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Switzerland

Health system review

Executive Summary

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Health System Review 2026

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in Europe. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues.

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The European Observatory on Health Systems and Policies is a partnership, hosted by the WHO Regional Office for Europe that includes the Governments of Austria, Belgium, Finland, Ireland, Netherlands (Kingdom of the), Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom and the Veneto Region of Italy (with Agenas); the French National Union of Health Insurance Funds (UNCAM); the Health Foundation; the European Commission; the London School of Economics and Political Science (LSE); and the London School of Hygiene & Tropical Medicine (LSHTM). The Observatory is composed of a Steering Committee, core management team, research policy group and staff. Its Secretariat is based in Brussels and it has offices in London at LSE and LSHTM and in Germany at the Berlin University of Technology. The Observatory team working on HiTs is led by Ewout van Ginneken (Director); Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors); Dimitra Panteli and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Anna Maresso. The production and copy-editing process was coordinated by Jonathan North, with the support of Lucie Jackson, Andrea Kay (copy-editing) and Sarah Moncrieff (layout).

EXECUTIVE SUMMARY

Switzerland achieves very good health outcomes, but population ageing and risk factors are increasing the pressure on the health system

Switzerland is a small, wealthy and mostly urbanized country in central Europe with around 9 million inhabitants. It has four national languages and a multicultural population, with a high share of foreign-born residents and people with a migration background. The country has high GDP per capita, low unemployment and comparatively strong public finances, although economic growth has slowed in the context of wider global economic pressures.

Health status is good by international standards. Life expectancy exceeds 84 years and is among the highest in Europe. Rates of preventable and treatable mortality are low, and quality-of-care indicators are generally favourable. Noncommunicable diseases (NCDs), particularly cardiovascular diseases, cancers and dementia, account for most deaths and disease burden. Population ageing, multimorbidity, social gradients in health, overweight and obesity, physical inactivity, tobacco and alcohol use and mental health problems remain important public health challenges.

The ageing of the population in particular is becoming increasingly important for the health system. People aged 65 years and over account for almost one fifth of the population, while fertility remains below replacement level and old-age dependency ratios are increasing. These developments have implications for health expenditure, long-term care (LTC), pensions and the future health workforce.

Decentralized governance is a defining feature of the Swiss health system

Switzerland's health system is shaped by federalism, subsidiarity and direct democracy. Responsibilities are divided between the Confederation, the 26 cantons and municipalities. The Confederation is responsible for key national policies, including mandatory health insurance (MHI), health protection, medicines and medical devices regulation, and national public health frameworks. Cantons retain primary responsibility for health care delivery, hospital planning, health promotion, prevention and implementation of many health policies. Municipalities also play a role, particularly in LTC and community services, depending on cantonal arrangements.

The decentralized governance structure allows policies to be adapted to local conditions and can support innovation at cantonal level. At the same time, it fragments responsibilities and produces regional variation and inequalities. Health responsibilities remain largely devolved to the cantons, while many regulatory frameworks are defined through federal law, especially the Federal Health Insurance Law (KVG/LAMal). Cantons therefore hold substantial implementation responsibilities but operate within a framework that is partly shaped at federal level.

The Health2030 strategy provides a broad national framework for health system development, with priorities including digital transformation and healthier environments. Implementation, however, depends heavily on voluntary cooperation among cantons, providers, insurers and other stakeholders. Cantons also develop their own health strategies, which may differ across regions.

Direct democracy and corporatist decision-making are central to Swiss health policy-making. Popular initiatives, referendums, stakeholder consultation and negotiated tariff setting give professional associations, insurers, providers and voters significant influence over reforms. This contributes to legitimacy and stability once reforms are adopted but also creates multiple veto points. Major structural reforms, therefore, often require long negotiation periods and tend to be incremental rather than rapid or centrally directed.

Universal MHI provides broad coverage, but premiums and OOP payments highlight affordability concerns

MHI ensures universal coverage and access to a broad statutory benefits package. Insurers must accept all applicants, premiums are community-rated within cantons or premium regions and risk equalization compensates insurers for differences in enrollee risk profiles. Premium subsidies protect lower-income households, although eligibility and generosity vary across cantons.

