Switzerland

53

Séverine Schusselé Filliettaz, Peter Berchtold, and Isabelle Peytremann-Bridevaux

53.1 Health Care in Switzerland

Switzerland includes three main linguistic regions (German, French and Italian) and comprises a population of about 8.5 million in 26 cantons (FSO 2019). It is a democratic federal state in which government responsibilities are divided among three levels: federal, cantonal ($n = 26$) and municipal ($n \geq 2500$). The Swiss healthcare system is highly decentralised, with each of the 26 cantons responsible for securing healthcare provision for their populations.

Cantons finance about half of hospital costs and are in charge of issuing and implementing the majority of federal health-related legislations; they also carry out prevention and health promotion activities (OECD and WHO 2011; De Pietro et al. 2015). Outpatient services are financed through the mandatory health insurance, which also covers half of the expenditure of inpatient services, using diagnosis-related group (DRG). Individual health insurance contributions are independent of income and are only subsidised if they exceed 8% of taxable income. There are around competing 30 insurance companies offering mandatory as well as private schemes to the Swiss population.

Ambulatory medical care is provided by primary care physicians and specialists working mostly independently in private practices, but also in group practices, in networks of physicians and sometimes in health maintenance organisations that rely on the principles of managed care; hospitals also provide regular general and

S. Schusselé Filliettaz (✉) · I. Peytremann-Bridevaux
Centre for Primary Care and Public Health (Unisanté), University of Lausanne, Route de la Corniche 10, Lausanne CH-1010, Switzerland
e-mail: severine.schussele@fmc.ch
URL: http://www.unisante.ch; http://www.fmc.ch

S. Schusselé Filliettaz · P. Berchtold
Forum managed care (fmc), Zugerstrasse 193, Neuägeri CH-6314, Switzerland

© Springer Nature Switzerland AG 2021

V. Amelung et al. (eds.), *Handbook Integrated Care*,
https://doi.org/10.1007/978-3-030-69262-9_53

specialised ambulatory care. Other outpatient care providers include mainly private pharmacies, an array of therapists in private practices and both private and public homecare services. Residents have direct and unrestricted access to primary care physicians and specialists. The important exception is those who have opted for an alternative health insurance plan (approximately two thirds of insured residents of Switzerland) (De Pietro et al. 2015), which offers lower premiums for those signing up to voluntary gatekeeping. Other therapists' care as well as medicines will only be included in the insurance scheme if prescribed by a physician. Inpatient care is provided by public and private hospitals that receive financial subsidies from the state if they are considered of "public interest".

In 2017, the costs of health system benefits have amounted to 12.3% of the gross domestic product, ranking second within the OECD countries. Total (public and private) healthcare expenditures were mainly devoted to ambulatory care (26.5%), inpatient hospital (19%) and long-term care (19.3%). Healthcare expenses are mainly financed by the mandatory health insurance (35.8%), by households (28.6%, e.g. out-of-pocket payments such as co-payments, deductibles, uninsured services and drugs, complementary private insurance) and by direct government spending (18.1%) (Andreani and Marquis 2019).

Because of the high level of decentralisation, governance of the system at the national level is weak (Quentin and Busse 2018). Several reform attempts have been made to strengthen the system governance and to build a national consensus on health care in Switzerland, but this has remained challenging (Cheng and Zeltner 2010). While consensus building has been successful with regard to hospital care financing, involving a shift from a daily-tariff system to a national DRG system ("SwissDRG") in 2012 (De Pietro et al. 2015), this has been difficult to achieve in other areas. In 2012, for example, both reform proposals that aimed to develop care integration, introduce population-oriented services and strengthen efficiency and cost containment, as well as a health promotion and prevention law, were rejected. In 2014, an initiative suggesting to replace the health insurance system run by more than 60 private insurers by a system run by a single public insurer was also rejected (De Pietro and Crivelli 2015).

In 2013, the Federal Council approved the comprehensive strategy "Health 2020" (Federal Office of Public Health 2013), which was the first overarching national health policy in Switzerland. Focusing on four domains (maintaining quality of life, increasing equal opportunities, raising quality of care and improving transparency), the overall objective of the "Health 2020" strategy was to prepare the Swiss health system for the challenges ahead, at affordable costs. Several disease-centred programs emerged from this strategy, such as the Addiction strategy, the Palliative care strategy and the Cancer strategy (von Wartburg and Näf 2012; Federal Office of Public Health 2015; Federal Office of Public Health and CDS 2018). This "Health 2020" strategy was replaced by the "2030 Swiss health strategy" (Federal office of public health 2019), which includes eight objectives broken down into political axes, one of which calling for the "Reinforcement of care coordination". This strategy builds upon a recent move towards care integration in Switzerland, with federal inputs such as the "Coordinated Care" project (von

Wartburg 2016; Federal Office of Public Health 2016) as well as the "Promotion of Interprofessional Collaboration in Health" programme (Federal Office of Public Health 2017). At the cantonal level, while only few cantons had already been building up strategies (see below), the Swiss Conference of the Cantonal Ministers of Public Health published in 2019 a guide to help cantons implement care integration (Berchtold et al. 2019).

