussions of Swiss policy-makers.

1) *Cost containment f premiums (see above)*

2) *Dependence on foreign health personnel (see above)*

3) *Lack of evidence-based policies*

Data gathering on key indicators in the health system is seriously deficient, as the OECD has already stated in 2006 (OECD 2006). This makes it difficult not only to judge on the performance and quality of the system but also to identify asymmetric developments in health sectors, to develop a more equilibrated strategy of health personnel development or raise competition among health providers on the base of a transparent system based on data. The lack of systematic data on health inequality makes adequate policy action difficult. Only the introduction of the "diagnose-related groups" in hospitals that allow raising data on hospital service costs and the establishment of the Swiss Health Observatory (Obsan) are new elements that can support future policies on the base of evidence. Other measures still need to come. The federal government is aware of this problem and mentions the negative implications for governance in its strategic paper.

4) *Good governance*

In terms of governance it is said that Switzerland belongs to the most complex health care systems in the OECD, not only because of the federal divide but also because of the large number of other players that have a say in many health care matters where the state has delegated powers to self-regulate, as for example in the determination of prices among providers and insurers.

Such a complex system produces high transaction costs, uncertainty about outcomes, a slow pace of reform, and forces the federal government time and again to take in a stronger coordinating role, which is the only way to achieve reforms. It is here that we see recent activities of the federal government to strengthen its coordination capacities, e.g. by demanding for enhanced competencies in public health matters (successful in the case of epidemic matters, unsuccessful with regard to a new health prevention and promotion law) or by using its emergency powers when insurers and providers cannot find an agreement about tariffs. In this case, the federal government has obtained the right to adjudicate. The federal government contends in its strategic paper that further strengthening of coordination capacities is necessary.

Social investment aspects

The expenditures of Switzerland on public health matters and especially on prevention are below the OECD average with 2.3% of total health expenditures against 2.7% (figures for 2010; OECD 2011: 40). With regard to the maintenance of a healthy workforce one can above all consider as relevant federal programmes combatting smoking, alcohol and other forms of unhealthy life style. Switzerland has had some success with anti-smoking campaigns. Rates of smokers declined from 1992 to 2007 to OECD average levels (20.4% of the population). Obesity increased but is still much lower than the OECD average (37% against 50%; Health Statistics 2012).

3.3 Reform debates

Unified health insurance (Einheitskasse)

The issue of cost containment in health care has led to regular discussions about a more fundamental reform of the health insurance system. One reform proposal that comes regularly back on the political agenda is the demand for a single health insurance agency with regional sub-agencies ("Einheitskasse"). Proponents argue that such a system would create a more simple, just, and cost-effective health system, although a number of scientific experts judge the cost containment effect to be small (marginally, approx. 5%) and rather of a long-term nature.[2] The federal government opposes such a reform and proposes instead to continue with a fine-tuning of the existing risk-selection system for health insurers and by making risk-selection a permanent adaptation mechanism. In addition, a strict separation of basic and additional insurances should create more transparency (Neue Zürcher Zeitung, 21-9-2013). [3] The proposal of a single health agency will come to a popular vote early next year. Currently, polls indicate that the support for a unified health insurance in the Swiss population is large, whereas the opponents of this proposal are weakly organized (Neue Zürcher Zeitung, 24-6-2013). For instance, some of the health insurances split from the national health insurance interest organisation Santésuisse, and formed a new interest association (Neue Zürcher Zeitung, 5-5-2013).

[2] Neue Zürcher Zeitung (NZZ), 28-2-2013 and 12-4-2013 ; SRF (http://www.srf.ch/news/schweiz/einheitskasse-bundesratsverzicht-erfreut-gegner-und-befuerworter, last access September 29, 2013).

[3] For more details: http://www.bag.admin.ch/aktuell/00718/01220/index.html?lang=de&msg-id=47932, last access, September 29, 2013.