The financing system is mixed and fragmented, with MHI premiums, general taxation and OOP payments as the main sources of revenue. Mandatory health insurers are the main purchasers of health care services, reimbursing providers at negotiated tariffs. Cantons also play a major role, especially in financing inpatient care, LTC and premium subsidies.

Affordability remains one of the key issues in the Swiss system. Premiums are not income-related, and households contribute through deductibles, co-insurance and direct payments for services not included in the statutory package. OOP spending remains high by international comparison. Important areas of household spending include routine dental care, vision correction, some complementary therapies, medical goods and costs associated with LTC. Premium subsidies and cost-sharing caps provide protection, but the financial burden remains relevant for lower- and middle-income households, older people and residents of cantons with less generous support schemes.

The MHI system operates under regulated competition. Insured people may choose among insurers and insurance models, and many now select alternative models with restricted provider choice, gatekeeping or telemedical triage in exchange for lower premiums.

Health spending is among the highest globally, and cost containment remains a recurring reform priority

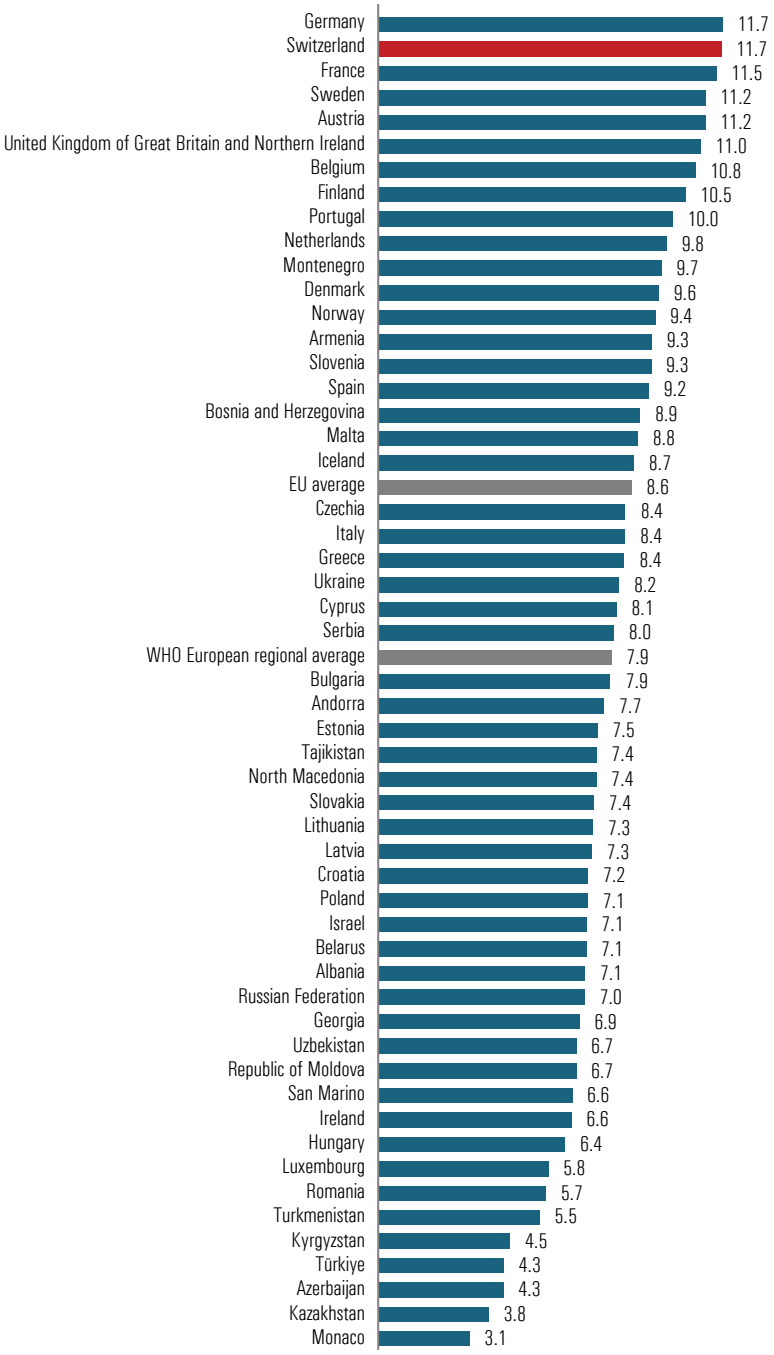
Switzerland is one of the highest-spending health systems in Europe and globally. In 2023, health expenditure reached 11.7% of GDP according to data from the Global Health Expenditure Database, and per capita health spending was surpassed only by the United States of America. High expenditure supports broad access, short waiting times, extensive provider choice and a high level of service availability. It also reinforces concerns about affordability, efficiency and long-term sustainability.

