



## **Skill-mix innovations and developments in primary and chronic care settings in Switzerland**

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## 1. Introduction

The Swiss case is particular since skill mix in terms of interprofessional practice has only recently started taking up momentum. Moreover, it is an indirect and till recently rather unintended outcome. In comparison to Nordic and Anglo-Saxon countries reasons of the delay derive from profession centred regulation, primarily evolving from medical stakeholder power. In general, interprofessional task sharing with nurses in medical practice is perceived as an offence or is rejected in principle. Moreover, compensation schemes do barely foresee remuneration, and if they do, the fees are not appropriate to qualification and service quality provided by highly qualified nurses. On the other hand, there are structural weaknesses in the non-medical workforce: the education gap refers to the fact that professions such as nursing and physiotherapy started training at university level in 2006 only, with the exception of some early adopters<sup>1</sup> who obtained their Master's degree or doctorate abroad, or the psychotherapists who mostly work on a delegation scheme. Since these non-medical health professionals with a bachelor or master degree are relatively new in the arena and often work in subordinated positions, their corporatist weight is low and, therefore, their stakeholder power is fragile (but still has significantly more weight than their colleagues in Germany). In addition, their strategies show deficits in professional development towards PHC due to their struggle for professional recognition and emancipation, and also due to the small number of highly skilled professionals interested in PHC and chronic care management.

Although regulation adversely affects skill-mix innovation, grade-mix, task shifting, interprofessional work and the implementation of co-creative arrangements and collaborative practice, a kind of slow bottom-up transformation is occurring. It is not based on a coherent national strategy, but there are focused measures and scattered actions. The endeavours are encouraged by reports and initiatives taken e.g. by the Swiss Federal Office of Public Health, the Careum Foundation, the Swiss Academy of Medical Sciences, Managed Care Organizations, some Medical Associations (e.g. the Family Doctors) and Institutes of Primary Care, and Care Giving Enterprises who launched debates on reforming practice and education, often inspired by convincing outcomes in other countries. Overall, there is a kind of feeling among many health professionals that new forms of cooperation need to be implemented in order to meet future needs and expectations of the healthcare system – thus considering the perspectives of patients, citizens and also the integration processes providing better care. Despite the unfavourable framework, there is a transformation underway in education and in early adopter organizations where connectors, facilitators and integrators undertake steps to overcome professional territories and boundaries. The processes are diverse and too often uncoordinated, fragmented and setting specific – triggered by easily available financial resources in a system with weak governance. Results are convincing but there is little effort to seize the opportunity of creating a learning system for sustainable skill-mix innovations.

## 2. Skill-mix reform strategy

### *Perceived skill gaps*

As in other industrialized countries, the health sector in Switzerland is subject to convergent and sometimes contradictory megatrends, leading to disruptive situations:

- **Demographic and epidemiologic changes in an ageing population**, causing higher morbidity, chronic conditions and dementia where cure and medical interventions have limited effects;

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<sup>1</sup> University hospitals offered joint degrees with partnering universities abroad. The pioneer was a Master in Nursing Science, starting 1996, jointly launched by the Red Cross College for senior staff training (which later became the Kalaidos University of Applied Sciences) and the Maastricht University.

- **Disproportionally growing health costs and unbalanced financial incentives** foster industrialization and thus boost fragmentation – ambulant treatments in hospitals allow to rapidly push patients in other sectors, i.e. towards rehabilitation, long term care or back to their homes;

- **Patient-Consumers** have new expectations. Given their substantial expenditures for premiums, services and out-of-pocket payments, they want benefits in return. Additionally, good education fosters co-producers who want take decisions based on second opinions, comparisons or individual choices and preferences;

- **Scarcity of workforce** is a constant issue despite the very comfortable situation compared to other countries. Four risk-factors are perceived: decrease is an effect of baby boomers leaving the labour market and the diminishing number of school-leavers; attrition is widespread since 32 % of the physicians and 46 % of the nurses leave their jobs (Lobsiger et al. 2016); loud and frequent complaints of professionals make the health sector less attractive; and: given the high dependency of immigrated health workers (estimated higher than 10000 per year)<sup>2</sup>, the severe limitation adopted in the “Stop Mass Immigration” referendum in 2014, launched by the right wing peoples party, constitutes a fundamental thread.

