Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Switzerland

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Content

Summary of Main Findings

Representative organisations of family carers and older people

- There is no evidence for an *increase in family care* in Switzerland, but rather a change in the availability of the family members for providing care. There are more nuclear families, more interethnic marriages and more women in the labour force, thus reducing the possibility of women to provide care.
- Women are still the *main care providers*, despite the fact that their availability has reduced due to their increased participation in the labour force. People live longer and in better health. Two generations are now at retirement age and more `young old´ provide care to the `old old´ generation.
- *Measures to facilitate the combination of work and care* are still very scarce, although indirectly the federal commission of the family (COFF) is discussing new actions and legislations to facilitate care of children, which will allow women to better manage multiple care situations for an aged parent.
- There are quite *substantive differences between different regions in Switzerland*, due either to the heterogeneity of Switzerland's 26 health systems, either to the geographical distribution (urban, rural and alpine) and socio-demographic structures of the population and even between local municipalities. Family caregivers and those in need of care thus do not have equal access and support regarding family care. For example in rural areas, family care givers are still the main source of care, as in urban areas, the main source of care is professional or institutional.
- *Financial support* to family carers is being discussed as either a bonus system, either as some tax benefit through deductions. Currently, the situation is very different between the 26 Swiss cantons and their health systems: while some cantons have put in place a regular financial support for family carers corresponding to a specific criteria, most cantons do not have any policy regarding family home care.
- *The offer for services for family carers* has developed more into socio-medical structures for temporary relief of care (day hospital, day center, animation centers for the elderly, ...), either at home through temporary formal day care from the out-of hospital care (Spitex organisation). The support for family care givers is yet to be further developed as the community approach is not part of the culture of care as in anglo-saxon countries for example or senior-to-senior help.
- *The primary health care sector* is well developed in most regions of Switzerland, although it varies from canton to canton depending on the

health system and policy concerning the 'moratoria' on older pensions homes and on structuring professional home care. Due to insurance coverage for home care and measures of financial support for older persons with financial difficulties, professional care is a convenient and affordable option for most persons in need.

- *The number of geriatric departments* in Switzerland has increased in the since the geriatric specialty in general medicine was officially recognized by the Swiss Medical Society. Thus, ward beds in hospitals have been increasing in number. The Geriatric departments have also developed specialized medical units with consultants posted for geriatric cardiology, geronto-odontology, etc. The multidisciplinary approach of geriatric medicine in Switzerland is allowing family to participate in decisions regarding therapy and follow up treatment at the time of hospital discharge if the patient agrees or is unable to respond,. The participation of family in home care is an essential component of the successful discharge of a patient.
- *Palliative care* is well developed either as specialized hospitals like in Geneva, or as specialized units. New forms of palliative care have taken place with Mobile Palliative Care Teams who are specialized in palliative care provided at home, often upon request or with the collaboration of family.
- *The involvement of carers in hospital care and in nursing home* care heavily depends on the policy of the hospital or the nursing home in question.
- *Residential care* is still an essential part of the caring process for the elderly. Not only can some not be taken care of at home, but older people themselves wish to enter a home and be autonomous even more. Studies have shown that the older persons don't want family to take care of them and prefer to be independent from the burden of being cared for by their family, preferring the help of a professional.
- *A large offer of community care services exists*, although each canton and linguistic region of Switzerland have developed some specific and culturally adapted services or care. A few federal organisations such as Pro Senectute or the Alzheimer's Association are playing the role of promotion, advocacy and financial support to many services in the field that are organized and managed independently by each canton. The Swiss Foundation for home aid and care is organized at the federal level but each canton government supports a Canton Fondation for home support and care.
- Through the Social Secury System, the federal government offers *compensations to elderly people* to pay for their care when weakened or lacking the ability to do things independently.

- *Care abuse and mistreatment* is a subject that has taken on certain importance but is still embedded in the context of violence within families. An association exists.
- *The main issues for representative organisations of family carers* and older people seem to be the lack of interest to federate families together on this issue for the moment and the order of priorities going towards child care, especially for monoparental families. The financing of home care can also be quite reduced depending on the health care policy of the canton, as all 26 cantons are autonomous in some of their decisions and legislations.

Service providers

- There is no evidence for an *increase in family care* in Switzerland, but rather a change in the availability of the family members for providing care. There are more nuclear families, more mixed marriages and more women in the labour force, thus reducing the possibility of women to provide care.
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- *Measures to facilitate the combination of work and care* are still very scarce.The Federal Commission on the Family (COFF) is discussing new actions and legislations to facilitate children's care, which will allow women to better manage multiple care situations for an aged parent.
- *Financial support* to family carers is being discussed as either a bonus system, either as some tax benefit through deductions. Family members taking care of an older parent with Alzheimer's disease at home have been offered small amounts of allowances in cantons like Fribourg, but this kind of financial support is not widely circulated.
- *The offer of services for family carers* has further developed into socio-medical structures for temporary relief of care (day hospital, day centre, for the elderly, ...), either at home through temporary formal day care from out-of hospital care (Spitex organisation). Support for family care givers or initiatives such as 'senior for senior' help are yet to be further developed given that the community approach is not part of the culture of care as much as in anglo-saxon countries for example .
- *The primary health care sector* is well developed in most regions of Switzerland, although it varies from canton to canton. The situation depends on the health system and the policy concerning the 'moratoria' on older pensions home and on structuring professional home care. Due to insurance coverage for home care and measures of financial support for

older persons with financial difficulties, professional care is a convenient and affordable option for most persons in need.

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- There are quite *substantive differences between different regions of Switzerland*, either due to the heterogeneity of Switzerland's 26 health systems, either to the geographical distribution (urban, rural and alpine) and socio-demographic structures of the population and even between local municipalities. Family caregivers and those in need of care therefore do not have equal access and support regarding family care. For example

in rural areas, family care givers are still the main source of care, as in urban areas the main source of care is professional or institutional care.

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- *Other major issues are* 1. the lack of support for family care in Switzerland and more specifically for migrant families; 2. the outsourcing of care in Germany due to support from health insurances of cheaper forms of care and rehabilitation (news December 2004); 3. e-health care developments.
- Service providers along with the government and cantonal health systems will have to reflect in the future on *the shortage of care providers, nurses and doctors* which brings more and more foreign carers into formal and informal care, therefore bringing some key communication and value system issues to the forefront, especially in end of life care matters.
- No data or information is available on the *needs and desires of elderly persons* for family care as well as their knowledge of existing local institutions.

Policy makers

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formal day care from the out-of hospital care (Spitex organisation). Support for family care givers or initatives such as 'senior to senior' help are yet to be developed given that the community approach is not a part of the culture of care as much as in anglo-saxon countries for example .

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- *Care abuse and mistreatment* is a subject that has taken on some importance but is still embedded in the context of violence within families. An association exists.
- How long older people can live within their own home will depend greatly on the availability of out-patient care services, in particular, home support and care services which are federated under the Spitex organisation (which is a professional home care organisation). Spitex includes approximately 27,000 employees distributed in 900 organisations providing nursing and care for almost 200,000 clients of whom 71 % are of retirement age and 42 % aged 80 and over. In 1998, 760 million Swiss francs were spent on Spitex services, corresponding to 2 % of all health service costs (OFAS, 2000).
- Spitex services are of particular importance for independent living in advanced years. The government report prepared for the 2nd World Assembly on ageing stressed that care should be taken that home care services are in sufficient amount and quality. In view of the new Financial Equalisation (NFA), which will lead to a loss of contributions from the social security fund to the Spitex organisations, the cantons are being asked to clearly define their financial support for Spitex (OFAS, 2002).
- *The affordability of home care or nursing homes* is and will be a major issue for policy makers. On the one hand some cantons have developed a very sophisticated formal home care system to maintain the elderly at home while other cantons have focused more on providing elderly pensions and homes. The harmonization of home care policies in Switzerland will be a challenge that the economic imperative of rationalization of care and decrease of health care costs will inevitably bring to a large debate between the family carers, elderly people, service providers, health insurances and policy-makers.

- *The rising cost of health insurances contribution* by the client in Switzerland has seen a dramatic evolution, which has put a heavy economic burden on families and the most disadvantaged. The basic health insurance being compulsory, the situation has created a large debate on how to reduce the health care costs and give more responsibility to the patient. It is not clear if the liberalization of health care systems will be the future choice or not of Switzerland, but future decisions regarding health care coverage by insurances will be fundamental in the development of formal / informal care and the quality of care provided for elderly persons.
- The Swiss Research Programme on Ageing final policy report underlined the problem of the federalistic structure of Switzerland in the health sector in particular, which leads to the development of differently structured forms of community healthcare in different regions. In many regions there are also structural incompatibilities and conflicts between the acute and community healthcare of the elderly. In many regions there is also a lack of an integrated, system-orientated information policy which would make it possible to cover all healthcare services of a community type in all its dynamic forms.

Introduction – An Overview on Family Care

In Switzerland as in most European countries, family care patterns have changed considerably as a consequence of many socio-demographic, economic and environmental changes during the last decades: lower birth rates, higher divorce rates, higher life expectancy, increased longevity, and unprecedented increase of professionally active women (Höpflinger and Stuckelberger, 1999, Stuckelberger and Höpflinger, 1996).

The family network available for caring is becoming smaller and geographically more distant. *First*, families have fewer children, thus the number of potential care providers is diminishing, but live longer and healthier with a potentially wider age range of care providers within the family. Although women remain at the centre of providing instrumental and emotional support to older people in Switzerland, a shift can be observed in the family: professional working time sharing witnessed by the raise in the number of women on the labour market, the strong increase in divorce rates or single parents which all gives less time to women for providing care. The care giving pattern within the family relies on the civil status and household composition: in a couple, the main provider of care is the spouse, as in the case of a widow(er) or single / divorced older person the children and grandchildren take on an important role. The fact that two to three generations are at retired age at the same time has also created new care patterns within the family: the older person taking care of their older parent or / and their grand children. The incentives that the state welfare will put in place to support the supporter financially will have a strong impact on the family care providers and family relations.

Second, the social and geographical mobility of the family networks have also increased through migration (internal and international) and interethnic marriages. Furthermore, family care provision has gone through profound changes linked to the complexification of the family and social structure during the last century: higher age at first marriage, higher rates of divorce. The number of family members of different generations living under the same roof has significantly decreased and the natural family care tradition of caring for the aged at home or in close proximity is diminishing or disappearing, even in remote rural or mountain areas of Switzerland. All those elements show a clear tendency towards the family structure and family relations becoming more complex.

Third, the technological revolution is creating new forms of health care systems and communication, which is affecting society, health care professionals and family relations (e-care, tele-care, smart housing, etc.) more and more. This trend is already starting to lead to generation gaps in offer / demand expectations between different health sectors, market constraints but also within the family between generations (European Population Forum, 2004; Stuckelberger, 2003).

Fourth, the economic and care dependency ratio between generations has modified the link 'family-society' at the structural level: it is not so much the longevity as the population distribution over the life cycle that accounts for the multiple generation family and gives a clearer view of the needs and potential provision of family care. Table 1 gives an overview of the population distribution in a life cycle perspective which very clearly shows the distribution per decade of the relative proportion of a generation needing care or economically dependant on the professionally active population. The percentage distribution per life cycle periods has since 1900 been increasingly tending towards a decrease in the professionally active population and an increase in the ratio of professionally non active vs. the active population. This socio-demographic factor is one of the keys to the ongoing modification in inter-generational relations and family care and economic concerns of policy-makers: less and less people must provide for the care and economic support of more and more people (Höpflinger und Stuckelberger, 1999; Stuckelberger, 2005; Wanner et al, 2004).

Table 1: Population distribution in a life cycle position perspective 1900-2050

Year	Total Population in 1000 (=100 %)	Economically non active population			Professionally active population		Retirees – professionally non active population		
		Children	Teenagers	Young adults	Adults	Older adults	Young old	Old	Old old
		0-12	13-19	20-24	25-39	40-59	60-69	70-79	80+
1900	3,315.4	27.4 %	13.3 %	9.1 %	22.0 %	19.0 %	6.0 %	2.8 %	0.4 %
1910	3,753.3	27.3 %	13.5 %	8.5 %	22.5 %	19.4 %	5.6 %	2.6 %	0.5 %
1920	3,880.3	24.0 %	14.0 %	8.9 %	21.8 %	22.0 %	5.8 %	2.8 %	0.5 %
1930	4,066.4	21.5 %	12.0 %	9.2 %	23.7 %	22.8 %	6.9 %	3.2 %	0.6 %
1941	4,265.7	19.0 %	11.0 %	7.6 %	24.3 %	24.6 %	8.2 %	3.9 %	0.8 %
1950	4,715.0	20.9 %	9.5 %	7.5 %	21.6 %	26.4 %	8.2 %	4.8 %	1.1 %
1960	5,429.1	20.2 %	11.2 %	7.4 %	21.6 %	24.5 %	8.6 %	4.8 %	1.5 %
1970	6,269.8	20.6 %	10.1 %	8.1 %	22.2 %	22.7 %	9.3 %	5.3 %	1.7 %
1980	6,366.0	16.0 %	11.1 %	7.5 %	23.1 %	23.9 %	8.8 %	6.7 %	2.6 %
1990	6,873.7	14.5 %	8.4 %	7.8 %	24.6 %	25.5 %	9.1 %	6.2 %	3.6 %
2000	7,243.6	15.2 %	8.3 %	6.2 %	22.7 %	27.4 %	9.2 %	6.9 %	4.1 %
2010	7,443.3	13.6 %	8.5 %	6.6 %	19.6 %	28.2 %	11.2 %	7.3 %	4.9 %
2020	7,552.7	13.4 %	7.6 %	6.2 %	20.0 %	26.1 %	11.7 %	9.3 %	5.8 %
2030	7,581.7	13.3 %	7.6 %	5.8 %	19.3 %	24.1 %	12.4 %	10.0 %	7.5 %
2040	7,490.6	12.8 %	7.7 %	6.0 %	18.5 %	24.7 %	10.5 %	10.9 %	8.8 %
2050	7,355.8	12.8 %	7.4 %	6.0 %	18.9 %	24.2 %	11.2 %	9.5 %	10.0 %

Source: Swiss federal statistical Office Censuses; Projection calculation of Scenario A-00-95, Swiss federal statistical Office, 1996; Höpflinger und Stuckelberger, 1999

Hence, family care cannot be understood without taking into account those features and acknowledging that family care is putting an increased burden on the active population and the image of the natural solidarity between family members, although still alive, has taken many different forms to suit the imperative of family and professional lives of the carers. The new family patterns are reflected by the housing arrangements of older generations: Switzerland has seen more and more older persons living alone in all age groups.

Family care data available: although the Swiss government financed a large national research programme on ageing to provide more facts and recommendations on the many aspects of the older population at the national and regional level (Höpflinger and Stuckelberger, 1999a, 1999b; Stuckelberger and Höpflinger, 2000; in print), family care issues in Switzerland have only been given attention through general care aspects or specific approaches. Some

results have thrown more light on some aspects of family and home care. An ongoing longitudinal Swiss Household Panel Survey is underway since 1999 bringing new perspectives on health changes in the Swiss families (Zimmermann et Tillman, 2004: Zimmermann and Burton-Jeangros, 2004: Zimmermann, Stuckelberger and Meyer, 2005)

Family care continues to be a central element of care of elderly affected by dementia. They are mostly cared for by relatives who are often subject to the great strain of continuous care, emotional situations or personality changes of their demented relative. It is essential that adequate psycho-social support and possibilities of temporary relief be arranged to preserve family care and the health of the carers (Molo-Bettelini, Clerici et Testa-Mader, 1998). The report recommends nationalizing a system of financial incentives or benefits for family carers of elderly persons at home (as is the case in some cantons such as Basel-City) stressing that family care should not be disadvantaged in favour of institutional care.