Reimbursement of health insurance premiums

Another issue of health insurance policies that has been debated in Switzerland is the reimbursement of health insurance premiums. Since the implementation of the federal law for health insurance in 1996, health insurance agencies collected in a number of cantons too high sums of premium payments in relation to the cost of the services that were paid for. As a consequence, some cantons had surpluses and others deficits in their health insurance accounts. The federal government proposes to reimburse insured individuals in those cantons where too high premiums had been paid and to impose additional fees in cantons with too low premiums. The Council of States has already adopted the suggestion by the federal government and adoption of this proposal is likely.[4]

Supervision of health insurances

Another project of the federal government entails a reform plan for the supervision of health insurances. The proposal aims at improving financial security and the management of health insurances. Furthermore, the goal is to increase the competences of the supervising authorities, sanctioning possibilities in cases of miss-management and transparency of health insurances.[5]

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

Today, in Switzerland, the system of long-term care is as decentralized as the health care system. On the national level, the most important institution of the policy field is the LAMal. It finances ambulatory medical care if it is related to sickness but not to old age. Other services, such as social assistance, activity therapy, or the stay in nursing homes are billed to the patient directly. Switzerland spends every year over two per cent of its GDP (2.2 per cent in 2011) on long-term care. This is about double of the OECD average (1.1 per cent in 2011). This is partly due to the large part of the population aged over 65 in Switzerland (17.1 per cent in 2011) in relation to the OECD average (12.2 per cent in 2011). It is also related to the fact that the Swiss health system is comparatively expensive (OECD 2011; OECD 2013).

4.1.2 System characteristics

As in the case of health care, the organisation of long-term care is decentralised. The responsibility for long-term care is with the cantons, which have the possibility to delegate this responsibility to the communities or private organisations, an option with they use frequently (Kocher 2010; OECD 2011). Health insurances, cantons, and municipalities finance directly about 40 per cent of

[4] http://www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20120026, last access, October 2, 2013.

[5] http://www.bag.admin.ch/themen/krankenversicherung/00305/06506/11597/index.html?lang=de, last access, October 8, 2013.

long-term care cost. The remaining 60 per cent are covered by households. Yet, to ease financial pressure on the families and individuals, social benefits, for instance invalidity allowances and supplementary benefits for the elderly cover another 24 per cent of the total expenditure, so that the households have to cover 36 per cent of the costs for long term care (OECD 2011).

The provision of care occurs either in medical nursing homes, nursing departments of old age or disability homes, or ambulatory. An organisation called Spitex (Acronym for the German phrase „Spitalexterne Hilfe und Pflege" – care services provided out of hospitals) is responsible for the provision of ambulatory care (Gmür and Rüfenacht 2010). In addition to services of formal care, informal care plays also an important role in Switzerland. Informal care entails care services that are provided by volunteers, families, and dependents of the needy person (Zumbrunn and Bayer-Oglesby 2010).

4.1.3 Details on recent reforms in the past 2-3 years

The following reforms have been conducted in the long-term sector, in recent years:

- In 2003, a national decree made budgeting and activity recording mandatory for long-term care providers, in order to increase transparency.
- In 2008, the federal parliament passed a law that reorganized the financing of long-term care, which had the goal to improve the situation of patients and to avoid additional financial burden for health insurances.
- The reform of the national fiscal equalisation system in 2008 shifted the financing of the provider of formal care services (Spitex) to the cantons. As a consequence, the cantons had to raise 15 per cent of the Spitex budget. It was left to the cantons, which instrument they wanted to choose to do this (i.e. covering deficits, wage subsidies, lump sum per inhabitant, or service hour, or subsidies per individual that are independent from income) (Gmür and Rüfenacht 2010).
- As of January 2011, health insurers have to contribute to long-term care, along with other social insurances. The smallest part of the costs that were not covered by the social insurances was passed on to the patients and the larger part had to be covered by the cantons, which are now demanding a national long-term care insurance (SRF, January 11, 2013).[6]
- Another reform that affected the long-term care sector is the national strategy for palliative care, which has been put into place in 2010 and was renewed last year, until 2015. Palliative care aims to improve quality of life for patients with incurable chronic illnesses. It comprises of medical care, nursing as well as psychological, social and spiritual support over a shorter or longer period, depending on the course of disease. In the strategy, the federal government and the cantons aim at implementing palliative care in all sectors of the health system that need to participate in it.[7]

6 http://www.srf.ch/player/radio/echo-der-zeit/audio/eine-pflegeversicherung-fuer-alle?id=817dde3e-7ee5-49f3-96ba-56d906f0e278, last access October 14, 2013.

7 http://www.bag.admin.ch/themen/gesundheitspolitik/13764/index.html?lang=de, last access, October 10, 2013.