As a consequence, cumulated effects lead to a shift of priorities, practices and policies. Although it appears obvious that the drift towards more complex situations in chronic care management, rehabilitation, PHC, medication, long term and palliative care will require interprofessional co-management, a terrible inertia is prevailing. It is mainly caused by medical stakeholder power, decentralized governance, and sectorial thinking which are constitutive for the Swiss health system (OECD/WHO 2011, De Pietro et al. 2015). They lead to discrepancies in assessing the gaps and needs. Accordingly, disagreement between policy makers, politicians, the insurance industry, health care managers, corporatist organizations and public health researchers is frequent. It hampers coherent action which would allow for the synergies and added values needed in the given well financed high-performance system.

The arena is dominated by discussions on raising the number of physicians and nurses while the tackling of other urgent legal, institutional and structural issues remains unpopular and unmet. Among them, interprofessional task-sharing and task-shifting are at the moment not yet considered to effectively contribute to alleviate the workforce shortage or to lead to better outcomes. Nonetheless, one should not think that the situation is inert. Since the year 2000, numerous reforms and strategies have been launched in a broad range of fields and subjects, covering e.g. the financing of hospitals, highly specialized treatments, pharmaceuticals, control of epidemics, the education and training of professionals in universities, universities of applied sciences and vocational schools, palliative care, cancer, non-communicable diseases, dementia, or nosocomial infections.

In respect to skill-mix innovations, major obstacles lie in reimbursement schemes focusing on acute care provided by physicians, weak governance due to distributed power, and the missing link between health policy, the regulation of education and organizational development. This leads to the assumption that skill-mix and interprofessional collaboration are indirect and rather unintended outcomes.

### **Audit and analysis**

Besides the corporatist headcount there is, at federal level, a dynamic registry for the medical professions (physicians, dentists, pharmacists, vets, chiropractors) existing for 10 years now. Based on new laws, parallel registries for the health professions (nurses, physiotherapists, occupational

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<sup>2</sup> Position paper of the Swiss Hospitals Union regarding the “Stop Mass Immigration”-referendum. Umsetzung der Masseneinwanderungsinitiative (MEI) : Flexibilität statt überbordende Bürokratie, published 30.06.15.  
[http://www.hplus.ch/fileadmin/user\\_upload/H\\_Politik/Positionen/Aktuelle\\_H\\_Positionen/20150709\\_Positionspapier\\_MEI\\_Umsetzung\\_d.pdf](http://www.hplus.ch/fileadmin/user_upload/H_Politik/Positionen/Aktuelle_H_Positionen/20150709_Positionspapier_MEI_Umsetzung_d.pdf)

therapists, dieticians, radiology technicians) and psychology profession (psychologists, psychotherapists) are being implemented currently. A systematic survey of the workforce is conducted by the Federal office of statistics and the affiliated Swiss Health Observatory ([www.obsan.ch](http://www.obsan.ch)) which is co-financed by the cantons and the Confederation.

With respect to skill-mix, more systematic analyses of the health workforce development started around 2005, initiated by the Federal Office of Public Health (Künzi & Detzel 2007). These considerations showed the potential of innovation by introducing non-medical professionals in PHC. The Careum Foundation worked on the potential for disruptive innovation by putting the user in the centre and offering responsive structures in primary care (e.g. Sottas & Brügger 2012; Haslbeck et al. 2015). In 2009, there was an attempt to fix a gate keeping and provider monopoly for family doctors in the constitution, and a tough bargaining process dominated the political arena for years. The Federal Government rejected the referendum in 2010. It submitted an alternative which acknowledges the important role of family doctors in PHC, but without preferential status and as a part of a cross-linked, coordinated and multi-professional system of care provision. The need for objective figures on the health workforce was imperative. Accordingly, various interested parties started assessments, and the mandate of the Swiss Health Observatory has been sharpened. It subsequently produced important audits and analyses (Jaccard Ruedin & Weaver 2009; Burla & Widmer 2012; Vilpert 2012; Künzi, Jäggi & Dutoit 2013; Merçay 2015; Burla, Vilpert & Widmer 2014, Lobsiger & Kägi 2016; Merçay, Burla & Widmer 2016; Senn, Ebert & Cohidon 2016). These analyses were often realized in collaboration with stakeholders and agencies, which allowed to validate many parallel studies, e.g. ZHAW 2014, Hostettler & Kraft 2015, Dolder & Grünig 2016.