A higher risk of unmet needs for care rises with age. It is higher among women, persons living without a partner and elderly people with medium or low levels of education. A simulation for the whole of Switzerland shows over 30,000 older people with an unmet need for care, over 10,000 of whom are 65-74 years old, 16,000 are 75-84 years old and over 5,000 are over 85 years. The largest component of the unmet need is domestic help, which is not reimbursed by the current social and health insurance system (Theodor Abelin, Valerie Beer, Felix Gurtner, 1998).

Preventive home visits prove to be a particularly effective strategy for the prevention of disabilities in old age, however, only under the conditions of a professionally executed multi-dimensional geriatric assessment and professionally organized home visits. Moreover, preventive home visits are especially effective if they are implemented early and are cost effective in the long term (Stuck et al., 1995, 2002).

The development of new micro-electronic instruments can also be of use to elderly disabled people. A pilot study, in which active and passive electronic aids were used with disabled elderly people, clearly demonstrated that the latest technology can be useful for the oldest generation, provided technological innovations are combined with careful social counselling.

In many regions, there is a lack of an integrated, system-oriented information policy that could include community nursing and care services in their dynamic interplay. In view of increasing demographic ageing and the rising costs of socio-medical care, however, it is more and more important to have exact information.

Although no data is available on family care in Switzerland, a recent report has attempted an extrapolation of the need of care of the older population in Switzerland from diverse data sources (national statistics, health surveys, epide-

miological studies, as well as dependency subsidies beneficiaries). The calculation reaches an amount of 109,000 to 126,000 older persons who would be in need of care today, estimation based on the activity of daily living measures. Those numbers concern between 9.8 % and 11.4 % of persons older than 64 years old. As Switzerland's older population has not suffered the devastation of the Second World War, the number and percentage of persons needing care is lower than in Germany or Austria. Population presently aged 65 and over also gained from the favourable economic situation observed during the fifties and sixties to reach a high standard of life and maintain a good health status (Pecoraro and Wanner, 2005). For these reasons Switzerland benefits from a higher life expectancy without disability than neighbouring countries do. Nevertheless, half of the persons in need of care suffer from organic cerebral disorders (i.e. Alzheimer's, etc.) and it is estimated that due to the ageing of the population, especially the group of 80 years old and more, this group in need of specific care will increase by 15 % between 2000 and 2010 (Höpflinger and Hugentobler, 2003).

In the future, family care policy and legislation for the elderly will need to be more thoroughly and systematically addressed at the national level and coordinated at the regional level (see Fondation Leenards, 2003). The Swiss programme on ageing conclusion underlines the challenges set by the federalist structure of Switzerland with 26 different cantonal health systems, bringing different forms of community healthcare and family care for each canton. There is a clear need for a more integrated health system covering all healthcare services to avoid the current regional inequalities concerning the health care costs and offers (hospital, medical care, consultation with a physician, insurance costs). Today's rising health costs tend to point toward a systematic national policy for reducing the health care costs and harmonizing the existing discrepancies. Different future demographic and health care cost scenarios have been drawn calling attention to the needs for care.

The current issues in Switzerland are related on one side, to the coordination between canton and federal policies. As the Swiss system allows for each canton autonomy of its health system and policy, the fine line between the responsibility of the federal government for mental health policies or prevention and promotion issues for example is continuously discussed among experts. On the other hand, the current burning issue today is the quality management of patients in the light of a climate opposing the medical doctors and institutions with the health insurance companies. The regulation of the system is at hand and solutions are being sought for reaching a win-win situation between the state-insurance and the population in many areas related to the care and family care of the elderly. In this context the supply and demand for care and care work will need to be addressed very carefully considering the many changes in the extended family functioning and socio-demographic structure.

Current issues in care are closely linked to the impact of the European population evolution tendencies: declining numbers of children, increase in the num-

ber of one-person-households, more equal workforce participation between men and women, growing numbers of older people living alone without children in private homes, and their emerging preference for formal services (European Foundation, 2003). To those trends, emerging issues and new phenomenon are rising rapidly and will have to be taken into account in future policy care: multi-generation family care, elderly migrant care or migrant family care, incentives to outsource family care abroad, end-of-life care management, rationalisation of care, amplification of technological care versus human care, etc.

1 Profile of family carers of older people

The profile of family carers items have not yet been included in the Swiss Census Questionnaire, therefore the data is extrapolated from the Swiss Household Panel .

1.1 Number of carers

According to the Swiss Household Panel 1999, 23.1 % of the Swiss population aged 15 and more have been caring – without payment – for a person aged 65 or more in the year prior to the survey, which amounts to 1.36 million persons (Table 2). Women report having cared for an elderly more often (27.1 %) than men (18.8 %). The pre-retired active population aged 50-59 years old (36.9 %) and the young retirees aged 60-69 years old (35.1 %) are those providing more care than other age groups. It is worth underlying that more than 1 out of 4 older retirees aged 70-79 years old (26.3 %) and of 40-49 years old (25.9 %) are still providing care to another retiree. Such data is confirmed by other studies (see for instance Gognalons-Nicolet et al., 1997 for which 28.8 % of men and 37.5 % of women aged 50-75 are carers). This data underlines the existence of two to three generations of retirees who provide intra-generational family care or care to a frail elderly older than them. This trend will most probably increase in the future for 2 reasons: a) the higher age-group, in particular the nonagenarians and centenarians, are the fastest growing segment of the population (Robine and Paccaud, 2005); b) disability-free life expectancy is increasing (Wanner et al., 2004), and will increase the number of older family carers at all ages.

Table 2: Care given to an elderly person without payment in the last 12 months

All	Yes (in %)	No (in %)	Sample size (N)
	23.1	76.9	7,795
(Extrapolated)	1,365,460	4,545,622	5,911,082
Sex			
Males	18.8	81.2	3,412
Females	27.1	72.9	4,383
Age			
15-19	11.3	88.7	700
20-29	10.5	89.5	1,076
30-39	14.4	85.6	1,802
40-49	25.9	74.1	1,592
50-59	36.9	63.1	1,220
60-69	35.1	64.9	814
70-79	26.3	73.7	475
80+	18.2	81.8	116

Source: Swiss Household Panel 1999.

1.2 Age of carers

The age distribution shows a very clear life course pattern of increased caring for an elderly patient with age . A peak in caring is observed between 40 to 69 years old with 1 out of 4 persons of 50-59 years old reporting taking care of an elderly person, compared to 1 out of 5 from the 40-49 and 60-69 age group (table 3).

It is interesting to note that the professionally active age-groups of 40-49 years old provides a similar proportion of care to the post-retiree group, despite the fact that their life course position places them in the group often referred to as the ‘sandwich generation’ with a ‘multiple family duties’ pattern of life, where they must care for their own children’s education, and are professionally active in order to maintain an income and care for an older parent.

Table 3: Care given to an elderly person without payment, distribution by age and gender

Age	Men	Women	Total
0-19	4.9	3.7	4.1
20-29	8.2	5.0	6.2
30-39	13.0	12.7	12.8
40-49	20.6	19.5	20.0
50-59	26.2	26.8	26.6
60-69	19.1	20.8	20.1
70-79	6.7	9.9	8.7
80+	1.3	1.5	1.5
Total	100.0	100.0	100.0
Sample size	639	1,177	1,816

Source: Swiss Household Panel 1999. Proportion after weighing .

1.3 Gender of carers

The number of women is two times higher than that of men who report giving care to an elderly person without payment in the last 12 months (table 3). Women are still the main health care providers as in most studies related to family care although men aged 50-59 and 60-69 years old have equal proportions of caregivers and even proportionally outnumber women at younger ages between 30 to 49 compared to other age groups.

1.4 Income of carers

No data available.

1.5 Hours of caring and caring tasks, caring for more than one person

A minimum of 2 hours and maximum of more than 21 hours per month spent giving care to an elderly patient were reported in the Swiss Household Panel (table 4). The majority of women and men provide between 3 to 20 hours per month of care, the peak duration being 6 to 10 hours care in the month prior to the survey. Women spend only a slightly greater amount of time than men do per week. Surprisingly, men are present in the care of older persons. It is interesting to note that only a very reduced proportion of carers spend just a few hours a month, while we still find 16.4 % of men and 18.9 % of women giving 21 hours or more of their time to care for an older person in a month.

Table 4: Care given to an elderly person, number of hours spent during the last month (in %)

Hours	Men	Women	Total
< 2	14.9	10.1	12.0
3 to 5	23.7	21.1	22.1
6 to 10	28.9	28.0	28.4
11 to 20	16.2	21.8	19.6
> 21	16.4	18.9	17.9
Total	100.0	100.0	100.0
Sample size	531	979	1,510

Source: Swiss Household Panel 1999.

1.6 Level of education and / or Profession / Employment of family carer

Data available demonstrates that among the categories of higher education levels, the pattern of care is very similar with little differences: between 22 % and 27 % of Swiss people with higher education report providing care to an elderly – without payment – in the last year. Among the elementary education levels, the care is lower except for the categories of 1 year schooling in commercial schools, thus reflecting a possible age group effect of the 15-24 year old age group interviewed.

Table 5: Care for the elderly without payment during the last 12 months according to the level of education (highest level of education achieved)

Level of Education	Carer	Non carer	Sample size
Incomplete compulsory school	11.4	88.6	287
Compulsory school	17.0	83.0	1,237
Domestic science school, 1 year school of commerce	26.4	63.6	381
General training school	29.7	70.3	88
Apprenticeship	23.7	76.3	2,812
Full-time vocational school	28.1	71.9	491
Bachelor's degree ('Maturity level')	22.9	77.1	791
Vocational high education	26.5	73.5	397
Technical or vocational school	22.6	77.4	203
Vocational high school	27.0	73.0	313
University, higher specialized school	22.8	77.2	768
All	23.1	76.9	7,768

Source: Swiss Household Panel 1999.

Naturally, the proportion of persons reporting caring for an elderly person – without payment – in the last 12 months is proportional to the availability presented by the occupational status (Table 6). Therefore full time paid workers, students and disabled retirees are fewer to report caring, although we still observe between 11.9 % and 19.4 % of carers. About a third of the persons retired, with part time work, working in the family company or at home do report caring for an elderly person. The unemployed are 21.8 % to report providing care.

Table 6: Care for the elderly without payment in the last 12 months according to the occupation status

Occupation status	Carer	Non carer	Sample size
Full-time paid work	18.6	81.4	3,061
Part-time paid work	30.1	69.9	1,466
In school, training	11.9	88.1	886
Work in the family company	26.0	74.0	101
At home	29.0	71.0	889
Retired (old age)	30.4	69.6	1,100
Retired (disablement, other)	19.4	80.6	114
Unemployed	21.8	78.2	117
Other situation	20.3	79.2	51

Source: Swiss Household Panel 1999.

1.7 Generation of carer, relationship of carer to older persons

52.3 % of the people surveyed declare caring for a member of their immediate family. Table 7 shows that this majority is present among slightly more men (57.3 %) than women (49 %). Next to the care of a close family member, only 17.4 % report either taking care of a friend or a neighbour and a very little proportion around 11 % report caring for another relative or a person they do not know.

Table 7: Care for the elderly: relationship of the carer to older persons (more than one possible answer)

	Men	Women	Total
Immediate family	57.3	49.0	52.3
Relatives	12.0	11.0	11.4
Friends	15.3	18.7	17.4
Neighbour	14.4	19.3	17.4
Person not previously known	9.1	12.3	11.1
Other person	3.6	4.0	3.9
Number of carers	639	1,177	1,816

Source: Swiss Household Panel 1999.

1.8 Residence patterns

Couples with children are less likely to provide care to an elderly person than couples without children. The highest percentage of carers is found among those aged 65 years and over, whether they live alone (28.2 %) or in a couple (31.4 %) which confirms that older age groups do provide substantial care to another older person (table 8).

Table 8: Care for the elderly without payment during the last 12 months according to the type of household

Type of household	Carer	Non carer	Sample size
One person aged 65 and more	28.2	71.8	365
One person aged 30-64	22.0	78.0	772
One person aged 15-29	7.0	93.0	216
Single parent with one or more children	18.3	81.7	421
Couple without children, with at least one aged 65 and more	31.4	68.6	657
Couple without children, both under 65	26.5	73.5	1,487
Couple with one child	15.7	84.3	532
Couple with two children	16.6	83.4	969
Couple with three children or more	17.6	82.4	519
Couple with at least one child over 16	25.7	74.3	1,670
Other household with all members related	15.6	84.4	105
Other household without all members related	28.0	72.0	82

Source: Swiss Household Panel 1999.

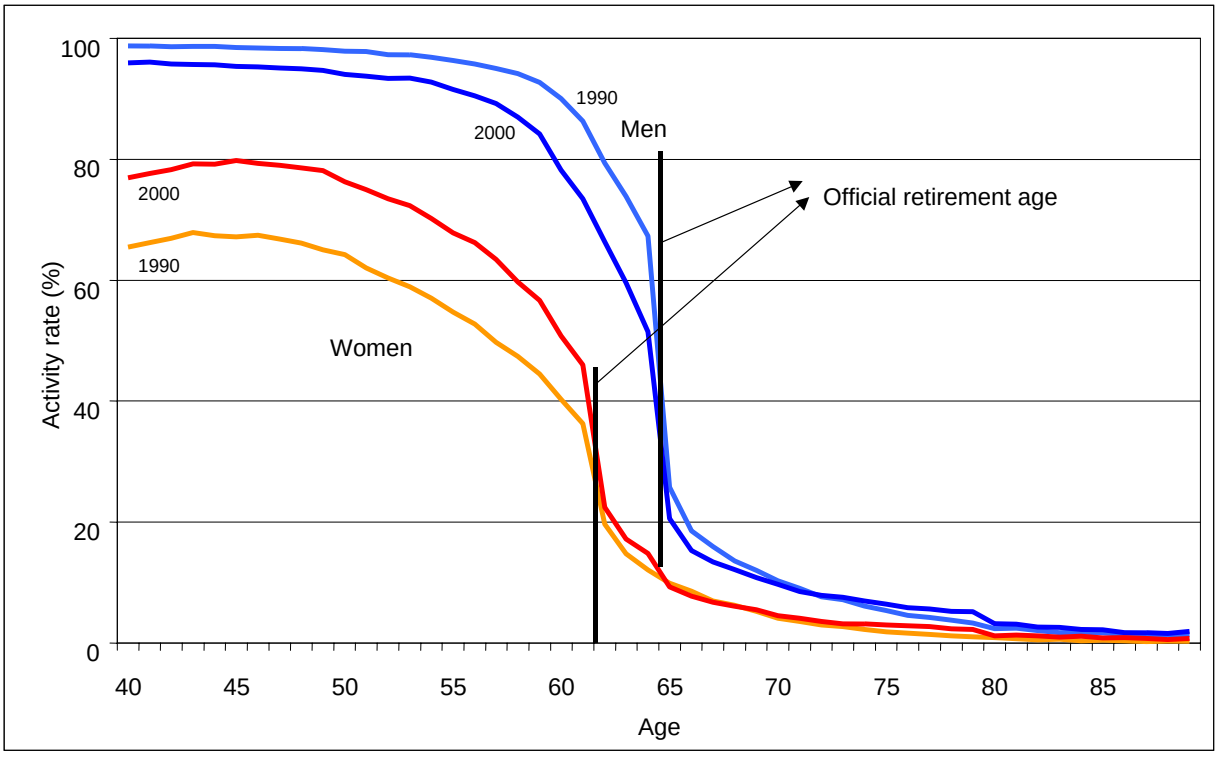
1.9 Working and caring

About 30 % of persons working part time or retired persons take care of an elderly person and are the groups reaching the highest percentage of carers (see table 6, section 1.6).

1.10 General employment rates by age

Figure 1 shows that the activity rates of men and women in Switzerland presented a wider gap in 1990 than in 2000, women working more today while men are slightly less active. The Swiss population follows a progressive and stable curve until the age of 45-50 for women and 60 for men. It then draws a sharp decline for the majority of the population until age 62 for women and 65 for men, official retirement ages in Switzerland. A remaining 10 % of the population remains active until 70-75. More often, older workers are self-employed, part-time active in the third sector. No data is available for carers.