Rising expenditure and premium growth have made cost containment a recurrent policy priority. Over the last decade, reforms have focused on strengthening tariff governance, improving cost monitoring, promoting more efficient reimbursement mechanisms, increasing transparency and addressing pharmaceutical spending. Several legislative packages have introduced measures affecting tariff setting, provider regulation, cost-control instruments and the use of lower-cost medicines.

Payment reform is central to this agenda. SwissDRG governs acute hospital payments, while LTC is financed through MHI and patient contributions, plus cantonal or municipal subsidies. In outpatient care, the TARDOC service tariff framework and ambulatory flat-rate tariffs have replaced the longstanding TARMED fee-for-service system, updating fee-for-service tariffs and introducing more bundled payments for selected treatments.

The Uniform Financing of Outpatient and Inpatient Services (known as EFAS) is one of the most significant recent reforms. Approved by popular vote in 2024, EFAS will gradually align financing responsibilities across outpatient, inpatient and LTC. It is intended to reduce incentives favouring inpatient care and support more appropriate allocation of services across settings. Its implementation will be phased in, and its effects on expenditure, care coordination and the role of insurers remain uncertain.

FIG. 3.1 Current health expenditure as a share (%) of GDP in the WHO European Region, 2023



EU: European Union; WHO: World Health Organization.

Note: Data for Ukraine are from 2021.

Source: WHO, 2025a.

Services are comparatively accessible, but coordination across sectors and cantons remains uneven

Service provision is characterized by broad access, extensive provider choice and short waiting times. The statutory benefits package covers a wide range of services, and provider density is high by international standards. Reported unmet need for medical care is low overall, although higher among lower-income groups and in some rural areas.

Public health remains largely a cantonal responsibility, although the Confederation sets national strategies such as Health2030 and the national strategy for NCDs. Implementation varies across cantons and is influenced by Switzerland's strong emphasis on personal responsibility. Spending on prevention remains relatively low as a share of total health expenditure compared with many other European countries.

Primary care is undergoing structural change. Interdisciplinary and group practices are increasingly replacing traditional solo practice models, while alternative insurance models have expanded gatekeeping and telemedical triage. These developments may strengthen coordination, but workforce pressures persist, particularly because of upcoming retirement waves of general practitioners.

Hospital care is shaped by cantonal planning and service mandates. Cantons use hospital lists to determine which providers may deliver services reimbursed by MHI. This allows planning to be adapted to regional needs but also contributes to variation in capacity and service distribution. Intercantonal coordination has become more important, particularly for highly specialized medicine and broader discussions on hospital planning.

Switzerland has also pursued policies to shift care from inpatient to outpatient settings. "Outpatient before inpatient" rules require selected procedures to be performed in ambulatory settings when medically appropriate. These policies are linked to broader payment and financing reforms, including TARDOC, ambulatory flat-rate payments and EFAS.