### **Unrelated triggers**

The major educational reforms (see chapter 8), implemented around 2007, could have created a sound basis for skill-mix innovations with appropriate workforce. However, as written earlier, harmonized regulation of qualifications and human resources was not a priority, and there was no awareness for the potentials in tackling chronic and primary healthcare issues, workforce shortage or cost containment.

Considering the megatrends and the foreseeable long term evolution, the Federal Government intended to implement a National Prevention Act. Prevention could be the key to achieving the target of a 20 percent saving in healthcare costs. However, it came to grief in Parliament in 2012 because stakeholder power of the consumer goods industries, and a majority of the MPs was against the funding arrangements and a national institute.

### **Reform priorities**

As a consequence, and with the aim of giving a new impetus, the Swiss government approved the "Health2020" health-policy agenda in January 2013. The publication of this first-ever comprehensive strategy for the Swiss healthcare system constitutes a disruptive change in the federal system and a significant milestone. It takes into account, among others, arguments put forward in the debates on the Prevention Act, the considerations against the family doctors' referendum, recommendations of the OECD/WHO Review of the Swiss Health System (2011) and reflects the WHO-Europe Health2020 framework (2012).

As the principal challenges for Switzerland, the document identifies the increase in chronic diseases, the need for change in healthcare delivery, the need to secure funding and the lack of manageability and transparency. These challenges are currently addressed in four priority areas: "Ensure quality of life", "Reinforce equality of opportunity and individual responsibility", "Safe-guard and increase the quality of healthcare provision" and "Create transparency, better control and coordination". In each priority area, three objectives are pursued, and each of these objectives will be achieved by means of three measures. Thus a total of 36 measures with different time frames are currently negotiated and implemented (<https://www.bag.admin.ch/bag/de/home/themen/strategien-politik/gesundheits-2020/eine-umfassende-strategie-fuer-das-gesundheitswesen.html>).

The aim is to enhance quality of life and equality of opportunity for the population as a whole, promote standards of healthcare delivery and further improve the transparency and manageability of the system. "Health2020" provides direction for all those involved in shaping the healthcare system. Considering the constitutional and legal framework, its implementation is to be accomplished in close cooperation with all stakeholders, first and foremost the cantons. In order to succeed, a great deal of consensus building and cooperation with other sectors, e.g. for the tackling of related issues in the social system, the field of education, the labour market, the environment, and research & innovation is necessary.

These issues and priorities are taken up in the National Health Report (Schweizerisches Gesundheitsobservatorium 2015) which provides an up-to-date picture of the Swiss population's health by evaluating a large number of health-related indicators covering the whole life span. Furthermore, it outlines measures for optimisation and advocates steps that would gear the health care system towards chronic diseases.

### **3. Innovations in Human capital**

Characteristic for the decentralized Swiss system are individual initiatives taken by various stakeholders and networks. Hence, tackling areas of importance like managed care, primary care, palliative care, cancer aftercare, dementia, mental health, informal and family caregivers etc. aiming at fostering skill-mix are developed in parallel, often not corresponding structures.

The drift observed towards skill-mix evolves from innovations and pressure for reforms. The following four areas do not cover all attempts but illustrate the dynamics: the FaGe-Case in nursing, palliative care, interprofessional education and practice, and interprofessional primary care.

#### ***Skill-mix in nursing – the "FaGe"-Case***

In Switzerland, the expression skill-mix was first introduced in nursing. It evolved 2004 from observations and reflections regarding clinically demanding processes and decisions in nursing which would allow for better task sharing. A pilot phase in hospitals in the Basel region provided the proof of feasibility (OdA 2007, Ludwig 2008) and opened the way to nationwide implementation (Horlacher et al. 2009, Ludwig et al. 2012). Regulation took up the innovation immediately and reflects the convincing results.