53.2 Swiss Integrated Care in Practice

Integrated care in Switzerland can be traced to physicians' networks that were first initiated in 1992 (Réseau Delta in Geneva) (Schaller 2008) and amounts approximately to 75 networks including approximately 50% of all general practitioners (GP) in Switzerland (Berchtold and Peytremann-Bridevaux 2011; Hostettler and Kraft 2018). Networks work on the principle of GP gatekeeping, and almost all have contracted with health insurances funds in which they assume budgetary co-responsibility.

There has then been increasing interest towards programmes to strengthen coordination of care for patients with one or more chronic diseases (Peytremann-Bridevaux and Burnand 2009; Berchtold and Peytremann-Bridevaux 2011) with a 2013 survey identifying 44 small-scale programmes targeting chronic diseases or multimorbidity in 14 of the 26 cantons (Ebert et al. 2015; Peytremann-Bridevaux et al. 2015).

In 2015, the Swiss Survey of Integrated Care (SSIC) was jointly initiated by the University of Lausanne, the Forum Managed Care and the Swiss Health Observatory. The objective of this survey was to produce a comprehensive overview of integrated care initiatives in Switzerland. Integrated care initiatives that met the following four criteria were included: (1) presented some type of formalisation, (2) considered at least two different groups of healthcare professionals, (3) integrated at least two healthcare levels, (4) were ongoing during the survey period. Data from 155 initiatives were gathered (Schusselé Filliettaz et al. 2017; 2018; Gilles et al. 2020). While some results will be described thereafter, brief descriptions of several initiatives are provided in textboxes; they were chosen for the purpose of illustrating the heterogeneity of care integration in Switzerland.

Box 53.1 "Mental health & psychiatry", example

Integrated Psychiatry and Addiction Care Winterthur (IPW)

This public organisation started before 1990 and focuses on persons with mental health issues. It includes 15 regional settings offering inpatient and outpatient services by various professionals (physicians, nurses, social workers, pharmacists, other therapists). Together with the patients and their environment, IPW develops goals that are based on their possibilities and resources. Interprofessional processes between different professional groups are promoted: they include the referring physicians, other specialists and

organisations. IPW also facilitates transitions when patients navigate back and forth between the community and inpatient services.

www.ipw.ch.

Box 53.2 "Physicians networks", example

Pizol care

A physicians' network founded in 2000 and including around 100 general practitioners, specialists with their own practices and hospital doctors, together with medical assistants, nurses, nutritionists and physiotherapists.

The network offers specific care/case management, disease management and medication management models. Guidelines as well as quality circles are used for quality improvement.

www.pizolcare.ch.

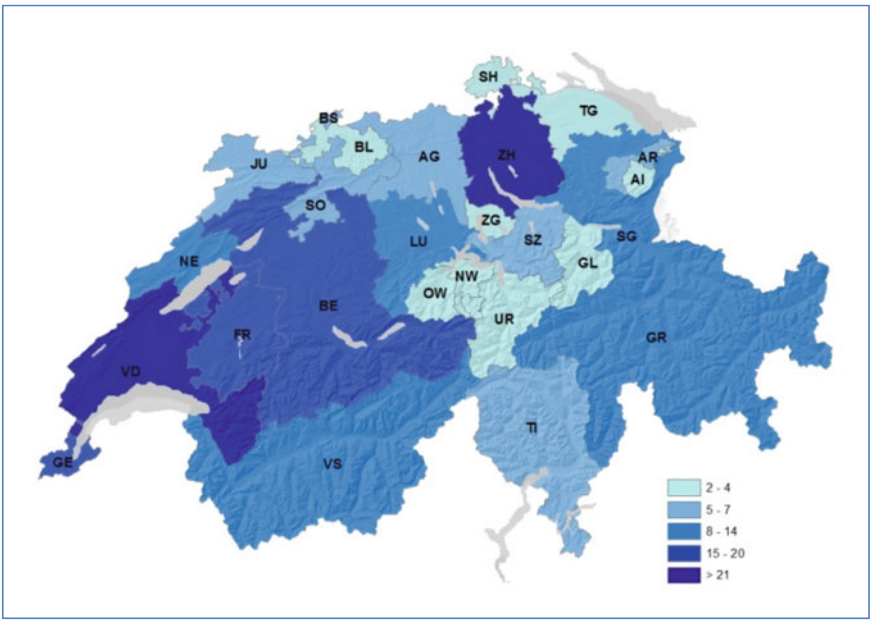
53.2.1 Number and Types of Integrated Care Initiatives