Hospital infrastructure planning remains strongly cantonal

Switzerland's hospital infrastructure has changed substantially. Acute hospital bed density declined by about 33% between 2000 and 2024, while ambulatory services expanded and LTC capacity remained relatively high. Hospital consolidation reduced the number of hospitals from 372 in 2000 to 270 in 2024, when Switzerland had 420 acute beds per 100 000 inhabitants.

Hospital infrastructure planning and capital investment are primarily cantonal responsibilities. Cantons define hospital lists and service mandates, while hospitals and their owners finance major investments. Integrating capital costs into SwissDRG payments has made operating performance more important for investment financing. Recent financial pressure has limited some hospitals' ability to self-finance capital renewal.

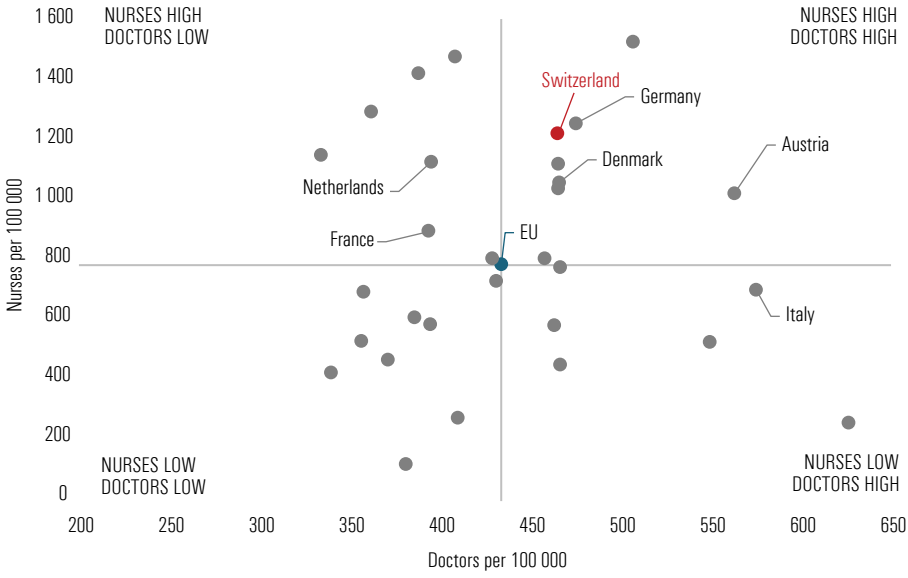
The hospital landscape remains unevenly distributed. Differences in bed density and service availability reflect cantonal planning, population structure, urbanization and the location of referral centres. Intercantonal coordination is increasing, but the absence of centralized planning continues to shape regional variation in infrastructure and capacity.

Switzerland is well equipped with advanced medical technology, including computed tomography (CT) and magnetic resonance imaging (MRI) units. Investment decisions are decentralized, with cantons mainly influencing high-cost equipment through hospital service mandates and approval requirements.

High numbers of health professionals coexist with shortages, maldistribution and reliance on foreign-trained staff

Switzerland has high densities of physicians and nurses compared with the EU average, with 465 physicians and 1 215 nurses per 100 000 inhabitants in 2024 (compared with 434 and 776 per 100 000 in the EU). The number of health care professionals in Switzerland has increased significantly over the last decade. The health and social care sector accounts for a growing share of total employment, reflecting the increasing labour market importance of health care. Despite this high supply, workforce shortages remain a major concern, in particular in primary care, child and adolescent psychiatry, paediatrics, nursing and in rural areas.