The Act on Vocational Professional Training (2006) moved the training of nurses on tertiary B-level (unlike Germany where it was kept on secondary II-level, and Austria where it was moved to UAS, tertiary A). Accordingly, the new law widened the scope of practice and allowed the introduction of an intermediary health associate position, called "Fachangestellte Gesundheit" (FaGe) in Nursing and in parallel also the "Fachangestellte Betreuung" (FaBe) for Social Work and Education. These were new categories of health professionals<sup>3</sup> with a completely new, somehow technical denomination, trained in a comprehensive three years-apprenticeship which leads to the provision of a Federal Vocational Education and Training Diploma. Teaching, acquired competences and the scope of practice make it distinct from diploma nurse profile.

Although meanwhile well established and indispensable in the field, there are still allergic corporatist reactions from the side of the Nurses federation fearing substitution, pressure on salaries and status downgrading. It took more than 6 years to appease the situation, whereby the nurses' status of superiority was confirmed and made the new task sharing acceptable to them.

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<sup>3</sup> In ILO's International Standard Classification of Occupations (ISCO) FaGe figure among the Health Associate Professionals and correspond to code 322 "Nursing and Midwifery Associate Professionals". With respect to their training they are distinct from Nursing Assistants corresponding to code 532 "Personal Care workers in Health Services".

Currently, the labour market pushes reflexions further in view of drawing a comprehensive picture of all nurse-related profiles and the skill-mix covering the full range between nursing assistants, diploma nurses, advanced nurse practitioners and those with an Advanced Federal VET Diploma.

### ***Palliative Care***

Precursors of palliative care reached Switzerland in the 1980s at the peak of the HIV epidemics with the international hospice movement. Cancer and HIV treatments drew the attention on the palliation of terminally ill patient's pain and symptoms and their emotional and spiritual needs. Accordingly, a system of interprofessional support for the dying and their families started slowly to be established in order to offer good quality of care in view of "adding more life to the remaining days" (Cicely Saunders). The novel approach was recognized in the Swiss national strategy for palliative care which started in 2010 and led to the national platform for Palliative Care in 2015, bringing together the Federal Office of Public Health, the cantons, palliative.ch and other partners.

With respect to skill-mix innovation, the palliative care strategy lead to two insights: First, it shed light on alternatives to therapeutic relentlessness and redefined quality of life of severely ill persons. Given the priorities currently set on curative treatment and acute care, this is an important outcome. Second, it clearly stated the need for a team approach and the indispensable co-productive attitude among medicine, nursing, social work, psychology, rehabilitation, spiritual guidance and informal caregivers. Palliative care is often cited as a forerunner in fostering interprofessional practice in the as yet physician-dominated structures.

In order to avoid vicious circles of power plays, losing trust, burn-out and quality degradation palliative.ch developed a standard for strengthening resilience, interprofessional team building, organizational development, conflict moderation, common learning and knowledge transfer (Hess-Cabalzar et al. 2010).

### ***Interprofessional education (IPE) and practice (IPP)***

The significant changes that have taken place in healthcare policy and training between 2005 and 2010 have led to a redefinition of professional roles and profiles. It has disconcerted the medical world but it has also given rise to innovative processes and made the issue of interprofessionalism more prominent. Four thrusts and initiatives illustrate the dynamics:

- The rejection of the referendum of the family doctors in 2010, in conjunction with the decreasing PHC workforce triggered the reflexion on coordinated and multi-professional care provision in the health policy arena. One of the promising fields was education. Based on deliberations in the National Health Policy Dialogue, a working group integrating 16 national bodies involved in the training of physicians was mandated to develop solutions. In a compromise acceptable to all parties, priorities were on measures likely to be put in place in the short term, mainly in medical training, but also regarding all the professions involved in collaborative practice. This work was also intended to provide inputs for amendments to the Medical Professions Act, the Health Professions Act, the Higher Education Institutions Act, the University Funding Act, the Vocational and Professional Education and Training Act which now all point somehow to interprofessional thinking. The report submitted (FOPH 2013) summarizes skills needed for interprofessional collaboration and draws elements to be considered in IPE.
- Another initiative leading to the "Charta on Collaboration of Health Professionals" was launched by the Swiss Academy of Medical Sciences (SAMW 2014). It aimed at providing a contribution to tackle challenges relating to quality of care, workforce shortage, and culture change.