Figure 1: Activity rate according to age and sex, 1990 and 2000



Source: Swiss Federal Statistical Office, Censuses 1990-2000. Wanner et al., 2004.

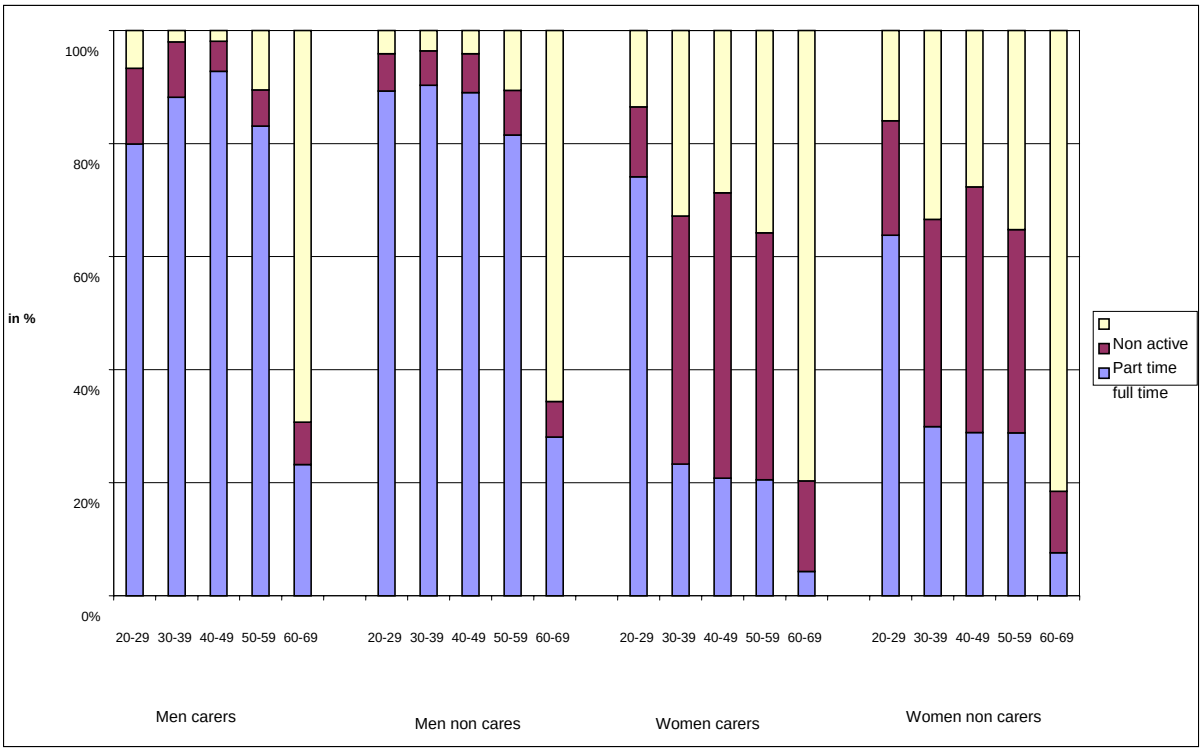
Table 9 shows that women and men reach a similar activity rate at the ages of 21-24. At all other ages Swiss men have a higher activity rate than women. This is mostly marked at the ages at 62 years old and above with rates of active men are systematically the double of women's activity rate.

Table 9: Activity rate per age group and sex, Switzerland 2000

Age	Men	Women
15-19	54.4	46.7
20-24	79.4	78.4
25-29	91.9	82.8
30-34	95.9	76.7
35-39	96.3	75.6
40-44	95.8	78.2
45-49	95.1	79.0
50-54	93.5	43.4
55-59	88.6	63.0
60-64	66.2	30.8
65-69	14.6	7.1
70-74	8.2	3.8
75-79	5.7	2.7

Source: Swiss Federal Statistical Office, Census 2000.

Figure 2: Activity rate according to age and sex and status of carer, 1999



Source: Swiss Household Panel 1999.

Although the activity rate pattern of carers is lower than the pattern of non carers, the patterns of women and men carers versus non carers activity are sur-

prisingly similar and the variation could have been expected to be much wider (Figure 2). This result shows that care does not influence working patterns.

1.11 Positive and negative aspects of care-giving

Negative aspects of family care-giving have been studied specifically for carers of persons affected by senile dementia in two culturally different regions of Switzerland: Basel, a Swiss German urban area in the North of Switzerland and Ticino, an Italian speaking, a semi-urban and pre-alpine region in the South of Switzerland, which is strongly influenced by the South-European culture (Molo-Bettelliini et al., 1997, 1998).

The most difficult aspects of caring for dementia patients indicated in Basel were their intellectual and emotional dementia symptoms, as well as difficulties in everyday life. The relatives in the Ticino more frequently assessed their own psychological problems as difficult. In both studies, the constant fact of being tied to the patient and the narrow limits of personal freedom were frequently mentioned. Relatives often had to give up their own social life, their hobbies and pleasures, but also their personal autonomy.

Nearly 60 % of the family care givers from Basel recorded great difficulty in asking other people for help. Even professional services were only called upon by half of the family carers from Basel. The other family carers were either of the opinion that they would manage alone or they did not want any strange people in their house. Some carers were not informed about available services..

The cultural differences between Italian- and German-speaking regions with regard to family structures and social networks are reflected in the family care of dementia patients. In the Ticino, professional services were more frequently called upon than in Basel. In the Ticino, the proportion of caring relatives showing difficulty in asking other people for help was lower than in Basel.

In Basel and the Ticino, around 30 % of the relatives interviewed felt they were only under a slight strain due to the nursing situation. In both regions, 43 % showed a light to moderate strain, a more than moderate to heavy strain was experienced by 26 %. The strain on a nursing relative is determined, on the one hand, by the cognitive deficiencies of the patient and their negative effects on daily life. Particularly hard to cope with are the negative behavioural effects of the illness, such as diminished flexibility and reduced behavioural control, changed personal and social behaviour as well as the neglect of physical cleanliness. On the other hand, family conflicts, the lack of social support in the task of nursing as well as feelings of anxiety on the part of the carer, are also important.

In the Ticino, 44 % of the family carers mention serious health-related problems of their own. In Basel, as many as 70 % of the carers indicated health-related problems which also worsened patient’s care. Mentioned most fre-

quently by the caring spouses – mostly very old themselves – were psychological or psychosomatic and rheumatic / orthopaedic problems. Over 40 % of the relatives interviewed in both studies showed anxiety symptoms, and 26 % of the Basel carers as well as 18 % of those in the Ticino showed depressive symptoms. If the patient's symptoms were less pronounced, anxiety seemed to be the predominant symptom in the carer. In advanced stages of dementia – with marked dementia symptoms and an increased need of nursing on the part of the patient – the subjective strain and also the danger of a depressive condition on the part of the family carer is higher.

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

Data on the active population, according to the branch of activity, shows that domestic jobs are more often occupied by foreigners, especially from women coming from Southern European countries or Latin American countries. Part of these women's domestic activities is represented by elderly care. Paid jobs in this sector of activity are probably often occupied by migrant women, often with illegal / clandestine status. However, no information on the trends in supply and demand of migrant domestic workers is currently available.

Moreover, an ongoing process of reflection has been set up by Pro Senectute with their project 'Age and Migration' (see www.alter-migration.ch).

1.13 Other relevant data or information

A regional survey in the Swiss German part of Switzerland[1] has assessed that:

- 80 % of home care is covered by relatives;
- 60 % of 'natural caregivers' are spouses (of which 80 % are women), 40 % are daughters or daughters-in-law;
- a third of the elderly declare they don't want home care services because they don't want foreigners at home.

Members of the family provide an average of 17.9 hours of care per week over a mean duration of 6.5 years. The number of 'natural caregivers' in Switzerland is estimated at 250,000 people. The economic value of their work has been calculated to reach between 10 and 12 billion Swiss francs, which exceeds the cumulated spending of both home care services and homes for the elderly in Switzerland.

[1] Zeitung im Espace Mittelland, 6.3.2004, mentioned in Taillens F. (2004). L'aide aux soignants naturels: un maillon essentiel du maintien à domicile, Soins Infirmiers, pp. 44-48. http://www.sbk-asi.ch/asp/keywordf.asp

90 % of the help is provided 7 days per week, more than 12 hours a day and 60 % of the ‘natural caregivers’ stand up at night.

In Switzerland, approximately 90,000 people are affected by Alzheimer’s disease and the majority do not enter an institution until the last phase of the illness. The patients suffering from dementia are mainly taken care of by family, which represents continuous presence to avoid that the person hurts him or herself. Thanks to the family carers, it has been estimated that the health system spares 1.5 billion Swiss francs every year.

60 % of family carers are aged between 60 and 90 years old and suffer from problems and diseases associated with their age.

2 Care policies for family carers and the older person needing care

An overview of the Swiss Social Security system is needed to understand its determining influence and role in care policies, the health system and care provision.[2]

Since the introduction of old-age and survivors insurance (AHV) in 1948, the elderly in Switzerland have gradually seen an improvement of their material security. The introduction of the AHV meant that persons who were no longer professionally active were legally entitled to a minimum standard of living. Old-age provision replaced social welfare.

Switzerland is organised on a the basis of a three-pillar social security system, embodied in the Federal Constitution in 1972 and which has proved to be successful:

- *First pillar*: the AHV and the invalidity insurance (IV): compulsory for everyone, based on a pay-as-you go system: persons of working age finance 80 % of the pensions of the current elderly population, the Confederation contributes 17 % and each of the cantons 3 % of the annual AHV expenditure. It compensates for the risk of price rises. The first pillar is supplemented by the second pillar.
- *Second pillar*: 'pension funds' constituted by individual occupational benefit, old age, survivors and invalidity pensions. From the age of 25, all official employees with a certain minimum income (about 15,000 euros) and their employers must contribute to the 2nd pillar. It is based on the the principle of pre-funding. Both 1st and 2nd pillars should enable older persons to maintain a decent standard of living.
- *Third pillar*: self-provision to additional needs, is voluntary and is encouraged through preferential tax benefits.

The AHV has also set up an additional benefit system (EL), funded by tax revenues, for low revenues and to fight the risk of poverty, especially (but not only) in old age. The EL guarantees that anyone entitled to a pension will receive a minimum income proportionate to their economic and health situation. This supplementary benefit system is often used to provide formal care for older persons.

The AHV and especially the supplementary benefit system play a decisive role in the care policies and the provision retirement homes and need additional resources to cover the high costs of their care. About two thirds of EL expenditure, 1.4 billion Swiss francs, goes to residents of such homes and a total of

[2] see also: http://europa.eu.int/comm/employment_social/missoc/2002/03/switzerland_en.pdf

140,000 for health care. More than a third of the beneficiaries of additional subsidies (EL) live in nursing or persons receive AHV supplementary benefits (OFAS, 2002). The introduction of old-age provision in Switzerland has greatly contributed to give to all eligible persons the AHV relative financial security, which allows older persons to remain in their home and cover some cost-effective solutions.

The care service provision in Switzerland cannot be mentioned without briefly explaining its unique federal organisation. Switzerland, officially known as the Swiss Confederation, is a federal state made up since 1979 of 26 cantons or semi-cantons. The particularity of Switzerland lies in its federalist governance: the relative independence of each canton and their responsibilities in a wide range of policies – such as some kind of health or social policies – has made Switzerland quite a specific constitution and legislative system and subsequently has specific management of its health care system.

Therefore, Switzerland today is composed of 26 entities that are sovereign in all matters that are not specifically designated for the responsibility of the Swiss Confederation by the federal constitution. Each canton and semi-canton has its own constitution and a comprehensive body of legislation stemming from its constitution, thus Switzerland can coexist with 26 different health systems and services. While some develop home care like the cantons of Geneva, Jura and Vaud, others do stay and count on more traditional care like in the mountain and central areas of Switzerland.

Health Policy: Many of the attempts by the federal government, cantons and other actors to achieve a common health policy have failed. A new attempt is currently being made. Health policy is understood here in its broadest sense. It covers not only organizing the provision of health services but also health promotion and the prevention and control of diseases. Health policy defined in this way encompasses not only policy on health care but also all policy areas that affect the health of the population, including economic policy, environmental policy and social policy. A new National Health Policy plan is currently being created, substantially influenced by the WHO policy framework for health for all (see the subsection on Health for all policy in the section on Proposed reforms) as well as the recent reports on health systems and mental health policies analysis (WHO, 2000, 2001). The later report revealed that Switzerland was among the countries in the world lacking a national policy on mental health, which is addressed today and in its final structure (PNS, 2004; Stuckelberger, 2002) as well as needs for health care of the elderly (Höpflinger and Hugentobler, 2003) or health promotion plans (Stuckelberger, 2003). A prominent element in the new health policy plan was the creation of a Swiss Health Observatory to eliminate the notorious information deficits that hamper the development of strategies on health policy.

Switzerland's health care system reflects its political federalism and liberalism. State intervention in health care at the federal level has traditionally been kept

to a minimum and much of the responsibility for financing, organizing and delivering health care is given to the canton government or other actors including the municipalities, private insurance companies and private providers.

The health service and delivery system is one of the areas of government activity in which the cantons have a relatively high degree of independence. The cantonal activities can be divided into the following four areas:

- Regulation of health matters
- Number of hospitals and their geographical situation
- Provision of health care
- Disease prevention and health education
- Implementation of federal laws

As Switzerland's health care system is a liberal and decentralized system, providers are free to choose where to locate and patients are free to choose providers within a canton. An older person can choose the formal provider of care, depending on the canton and his specific needs. Consequently, the formal care system organized for the older person and supported by the health insurance system does play a key role in the care of the older person, in particular in the articulation between the formal care and / or family care provided to the older person.

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

Consequently a National Care policy for family carers does not presently exist due to the structure and organisation for old-age care provision in Switzerland. The philosophy of care set by the Swiss system tends to give to each older citizens the responsibility for choosing the type of formal care they wish and leaves it up to the individual to decide if family carers are their need and choice. This philosophy seems to be in concordance with some research findings, which confirms that the majority of older persons in need of care prefer formal care to family care as they wish to keep their independence and avoid any feeling of being a burden to the family (Höpflinger and Stuckelberger, 1999).

Despite this fact, local policies exist in cantons such as Basel or Fribourg to support families specifically caring for older persons affected by dementia.

The improvement of the economic situation of the retired population is today proven and is mainly the consequence of establishing a sound social security and old-age provision system with safety nets (supplementary subsidies for low income, invalids, widowed, etc.); today there are 150,700 people living in a private household who receive a supplementary subsidy from the Swiss Fed-

eral Social Insurance. This benefit aims at facilitating their access to the health care system (including health insurance, homecare programs, dentistry, etc.). Despite this kind of policies, research on poverty among the older persons in Switzerland has shown that not all those entitled to the subsidy claim it by either lack of information, either shame to request the subsidy (Leu, Burri and Priester, 1997).

2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

Switzerland still has a strong traditional view concerning social welfare, supported by the current family, that family care of the elderly is a norm and the formal care intervenes when nothing else is possible. The expectations are based on the principle of subsidies, where the family, the individuals take their own responsibility in terms of care. The state intervenes only when the family cannot find any other alternative (Fondation Leenardts et al., 1997). Therefore policies are still very indifferent to the importance of family carer and have not really grasped the scope of the issue, neither in economic terms, or in societal terms.

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

Today, basic health insurance is compulsory for all Swiss residents and is based on the principle of solidarity, with basic fees equal for all ages, origins or health situation. Nevertheless, it is important to note how the health insurance system works to better grasp the role of the family care of older persons in Switzerland and the current debate.