4.2 Assessment of strength and weaknesses

4.2.1 Coverage and access to services

In Switzerland, the access to long-term care depends largely on private assets (Höpflinger et al. 2011). Health insurances partly pay ambulatory long-term care services by the Spitex, if a doctor prescribes them. The insurances contribution comprises of a daily rate for basic care, yet patients have to contribute to it out of their own pockets, in addition to the franchise of their health insurance. In case that an individual cannot raise the out-of –pocket contributions, there is the possibility to apply for complementary benefits (Ergänzungsleistungen) by the AHV (Alters- und Hinterbliebenen-Versicherung - Old Age and Survivors Insurance) and IV (Invalidenversicherung – Disability Insurance) insurances. If the insurances do not pay for the services a patient needs, or if these services were removed from the portfolio of the insurance's contribution, and if there are no private means available, those in need can apply for social assistance with the foundation ProSenectute. This is a national foundation with the goal to prevent and relieve poverty in old age, which has cantonal and regional centres.[8]

In the Swiss population, income and wealth is most unequally distributed in the group that is over 60 years old. Every 7th couple has a fortune of over 1 million Swiss Francs, whereas every 10th couple has less than CHF 10,000 in the bank. If an individual has less than CHF 28,700 per year, it is considered poor. Yet, in comparison to other countries, old age poverty is less spread, in Switzerland (Pilgram and Seifert).[9] However, living costs, such as health insurance contributions, increase faster than pensions. Therefore, ProSenectute demands to raise complementary services and adapt them to rent and energy prices, as well as more tax reliefs for the poorest seniors.[10]

4.2.2 Quality and performance indicators

The lack of coordination in the Swiss health system, mentioned above, is similarly visible with regard to quality control in long-term care. Until today, Switzerland does not have a national strategy, or policy to improve and coordinate long-term care in general; it only exists for the area of palliative care. As a consequence the responsibilities for quality control are fragmented. The main responsibility for quality control is with the cantons, which use their public services to implement quality controls. However, health insurances and health care providers also implement quality control measures. Health insurers are mostly concerned with controlling cost efficiency of health insurances. Providers of care, such as CURAVIVA (Association of Swiss Nursing Homes), implement also quality control measures. Currently, three different instruments of need assessment are used in Switzerland. BESA, which was created by CURAVIVA itself, is used in most of the cantons. Four of the French-speaking cantons (Geneva, Jura, Neuchatel and Vaud) use the system PLAISIR, which had been developed in Canada. Four cantons use the system RAI/RUG (Aargau, Basle City, Solothurn and Zurich), whereas Ticino and Fribourg have their own system (Gobet et al. 2009).

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8 http://www.srf.ch/gesundheit/gesundheitswesen/spitex-wie-man-zur-hilfe-kommt-was-sie-kostet, last access October 11, 2013.

9 http://drs.srf.ch/www/de/drs1/sendungen/wissen-aktuell/2802.sh10160075.html, last access October 10, 2013.

10 http://www.srf.ch/player/tv/tagesschau/video/altersarmut-existiert?id=7074efe3-04ec-42e1-a4a1-638998a62f2f, last access October 10, 2013.

4.2.3 Sustainability

As in many other developed democracies, the sustainability of long-term care services is one of the biggest challenges of health policy, because the share of over 65-year-olds in the population will increase steeply in the future. Projections of the expected increase of health expenditures assume that the cost of long-term care will triple until 2060. Especially the cantonal households are affected, as they currently finance over 60% of the public expenditure for healthcare. The strongly expected increase in long-term care expenditure affects also the budgets of municipalities, as well as the disability and survivors insurances. To the contrary, the cost pressure on the federal government is smaller, as it is mostly engaged in the co-financing of insurance premium reductions (Colombier 2012).

Another important aspect of the sustainability of the Swiss system of long-term care is the development of the workforce. The increasing demand for long-term care services has consequences for the workforce in this area. In 2004, the federal government passed a new law on occupational formation and included also the regulation of health professions, an area that had formerly been in the responsibility of the cantons and was regulated by the GDK (Gesundheitsdirektorenkonferenz - Cantonal Conference of Health Ministers).[11] Since 2006, new academic degrees have been created in the field of long-term care (Bachelor, Master and PhD) (Schäfer et al. 2013). Another dimension of the dynamics in the workforce of the long-term care sector is the increase of migrants in long-term care services. Since the introduction of unrestricted mobility for EU citizens, in 2011, more and more immigrants, often from Eastern Europe, have been hired privately to provide long-term care services (Holten et al. 2013).