14 experts elaborated nine core elements and six steps for implementation which were disseminated in transfer workshops <sup>4</sup>. It had a good echo, except from the Swiss Medical Association. However, since its impact on daily practice and the indispensable shift toward co-productive professional behaviour was questionable, the Academy commissioned a report (Atzeni et al. 2017). The authors concluded that the message of this rather normative discourse was heard, but remains vague. It was found that coordinative or project-like aggregations in view of raising efficiency are much more frequent than truly co-creative arrangements.

- A third initiative was started late 2013 by the Swiss Family Doctors Association with the aim to conceive and determine practice models in primary care independently from the authorities (Martínez-González 2014, 2015). The "Work Force Study 2015" and also the analysis of Senn et al. (2016) reflect, from a corporatist point of view, workforce shortage and the transformations needed. The "lone-doctor-with-helpers" model (Ghorob/Bodenheimer 2012) is the traditional setting, but not anymore appealing to young physicians who have taken been trained in hospitals and larger clinical settings. Regarding skill-mix innovations, a handful of early adopters in group practices demonstrated independently the proof of practice by introducing nurse practitioners with Master diploma. All cases produced convincing results within a specific scope of practice and find this up to now unprecedented approach a constructive and promising solution. Currently, a series of other similar pilot projects are initiated in different regions.

- A fourth initiative arose from the "Stop Mass Immigration"-referendum in 2014. Since the Federal Government anticipates adverse effects on the labour market, it presented a so-called "Qualified Workers Initiative" embracing around 40 measures. While most instruments regarding human capital serve mono-professional goals (e.g. more doctors and nurses), one consists of the National Promotional Programme "Interprofessionality in the Health Sector", launched early 2017. Its first phase stretches over a period of 4 years and aims at compiling basic knowledge regarding effects on quality of care, reduction of workforce shortage and cost containment/higher efficiency. Incentives for pioneers and pilot models are foreseen from 2020 onward – considering the initiatives taken these subsidies will arrive too late.

#### **4. Reform outcomes**

A comprehensive and consistent skill-mix policy is not likely and not feasible due to legal, financial, institutional and organizational reasons. Pioneers go for entrepreneurial venture and seize opportunities, benefitting of general trends in society. Hence, hierarchies erode, pluralism is *en vogue*, economic pressure and scarce workforce urge for alternatives in service models and organization. In this context, it is not sacrosanct anymore that the provision of health services is exclusively assigned to physicians.

The initiatives taken are not yet generating substantial outcomes and perceptible transformation. Skill-mix innovations occur as a result of a set of slow bottom-up mechanisms and altered appreciations, rooted in completely different contexts. Convincing cases in other countries and settings, international comparisons, position papers and the advocacy of think tanks, debates launched by researchers and the audacity of early adopters have trickle-down effects fostering organizational and cultural change. In the sum, it is an unintended conjunction and a positive response from patients/consumers/citizens which make pressure on reluctant corporations. In this context, education of health professionals plays a decisive role. However, since it is still strictly monoprofessional, it does not yet keep the pace.

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<sup>4</sup> [http://www.samw.ch/dam/jcr:c5fd1ba0-03f4-4e7a-adaa-2ab50a56253b/charta\\_samw\\_zusammenarbeit.pdf](http://www.samw.ch/dam/jcr:c5fd1ba0-03f4-4e7a-adaa-2ab50a56253b/charta_samw_zusammenarbeit.pdf)

## 5. Enablers and Barriers

As discussed above, there is no coherent skill-mix reform strategy in Switzerland. The Federal System with decentralized and fragmented governance in the given complex political and institutional structure allows for independent decision making by the cantons, enterprises and organizations. The different initiatives show that resulting changes in competence, scope of practice and professional behavior are, in a first period, contested by concerned groups or related stakeholders.