The system evolved in a largely fragmented and uncoordinated fashion. Individuals were responsible for purchasing statutory health insurance from accredited insurance companies (as many as 98 % of the population were covered under this voluntary system). However rising health care costs combined with a lack of solidarity between insurance companies meant that reform had become necessary. In 1994 the most comprehensive change to the system was proposed and passed into the law. The health insurance law made the purchasing of health insurance compulsory and made significant changes to the systems of subsidies within the system. It expanded the benefits package to include nursing care in particular and by creating a legal obligation for insurance companies to accept anyone applying to them for compulsory health insurance, whatever the age, sex or prior illnesses. Therefore, depending on the canton legislation and agreements with insurance companies, the basic older persons formal care costs are covered and guaranteed by the insurance company.

Despite these changes, some important issues still remain today, namely the constant cost rise in the basic mandatory insurance for every Swiss citizen and the differences in those costs and the delivery system of care according to each canton. Two other important burning issues on the financial link between doctor-patient-insurance could be mentioned here: first, the increasing restrictions on different aspects such as surgery or reimbursement of medication, and secondly, doctors' medical fees which have become ruled by a precise account and billing of each medical act as well as the duration of consultations. The concern for the care of older patients is the decrease in the quality of medical care due to economic imperatives and pressure on physicians. Switzerland is facing the same problem as Germany, for instance, the introduction of DRGs (Diagnosis Related Groups) in hospitals designed to make treatment in hospitals more effective and efficient and the consequences for geriatric patients and chronically ill persons are not yet taken into consideration or anticipated.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

Health insurance is the mainstay of access to the health care system. Social security health insurance in Switzerland is governed by the federal law of 18th March 1994 on health insurance (LAMal), which became effective on 1st January 1996. It is divided into two parts: insurance covering medical care and pharmaceutical products (which is mandatory for the entire population) and daily allowance insurance (which is optional). Social security health insurance delivers benefits in the event of sickness, maternity and, secondarily, accidents (accidents are only covered if they are not compensated by an accident insurance policy).

The Confederation is responsible for establishing health insurance, which is covered by Article 117 of the Federal Constitution. However, the organisation and security of health care provision falls clearly within the responsibility of the cantons. Moreover, the legislation on health insurance allocates certain tasks to the cantons, such as controlling the obligation to take insurance, reduced premiums for those with limited means and tariff rules.

When it set up a new health insurance system in 1994, the legislature was pursuing three main aims. The first aim of mandatory health care insurance was to ensure that the entire population had access to high quality health care. The second aim was to strengthen solidarity between individuals (the sick and the healthy, young and old, rich and poor). Finally, the third aim was to control health insurance costs in order to prevent the share of national income devoted to health care from rising endlessly.

Health care insurance is mandatory for the entire population. Insurance is individual in that each member of the family must be insured. The law stipulates

that insurance must be taken out and not that insurance is automatic. Inspections carried out by the cantons ensure that the whole population is really insured. All persons (or their legal representative) choose their health insurer from those authorised by the Confederation to provide health insurance (about 100 insurers are presently authorised). The obligation to have insurance is necessary to guarantee solidarity.

The law defines the benefits to be provided by health care insurance in a mandatory and exhaustive manner. Other benefits may be covered by complementary insurance, which is not covered by the LAMal, but which sickness insurers can offer in addition to the basic statutory insurance.

This system guarantees all insured parties access to standardized benefits. Only benefits that fulfil the legal requirements of effectiveness, suitability and economy are covered by health care insurance. The services delivered by doctors are presumed to fulfil these conditions (no positive list, with the exception of maternity benefits, preventive medicine and dental care). When reimbursement is disputed, the benefit is examined by a committee of experts and payment for the benefit may then be governed by a legal decision. The legislation also contains a list of the means and appliances, a list of analyses and a list of medicinal products that make up the positive lists.

The cost of hospital treatment and accommodation is guaranteed by fixed prices concluded between the insurers and the hospitals. The prices of medicinal products covered by health insurance are fixed in the list of medicinal products (positive list). The list of medical analyses (positive list) and the applicable tariff are established by the government.

Insured parties are free to choose between service providers approved for treating their illness. In the case of outpatient treatment, the insurer pays the cost up to the applicable tariff in the place of residence or work of the insured party or in the area. In the case of hospital or semi-hospital treatment, the insurer pays the cost up to the applicable tariff in the canton where the insured party lives. If for medical reasons the insured party uses a service provider outside of the canton, the insurer covers the cost according to the tariff applicable to this other service provider. Medical reasons include emergencies and cases where the service is not provided in the place of residence or work of the insured party or nearby for outpatient treatment, and in the canton where the insured party lives for hospital or semi-hospital treatment.[3]

The benefits paid by mandatory basic health care insurance are the following:

- **General benefits in the event of sickness:**
  - examinations, treatment and care dispensed as outpatient treatment, in the home of the patient, in a hospital or semi-hospital establishment or in

[3] for complete information see: http://europa.eu.int/comm/employment_social/missoc/2002/03/switzerland_en.pdf

a medical-social establishment by doctors, chiropractors or persons providing services on prescription or on medical orders;

- analyses, medication, diagnostics or therapeutical means and appliances prescribed by a doctor or, within by a chiropractor within certain limits;
- participation in the cost of spa health cures prescribed by a doctor;
- rehabilitation carried out or prescribed by a doctor;
- stay in a communal section of a hospital;
- stay in an institution providing semi-hospital care;
- contribution to the cost of medically necessary transport and rescue costs;
- services of pharmacists (advice) when providing prescribed medicinal products.

Prevention measures: health care insurance pays for certain examinations designed to detect diseases early, as well as preventive measures for the benefit of insured parties particularly at risk. These examinations or preventive measures are carried out or prescribed by a doctor.

Specific **maternity** benefits:

- control examinations carried out by a doctor or a midwife or prescribed by a doctor, during and after pregnancy;
- contribution during preparation for the birth;
- delivery at home, in a hospital or in an institution providing semi-hospital care and the assistance of a doctor or a midwife;
- advice on breast feeding;
- care for the healthy child and his stay, as long as it remains in hospital with the mother.

As for **dental care,** it is only reimbursed:

- if it is caused by a serious and unavoidable illness of the mastication system;
- if it is caused by a another serious illness or its after-effects;
- if it is necessary in order to treat a serious illness or its after-effects.

Benefits are also provided for the cost of the treatment of lesions to the mastication system caused by an accident that is not covered by an accident insurance policy.

- **Service providers:**

The following service providers are allowed to practice under the mandatory health care insurance scheme:

- doctors;
- pharmacists;
- dentists;
- chiropractors;
- midwives;
- physiotherapists, occupational therapists, nurses, speech / language therapists and dieticians providing care under prescription or on medical orders, as well as the organisations that employ them;
- laboratories;
- centres for providing diagnostic or therapeutic means and appliances;
- transport and rescue services;
- hospitals;
- semi-hospital institutions;
- medical-social establishments;
- spa health cure establishments;
- institutions with doctors dispensing outpatient care.

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

In most cantons the law does not cover rights and obligations of family carers. However, the canton of Geneva in its legislation does have the right to ask the family to pay for the health care bills of their elder parent or grand-parent in certain conditions (high income of the family and lack of resources of the elderly relative).

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)?

Retirement age for women is at 63 years old (since 2001, 62 years before) and men at 65 years old since the establishment of the retirement system. Women's retirement age will rise to 64 years old for the cohort of 1942. Anticipation or delaying of the rent is however possible for men and, since 2001, for women too.

A controversy has started with the government's decision to raise the age of retirement or establish a system of progressive retirement in order to anticipate

the economic crisis emerging in financing old age pension. Among others, right-wing parties and economic lobbies have proposed to rise the age of retirement up to 67 years old. Alternative proposals include the calculation of a retirement age according to the duration of work, the income or even life expectancy, which varies according to the social status. The rise of retirement age is on the political agenda for the years 2005 and 2006.

2.2 Currently existing national policies

2.2.1 Family carers?

See 2.2.2 and 2.3.

2.2.2 Disabled and / or dependent older people in need of care / support?

The cantons can provide nursing and home care or delegate this responsibility to the municipalities. The canton is responsible in any case for licensing providers of nursing and home care services. They also have full authority in deciding to either favour staying at home for the elderly by providing and developing home care services and downsizing or closing nursing homes (e.g. the canton of Geneva blocked all new constructions of nursing homes between 1992 to 2000) either, on the contrary, to encourage the construction of nursing homes and limit the provision of care at home (Cf. Geneva new executive plan of nursing home 2010[4]; for the canton of Vaud, this decisions was also taken over a similar period[5]).

The number of care institutions in Switzerland in 1997 amounted to about 2,300, of which 1,500 (65 %) were residential facilities more specifically for older persons (Table 10). Two thirds of the institutions are financed by public founds, one-third by private founds.

For 2000, the Forum Health Switzerland reports 1,422 homes, corresponding to 76,024 beds, specifically for older persons recognized by health insurances according to the federal criteria LAMal (Wenger, 2003).

[4] http://www.geneve.ch/ems/doc/BA-4_plan-directeur.pdf
[5] http://www.bicweb.vd.ch/communique.aspx?pObjectID=173959

Table 10: Number and type of institutions for the disabled, the elderly and others requiring care, 1997

Type of institution	Number
Residential facilities for elderly	
Public homes	984
Private homes	518
Unknown	1
Total 1	*1,503*
Institutions for the care of the disabled and other institutions	
Public institutions	697
Private institutions	115
Unknown	1
Total 2	*813*
Total 1 + 2	2,316

Source: Swiss Federal Statistical Office, Statistics of the hospitals 2002.

The revised health insurance law has brought about improvements by expanding cover for home nursing care and care in nursing homes. However, the providers of health insurance are not yet fully obligated to pay the cost of home nursing care in full.

An unknown, but certainly large, proportion of people requiring nursing care are looked after by informal carers, with or without assistance from nursing and home care organisations (known as 'Spitex' services in the Swiss German region). The formal nursing care network provides outpatient, short-term stay and inpatient services. There are two main categories of ambulatory service providers: practising doctors and Spitex services. The high density of doctors in Switzerland means the capacity exists to provide home medical care services throughout the country. Coverage by Spitex services is fairly comprehensive, although there is regional variation. It is not yet possible to quantify the level of inpatient services provided for the disabled and the elderly. Although the cantons generally subsidize the construction of nursing homes, many cantons keep no detailed statistics on the number of beds available. In most cantons, the municipalities are responsible for nursing homes and often commission private organisations to build and run such facilities. Various indicators suggest that the capacity of the available inpatient services is sufficient – with regional variation – to meet current needs.

In recent decades there has been a massive shift in Switzerland from residential accommodation (i.e. without nursing care) to accommodation for people who require light to intensive nursing care in old people's homes, some cantons have even classified older peoples home according to the intensity and availability of medical care on site. Despite this change, and depending on the canton policy, some elderly people requiring nursing care are probably still being admitted to hospital because not enough nursing beds are available. Be-

fore the revised health insurance law was introduced with extended cover to include reimbursement of nursing care, there was also a financial incentive to hospitalize patients requiring nursing care, health insurance companies paid for hospital stays in full and for nursing care at home only partially. In nursing homes, private households paid the largest share of the costs. Disability insurance covers the cost of medical, nursing and rehabilitation services prescribed in the course of treatment following disability. Disability is defined in the disability insurance law as damage to health resulting in permanent or long-term incapacity to work. One of the most significant additions to the compulsory health insurance benefits package, introduced by the revised health insurance law, is the covering of services provided in nursing homes and by home nursing organisations.

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)

No legislation exists regarding facilitating measures. However, case by case situations may rise and be negotiated by the employer directly with his employee.

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

As mentioned above, Switzerland is characterised by its federalism and the fact that we do have 26 different health care systems with different legal frameworks and pricing / subsidies systems.

However the Swiss Federal Office of Social Insurance sets a general legal framework regarding policies on the financing of services for older persons (see section 2.2.2).

Supplementary benefits are available to make up the shortfall (up to a fixed level) between the costs of care of old-age pensioners or recipients of a state disability pension and the money they have available. Since personal wealth / income and level of nursing care required both vary, cantonal or municipal welfare assistance systems, which are funded out of taxation, come into play. The systems vary greatly between cantons, but there are two basic forms that welfare assistance takes. Under the first, it is the municipalities' responsibility to finance the costs of nursing care that cannot be covered either by the individual or supplementary benefits. Under the second, the cantons make top-up payments in addition to the supplementary benefits, either alone or in conjunction with the municipalities. In some canton, the law requires that the family and kin should take over the costs of their elder parents if their financial situation permits. This inter-generational law is however rarely applied and not consistent in all cantons, although it is a subject of discussion today in many countries (Council of Europe, 1999). Another new aspect, gaining more and more

attention from governments and Swiss authorities is the possibility to support informal care provided to a family member for an elder parent, such as in the case of Alzheimer's disease. This recommendation was an important point of the final report of the Swiss National Programme on Ageing (1992-1999) (Höpflinger and Stuckelberger, 1999a, 1999b).

2.4 Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

Canton and municipalities have a degree of independence and interdependence in the provision of care for the older persons. But given the diversity of the health care systems in Switzerland, the review of those differences would be an interesting but long research.

3 Services for family carers

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)	X		2007?					
Counselling and Advice (e.g. in filling in forms for help)			X[6]	X[7]	X			
Self-help support groups	X							
'Granny-sitting'	X							
Practical training in caring, protecting their own physical and mental health, relaxation etc.		X				X		
Weekend breaks		X				X		
Respite care services		X				X		
Monetary transfers	X							
Management of crises		X				X		X
Integrated planning of care for elderly and families (in hospital or at home)	X							
Special services for family carers of different ethnic groups	X							
Other	X							

Services for family carers in Switzerland are very scarce and do not exist on an independent basis, neither at the national, neither at the canton level. Thus services for family carers exist solely within a larger organisation providing care to the ageing population and are more optional services offered by only a few professional health care organisations or organisations for the elderly. Among these are community services (Spitex service, day-care facilities), respite stays to relieve the carers (medically-indicated short stays in hospitals or homes, holidays for dementia patients), well-devised counselling and therapy

[6] Pro Senectute Switzerland counts some 120 advice centres in Switzerland.

[7] A Cantonal Pro Senectute organisation exists in every Canton of Switzerland responsible for providing advice and services. It is funded on one hand by contributions paid by other clients for the various services rendered and on the other hand the foundation receives support from the public authorities (The Swiss Confederation, Cantons and municipalities). Pro Senectute is however also dependent on donations, legacies and bequests.

facilities (memory training) and well-organized relatives' associations (as, for example, offered by the Alzheimer's association). Other organisations such as the Swiss Red Cross, Pro Senectute and Caritas also include the aspect of support to caregivers.

An increase in special places for dementia patients in day-care centres is necessary, particularly for the periodic relief of relatives under great strain. There is still a shortage of such places in most regions of Switzerland.

3.1 Examples

3.1.1 Good practices

Family carer work for an elderly relative is not well recognized and is underestimated in Switzerland except in some regions such as the canton of Fribourg, a pioneer in supporting family care:in 1993, this canton adopted a legislation where the commune allocates 25 Swiss francs per day, equivalent to 750 Swiss francs per month to the 'natural caregiver' providing home care to an elderly member of their family. Many discussions took place concerning the criteria and definition of the 'natural link' with the elderly person. In order to get a financial support from the municipality, the following criteria were developed:

- Care must be important and provided daily since at least 60 days.
- A daily allowance is given after the assessment of a home nurse through a grid assessment. In 2001, in the Southern part of the canton, in Gruyère, 137 women and 37 men received this allowance (15 husbands, 43 spouses, 43 daughters in law and 10 nieces).

Family care should not be disadvantaged nor replaced by institutional care or by incentives to local authorities to not develop professional help care and relief systems.