In most cases, initiatives were limited to cantonal borders. Indeed, only 25 of the 155 initiatives were active in several cantons, including two covering the whole country. While all 26 cantons had a least two initiatives, Zurich and Vaud had the highest number of initiatives, with 31 and 40, respectively (Fig. 53.1).

While the implementation of integrated care had been steadily raising since the 1990s (Fig. 53.2), upwards trends started later in the French/Italian-speaking region of Switzerland and eventually surpassed in 2012 the number of initiatives present in the German-speaking region.

The 155 Swiss initiatives were divided into the following six categories:

1. "Health centres": Initiatives including several structures and levels of health care under the same governance, such as primary health care (physician or other), specialised outpatient care (physician or other) and inpatient acute care. This category does not include psychiatry or mental health initiatives (see below).
2. "Physicians networks": Networks of general practitioners and/or family doctors and/or medical specialists, who develop/use guidelines and organise quality circles.
3. "Specific target groups": Initiatives targeting more than one somatic condition or specific patient group (except psychiatry or mental health—see below).
4. "Mental health & psychiatry": Initiatives targeting psychiatry (as a whole or a specific pathology) and/or mental health.
5. "Medicines": Initiatives targeting treatment/drug management and/or reconciliation.



Source: Swiss Survey of Integrated Care

Fig. 53.1 Absolute number of initiatives per canton (n = 155). *Source* Swiss Survey of Integrated Care © Obsan 2017

6. "Transition & coordination": Initiatives focusing on transition/coordination activities between several organisations/levels of health care, such as case/care management, interprofessional and interinstitutional care teams.

The implementation of the six categories of integrated care initiatives over the last 26 years showed heterogeneous trends (Fig. 53.2). The "Health centres" initiatives were the most frequent in 1990 and went through an almost four-fold increase until 2016. The first "Transition & coordination" initiative was launched in 1994 and intiatives in this category went into a much higher increase until 2016. Furthermore, while "Specific target groups" and "Mental health & psychiatry" initiatives were rare in 1990 and increased by more than ten-fold over the last 26 years, the number of "Physicians networks" remained very stable.

Box 53.3 "Specific target groups", example

Wound care service, Regional Hospital of Mendrisio Beata Vergine

This outpatient clinic started in 2010. It is available both for patient admitted to the various wards of the hospital and for outpatients sent by external doctors, long-term institutions and homecare services. It pays particular attention to the continuity of care, through close collaboration with