FIG. 4.2 Practising nurses and physicians per 100 000 population, 2024

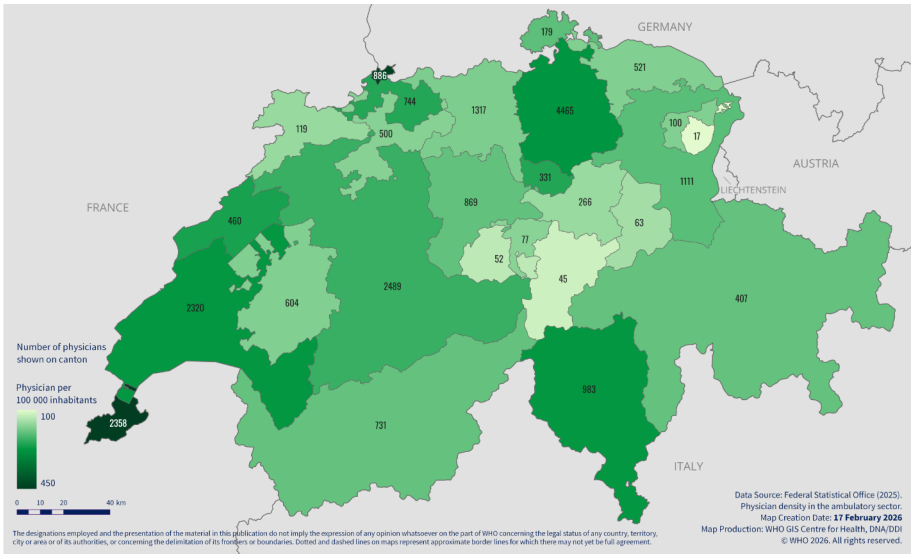


EU: European Union.

Notes: Data for nurses: France refer to 2023.

Source: Eurostat, 2026b.

FIG. 4.5 Distribution of the number of physicians and physician density in the ambulatory sector across Swiss cantons, 2023



Source: FSO, 2025b.

Switzerland relies heavily on foreign-trained health professionals. More than 40% of practising physicians obtained their medical degree abroad, and nursing and midwifery also rely on foreign-trained staff. This reflects the gap between domestic training capacity and workforce demand and raises sustainability concerns as neighbouring countries seek to retain their health workers. Health workforce governance is decentralized and lacks a comprehensive national planning framework. Cantons address workforce issues through their responsibility for health care provision and alignment of training capacity with regional needs, resulting in varied approaches and limited national coordination.

Recent reforms have expanded medical education capacity, strengthened nursing education and improved workforce monitoring. The Nursing Care Initiative, approved in 2021, has led to measures to expand training, improve working conditions and strengthen nursing career pathways. New monitoring tools track workforce trends and support policy responses.

Digital health reform is advancing, but fragmented governance limits interoperability and data use

Digital transformation is a central reform area, but implementation has been uneven. Switzerland's health information system remains fragmented: the Confederation manages national data collection and monitoring, while cantons operate their own systems. This limits interoperability, performance monitoring and data exchange across care settings.

The Electronic Patient Record was intended to support more integrated information exchange among providers. Implementation has been slow, partly because participation has been limited for some providers and patients and because governance responsibilities have been divided. A total revision of the Electronic Patient Record law is intended to address these limitations. Proposed reforms include mandatory participation for all providers, an opt-out model for patients, and a stronger federal role in infrastructure management.

The DigiSanté programme, covering the period 2025–2034, represents a broader effort to strengthen national digital infrastructure and improve data exchange. It focuses on interoperability, digital public services and secondary use of health data for planning, governance and research.

Digitalization also has implications for service delivery. Telemedicine and digital consultations have expanded, particularly through alternative (managed care-type) insurance models, but they remain only partly integrated with national information systems. The challenge is, therefore, not only to increase digital tools, but to embed them in a coherent system of data exchange, governance and care coordination.

Recent reforms address longstanding problems in financing, workforce, digitalization and coordination

Switzerland has implemented a wide range of reforms over the past decade. They have addressed financing, cost containment, service delivery, workforce, public health and digitalization. Most have been incremental and sector-specific, reflecting the constraints of federalism, stakeholder consultation and direct democracy.

Several recent reforms are more structural in scope. EFAS aims to align financing across care settings. TARDOC and ambulatory flat-rate payments reform outpatient reimbursement. The Nursing Care Initiative addresses workforce sustainability. Reforms to the Electronic Patient Record and DigiSanté seek to improve digital infrastructure and data integration. Public health reforms include revisions to the Epidemics Act, tobacco control measures and changes in organ donation policy.