In the given complex political system it is, therefore, quite frequent that intended action plans are overridden and hampered by other urgent affairs, forwarded in the parliamentary process e.g. by corporatist actors (insurance companies, physicians, hospitals) or health related industries. At present, initiatives are being slowed down by the austerity measures reducing public spending and the effects of the 2014 "Stop Mass Immigration"-referendum.

One may conclude that despite the small size of the country, the manageable arena and the manifold ties between the stakeholders concerned, skill-mix reform remains uncertain but inevitable.

### *Regulation of practice*

All formal educational programmes in the Health sector are regulated by laws (Medical Professions Act, the Health Professions Act, the Psychology Professions Act, the Vocational and Professional Education and Training Act, the Higher Education Institutions Act, the University Funding Act) under the authority of the Confederation. Educational requirements and professional standards are stated in federal ordinances, and specified in reference documents elaborated by the involved non-governmental agencies working under the auspices of the Confederation. They usually have delegated competences and benefit of considerable room for manoeuvre.

A Federal Diploma obtained at all levels and in all professions is a formal *Licence*, granting the right to engage in the given health profession in the whole country. Once acquired it has no expiration but a life-long validity.

For university diploma holders (i.e. Bachelor and Master Diploma as well as the CAS/DAS/MAS-credentials), mutual recognition with EU-countries is guaranteed based on the Bologna agreement. In this respect, Switzerland as non-EU member state is part of the European Educational Cooperation System.

Accreditation procedures have been simplified and unified under the Higher Education Act in the past years. Institutional accreditation is being granted by the National Accreditation Council upon evaluation of the Agency for Accreditation and Quality Assurance or another recognized Agency. At university level, standards and procedures correspond to, and are well integrated into the European Higher Education system. In the Vocational Training sector, Switzerland has implemented its own system, in particular for the tertiary B tracks which do not have parallels in the EU area.

Registration as a formal standard has been introduced in 2007 by the Medical Professions Act. Parallel instruments are currently implemented for the other health professions. Their relevance lies primarily in administrative control; citizens and professionals have limited benefits, it is however expected that the official listing could be useful in e-health.

### *Payment mechanisms*

Compensation schemes work in different ways in the sectors:

- The hospital sector has introduced payment based on diagnosis-related groups in 2012. Accordingly, personnel is employed. Although salaries paid vary across the cantons, they are substantially higher than in the neighbouring countries. Accordingly, good wages are a major attractor for foreign health professionals.
- In the ambulatory sector physicians work on a very complex fee-for service framework (TARMED).



It covers notably the tasks of specialists and technical interventions. It is blamed to be outdated and that it would not adequately consider "talking medicine". Recent efforts led to covering services provided by medical assistants, namely in PHC.

The pay-differentials between family doctors and specialists are said to be considerable and charged to be a disincentive in career planning of young doctors.

For early adopters wanting to integrate nurse practitioners, there is, however, no fee foreseen and no recognized arrangement to be expected soon. In the known rare cases, payment is aleatory, i.e. 80% or 50% of a doctor's fee or a monthly compensation.

- Visiting nurses, physiotherapist, psychotherapists, speech therapists and other professionals in the ambulatory sector are paid on tariffs which have remained unchanged for at least 12 years and which are considered too low. They do not take into account the educational change to university diploma and the resulting provision of better interventions and more effective therapies.

- Elderly Care Organisations and Nursing Homes pay often lower salaries than hospitals.

- Besides campaigns addressing issues like smoking, nutrition, movement, communicable diseases, etc. efforts in prevention are concentrated in the education sector and in labour medicine. Prevention is marginal. It is mainly regarded as one's individual responsibility.