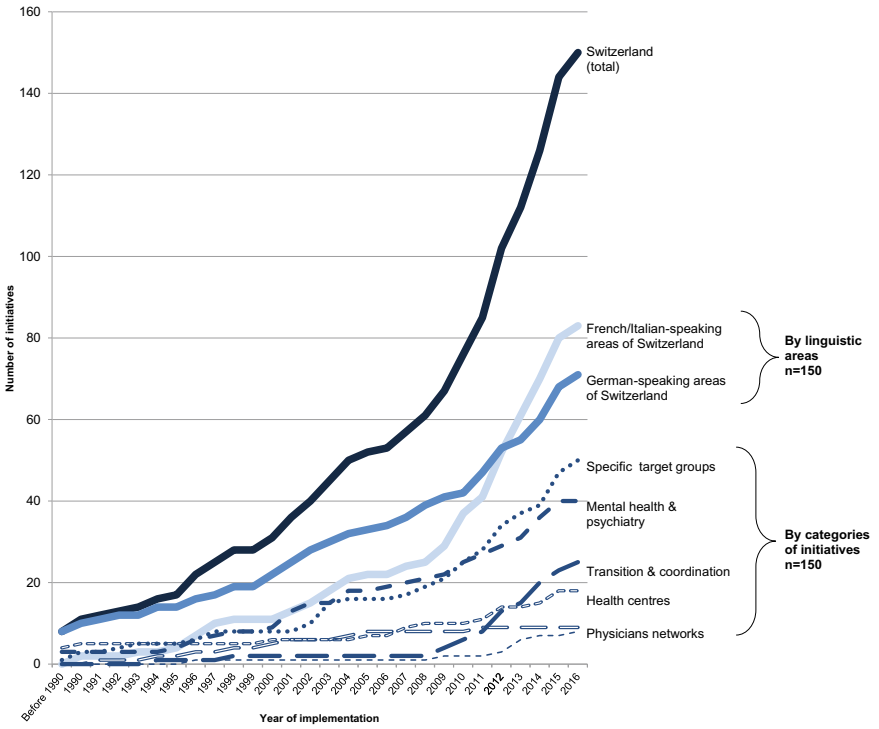


Fig. 53.2 Cumulative number of initiatives: Overall, by linguistic areas and by categories of initiatives (from before 1990 and 2016). Reprinted from Schusselé Filliettaz et al 2018, Fig. 53.2, with permission from Elsevier, License Nr. 4743740605260

patients, inpatient and primary care services: for instance with hotline for patients, telemedicine services and care/case management. It started in 2010. www.eoc.ch/Ospedali-e-Istituti/Ospedale-Regionale-di-Mendrisio/Consulenze/Cura-ferite.html.

Box 53.4 "Health centre", example

Cité générations

A private health centre built in 2012 and hosting more than 30 medical (family and specialist) independent practices, a pharmacy, a radiology, a short-stay medical unit, a physiotherapy and a nursing centres, an emergency service and two teams of the public homecare service.

Most health professionals share the same electronic medical record, thus easily accessing patient's data and communicating with each other. Integrated pathways for specific diseases (eg. diabetes, hypertension) coexist with care/case management models for frail patients and with the implementation of interprofessional and interinstitutional coordination processes for complex needs patients.

www.cite-generations.ch.

53.2.2 People-Centeredness of the Initiatives

Except for 5% of the identified initiatives, all implemented different types of measures to encourage greater patient involvement in their own care (Fig. 53.3). In fact, the majority of initiatives provided information documents to their patients, and they also promoted active participation of patients in decision-making and in the development of care/treatment plans; structured learning and tutoring schemes were only available in one third of initiatives.

Respondents were also asked to report the extent to which specific difficulties hindered patient involvement or a patient-centred approach (Fig. 53.4). The majority of respondents (62.8%) reported inadequate compensation/payment systems as barriers; lack of time of the different care providers was also highlighted as a barrier by just over 60% of the respondents.

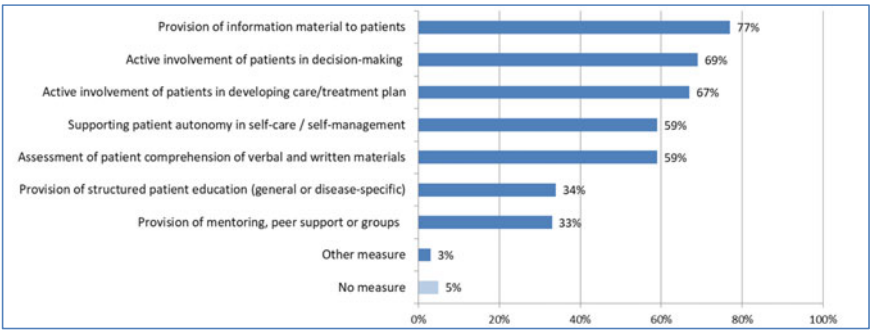
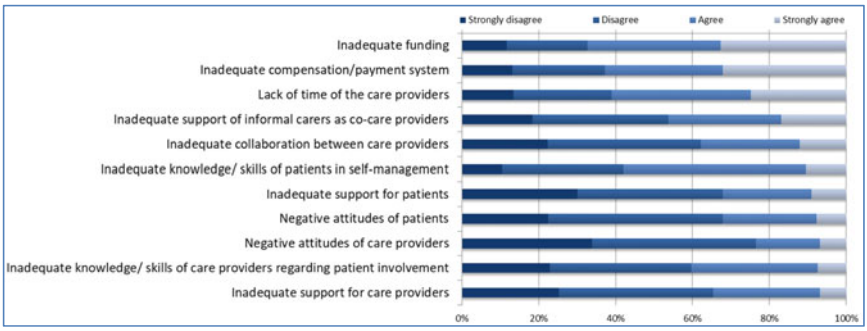


Fig. 53.3 Measures to involve patients, % of initiatives (n = 140–142). *Source* Swiss Survey of Integrated Care © Obsan 2017