3.1.2 Innovative practices

Technology allows the disabled person to increase his / her autonomy and safety (e.g. alarming relatives). It should accommodate the needs of today's elderly people – for whom autonomy and safety represent the highest values.[8]

The Swiss programme on Ageing supported a large research on innovative technology and home care of the elderly. It demonstrated that daily life and activities (such as telephoning, automation of doors, beds, smart home de-

[8] The possibilities and advantages of electronic aids for elderly people are introduced and illustrated by a special NRP32 video film: A. Jolliet (1997) "Vieillir heureux chez soi". Techniques and domestic aids in the service of elderly people, Geneva: Univideo Genève (German version: Glückliches Altern zu Hause, Italian version: Invecchiare felici in casa propria) (video duration 26 minutes). Information at: http//www.unige.ch/univideo.

vices, etc.) was facilitated by electronic aid without the need to re-organize daily living or introduce new activities. It was also found that the use of electronic aids neither promotes the isolation of the elderly people (less contact, as more independent) nor increases social contact. Social consequences occurred insofar as the relatives and carers of the elderly people felt more secure (above all if a telephone alarm had been installed, but also if telephoning had been made easier). The elderly people themselves also felt safer, e.g. being able to call for help in an emergency. And this feeling of security relieved the burden on social relationships, especially on all the relatives who could not visit daily or lived further away. The feeling of greater security, meant moreover, that the autonomy of the elderly people also increased as they could decide on their own when they needed help (Hainard, Gabus et Masson, 1995). Today, more and more age-friendly technological devices are developed and exist in Switzerland to ensure a longer stay at home and facilitate the efficiency of home care and security (e.g. telealarm systems, video camera, phones with big digits, etc.).

Quo Vadis, a passive electronic device for mentally dependent elderly persons was experimented with in diverse type of homes for strongly dependant or demented old people as to relieve health care professionals from the continuous surveillance of the older person through a system of monitoring and alarm cells placed in different areas of the building. While allowing a certain degree of free mobility to the patient, at each of those points, the position of the patient is known and an alarm set if the institution's boundaries are transgressed. This passive electronic aid proved particularly valuable for non-specialized old people's homes as they make it possible to admit a mixture of patients. Thanks to suitable aids, both the private sphere of residents can be better safeguarded (for example, against unauthorized entry) and the safety of confused people better guaranteed. Fewer conflicts occur and the burden on staff (unnecessary checks, anxiety) is reduced (which also benefits the elderly residents). On the basis of the pilot study and the experience gained, the electronic security system for residential and nursing homes of the Neuchâtel 'Fondation Suisse pour les Téléthèses' has been further developed and marketed under the brand name of 'Quo Vadis'. It has already been installed in many institutions caring for severely affected Alzheimer's or demented patients (www.fst.ch).

This device is promising as it could well be adapted and applied in the future for home care.

To mention that Internet is being increasingly used by active senior citizens, and corresponding courses find a large echo. Since May 1998 a special senior citizens web was developed, which is supported by the EURAG, the Pro Senectute and Migros (http://www.seniorweb.ch). In this context, e-health and e-care is rapidly developing for all age groups and setting a new health behaviour pattern that might well be a substantive part of the next generation's and future family home care management.

In addition to the above mentioned institutional care, professional services provision in ambulatory care as well as home care, volunteer organisation play an important role in complementing the needs of the older population.

The Swiss Health Survey 1992 / 93 reports the frequency of volunteer help to close parents, friends and neighbours. The main providers of voluntary work as demonstrated in the following table are women, although men declare giving help in higher proportions in the age group of 65-74 years old (Table 11).

Table 11: Frequency of volunteer help given to close family, friends and neighbours, Population living at home (Swiss Health Survey, 1992 / 93)

Frequency	Men			Women		
	40-64	65-75	75+	40-64	65-74	75+
daily help or at least once a week	13.7	15.9	11.2	27.9	27.9	21.4
once a month	11.4	14.2	8.5	14.3	13.2	8.3
a few times a year	28.1	26.5	19.2	21.6	18.6	13.7
never	37.1	32.7	41.0	30.3	31.9	35.2
not able to give any help	3.0	2.8	6.7	3.5	5.0	14.1
no answer	6.6	7.8	13.6	2.3	3.4	7.5

Source: Swiss Health Survey 1992 / 93, ref. Federal Office for Men and Women Equality 1997: 212

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The value of volunteer work of persons aged 55-74 years old, according to another survey contributes every year to 23.5 million hours of work, 12,600 working places, which has been calculated to correspond to the value of 350 million Swiss francs, according to the survey. If we were to count, the estimated value of volunteer work, it would amount to about 500 to 700 million Swiss francs (Lichtsteiner, 1995).

More studies or a clear item in the census questionnaire would be needed on the contribution of volunteer work to bring an accurate estimation of its magnitude (just a remark: the 2000 Census asked about volunteer work, but didn't provide any information on the kind of work undertaken – this includes not only care but other kinds of work like participation in associations, public work, etc.).

4 Supporting family carers through health and social services for older people

With increasing age, the population living at home is more and more likely to require home care. Data from the Health Swiss Survey on the homecare programme SPITEX confirms that while 29 % of the population required home care either in the age groups of under 65 years old, or between 65 and 79 years old, the proportion rises to 43 % of homecare among the 80 years old and more (table 13).

Table 12: Numbers of clients requiring homecare by age group

Age of client receiving home care	Numbers	% of total clients
0-64	77,300	28.0
65-79	78,000	29.0
80+	116,200	43.0
Total	271,500	100.0

Data on dependency, Swiss Health Survey 2002.

It is important to consider the socio-economic situation of the retired population requiring home care as it can be a determinant factor in the decision of staying at home with care services or in having old age pension.

4.1 Health and Social Care Services

Health services are widely available but due to the federalist system, are very different in their provision and organisation. In Switzerland, the responsibility of organizing health services lies mainly in the hands of canton authorities according to their needs, from decisions on the numbers of structures and services to the way it functions. Thus, considerable disparities exist between cantons regarding the access to acute, rehabilitation or chronic care either at home, in ambulatory care or at the hospital. Therefore, national data on health and social care are either scarce or very recent and are faced with the methodological problem of the various local definitions linked to health service provision. The main federal socio-medical indicators of services are the quantitative distribution of those services for Switzerland from the Swiss Federal Statistical Office and Swiss Medical Federation.

Federal and cantonal authorities have direct planning control over hospitals and residential nursing homes. Hospitals and nursing homes can only be reimbursed for services under compulsory health insurance if they are included in the canton's official list of hospitals and nursing homes.

Most cantons operate their own hospitals; some also subsidize private hospitals. There are also private clinics that do not receive any state support. The

revised health insurance law requires the cantons to draw up plans for providing hospital care according to need and to produce a list of hospitals and nursing homes that are eligible for reimbursement under compulsory health insurance. This list includes public and publicly subsidized hospitals but may also include private providers. Today, due to health care costs constraints, there is strong pressure from the federal government to centralize poles of competencies for large areas (i.e. for transplantation, Swiss Transplant) and merge hospitals according to geographical specificities (mountain / valley, rural / urban).

4.1.1 Health services

Health services are widely available in all cantons although Research and University Hospitals are the privilege of the five main cities of Switzerland: Basel, Bern, Geneva, Lausanne and Zurich.

Independent practice doctors provide most ambulatory care. In principle there is unlimited free choice of physicians and dentists. Nevertheless, most Swiss have a regular doctor. Outpatient treatment is provided with a range of private surgery (independent GPs and specialist physicians), in certain hospital units and in polyclinics. HMO-style self-financed medical centres can also be found in some large towns. There is no compulsory gatekeeping, but although ambulatory specialists are easily accessible, most patients are referred to hospital-based specialists.

The recent Swiss Health Survey (i.e. Stuckelberger et Wanner, 2002) and the recent secondary analysis (Swiss Health Observatory, in print) provide some overview data on the services in Switzerland (table 13).

Table 13: Number of health care providers in Switzerland, 2001-2002

	Number for 100,000 inhabitants
Medical doctor: general practitioners in private practice, 2001	67.4
Medical doctor: specialised or non-general practitioners in private practices, 2001	128.6
Dentists in private practice, 2001	47.5
Pharmacies (without hospital pharmacies), 2001	22.4
Ratio of generalist / specialised general practitioner in private practice, 2001	1.9
Percentage of women medical doctors in private practice (%), 2002	22.9 %

Source: Swiss Health Survey 2002; Swiss Health Observatory (in print).

The number of specialised medical doctors is quite high compared to general practioners: the mean distribution for Switzerland is of about 127 specialized medical doctors versus 67 per 100,000 inhabitants. The differences between cantons can vary very strongly between urban and rural areas: Geneva can-

ton, essentially urban, counts per 100,000 inhabitants, 260 specialised medical doctors while the canton of Fribourg semi-rural counts 92 of them for the same number. Some marked differences are very similar between urban and rural or mountainous regions for the number of dentists and the number of pharmacists. More than 3 out of 4 Swiss persons consulted a medical doctor in the last 12 months, 71 % of all men and 82 % of all women. With advanced age, the probability of consulting a medical doctor is much higher than in younger age groups and women are systematically more frequent users of medical services (Table 14).

Table 14: Use of health care by patients, by gender and specific age groups, 2002

	Men (%)	Women (%)
Persons declaring no family doctors (%)	10.3	9.7
Persons consulting a medical doctor in the last 12 months (%)	71.3	82.1
Women consulting a gynecologist in the last 12 months (%)	-	52.0
Persons consulting a chiropractioner in the last 12 months (%)	4.4	5.3
Persons consulting at least an other alternative medicine specialist in the last 12 months (%)	14.7	24.0
Persons of 25-79 years old consulting for a blood pressure check up in the last 12 months (%)	72.8	82.6
Persons hospitalised at least one day in the last 12 months (%)	10.7	13.0
Persons 60 years old and more who had an eye cataract surgical operation (%)	11.2	14.3
Persons 60 years old and more who had a hip surgical operation (%)	8.1	6.5

Source: Swiss Health Survey 2002; Swiss Health Observatory (in print).

Family doctors, known doctors you can visit for any health problems encountered, are less frequent in urban areas where the rate of specialised medical doctors is high: Switzerland counts only 10 % of its population declaring not having any family doctor, whereas in Geneva more than 1 man out of 5 declare not having any regular doctor. Despite economic disparities in the Swiss population, the compulsory health insurance system (same basic insurance fee for all) guarantees health coverage and access to any basic needs at any age for everyone.

Hospital accommodation is of three types: ward (“allgemein” in Swiss German part), semi-private (‘halb-privat’) and private (‘privat’). Wards have 4-8 beds, semi-private rooms have 2 beds, while private rooms have only 1 bed. All city and canton hospitals have all three types. Basic insurance entitles patients to

treatment in a ward of a public or non-profit hospital in their canton of residence. Supplementary insurance policies provide the gateway to greater privacy, the for-profit private sector, and to hospitals in other cantons.

Table 15: Data on hospital and institutions infrastructure, 2002

	Number for 1,000 inhabitants
Beds in general public hospitals, per 1,000 habitants, 2002	3.6
Beds in specialised or private clinics, 2002	2.2
Number of hospital and semi-hospital days in general public hospitals and specialised clinics, 2002	1,850
Beds in institutions or other institution's beds (without the institutions for older persons and / or chronic illnesses), 2002	3.6
Workplaces in institutions for handicapped or other institutions (without the institutions for older persons and / or chronic illnesses), 2002	3.3
Persons cared for in institutions for handicapped or other institutions (without the institutions for older persons and / or chronic illnesses) on 31.12.2002	3.3

Source: Swiss Health Survey 2002; Swiss Health Observatory (in print).

For 1,000 inhabitants, Switzerland counts 3.6 hospital beds in general public hospitals, 2.2 beds in specialised or private clinics and 3.6 beds for institutions with handicapped or chronic patients. Those later institutions occupy many workplaces, as the rate per 1,000 inhabitants is the same (Table 15).

Basic and specialty medical training is provided at seven cantonal universities and public hospitals and clinics. Training follows the federal regulations on medical examinations and qualifications, there are currently official Geriatric Departments in the main University hospitals of Switzerland, and Geriatrics as a medical specialty has only been officially recognized in 2003 by the Swiss Medical Association (Foedaratio Medicorum Helveticorum) that regulates postgraduate training for doctors.

4.1.1.1 Primary health care

The cantons can provide nursing and home care or delegate this responsibility to the municipalities. The canton is responsible in any case for licensing providers of nursing and home care services. They also have full authority in deciding to either favour staying at home for the elderly by providing and developing home care services and downsizing or closing nursing homes (like the canton of Geneva did in the last decade) either that or, on the contrary, to encourage the construction of nursing homes and limit the provision of care at home.

As a result there are many differences between the cantons' performances in providing health care to their older citizens, while some cantons have set up a

strong hospitalo-centred policy, some others are home-centred and have developed a very strong network of formal home care.

The data available shows (Table 16) that about 27 persons out of 1,000 Swiss receive professional home care, and majority (71.5 %) of home care services are provided to persons aged 65 years and older.

Table 16: Data on home care services infrastructure, 2002

	Number for 1,000 inhabitants
Number of persons receiving professional home care, 2002	26.9
Percentage of home care services provided to clients aged 65 years and above, 2002 (%)	71.5 %
Workplaces in the sector of home care, 2002	1.4

Source: Swiss Health Survey 2002; Swiss Health Observatory (in print).

Another point can be made in the difference between organisation of health care in rural or urban cantons which changes the geo-politics of provision of care. In the more mountainous cantons, decentralised provision of home care to the elderly has been developed with concentration of hospital care in one city. The trend today is to develop high-tech and specialised hospital care in fewer cities and close down regional hospital care for financial reasons. This trend is not always in favour of older persons care as the amount of time to reach the central hospital is longer.

A more detailed review of the legislative, financial and delivery aspects of the overall health care system of Switzerland has been conducted within the Health Care Systems in Transition Series (European Observatory on Health Care System, 2000).

4.1.1.2 Acute hospital and tertiary care

Acute hospital and tertiary care is available for all Swiss residents and are mainly organised within the 5 main University hospitals and University-affiliated hospitals in Switzerland.

Switzerland has one of the longest average lengths of stay in acute hospitals in western Europe, even though the duration has dropped continuously since the mid-1980s from around 25 to about 13 days. the number of acute beds per 1,000 population in 1990 in Switzerland (6.1) was above the European average (5.0). The latest figure available shows that Switzerland has followed the trend in bed reduction seen in most other western European countries including France and Italy. The main reason for the reduction in numbers of beds throughout Europe is the decline in the length of stay in hospital. This is a result of technological development and the political desire to increase efficiency through a reduction of excessively long stays (EHCS, 2000).

A comparative study shows that Germany and Switzerland have much higher hospital admissions per capita, average length-of-stay, and acute care beds per capita than the United States. Yet both countries spend far less than the U.S. per capita and as a percentage of GDP on hospital care than the U.S. (http://www.healthaffairs.org/press/mayjune0301.htm).

4.1.1.3 Are there long-term health care facilities?

Federal and cantonal authorities have no direct planning control over ambulatory services but have significant control over hospitals and residential nursing homes. Hospitals and nursing homes can only be reimbursed for services under compulsory health insurance if they are included in the canton's official list of hospitals and nursing homes. The cantonal health laws confer responsibility for health policy in the municipalities. The responsibility for providing nursing care for certain vulnerable groups is usually delegated to the municipalities, with emphasis on home care, residential and nursing homes for elderly people and community-based mental health services. Despite local and regional policies, Switzerland has only recently conducted reviews to create a federal mental health policy (Stuckelberger, 2002) and has recently reached a national consensual guideline on mental health policies (www.ofsp.org).

Table 17 shows that in 2002, Switzerland counted on average 11.7 beds in such institutions per 1,000 inhabitants of which a large part is devoted to persons aged 65 year olds and more (7.5 for 1,000 inhabitants).