Taken together, these reforms point towards stronger coordination within a system that remains highly decentralized. They seek to align incentives, improve efficiency, address workforce constraints, modernize digital infrastructure and strengthen integration across sectors. Implementation will be decisive. Switzerland's institutional structure requires cooperation between the Confederation, cantons, insurers, providers, professional associations and voters. This can slow reform, but it also increases legitimacy and durability once changes are adopted.

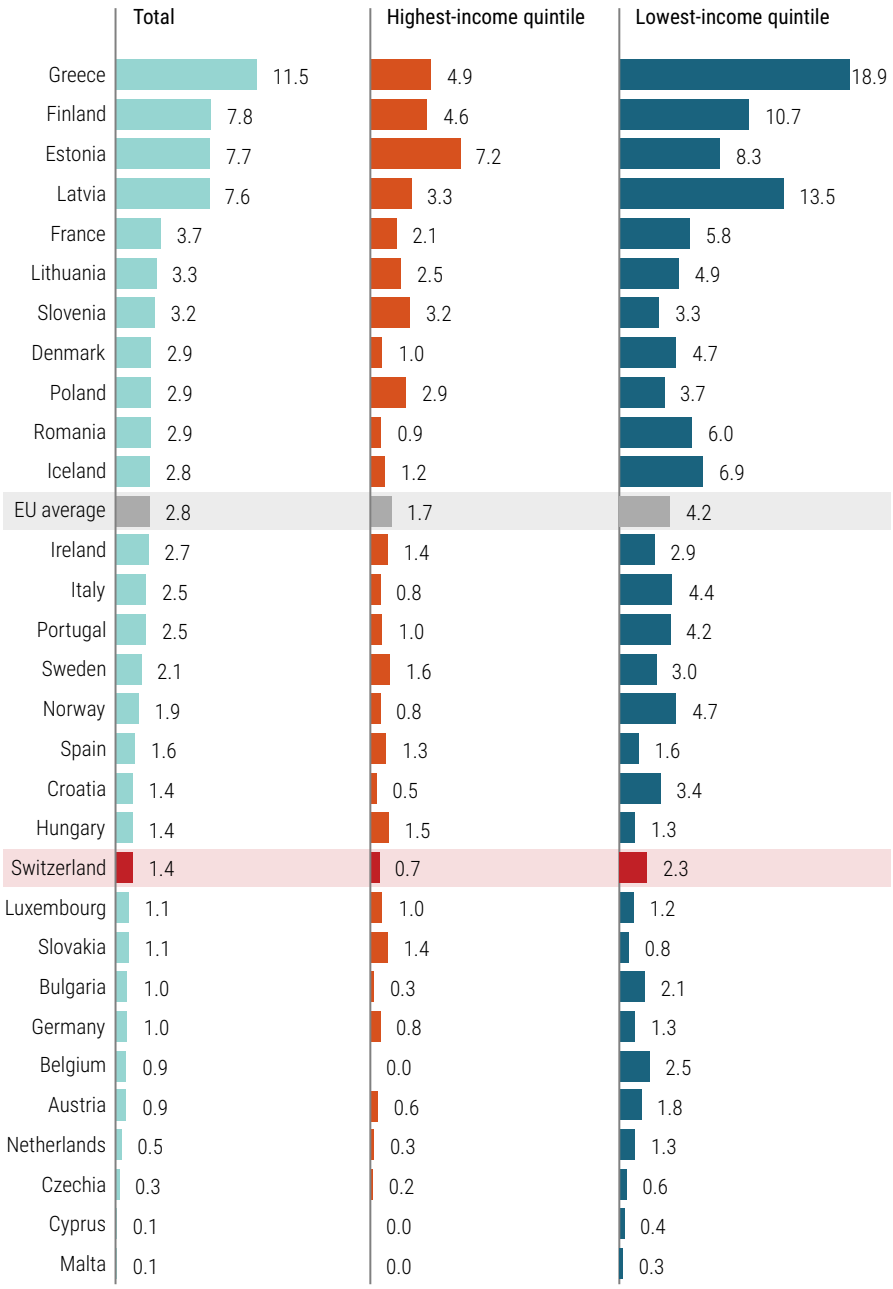
The central challenge for the coming years will be to preserve the strengths of the Swiss health system – high quality, broad access, patient choice and political legitimacy – while addressing rising costs, affordability pressures, workforce shortages, digital fragmentation and uneven coordination across sectors and cantons.