Source: Swiss Survey of Integrated Care

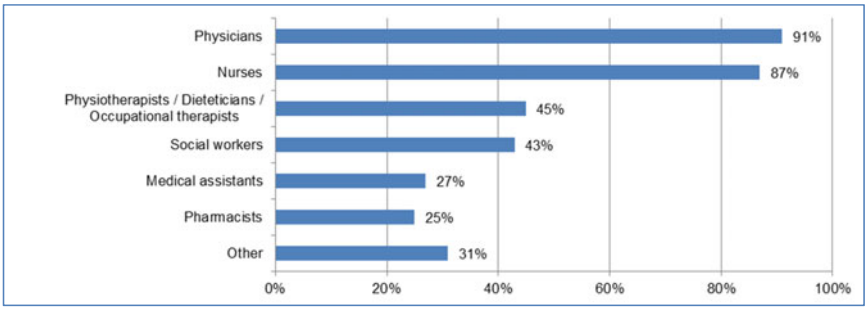
Fig. 53.4 Perceived barriers to patient centeredness, % of initiatives (n = 136–149). *Source* Swiss Survey of Integrated Care © Obsan 2017

53.2.3 Professionals Involved & Interprofessional Practices

Physicians and nurses were the most frequent professional groups involved in the initiatives (Fig. 53.5).

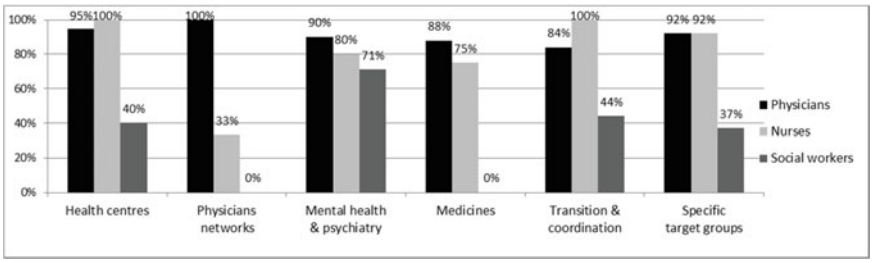
However, professional groups were diversely involved in the categories of initiatives. Figure 53.6 illustrates, for example, the involvement of physicians, nurses and social workers. It shows that social workers were involved in more than two thirds of the "Mental health & psychiatry" initiatives, but were absent from both "Physicians networks" and "Medicines" initiatives.

Meanwhile, initiatives included specific elements designed to foster teamwork and cooperation within and between professional groups. For example, three out of four initiatives organised regular meetings between health professionals and/or offered multi/interprofessional training.



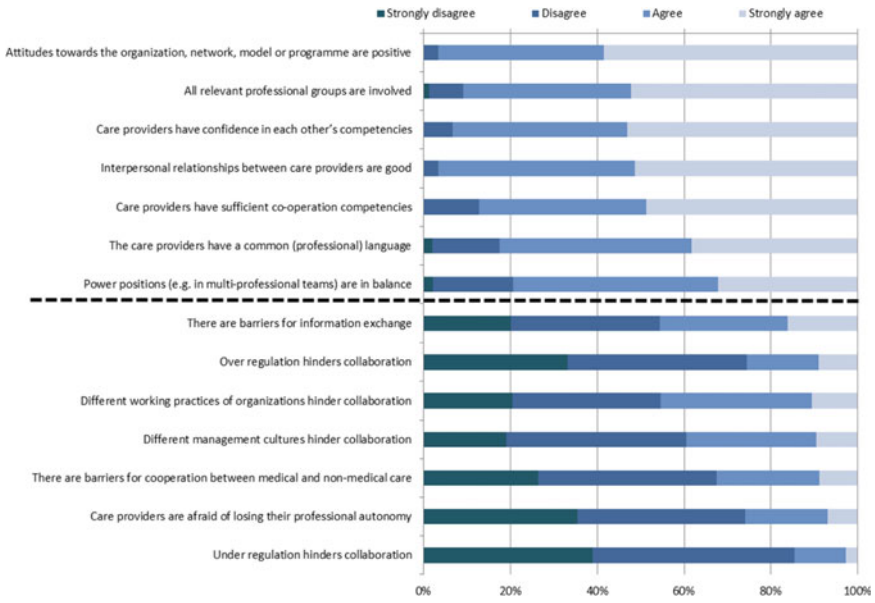
Source: Swiss Survey of Integrated Care

Fig. 53.5 Healthcare professionals involved, % of all initiatives (n = 155). *Source* Swiss Survey of Integrated Care © Obsan 2017