Table 17: Data on infrastructure for older persons' institutions, 2002

	Number for 1,000 inhabitants
Beds in institutions older persons (nursing homes) and / or chronic disease, 2002	11.7
Number of beds for 100 older persons aged 65 years and more, 2002	7.5
Workplaces in institutions for older persons (nursing homes) and / or persons suffering from chronic diseases at 31.12.2002, 2002	8.2
Persons in institutions for older persons (nursing homes) and / or persons suffering from chronic diseases at 31.12.2002, 2002	11.2

Source: Swiss Health Survey 2002; Swiss Health Observatory (in print).

4.1.1.4 Are there hospice / palliative / terminal care facilities?

Palliative / terminal care facilities exist in different forms, either as independent institutions, either within some hospital units and institutions in Switzerland. The system is variable throughout Switzerland depending on the needs and organised according to the terminal illness (i.e. HIV / AIDS, terminal cancer), but also to older age groups.

New initiatives called ‘Unit of Mobile Palliative Care’ have taken place to ensure palliative care outside the main hospitals with a multidisciplinary team (i.e. doctor and nurses). Those teams provide palliative care at home, in nursing homes or in general hospitals that don’t have a specialised facility.

The training of palliative care professionals is not yet standardized, efforts are currently made to develop three standardized levels (basis, advanced, expert) of professional formation for palliative care physicians and nurses.

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

Switzerland has not put in place a practical family care policy to sustain, support or engage the family carers. Based on the principle of subsidiary, Swiss Family Policy expects the family and the individual to take responsibility in their decision and choice of the type of care and health care provision needed and wanted. Therefore no expectation or regulations have been put in place to encourage or request an active role from family carers.

However, as most patients suffering from dementia are cared for by their families in Switzerland, families are still expected to respond and provide care. This puts a heavy burden on families, both emotionally and in terms of time. It may bring the carers who are frequently quite old themselves to the limits of their endurance, restrict their social life and provoke subsequent stress and physical ailments. Dementia is a disease that in most cases affects the entire family structure and functioning. Studies have shown that the supply of special day care and individual services by trained staff is in part inadequate and insufficient (Höpflinger and Stuckelberger, 1999) and future needs of care are on the rise (Höpflinger et Hugentobler, 2004).

4.1.2 Social services

Although the organisation of nursing care outside hospitals is currently being streamlined, making the services provided more comprehensive and accessible to the user, services are still inadequate in some cases. The revised health insurance law has brought about improvements by expanding cover for home nursing care and care in nursing homes. However, the providers of health insurance are not yet fully obligated to pay in full the cost of home nursing care. An unknown, but certainly large, proportion of people requiring nursing care are looked after by informal carers, with or without assistance from nursing and home care organisations (known as ‘Spitex’ services).

The formal nursing care network provides outpatient, short-term stay and inpatient services. There are two main categories of ambulatory service providers: practising doctors and Spitex services. The high density of doctors in Switzerland means the capacity exists to provide home medical care services throughout the country.

4.1.2.1 Residential care (long-term, respite)

Some Swiss cantons have put in place a system of respite-care in day-care centres or short-stay hostels. As mentioned, the cantonal health laws confer responsibility for health policy to the municipalities. Thus, the responsibility for providing nursing care for certain vulnerable groups is usually delegated to the municipalities, with the emphasis on home care, residential and nursing homes for elderly people and community-based mental health services.

The municipalities have delegated responsibility to independent organisations for most home care services. Larger municipalities and associations of municipalities often run their own residential and nursing homes for elderly people. Municipalities run nursing homes and hospitals either alone or in conjunction with other municipalities (through hospital associations) or are represented on the boards of such facilities. The municipalities are also responsible for supporting and counselling pregnant women and mothers, providing obstetric services and health and dental care in schools.

The Swiss Alzheimer's Association organises holidays involving the participation of not only the patient and the carer(s), but also of a volunteer. This enables the family member(s) to have some time off, while patients benefit from the change and from qualified care by the volunteer. Currently, the demand surpasses by far the supply.

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes).

Table 18 shows the age distribution of the men and women in Switzerland according to the type of residence in 2000.

Table 18: Distribution of the population according to the type of residence

Age	Men				Women			
	Private household	Hospitals, carers	Medico-social	Other kind of collective household	Private household	Hospitals, carers	Medico-social	Other kind of collective household
65-69	142,230	187	1,319	426	164,949	210	1,529	873
70-74	115,309	179	1,804	404	151,397	224	2,771	853
75-79	88,080	184	2,735	377	129,862	358	6,392	977
80-84	51,012	183	3,777	350	82,463	462	11,480	1,033
85-89	24,723	187	4,378	261	47,511	536	16,895	1,173
90-94	7,060	98	2,599	107	15,742	375	12,167	678
95-99	930	19	555	30	2,475	110	3,476	131
100-104	64	2	40	1	215	16	393	17

Source: Swiss Census 2000.

No data on sheltered housing.

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

Switzerland's variability in nursing homes criteria reflects its federalism. Each canton can apply criteria admission in concordance with the medical status or the health insurance system. While some institutions admit only independent persons, other institutions admit without reserve independent and dependant persons, and others take only heavily dependant patients. Age is also a criteria of admission in most cases.

Health care insurance and financing is also closely linked to admission criteria and entitlement to a certain type of health care. Disability insurance covers the cost of medical, nursing and rehabilitation services prescribed in the course of treatment following disability. Disability is defined in the disability insurance law as damage to health resulting in permanent or long-term incapacity to work.

Supplementary benefits are available to make up the shortfall (up to a fixed level) between the costs of care of old-age pensioners or recipients of a state disability pension and the money they have available. Since personal wealth / income and level of nursing care required both vary considerably from one person to the next, the amount paid in supplementary benefit also varies widely.

If supplementary benefits are not sufficient to make up the shortfall, the cantonal or municipal welfare assistance systems, which are funded out of taxation, come into play.

Latest beginning of 2006, all organisations of home services and care will be requested to use the RAI-Home-Care (Resident Assessment Instrument – Home Care) as a standard assessment tool for needs (www.spitexch.ch).

4.1.2.1.3 Public / private / NGO status.

Among the 1,504 institutions for older persons / nursing homes or for persons suffering from chronic diseases in Switzerland, one third are private and two thirds are public or subsidised (SFSO, 2001)

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

Carers can be involved, but not necessarily so. A lot depends on the carers themselves, and on the policy of the institution concerned.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

Many cantonal and municipal organisations offer social care through financially supporting older persons' associations or centres for the counselling and care, such as Pro Senectute, Red Cross, local councils or associations for retired persons.

In recent decades there has been a massive shift in Switzerland from residential accommodation (i.e. without nursing care) to accommodation for people who require light to intensive nursing care in old people's homes. Despite this change, some elderly people requiring nursing care are probably still being admitted to hospital because there are not enough nursing beds available. Before the revised health insurance law was introduced with extended coverage to include reimbursement of nursing care, there was also a financial incentive to hospitalize patients requiring nursing care. In contrast to stays in nursing homes, the health insurance companies paid for hospital stays in full. In nursing homes, private households paid the largest share of the costs.

Community care is organised according to the canton and municipal policy. However some associations have created an national 'umbrella organisation' of community care and help that is distributed in each canton. The most known are Pro Senectute and Swiss Red Cross. In the specific area of home care, as already mentioned above, SPITEX, the 'Swiss association for home services and care' has taken the lead (with 95 % coverage) as a non profit organisation with local and cantonal authorities support to provide a range of services to the older persons in each region and canton of Switzerland (www.spitexch.ch).

Facts on Spitex (2003)

- 1 umbrella organisation
- 26 cantonal association

- 791 local organisations
- 27,500 collaborators (10,600 full time jobs)
- about 200,000 clients each year (44 % are 80 years old and more)
- 319 million francs benefit for obligatory care provision
- 11 million hours of paid work
- 91.- Swiss francs charged per hour / 40.- Frs per hour of total benefit
- financing: 50 % by care provision, 50 % by subsidies (federal, cantonal, municipal)
- the costs for home service and care in Switzerland represent 2 % of the health care cost
- rates vary from canton to canton as follow:
  - basic health care in simple and stable situations: 20.- to 45.- Swiss Fr. / hour
  - basic health care in unstable or complex situations with health examination and care provision: 45.- to 65.- Swiss Fr. / hour
  - need assessment and medical prescription advice: 50.- to 70.- Swiss Fr. / hour

(Source: OFAS, 2003. Statistics for home service and care – Statisitique Aide et soins à domicile. Bern.)

4.1.2.2.1 Home-help

Thanks to the provision of home services and care provided, any elderly persons today can continue to leave at home despite their disabilities or handicap. The Spitex aims at maintaining and stimulating the autonomy of the client. Spitex's policy is to involve the family and personal network of the client as much as possible.

A large range of services are provided: counselling, evaluation, nursing care (covered by health insurance), health advice and prevention, financial management support for instance.

4.1.2.2.2 Personal care

Based on a thorough socio-medical assessment, services and care needs are identified. This need assessment is compulsory by law for reimbursement to avoid insufficient or unnecessary provision of care. Care provision is not offered on a 24 hour basis. If care and security of the client cannot be ensured due to technical, human or economic reasons, the transfer into an institution would be proposed.

Types of care include: pedicure, hairdressing, occupational therapy and general care linked to the disease of the client and prescription of the doctor.

4.1.2.2.3 Meals service

Meals-on-wheels services are organized and the price adapted according to each canton and health insurance rates. Meals can also be organised in a day centre. The idea of implementing a 'restaurant voucher' to encourage older persons to get out of their isolation and immobility is being discussed.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Spitex as well as many other local organisations offer different services such as transport, laundry, shopping, cleaning, house and clothes repair, installing technological devices such as 'telealarm', walking aids but also the organisation of holidays, gardening, social advice, health technology advice, volunteering for diverse tasks. End of life care is also provided by some more specialised organisations (see 4.1.1.4).

4.1.2.2.5 Community care centres

Community care centres are mainly organised around the concept of day-hospitals for the more dependant clients or senior organisations for the most independent retirees. In order to be sustainable, the community care centres work on the basis of health insurance reimbursement and subsidies from the authorities.

4.1.2.2.6 Day care ('protective' care)

Day care centres or institutions have been set up in different formats, either within hospitals, rehabilitation centres or with independent institutions.

4.1.2.3 Other social care services e.g. counselling agencies, technical aids, home adaptations, training of care-personnel and / or family carers for providing care at home

Technical aids are developing at a fast pace as younger generations are using them and initiating or involving more and more their elderly relatives in a new style of communication and care (i.e. Mobile phones, video surveillance, Internet, security systems, remote control systems, smart houses). No data yet exists.

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modeling of both home and other support care services

4.2.1 Who manages and supervises home care services?

The Conference of cantonal directors of health affairs meet regularly and come to a consensus for making main decisions or to make recommendations to cantonal governments. The most recent example is the decision to introduce at the beginning of 2006, the RAI-Home-Care Assessment as a standard tool to assess the health and care needs of an older persons for all organisations of home services and care (www.spitexch.ch).

4.2.2 Is there regular quality control of these services and a legal basis for this quality control? Who is authorized to run quality control?

Quality control is ensured by the obligation to get a medical prescription for reimbursed care – this ensures the regular assessment of the services that are insufficient or the opposite - unnecessary. Health insurance companies also play the role of cost / benefit / quality control more and more. Also, ethical guidelines have been produced by professional groups such as those of the Heimverband Schweiz (Swiss Association of older persons homes with care) guidelines to be observed in all homes. The lack of nursing organisations in some regions could be met by creating flexible sheltered housing groups (OFAS, 2002).

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

There are some norms as to the accreditation of a nursing home to benefit from reimbursement. Certification might be introduced if the liberalisation of health insurances that is now being discussed is approved.

4.2.4 Is training compulsory?

For general service, there are no rules, but for specific health care needs, nurses must be trained. Many services are provided after training the service providers.

4.2.5 Are there problems in the recruitment and retention of care workers?

A shortage in health care workers exist in Switzerland and more and more migrants are employed in older persons' homes, nursing homes and geriatric

hospitals. This created some new situations stemming from a dual cultural conflict between different generations and cultures. This subject is one of the key themes the Swiss Society of Gerontology wants to address and advocate among health care professionals, but also among policy-makers and decision-makers.

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels).

The integration of social and health care in elderly persons is certainly one of the main issues of efficient care and management. Policy makers at the federal, cantonal and municipal levels set the case management policy and also the regulations between the number of nursing or retirement homes and home care balance (OECD, 2004).

4.3.1 Are family carers' opinions actively sought by health and social care professionals usually?

The policy varies from organisation to organisation, and from institution to institution. For example, geriatric hospitals have a more standardized way of working with multidisciplinary teams and are used to involve the family carers in the rehabilitation process before hospital discharge. Other non geriatric hospital wards usually do not have a strong policy of integrated family-home care management and often discharge the patient with a minimal consultation with the family.

5 The Cost – Benefits of Caring

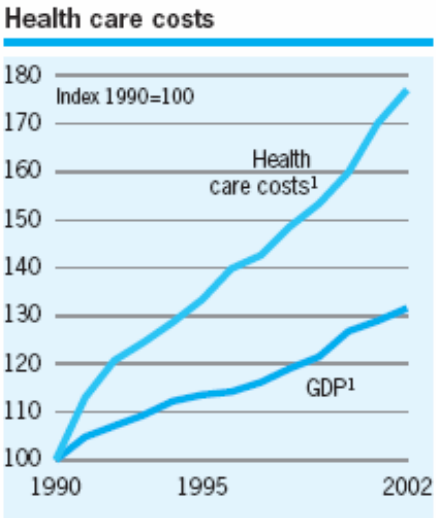
Switzerland allocated 11.1% of the GDP to health in 2002, (SFOS, 2005) and 10.9% in 2001 (OCDE, 2004), which is less than the United States, but more than other industrialized countries like Germany, France, Australia. In 1995, the percentage was only of 9.7% and in 1990 of 8,3%. The graphic below shows the significant rise of health care costs compared to GDP. The distribution of the amount, which equals 6'300 Swiss francs (more than 4'000 euros) per inhabitant, according to the sector (preventive medicine, curative medicine according to the kind of care provision, formal care, etc.) is unknown. However, about 18% of this amount is devoted to institutions other than public hospitals or ambulatory services.

This amount covers treatment by doctors and chiropractors and any medicine, psychotherapy, physiotherapy and occupational therapy prescribed by these, as well as hospital costs. Coverage also extends to Spitex services, the costs of approved nursing homes and medical rehabilitation measures.

The increase of costs during the last ten years is due to numerous factors, among others: the increase of costly technology, the rise of drug prices, and the increase of private doctors. Population ageing and the diminution of family support are also considered as factors explaining this evolution. Even if empirical evidence is missing to prove the contribution of family support and care in the calculation of health costs, it is generally agreed that informal care decreases the amount of these costs.

On the other hand, informal care provided by the family provokes opportunity costs, i.e. it diminishes the amount of wages (and on an overall level economic growth), especially when caring needs a decrease of working hours. No data is available to check if direct and indirect costs of caring are lower or higher than decrease of health costs generated by caring.

Figure 3: GDP vs Health Care Cost Evolution in Switzerland



(SFSO, 2005)

Health care financing

Health care insurance is financed by a contributory system. Current expenditure is covered in principle by normal receipts. The insurers therefore set their premiums to a level that will guarantee enough income to pay for the benefits due during the same period. They have to ensure a balance between expenditure and income for a two-year financing period. Therefore there are no standard and common premiums amongst insurers. Insured parties pay the same price with the same insurance company. Consequently, the premiums do not vary in line with the different risks (e.g. age or sex) or with the income of the insured party. The only exception concerns the premiums of children (less than 18 years) and young adults (18-25 years), which must be lower. Variations in premiums by region are allowed with the same insurer because there may be regional differences in health care tariffs and costs, depending on the measures taken by the cantons in the field of health policy.