All in all, there is a notorious critique that the existing incentives do not address or match health priorities and organisational changes. Capitation which could ease skill-mix is negligible, lump sums are vetoed by physicians, and value for money in terms of "choosing wisely", clinical outcomes, consistent intersectoral pathways, patient satisfaction, etc. are not considered in the prevailing payment mechanisms. Accordingly, it is obvious that they hamper skill-mix innovation, and it is assumed that they undermine intrinsic motivations and attitudes of health professionals. It is, therefore an important point on the research agenda to determine whether or not experiences among the early adopters can contribute to counterbalance barriers and strengthen enablers of skill-mix and task shifting.

### **Health Profession Education (HPE)**

Major educational reforms started around the millennium, and a series of sectorial laws became effective from 2006 onward, i.e. the Vocational and Professional Education and Training Act, the Medical Professions Act, the Health Professions Act, the Psychology Professions Act, the Continuing Education and Training Act, framed by the Higher Education Institutions Act. All of them mention interprofessional collaboration as a learning objective to be achieved.

However, given the diversity of historical thrusts and institutional circumstances, their focus is strictly mono-professional. Accordingly, there is neither an explicit cross-reference of objectives and competencies, nor an obligation for common learning and collaborative practice, and there is no platform for exchange between the types of educational programs.

As a result, the potentially positive impact of skill-mix and interprofessional collaboration on the quality of care, efficiency and the tackling of labour shortage is not a subject of teaching, and it is reflected only exceptionally during undergraduate education.

Completely separated from formal education a trend towards structured attempts to educate patients and citizens is observed. Initiatives were launched in University Hospitals and by Public Health advocates which formed a national alliance of like-minded stakeholders. The Careum Foundation financed a substantial research and dissemination program for six years. Federal Government took up the issue and put it among the priorities of the Health 2020 Strategy.

### **Employment and working conditions**

With respect to skill-mix innovations, employment and working conditions are to be considered neutral. There are no particular incentives or disincentives or barriers. In case there is innovation, it derives from strategic goals or organizational concerns of the employer. The Employment Act is liberal and gives room of manoeuvre regarding working hours, work schedules and family-work

balance. Professional development is appreciated and – especially in the health sector – co-financed by the employer.

Whereas hospitals seem to be more open to culture change, it will be interesting to evaluate how skill-mix and task sharing/task shifting with nurse practitioners is perceived and accepted in the conservative setting of PHC.

## 6. Socio-economic context

Switzerland has one of the most expensive health systems in the world. In the OECD comparison of 2013, Switzerland figured among the countries in the top tier, investing around 11 percent of their GDP for health.<sup>5</sup> Switzerland is in fact spending 80 billion Euros for 8 million inhabitants. Citizens and providers perceive it as high performing and responsive due to comprehensive coverage, almost unconstrained choices and freedom of provision, especially in the ambulatory sector. Governance structures are weak in the prevailing federal system. They are deeply rooted in a unique political system of direct democracy which leads to complicated and long negotiations for consensus building with almost all issues being decided in bottom-up processes in the 26 cantons. Above all, health related issues are highly rated. In the Swiss system, citizens have several times a year the opportunity to influence health policy and other policies through public referendum.

Health expenditures of 4163 € per capita lay significantly above the amounts spent in neighbouring countries (Germany 3550 €, Italy 2108 €, and well above the EU average).<sup>6</sup> Health costs are a high burden for the households. By European standards, the share of out-of-pocket payments is exceptionally high at 26% of total health expenditure (compared to the EU average of 16%).<sup>7</sup>

The volume, the annual increase of 3 to 4 percent and its purpose are, however, subject to critical considerations and arguments. Substantial increase of costs occur in outpatient and inpatient care. Compared with spending in previous years, it is especially the outpatient care sector which shows an above-average increase. Overall, there is a critically assessed but not addressed problem of unnecessary treatments which are estimated to represent 20 percent of the whole health budget, i.e. roughly 700 € per person per year spent for unnecessary or contra productive interventions<sup>8</sup>. This issue is considered one of the most serious problems in the health system, whereby the ambulatory sector shows to be particularly non-cooperative in establishing transparency und value for money.