Source: Swiss Survey of Integrated Care

Fig. 53.6 Initiatives involving physicians, nurses or social workers, % by category (n = 155). *Source* Swiss Survey of Integrated Care © Obsan 2017



Source: Swiss Survey of Integrated Care

Fig. 53.7 Perceptions of collaboration between providers, % of initiatives (n = 144–153). *Source* Swiss Survey of Integrated Care © Obsan 2017

Despite of these measures, some barriers to interprofessional collaboration were highlighted (Fig. 53.7). For example, 45% of respondents still thought that interprofessional collaboration was hampered by difficulties in information sharing and by different work procedures between organisations.

53.2.4 Use of Clinical Information Systems

When asked about the use of clinical information systems in the initiatives, respondents mentioned three main communication tools: the electronic patient record, used in 77% of the initiatives; communication systems between healthcare providers, available in 58% of the initiatives; and email contacts between patients and providers, available in 44% of the initiatives. Other clinical information systems, such as electronic prescriptions, telemonitoring and teleconsultation, registries and on-line appointments, were available in one third—or less—of the initiatives.

Box 53.5 "Medicines", example

Interdisciplinary therapeutic adherence program and risk management plan

This program started in 2013. It aims to support and to reinforce multimorbid patient medication adherence through a multifactorial and interdisciplinary intervention provided by a physician, a nurse and a pharmacist. Motivational interviewing is combined with medication adherence electronic monitors, and regular evaluations shared with involved actors.

https://dx.doi.org/10.1155/2015/103546.

Box 53.6 "Transition & coordination", example

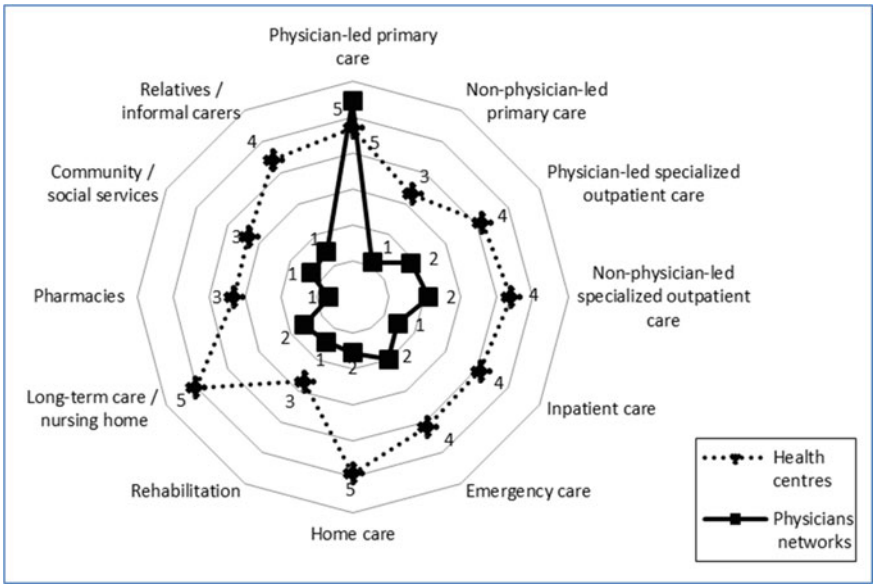
Association for health and social orientation (AROSS)

AROSS started in 2018 and aims to supporting elderly people in their choices, such as homecare, long-term care and social resources. AROSS also aims to support family carers and to coordinate action in favour of frail and/or dependent elderly people. AROSS professionals include physicians, nurses, occupational therapists and social workers, working in close collaboration with the actors already involved in the situation.

www.aross-ne.ch.

53.2.5 Integration Between Levels of Care

The levels of care between which the initiatives sought to improve integration are presented in Fig. 53.8. The latter, which presents two emblematic patterns, reflects the average number of times each level was integrated with another one: the larger the area covered, the greater the number and variety of levels integrated. The "Physician networks" mainly focussed on improving the integration of primary care by a physician with the other levels, while the "Health centres" targeted the integration of a broader range of levels within the health system.



Source: Swiss Survey of Integrated Care

Fig. 53.8 Targeted levels of care, average frequency by each initiative from the "Physician networks" category (n = 9) and from the "Health centres" category (n = 20). *Source* Swiss Survey of Integrated Care © Obsan 2017

53.3 Conclusion

This Swiss Survey of Integrated Care (SSIC) highlighted the existence of a number of integrated care initiatives. These results are encouraging and consistent with those obtained by other similar European projects (Nolte and Hinrichs 2012; Rijken et al. 2013; INTEGREO 2015; van der Heide et al. 2015; National Health Services Scotland 2017; SELFIE 2017; Borgermans et al. 2017).