In addition to payment of the monthly premium, insured parties participate in the cost of the services from which they benefit. Their participation includes a fixed sum each year (deductible), currently set at 230 CHF (156.75 €), and 10 % of costs exceeding the deductible (share) up to a maximum of 600 CHF (408.90 €) a year. For children there is no deductible sum and the maximum amount of share is set at 300 CHF (204.45 €). Several children from the same family, insured by the same insurer, pay a maximum total of 830 CHF (565.66 €). In the event of hospitalisation, insured parties not living with the other members of their family pay an additional 10 CHF (6.81 €) a day as a contribution towards accommodation costs. For specific maternity costs, no participation is required.

Insurers may provide in addition to ordinary health care insurance, special forms of insurance involving a reduction of premiums.

These are:

Insurance with an optional deductible sum: a reduction in premiums is granted to insured parties who have come of age and elect to get a higher deductible sum, and to those who are under age and get a deduction.

Insurance with bonuses: a reduction in premiums is granted if an insured party has not been provided with any benefits during one year. This excludes maternity benefits and prevention measures.

Insurance involving a limited choice of service providers (such as HMOs): the insurer may in this case renounce all or part of the share and the deductiion.

Subsidies granted by the Confederation for sickness insurance are used exclusively for the reduction of individual premiums for insured parties with modest means. These subsidies go to the cantons. The latter are required, using their own funds, to increase by half the amount of the share of the subsidies allocated to them by the Confederation. The government sets the amount of the federal subsidies each year (2,280 million CHF (1,554 million €) in 2002)

and the share of these subsidies that goes to each canton according to its resident population and financial resources. The administration of the premium reduction mechanism is in the hands of the cantons. It is the responsibility of each canton to define the circle of beneficiaries, the amount, the procedure and the mode of payment in the reduction of premiums. However, in order to ensure minimum unity throughout the country, the law stipulates a few obligations that apply to the cantons. The latter are therefore required, when examining the conditions for granting these subsidies, to take into consideration the most recent economic and family circumstances, notably at the request of the insured party. After having determined the circle of beneficiaries, the cantons must also ensure that the amounts paid for the reduction of premiums is paid in such a manner that the insured parties do not have to fulfil their obligation to pay the premiums in advance. Lastly, in general the cantons must inform insured parties regularly of their right to a reduction in premiums.

From 1997 to 2000, the benefits provided by the mandatory health care insurance scheme (expenditure) rose from 11.3 to 13.2 billion CHF (7.70 to 9 billion €), an increase of 14.5 %. Apart from factors such as population ageing, the difficult economic situation and technical progress in the field of medicine were the two main reasons for this increase: firstly a transfer of benefits from the hospital sector (services financed half by the cantons and half by health care insurance) to the outpatient sector (services fully covered by health care insurance); secondly, constantly rising costs of medicinal products (increase in prescriptions of medicinal products). There is no limitation in the form of a budget governing control of the cost to insured parties. However, on the price side, there are tariff agreements between service providers and insurers, but no restrictions on the volume.

Premiums (income), which in our system are closely linked to costs, increased from 12 billion CHF (8.18 billion €) in 1997 to 13.5 billion CHF (9.20 billion €) in 2000, representing a rise of 10.4 %. It is also interesting to compare annual increases in premiums from one year to the next and the net benefits paid by insurers. In 1997, the effective increase in premiums was 8.2 %, whilst the increase in benefits paid out was 5.5 %. In 1998, the effective increase in premiums was 5.5 %, whilst the increase in benefits paid out was 5 %. In 1999, the effective increase in premiums was 2.6 %, whilst the increase in benefits paid out was 4.2 %. Finally, for 2000, the effective increase in premiums was 3.1 %, whilst the increase in benefits paid out was 6.1 %. Note also that the insurers' operating profits, i.e. the difference between all expenditure (net benefits paid and the various operating costs) and all income (premiums collected and other financial income) is, in the case of a profit, allocated to the reserves of the insurers and, in the event of a loss, withdrawn from the existing reserves, but under no circumstances can there be any distribution of profits in any form whatsoever.

The most recent reforms or reforms under discussion

Given the relatively recent introduction of the new sickness insurance system (1996), no fundamental change is planned, only ad hoc measures to correct certain weaknesses.

Since it came into force, the LAMal (Loi sur l'Assurance-maladie) has been subject to a first partial revision adopted in the spring of 2000 and came in force since 1 January 2001. It was used largely to introduce measures to strengthen solidarity between insured parties.

In the recent years, the government presented partial revision plan, debated in parliament. Since the adoption of the first legislation in 1994, effective in 1996, and the health cost framework (tarifs-cadres) in 1998, in order to control the financial increase of health care, the need for a new reform of health care financing emerged as a must. Therefore the Swiss Federal Council decided on 25th of February 2004, in the context of its LAMal reform plan, to adopt by end of 2004 a message concerning this new reform. Formalized in January 2005 this message clearly states a health care financing model 'harmonized' with diverse social insurances. At the centre of the model, the idea that health insurance take totally in charge the costs of medical care for treatment or palliative care, but reduces its participation to basic health care costs to the basic fundamental human needs. The model would apply to all for health care received either at home or in older persons homes, but not in hospital settings. The reform proposed will also allocate a subsidy to persons needing daily care at home. The reform model proposed continues in the same above mentioned policy direction toward empowering and financing directly the individual at home, but does not address any possible direct financing or subsidies for the third parties being family members although there is mention that this questions should be studies in the future (point 1.1.4 of the text, Administration fédérale Suisse, 2005).

Table 19: Table: Percentage of persons in Switzerland with lowest cost insurance or financially supported by the State (2002)

	Men	Women
Persons having contracted a basic health insurance, non standard : type Bonus, HMO or family doctor model (in %)	6.0	5.6
Persons receiving subsidies for payment of their health insurance (in %)	19.2	21.5

5.1 What percentage of public spending is given to pensions, social welfare and health?

According to the Global report on the financing of social welfare, in 2001 the proportion of social spending was 28.4% of the GDP. According to this data,

the distribution of the spending for social services and care provision is as follow: ageing, 48,895 million Swiss Francs (45,4%), Health 26,895 million (24,9%), Handicaps 13,816 million (12,8%), Survival (subsidies for the survival partner of a couple) 6,818 million (6,32%), Family 5,521 million (5,12%), Unemployment 2,570 million (2,38%), social exclusion 2,714 million (2,52%), housing 0,564 million (0,52%). The 2005 report on the global cost of the Swiss health system reports a total of 49,9 million Swiss Francs for the year 2003 (+4,1% compared to 2002), corresponding to 11,5% of the GDP spent on in 2003 (OFS, 2005).

5.2 How much - private and public - is spent on long term care (LTC)?

Both private and public sectors contribute to long-term care spending. Thus, any estimation of the amount devoted to LTC is difficult. In 1999, about 4.9 billons of francs were devoted to private and public homes for the elderly and 850 millions Swiss francs to Spitex (home care/extra-hospital care).

According to the Health Care Insurers statistics, private insurances spend about 245 Swiss Francs per inhabitant each year on costs of institutions for the care of older persons (meaning 10% of the total expenditures of insurers). This amount includes Spitex expenditures. In 2003, Spitex costs increased 13% while costs for institutions increased 2% (www.sante-suisse.ch).

Figure 4: Total Expenditure and Income by System 2002

Total expenditure and income by system 2002

Total expenditure (in CHF million, without double accounting)

Insurance	103,290	Continuation of salary payments	4,063
Old-age and survivors' insurance (AHV)	28,859	Benefits depending on need	7,509
Company pension schemes (BV)	34,590	Suppl. benefits (AHV, IV)	2,528
Disability insurance (IV)	9,793	Welfare payments	2,233
Compulsory nursing insurance (OKPV)	15,659	Asylum Policies	958
Compulsory accident insurance (OUV)	5,213	Other	1,790
Unemployment insurance (ALV)	4,186	Subsidies	8,610
Cantonal family allowances (FZ)	4,544	Health system	7,311
State-funded insurance	446	Other	1,299

SFSO, 2005

5.3 Are there additional costs to users associated with using any public health and social services?

Health Care insurance does not cover the total amount of costs devoted to public and social services. As a result of the social insurance system, the amount of additional costs provided by users depends on the economic situa-

tion of the user. In the case of poverty, additional costs are taken into account by the supplementary benefits system (EL).

5.4 What is the estimated public/private mix in health and social care?

The largest part of the health costs are covered by the private sector (household and private insurers). About 32% of the health costs are covered by private households while 40% of those costs are paid by social insurances (including private insurances) and only 17% by the Cantonal or Federal Government.

5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

Some of the costs of using residential care are paid by health care insurance. In this case (including medical treatment, physiotherapy, etc.), the user has to pay a participation of 10% of the costs. Other costs such as domestic help, cooking, pedicure, must be covered by the user. They depend on the regional organization, but are often low (for instance, in Spitex St-Gall, one hour of domestic activities costs between 7 and 35 Swiss francs (between 4 and 20 euros). In the canton of Bern, the minimal tarification for domestic activities within the Spitex is 12 francs/hour. In comparison, in private economy, one hour generally costs between 25-35 Swiss francs.

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or/and social contributions?

In Switzerland, the annual cost of Spitex reaches 132 francs per inhabitant (cantonal range: Schwyz 73 francs; Geneva 283 francs). Statistics are available for Switzerland in 2003 (covering 709 organizations providing care, see. http://www.bsv.admin.ch/statistik/details/f/f_spitex_2003.pdf). Generally speaking, 31% of the costs of Spitex activities is provided by Health Insurances (which means this percentage is covered by individual funds as well as public support); 15% of the costs representing cooking, domestic help, etc. are directly paid by the beneficiary; 16% by social insurances (i.e the Government - first pillar), 16% by the cantons and 17% by the local authorities. The remaining 5% is provided by private funds. These statistics covers both private and public Spitex organizations.

It is however important to stress that the Spitex institution is a network of cantonal or communal organisations. The funding may vary from one canton to another. In 2002 in Bern, 35% of the costs were paid by Health insurances,

14% by the beneficiaries, 19% by social insurances and 26% by the canton, the remaining 6% by private funding.

5.7 Funding of family carers

Policy on funding family carers has not been addressed seriously in Switzerland as a Family Policy in general for the reasons presented in section 2.

There is no funding of family carers at the federal level. However some cantons like the Canton of Fribourg have implemented a policy and legislation for funding family carers – the amount and conditions are set by the districts (Grand Conseil du Canton de Fribourg, 1990). In this canton, 653 families met the criteria to be granted for care in 2002. About 7500 francs per carer were distributed during the year as a financial compensation for care provided.

Are family carers given any benefits (cash, pension credits/rights, allowances etc.) for their care? Are these means tested?

There is no benefit at the federal level. A special case, the canton of Fribourg provides a legislation framework allowing each districts to decide about the allowance and conditions. For example the district of Gruyère allocates 25 Swiss Francs per day (about 17 Euros) paid every three months to the member of the family providing care. The person taken care of must have lived in that district and paid taxes for a minimum of 2 years prior to the request for the allowance. The criteria is based on a daily need for assistance or surveillance for more than 60 days (Association des communes de la Gruyère, 1996).

	Attendance allowance	Carers´ allowance	Care leave
Restrictions			
Who is paid?			
Taxable			
Who pays?			
Pension credits			
Levels of payment / month			
Number of recipients in 2002			

5.7.1 Is there any information on the take up of benefits or services?

Compulsory health insurance (KGV revised 1996) provides universal access to a basic level of health care except for dental treatment. Patients are required to make moderate payments up to an annual maximum cost. Premiums paid by the insured are independent of age and sex. Insurance funds cannot refuse to accept subscribers to their plans and there are subsidised premiums for low

income earners. Reform introduced hospital planning and competitive tools for insurance funds, in particular special contracts with private service providers.

5.7.2 Are there tax benefits and allowances for family carers?

At the fiscal level, a deduction is possible for persons in charge. The amount of deductions depends on the canton.

5.7.3 Does inheritance or transfers of property play a role in caregiving situation? If yes, how?

No information is available

5.7.4 Carers' or Users' contribution to elderly care costs (check list of services and costs to user)

Medical nursing rehabilitation services and social care are generally provided by either public or private organizations. Costs recognized by Health Insurances are partly reimbursed by insurers, with participation of the beneficiary. As far as social care services are concerned, the situation depends on the kind of services with a contribution of the beneficiary and a public support in general.

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner		X				
Specialist doctor		X				
Psychologist		X				
Acute Hospital		X				
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)		X				
Day hospital		X				
Home care for terminal patients		X				
Rehabilitation at home		X				
Nursing care at home (Day / Night)		X				
Laboratory tests or other diagnostic tests at home		X				
Telemedicine for monitoring		X				
Other, specify						

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home		X				
Temporary admission into residential care / old people's home in order to relieve the family carer		X				
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)				X		
Laundry service		X				
Special transport services		X				
Hairdresser at home						
Meals at home		X				
Chiropodist / Podologist		X				
Telerescue / Tele-alarm (connection with the central first-aid station)				X		
Care aids			X			
Home modifications			X			
Company for the elderly			X			
Social worker			X			
Day care (public or private) in community centre or old people's home					X	
Night care (public or private) at home or old people's home					X	
Private cohabitant assistant ("paid carer")*						
Daily private home care for hygiene and personal care					X	
Social home care for help and cleaning services / "Home help"*						
Social home care for hygiene and personal care*						
Telephone service offered by associations for the elderly (friend-phone, etc.)			X			
Counselling and advice services for the elderly*						
Social recreational centre*						
Other, specify						

** As Switzerland is a federal system, participation in payment or free access can depend on canton and communes*

c. Special services for family carers*	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring						
Telephone service offered by associations for family members						
Internet Services						
Support or self-help groups for family members						
Counselling services for family carers						
Regular relief home service (supervision of the elderly for a few hours a day during the week)						
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)						
Assessment of needs						
Monetary transfers						
Management of crises						
Integrated planning of care for the elderly and families at home or in hospital						
Services for family carers of different ethnic groups						
Other, specify						

** see chapter 2 for policy on family carers*
As Switzerland is a federal system, participation in payment or free access can depend on canton and communes

6 Current trends and future perspectives

As for most European countries, the ageing population phenomena and its increasing consequences on the political and economic situation in Switzerland has recently led to a more intensive debate on the urgent need to address the current and future problem of financing social security and social welfare. The explosion of health care costs as well as the financing of the pension system is today an area of high concern as the dependency ratio of professionally active persons on non active persons is decreasing steadily. In 1970, the ratio between those age 20-64 and those aged 65 and over was 100:20. Now this ratio is 100:25 and will probably reach 100:40 by 2020.

The current issues in Switzerland are related on one side, to the coordination between cantons and federal policies in matters such as the new health policy plan for mental health or the health promotion models for 50 years old (Stuckelberger, 2002, 2003). As the Swiss system allows canton autonomy in structuring and managing its health system and policy, the share of decision allocated to the federal government for prevention and promotion issues, but more importantly for financing of the health care for example is continuously debated in parliament and among health specialists.

On the other hand, focus today is on patient quality management and financing with a trend to ‘harmonize’ the interests of patients, health professionals, institutions and health insurance companies. Reform of the LAMal (health insurance legislation) is underway, especially on the financing of health care for dependant persons.

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers’ point of view? Are older people and/or carer abuse among these issues?

Very little debate has up to now taken place addressing family care policy as explained in section 2. Priority has not yet been set on the insufficient link between health care and family policy in Switzerland, although informal care has started to be recognized as an issue to measure and better understand. Abuse among older people has emerged in the last years as an important issue stressed by a few associations and pressure groups but has not yet gained a lot of attention at the policy level.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

Support of the permanent need of care of a dependant older person living at home will be improved according to the new federal proposal for financing (Administration fédérale Suisse, 2005). Family support is not a priority on the Swiss health policy plan in the short term. If European countries all adopt a firm policy to support family carers, Switzerland will certainly address the issue in the future.