4.2.4 Summary

Summing up the strengths and weaknesses of long-term care in Switzerland, we can conclude the following ***strengths***:

- Many possibilities for financing and assistance for needy elderly
- Services are available countrywide
- Comparable low poverty rate in general makes it easier to organize long term care

To the contrary the ***challenges*** of the Swiss system of long-term care are the following:

- Access depends largely on private means
- Cantons and municipalities will have to bear the increasing costs in long term-care
- Service provision and quality assurance vary regionally
- Better coordination of general service provision, quality control and prevention in the long-term care sector are necessary (OECD 2011)
- For Switzerland, there exist no recommendations by the EU in the area of long-term care

4.3 Reform debates

The following issues have been debated in the long-term care sector:

[11] http://www.bag.admin.ch/themen/berufe/00416/00583/index.html, last access October 11, 2013.

- **Cost containment:**
  - ***Improve prevention and Long term care services:*** A study by the Swiss Health Observatory proposed already in 2008 the following points to reduce the increasing costs: 1. Create more prevention programs to improve health of the elderly population and to keep older individuals independent from third party care as long as possible. 2. Extend the scope of ambulatory care, such as the Spitex services in comparison to nursing homes (Weaver et al. 2008). The strategy of the federal government on health in Switzerland 2020 confirms these findings (EDI 2013)
  - ***Long-term care insurance:*** Some cantons propose long-term care insurance based on solidarity. This means that, similarly to the old age and survivors insurance, a certain percentage of the salary would be taken out and paid into a social insurance fund. The Social Democrats (SP) suggested financing this insurance through progressive contributions from salaries, as well as from taxes, because in this case employees as well as retired individuals contribute. The suggestion also entails to make such the insurance mandatory only after certain age.
  - ***Cut spending:*** The right-wing Swiss People's party (SVP) however refused these ideas and suggested that rather than creating a mandatory long-term care insurance, it would be better to cut spending.
  - ***LTC premium:*** To the contrary, the Christian Democrats (CVP) are afraid that another social insurance would put a too large burden on the economy. They proposed to cover long-term care over the existing health insurance and to raise a LTC premium only after a certain age (SRF, 11-1-2013).[12]
  - ***Reduce possibilities to obtain complementary benefits:*** Other suggestions are to correct some loopholes that allow citizens to resort to the complementary benefits, for instance to restrain possibilities to disburse pension funds when retiring, in order to buy real estate (Neue Zürcher Zeitung, 25-9-2013).
- **Sustain the workforce:** In the last two years, experts and professionals have demanded that it is necessary to train more personnel for long term care. Thereby, it is debated whether academic training of personnel would increase the quality of care. Yet, it is clear that in many cantons there is a shortage of personnel in the long-term sector and some of them have problems to fill all positions that are vacant (Neue Zürcher Zeitung, 24-10-2008, 2-2-2009, 3-3-2009, 10-1-2010), for instance until 2020, there is an additional demand for 5000 qualified employees, in Switzerland (Neue Zürcher Zeitung, 1-12-2010; EDI 2013).

12

http://www.srf.ch/player/radio/echo-der-zeit/audio/eine-pflegeversicherung-fuer-alle?id=817dde3e-7ee5-49f3-96ba-56d906f0e278, last access October 14, 2013.

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Annex – Key publications

[Pensions]

DFI (2013) Lignes directrices de la réforme Prévoyance vieillesse 2020, Berne.

This document, published by the federal government in June 2013, is a sort of Green Paper for a major pension reform to be enacted before 2020. It contains numerous proposals for change, some of which are fairly detailed while other ones are more directions. The key points are a promise not to reduce benefit levels and the fact of combining the reform of the first and the second pillar into one single reform.

GENTINETTA, K. UND ZENKER, C. (2009) Die AHV. Eine Vorsorge mit Alterungsblindheit, Zurich, Avenir Suisse.

This report was published by the liberal pro-employer think tank Avenir Suisse. It shows that the basic pension (AHV/AVS) will face serious financial difficulties because of demographic ageing, and suggests to couple the age of retirement with changes in life expectancy. It also makes other proposals for pension reform such as a more flexible pensionable age.