The patterns of integrated care in Switzerland were rather heterogeneous: in the number of initiatives implemented in the various cantons and in the regions, in the chronological implementation of initiatives, in the number of healthcare professionals involved and in the healthcare delivery levels integrated. Because integrated care requires complex processes whose implementation remains highly context-dependent, this heterogeneity is probably very coherent with the Swiss federalist organisation.

This increase of care integration in Switzerland is probably due to a multitude of factors, such as: increasing burden of chronic diseases, multimorbidity and complex needs; increasing awareness of fragmentation and of the need for integration; interest of stakeholders in making their projects visible; better knowledge and skills of actors in the establishment and maintenance of integrated systems and increasing political support at the federal and cantonal levels.

However, a number of challenges remain in integrated care implementation, especially in terms of changes in organisation, practices and communication, as well as in resources for implementing and maintaining coordination activities. Integrated care also requires clear inputs from healthcare providers, patients and caregivers. Healthcare authorities must also show clearer and firmer political will that includes participative leadership, as much as they must develop an unequivocal vision about integrated care and the future of health care. Such a systemic approach, including change management, should allow a progressive but positive change in the organisation and provision of health care in Switzerland.

References

Andreani, T., & Marquis, J.-F. (2019). *Statistiques de la santé 2019 [Health Statistics 2019]*. Neuchâtel (Switzerland): Federal Statistical Office.

Berchtold, P., & Peytremann-Bridevaux, I. (2011). Integrated care organizations in Switzerland. *International Journal of Integrated Care, 11*(Spec Ed), e010.

Berchtold, P., Schusselé Filliettaz, S., & Zanoni, U. (2019). In *Nouvel élan pour les soins intégrés dans les cantons : un guide* [New Impulse for Care Integration in the Cantons: a Guide]. Bern, Switzerland: Swiss Conference of the Cantonal Ministers of Public Health.

Borgermans, L., Marchal, Y., Busetto, L., Kalseth, J., Kasteng, F., Suija, K., et al. (2017). How to improve integrated care for people with chronic conditions: key findings from EU FP-7 Project INTEGRATE and beyond. *International Journal of Integrated Care, 17*. https://doi.org/10.5334/ijic.3096.

Cheng, T.-M., & Zeltner, T. (2010). Understanding the "Swiss watch" function of Switzerland's health system [Interview]. *Health Affairs (Millwood), 29,* 1442–1451. https://doi.org/10.1377/hlthaff.2010.0698.

De Pietro, C., Camenzind, P., Sturny, I., Crivelli, L., Edwards-Garavoglia, S., Spranger, A., et al. (2015). *Health system review: Switzerland*. Copenhagen, Denmark: European Observatory on Health Systems and Policies.

De Pietro, C., & Crivelli, L. (2015). Swiss popular initiative for a single health insurer… once again! *Health Policy, 119,* 851–855. https://doi.org/10.1016/j.healthpol.2015.05.004.

Ebert, S., Peytremann-Bridevaux, I., & Senn, N. (2015). *Les programmes de prise en charge des maladies chroniques et de la multimorbidité en Suisse* [Chronic disease and multimorbidity management programmes in Switzerland]. Neuchâtel, Suisse: Observatoire suisse de la santé.

Federal Office of Public Health. (2013). *Santé 2020: Une stratégie globale en faveur du système de santé* [Health 2020: A global strategy for the health system]. Bern, Switzerland: Department of Home Affairs.

Federal Office of Public Health. (2015) *Stratégie nationale Addictions 2017–2024* [National addictions strategy 2017–2024]. Bern, Switzerland: Federal Department of Home Affairs.

Federal Office of Public Health. (2019). *Politique de la santé : Stratégie du Conseil fédéral 2020–2030* [Health policy: Federal Council strategy 2020–2030]. Bern, Switzerland: Swiss Confederation.

Federal Office of Public Health. (2016). *Soins coordonnés : Groupe de patients 1: Personnes (très) âgées et polymorbides - Champs d'action et mesures* [Coordinated care: Patient group Nr 1: (very) old and polymorbid patients—fileds of action and measures]. Bern, Switzerland: Department of Home Affairs.