The health care delivering system, contracting, payment schemes, and reimbursement are primarily physician-centred and oriented towards acute care services in the hospital and ambulatory settings. Rehabilitation and long term care are much less comfortably rewarded, dentistry and oral health are not in the universal coverage package. Prevention, health promotion, health literacy, patient education and other strategies addressing chronic conditions are marginally financed and have mitigated impact. This is also a result of the highly decentralised nature of the health system, which hampers the implementation of nationwide policies but fosters fragmentation.

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<sup>5</sup> <http://www.oecd.org/berlin/presse/Health-Statistics-Deutschland-Laendernotiz.pdf>

<sup>6</sup> Indikatoren «Gesundheit 2020», erste Auswertung 2016. <http://www.bag.admin.ch/gesundheit2020/16066/index.html?lang=de> (download 2.10.2016)

<sup>7</sup> De Pietro C. et al. 2015. Switzerland: Health Systems Review 2015:106

<sup>8</sup> Brand H. 2017. Daten müssen Versicherten nützen. Neue Zürcher Zeitung 19.1.2017: 9

The health sector works according to the principle of “managed competition” – in care provision, market forces are limited by protective mechanisms, referendums and interventions at mainly cantonal levels. Moreover, there are almost no intersectoral instruments implemented; caregiving in the hospital sector, outpatient services, specialized physicians practices, general practice, visiting nurse services in ambulatory and home care but also nursing homes are subject of different laws as well as divergent contracting and reimbursement schemes. In addition, evaluations of quality, cost-effectiveness and value for money of interventions, effectiveness of care in longitudinal trajectories, but also patient’s experience, their attitudes and motivations are rather the exception, despite the Health Insurance Law requiring effectiveness, appropriateness and efficiency. Since health systems research based on rigorous methodology is not yet well established, the system lacks transparency.

## **7. Outlook**

At present, it appears that skill-mix policy and practice is a rather new and unintended phenomenon. While in education and practice, silos are the dominant and preserved model, the voices calling for reform get a larger audience. In the hospital sector, especially in the larger hospitals and in rehabilitation, interprofessional skill-mix is more frequent than in long term care of nursing homes. In the ambulatory sector, in PHC and in nurse visiting services, there is significant room for improvement and change of traditional patterns. Looking forward one may perceive two thrusts.

On the one hand, entrepreneurs who see themselves as innovators are willing to engage in unconventional models. The motivation is, in most cases, trifold: removing bottlenecks in care provision, cost containment, and taking profit of the «Academic drift» by integrating experienced and motivated professionals with Masters Degrees who are able to adequately tackle issues related to chronic care management and PHC (that are not taught in medical schools).

On the other hand, there is a modest probationary, on the strategy and policy level, presented by government and stakeholders. It is recognized that enablers have to be strengthened and barriers removed in view of improving the match between skills and tasks to be conducted. At present, the prevailing fear of loss of corporatist power, as well as the administrators’ fear of unpredictable/undesired effects on regulation, established procedures and tariff systems do not allow for significant modifications in the regulation of practice, payment mechanisms, health professional education, and the acknowledgement of new forms of service provision in the laws.

Considering the Swiss approach in handling such disparate evolutions, one is tempted to say that a consistent skill-mix rule is a matter of time. Since change does not happen by disruptive innovation, transformation is slowly occurring bottom-up, based on rhetoric performance of early adopters, undeniable proofs provided by pilot projects, and complicated negotiations. In this respect, initiatives launched by the Swiss government (e.g. The National Research Programme 74 focusing on Smarter Health Care started in 2016, or the National Promotional Programme “Interprofessionality in the Health Sector”, started in 2017) may be unsatisfactory for dynamic innovators. Indeed, they are definitely not the big push expected to overcome lack of governance. However, in the given system, they allow for momentum by sending an official signal that change of the skill-mix policy is needed and wanted. Seen positively, this could bring some soft power into the arena, and smoothly gear stakeholders into a dialogue on transferability and scalability of promising skill-mix approaches. One may, therefore, assume that the complex but not yet learning system will become adaptive continuously - skill-mix will definitely become a normal part of standard procedures - but transformation is slow, as always in Switzerland.

## 8. References

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