Switzerland combines strong health system performance with comparatively high resource use

Unmet need for health care due to costs, waiting time or distance are low in Switzerland in 2025, with 1.4% of the population reporting unmet need compared with 2.8% across the EU. However, unmet need was higher among lower-income groups (2.3% compared with 0.7% among higher-income groups), and access can be more limited in rural and remote areas.

Switzerland also records favourable health outcomes, including very low levels of treatable mortality, while health expenditure remains among the highest internationally. The allocation and use of resources varies across the health system: spending remains strongly oriented towards hospital care, while progress in shifting selected services towards ambulatory settings has been uneven. Other factors affecting efficiency include fragmented financing and governance, administrative complexity, comparatively high pharmaceutical spending and prices, and low uptake of generics. Recent reforms to financing and provider payment, alongside policies promoting outpatient care, are intended to address some of these issues, although their effects are not yet fully established.

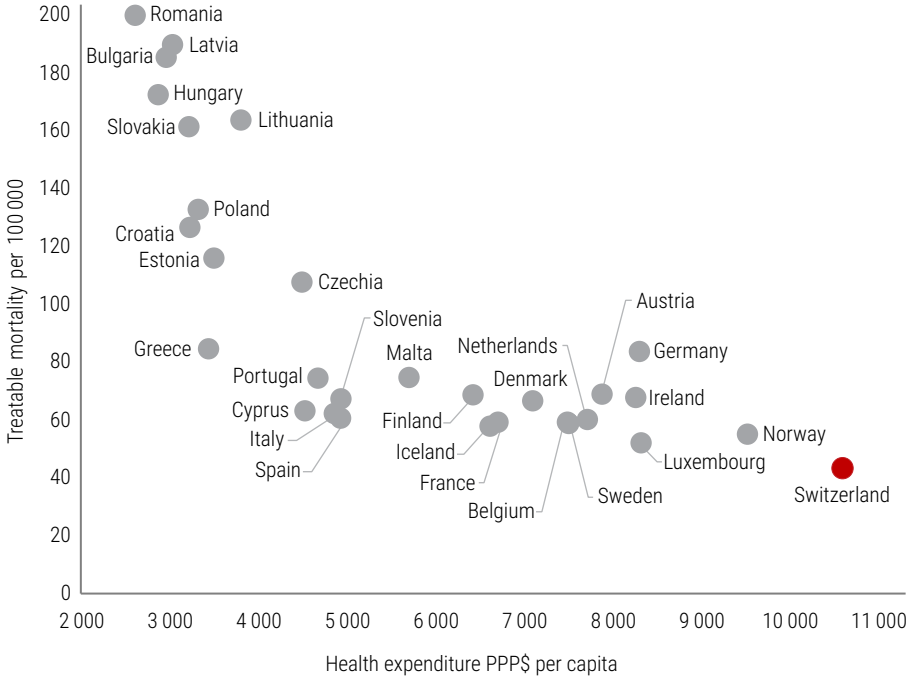
FIG. 7.1 Unmet needs for health care due to cost, waiting time or travel distance, by income quintile, EU/Europea Economic Area, 2025



EU: European Union.

Source: Eurostat, 2026d.

FIG. 7.7 Treatable mortality per 100 000 population versus health expenditure per capita, 2023



PPP: purchasing power parity.

Source: WHO, 2025a and Eurostat, 2026e.

The complete Health System Review for Switzerland (2026) gives a detailed description of the Swiss health system and recent changes – please refer to the table of contents which follows.

You will be able to download the full HiT from here
https://eurohealthobservatory.who.int/publications/health-systems-reviews

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