Federal Office of Public Health. (2017). Programme de promotion de l'interprofessionnalité dans le domaine de la santé 2017–2020 [Promotion of interprofessional collaboration in health—Program 2017–2020]. Bern, Switzerland: Department of Home Affairs.

Federal Office of Public Health, CDS. (2018). *Poursuite de la stratégie nationale contre le cancer 2017–2020* [Continuation of the National Cancer Strategy 2014–2020]. Bern, Switzerland:

Department of Home Affairs & Swiss Conference of the Cantonal Ministers of Public Health (CDS).
FSO. (2019). *Memento statistique de la Suisse 2019* [Switerland's statistical memento 2019]. Neuchâtel, Switzerland: Federal Statistical Office (FSO).
Gilles, I., Schusselé Filliettaz, S., Berchtold, P., Peytremann-Bridevaux, I. (2020). Financial barriers decrease the benefits of interprofessional collaboration within integrated care programs: Results of a nationwide survey. *International Journal of Integrated Care*.
Hostettler, S., & Kraft, E. (2018). Statistique médicale 2017 de la FMH [FMH physician statistics 2017]. *Bulletin des médecins suisses, 99*(1314), 408–413. https://doi.org/10.4414/bms.2018.06573.
INTEGREO. (2015). *Plan conjoint en faveur des malades chroniques: Des soins intégrés pour une meilleure santé* [Joint chronic care plan: Integrated care for better health]. Belgium: Belgian Ministry of Public Health.
National Health Services Scotland. (2017). *Scaling integrated care in context (SCIROCCO)*. www.scirocco-project.eu. Accessed May 14, 2017
Nolte, E., & Hinrichs, S. (2012). *DISMEVAL: Developing and validating disease management evaluation methods for European healthcare systems*. Cambridge, United Kingdom: RAND Europe.
OECD, WHO. (2011). *OECD reviews of health systems: Switzerland*. Paris, France: Organization for Economic Co-Operation and Development (OECD) and World Health Organization (WHO).
Peytremann-Bridevaux, I., & Burnand, B. (2009). Inventory and perspectives of chronic disease management programs in Switzerland: An exploratory survey. *International Journal of Integrated Care, 9,* e93.
Peytremann-Bridevaux, I., Ebert, S. T., & Senn, N. (2015). Involvement of family physicians in structured programs for chronic diseases or multi-morbidity in Switzerland. *European Journal of Internal Medicine, 26,* 150–151. https://doi.org/10.1016/j.ejim.2015.01.007.
Quentin, W., & Busse, R. (2018). The strongly decentralized Swiss health system achieves good results: Past research has addressed persisting challenges-but more is encouraged. *Health Policy, 122*(6), 565–567. https://doi.org/10.1016/j.healthpol.2018.06.002.
Rijken, M., Struckmann, V., Dyakova, M., Melchiorre, M. G., & Rissanen, S., & van Ginneken, E. (2013). ICARE4EU: Improving care for people with multiple chronic conditions in Europe. *Eurohealth*, *19*.
Schaller, P. (2008). Le Réseau de Soins Delta (RSD) [The delta physicians' network]. *Care Management,* 12–15.
Schusselé Filliettaz, S., Berchtold, P., Kohler, D., & Peytremann-Bridevaux, I. (2018). Integrated care in Switzerland: Results from the first nationwide survey. *Health Policy, 122,* 568–576. https://doi.org/10.1016/j.healthpol.2018.03.006.
Schusselé Filliettaz, S., Kohler, D., Berchtold, P., Peytremann-Bridevaux, I. (2017). *Soins intégrés en Suisse : résultats de la 1re enquête (2015–2016)* [Integrated care in Switzerland: results of the 1st survey (2015–2016)]. Neuchâtel, Switzerland: Swiss Health Observatory (OBSAN)
SELFIE. (2017). SELFIE workshop presentations. In *17th International Conference on Integrated Care*, Dublin (Ireland).
van der Heide, I., Snoeijs, S., Melchiorre, M. G., Quattrini, S., Boerma, W., Schellevis, F., et al. (2015). *Innovating care for people with multiple chronic conditions in Europe: An overview*. Netherlands: Netherlands Institute for Health Services Research (Nivel).
von Wartburg, L. (2016). *Soins Coordonnés* [Coordinated care]. Bern, Switzerland: Federal Office of Public Health (FOPH).
von Wartburg, L., & Näf, F. (2012) *Stratégie nationale en matière de soins palliatifs 2013–2015* [National strategy for palliative care 2013–2015]. Bern, Switzerland, Federal Office of Public Health (FOPH) & Swiss Conference of Cantonal Health Directors.