HAUSERMANN, S. (2010) The politics of welfare state reform in continental Europe, Cambridge, Cambridge University Press (chapter 8).

This book provides a political science account of pension reform in western Europe. One chapter (No. 8) is on Switzerland, and contains information on the reforms of the 1990s and of the early 2000s. It shows how political actors managed to build a sufficiently large consensus by coupling some moderate cuts with the expansion of prevision relateing to aspects such as gender equality or the inclusion of part-time workers in occupational pensions

WANNER, P. (2008) La situation économique des actifs et des retraités, (Berne, OFAS).

This report was commissioned by the Federal office for social insurance. It used fiscal data in order to investigate the economic situation of older people in comparison to younger generations. Thanks to access to fiscal data, the author was able to consider not only income but also wealth. The main findings were that the groups most exposed to the risk of poverty are lone parents and large families. Older people in general are less exposed to this risk, even though there are big inequalities among the retired population. On the basis of these findings, the proposal was made to strengthen intra-generational redistribution among older people.

WANNER, P. AND LERCH, M (2012) Mortalité différentielle en Suisse 1990-2005, Rapport de recherche de l'OFAS n° 10/12

In this report, commissioned by the Federal office of social insurance, the authors investigate differences in life expectancy across social groups in Switzerland. The findings are in line with what similar studies have found in other countries, i.e. a clear relationship between income and other indicators of social stratification (such as education level) and life expectancy. The study was commissioned as part of a broader research programme meant to provide the scientific basis

for pension reform. The authors, however, recognise that it is extremely difficult to use information on differences in life expectancy to determine key pension parameters such as for example the age of retirement.

[Health care]

HÖPFLINGER, F., L. BAYER-OGLESBY, et al. (2011). Pflegebedürftigkeit und Langzeitpflege im Alter: Aktualisierte Szenarien für die Schweiz. Bern, Verlag Hans Huber.

This book summarizes the structure and the demand of long-term care policy in Switzerland, and puts the country into an international comparison. It analyses scenarios of demographic development, expected development of long-term care and estimates possible ratios of elderly needing long-term care. Subsequently, the authors discuss forms of long-term care, in Switzerland, distinguishing informal care, ambulatory care and long-term care in nursing homes. The book concludes with a chapter that puts long-term care in Switzerland into a comparative perspective.

KOCHER, G. AND OGGIER, W. (2010) Gesundheitssystem Schweiz, 2010-2012. Bern, Hans Huber.

This is the only compendium on the Swiss health system that systematically discusses all aspects of health policy in Switzerland. The contributions explain organisation, financing, and provision of health care, preventive health policy, and long-term care. It comprises of 39 chapters that have been written by experts of Swiss health policy. However, due to the broad scope of the book, the articles do not go very deeply into the subject.

OECD (2011). OECD-Reviews of Health Systems: Switzerland. Paris, OECD Publishing

Certainly the most encompassing and detailed account of the Swiss health care system which is currently available, even considering national literature on the topic. It is based on country site visits of OECD experts and evaluation of primary and secondary literature in 2010 and 2011. The OECD has given a number of recommendations back in 2006 and analyses to what extent Switzerland has achieved improvements of its health care system on the base of these recommendations.

UHLMANN, BJÖRN AND DIETMAR BRAUN (2011). Die schweizerische Krankenversicherungspolitik zwischen Veränderung und Stillstand. Chur/Glarus, Rüegger Verlag

A recent overview - in German - of the political struggle about the introduction of the new health insurance law in 1994 and its adoption in 2006 with an analysis of reform discussions in Swiss parliament and reforms until 2008. The book emphasises the difficulties of the Swiss political system to adopt major reforms on the base of party-ideological differences and party control.

ROSENBROCK, R. AND T. GERLINGER (2006). Gesundheitspolitik. Eine systematische Einführung. 2. Auflage. Bern, Huber.

This book is amongst the best references on the German health system and contains also one chapter on health policy in Switzerland. Although it is very concise, the section gives an excellent account of the distribution of competences amongst the federal government and the cantons, in health care and prevention. In the following, the section discusses in detail the health insurances, ambulatory care, hospital care, pharmaceutical policy, long-term care, as well as the consequences of the introduction of mandatory health insurance and expected tendencies in the Swiss health system.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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