6.3 What is the role played by carer groups / organisations, "pressure groups"?

no information is provided

6.4 Are there any tensions between carers' interests and those of older people?

no information is provided

6.5 State of research and future research needs (neglected issues and innovations)

There is a strong need to gather data of family carers and quantify informal financial contribution of caregivers (family or others). It would also be important to calculate and give a clear picture on the informal socio-economic gain the state makes when caregivers graciously provide care for an older person versus the visible cost for the state when providing formal care to that same type of person. The question is what economic consequences can policy-makers envisioned if non paid informal caregivers increasingly renunciate to provide care.

Consideration should also be given to deepen our understanding of a society in full transformation of family and intergenerational links, what factors contribute to maintain or not informal family care, as to support incentives to maintain best the informal care networks? Poverty today concerns not only a life course poverty but usually has consequences on the next generations poverty. Therefore poverty transmits through generations and full lineages of families are put a person at risk of cumulative disadvantage later in life (Zimmermann, Stuckelberger, Meyer, 2005). How can we prevent better those situations with stronger safety nets such as education bonus, divorce compensation, widowhood, etc.? The mechanisms of new poverties linked to family care should be studied more thoroughly in the context of absent or existing family care policy.

End of life care and dignity is also a promising area. The concept of dying well for example should be studied with consideration on the impact of the 'way one dies' on the next generations life and concept of life. The debate about legalizing active euthanasia needs more solid data as to the impact of assisted suicide on the mental health of the surviving family, generations or society as a whole.

Another innovative area of research is to investigate the cost-effectiveness of applying new technologies in health care to the older generations (e-health, e-care, telemedicine, etc.). (see panel report of the European Population Ageing Research Forum (Stuckelberger, 2002)
(http://www.shef.ac.uk/ageingresearch/reports.php or
http://www.shef.ac.uk/ageingresearch/pdf/hcm03bw.pdf)

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

The Swiss Federation of Téléthèse (FST) has developed a non invasive surveillance system for institutions called Quo Vadis. This device could be applied for family surveillance. http://www.fst.ch/FST2/fr/default.php?CAT=3&SNAV=2&CONT=8

6.7 Comments and recommendations from the authors

The Swiss Research Programme on Ageing conducted during the last decades has helped improved policies on ageing in Switzerland (Höpflinger and Stuckelberger, 1999), today a new National Research programme aiming at addressing intergenerational issues is underway and aims at filling the gaps in Family Policies in Switzerland. It would be important that decisive changes are made in family policies in a comprehensive way which integrates and recognizes fully the extended family as the primary carer and addresses its financing. More research should be conducted on differential ageing between men and women (Stuckelberger et Höpflinger, 1996; Stuckelberger, 1997) and on cumulative disadvantages (Zimmermann, Stuckelberger, Meyer, 2005) in order to better address the gaps between population reality and family and ageing policy. The important estimation of care contingencies needed in the future (Höpflinger et Hugentobler, 2004) underlines the urgency of addressing care issues and financing.) but also to develop better mental health policies (Stuckelberger, 2002).

The Swiss health care system is going though a reform linked to reduce the increasing financing of health care. Since January 2005 a new legislation on health care financing was adopted. Although the individual, especially the permanently dependant older person will be guaranteed to be covered financially, no points of this new legislative decision is addressing the family as caregiver (Administration Fédérale Suisse, 2005). As long as the role of women and of the family will be not supported in Switzerland, the risk of a sys-

tematic decline of informal care remains high and will only contribute to the increase of formal health care cost. The new government in place is focusing on the directly financing the individual needing care, placing responsibility in the person decision, and in a way not recognizing family support as a potential substitute for or support to formal care.

Encouraging and financially supporting the contribution of the family in old age care can only reinforce cohesion in society and prevent isolation, exclusion and health problems such as depression in old age. We would recommend creating EU guidelines to stimulate governments to adopt such measures which would certainly enhance Switzerland to reconsider it’s present policy.

7 Appendix to the National Background Report for Switzerland

7.1 Socio-demographic data

7.1.1 Profile of the elderly population-past trends and future projections

Table 19 shows the evolution of the elderly population according to the age group (65 and more, 80 and more). It clearly shows the explosion of older persons in the population and the growing difference between genders.

Due to the wide range of possible scenarios on mortality among oldest old and on migration among future retirees, projections on the evolution of elderly population are rather uncertain. We can however consider that table 19 is one of the 'possible futures'. According to Swiss Federal Statistical Office projections, the percentage of the oldest-old in the population will be multiplied by more than two, reaching 10% in 2050 (4.1% in 2000).

Table 20: Population aged 65+ and 80+ in absolute numbers and in % of the total population, 1900-2000

Year	In numbers				In % of the total population			
	Males		Females		Males		Females	
	65+	80+	65+	80+	65+	80+	65+	80+
1900	88501	7667	104772	9420	5.4	0.5	6.2	0.6
1910	96267	9124	121524	12025	5.2	0.5	6.4	0.6
1920	97103	9923	129870	14892	5.2	0.5	6.5	0.7
1930	119730	11115	160098	17740	6.1	0.6	7.6	0.8
1940	156834	14814	208261	24522	7.6	0.7	9.4	1.1
1950	194073	21010	259203	34676	8.5	0.9	10.6	1.4
1960	230530	31501	323814	52759	8.7	1.2	11.7	1.9
1970	289968	39434	424872	72207	9.4	1.3	13.4	2.3
1980	353667	55116	529255	116306	11.4	1.8	16.3	3.6
1990	393572	81082	597483	175607	11.6	2.4	17.1	5.0
2000	453585	97616	665421	201271	12.7	2.7	17.9	5.4

Source: Swiss Federal Statistical Office, Censuses

7.1.1.1 Life expectancy at birth (male/female) and at age 65

Table 20 shows the regular increase of life expectancy at birth and at age 65. It also shows that the increasing difference between men or women, which characterized not only Switzerland during the 20th Century but also other countries in Europe. With a life expectancy at birth equal to 77,3 years for men and

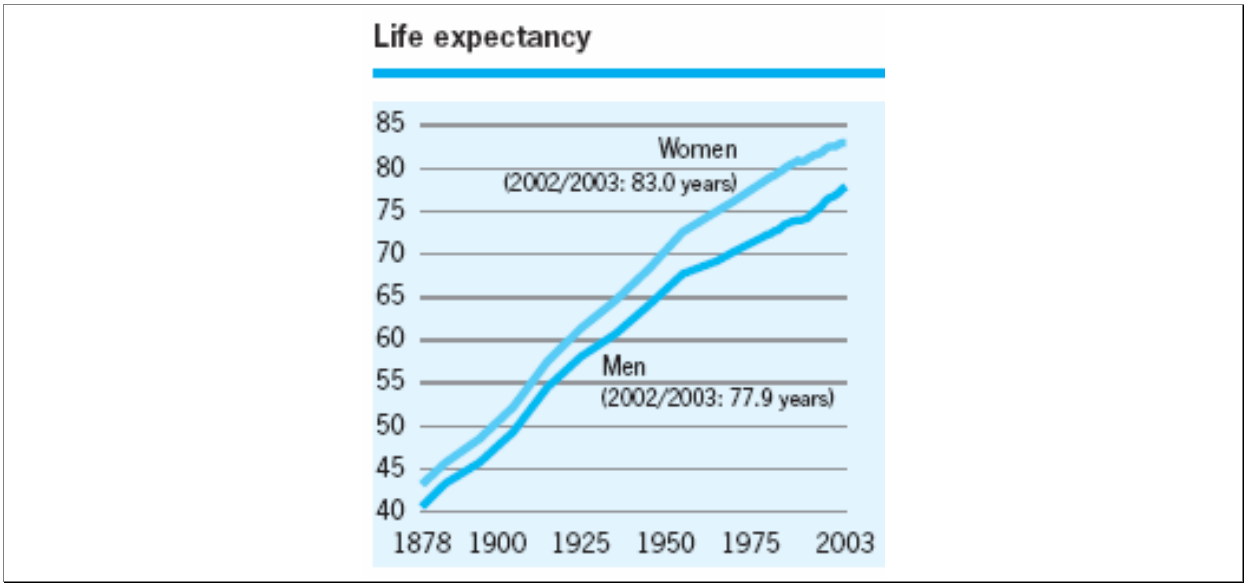
82,8 years for women, Switzerland shows one of the highest life expectancies after Japan.

Table 21: Life expectancy at birth and at age 65 years, by sex

	Men		Women	
	At birth	65 years	At birth	65 years
1910/1911	50.65	10.15	53.89	10.9
1929/1932	59.25	10.98	63.05	12.1
1948/1953	66.36	12.4	70.85	14.76
1968/1973	70.29	13.32	76.22	16.33
1988/1993	74.19	15.51	81.05	19.72
1999/2002	77.32	17.23	82.85	20.94

Source: SFSO, 1999/2002 own computations

Figure 5: Life expectancy



(SFOS, 2005)

7.1.1.2 % of >65 year-olds in total population by 5 or 10 year age groups

See table 21.

Table 22: Population by sex and age group, 2000

Age group	Absolute numbers			Percentage		
	Men	Women	Total	Men	Women	Total
0-4	198738	188450	387188	5.6	5.1	5.3
5-9	218782	208323	427105	6.1	5.6	5.9
10-14	220319	210048	430367	6.2	5.6	5.9
15-19	216059	204894	420953	6.1	5.5	5.8
20-24	218823	21249	431272	6.1	5.7	5.9
25-29	245247	243625	488872	6.9	6.5	6.7
30-34	295449	295977	591426	8.3	8.0	8.1
35-39	318448	311041	629489	8.9	8.4	8.6
40-44	287213	278662	565875	8.1	7.5	7.8
45-49	254135	250747	504882	7.1	6.7	6.9
50-54	249326	246915	496241	7.0	6.6	6.8
55-59	221861	222179	444040	6.2	6.0	6.1
60-64	169582	181712	351294	4.8	4.9	4.8
65-69	145343	168756	314099	4.1	4.5	4.3
70-74	118558	156401	274959	3.3	4.2	3.8
75-79	92068	138993	231061	2.6	3.7	3.2
80-84	55862	96826	152688	1.6	2.6	2.1
85-89	30025	67495	97520	0.8	1.8	1.3
90-94	10047	29809	39856	0.3	0.8	0.5
94+	1682	7141	8823	0.0	0.2	0.1
Total	3567567	372043	7288010	100.0	100.0	100.0

Source: SFSO, Census 2000

7.1.1.3 Marital status of >65 year old (by gender and age group)

Table 22 shows the traditional distribution of marital status by age group, with an increasing proportion of widowers and a declining proportion of married persons. We can also observe that more than 10% of men and 20% of women are either single or divorced, which means a high probability of absence of descendants.

Table 23: Marital status of > 65 year-olds

Age	Men				Women			
	Single	Married	Widowed	Divorced	Single	Married	Widowed	Divorced
In numbers								
65-69	10036	118344	7001	9962	14174	103967	35772	14843
70-74	7988	94821	9421	6328	14417	80429	50422	11133
75-79	6195	70301	11969	3603	14513	52671	63448	8361
80-84	3814	38611	11711	1726	11200	23649	57021	4956
85-89	2062	17213	10017	733	8510	8935	47065	2985
90-94	678	4361	4798	210	4262	1750	22506	1291
95-99	108	424	1005	34	1088	122	4997	258
100+	11	16	82	2	121	8	520	27
In %								
65-69	6.9	81.4	4.8	6.9	8.4	61.6	21.2	8.8
70-74	6.7	80.0	7.9	5.3	9.2	51.4	32.2	7.1
75-79	6.7	76.4	13.0	3.9	10.4	37.9	45.6	6.0
80-84	6.8	69.1	21.0	3.1	11.6	24.4	58.9	5.1
85-89	6.9	57.3	33.4	2.4	12.6	13.2	69.7	4.4
90-94	6.7	43.4	47.8	2.1	14.3	5.9	75.5	4.3
95-99	6.9	27.0	64.0	2.2	16.8	1.9	77.3	4.0
100+	9.9	14.4	73.9	1.8	17.9	1.2	76.9	4.0

Source: SFSO, Census 2000

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups.

Consequently, the proportion of persons living alone increases with age and reaches 36% for men aged 100 and more and 54% for women aged 80-84. At the same time, the percentage of elderly living in a collective household also increases with age. Collective households are more frequent among women than men (Table 23).

Table 24: Living arrangement of 65+

Age	Men			Women		
	Alone	other private household	collective household	Alone	other private household	collective household
In numbers						
65-69	19717	122513	1932	50818	114131	2612
70-74	17330	97979	2387	60629	90768	3848
75-79	15858	72222	3296	67351	62511	7727
80-84	11870	39142	4310	51746	30717	12975
85-89	7833	16890	4826	33277	14234	18604
90-94	2856	4204	2804	11510	4232	13220
95-99	466	464	604	1712	763	3767
100+	39	25	43	122	93	431
In %						
65-69	13.7	85.0	1.3	30.3	68.1	1.6
70-74	14.7	83.2	2.0	39.1	58.5	2.5
75-79	17.4	79.0	3.6	49.0	45.4	5.6
80-84	21.5	7.8	7.8	54.2	32.2	13.6
85-89	26.5	57.2	16.3	50.3	21.5	28.1
90-94	29.0	42.6	28.4	39.7	14.6	45.6
95-99	30.4	30.2	39.4	27.4	12.2	60.3
100+	36.4	23.4	40.2	18.9	14.4	66.7

Source: SSO, Census 2000

7.1.1.5 Urban/rural distribution by age (if available and/or relevant)

Age group	Centres of agglomerations			Other "communes" of agglomerations			Little towns (10000 inhabitants and more			Rural "communes"		
	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes
% 0-19	20.3	17.9	19.0	24.3	22.3	23.3	24.9	22.2	23.5	27.0	25.4	26.2
%20-65	65.8	60.8	63.2	63.7	61.8	62.7	63.3	60.6	61.9	60.2	57.3	58.7
%65+	13.9	21.4	17.8	11.9	15.9	14.0	11.8	17.2	14.6	12.8	17.3	15.1
%80+	3.3	7.0	5.3	2.3	4.4	3.4	2.4	5.1	3.8	2.8	5.2	4.0

7.1.1.6 Disability rates amongst >65 year-olds. Estimates of dependency and needs for care.

Disabled[3] 2003		
Degree of disability	Women	Men
40–49%	4,901	3,856
50–59%	19,815	20,499
60–69%	7,512	8,356
70–100%	75,393	101,735

7.1.1.7 Income distribution for top and bottom deciles i.e. % aged >65 years in top 20% of income, or % > 65s in top 20%, and the same for poorest 20% income groups.

No data is available

7.1.1.8 % >65 year-olds in different ethnic groups

Table 24 shows that Swiss nationals represents between 87% and 96% of the population aged 65 and over (against 20.5% of the total population).

Table 25: Distribution of the population according to the nationality

Age	Males		Females	
	Swiss	Foreigner	Swiss	Foreigner
In numbers				
65-69	126405	18938	153924	14832
70-74	107884	10674	146250	10151
75-79	86377	5691	131847	7146
80-84	53447	2415	93262	3564
85-89	28739	1286	64854	2641
90-94	9595	452	28583	1226
95-99	1488	83	6171	294
100+	103	8	653	23
In %				
65-69	87.0	13.0	91.2	8.8
70-74	91.0	9.0	93.5	6.5
75-79	93.8	6.2	94.9	5.1
80-84	95.7	4.3	96.3	3.7
85-89	95.7	4.3	96.1	3.9
90-94	95.5	4.5	95.9	4.1
95-99	94.7	5.3	95.5	4.5
100+	92.8	7.2	96.6	3.4

Source: SFSO, Census 2000

7.1.1.9 % Home ownership (urban/rural areas) by age group

The vast majority of dwellings (73.3%) belong to private individuals (in 2000) – and not, as is often supposed, to corporate bodies. Nevertheless, the home-ownership rate in Switzerland is relatively low: in 2000, only 34.6% of all permanently occupied dwellings were used by the owners themselves. That is by far the lowest percentage of all European countries. However, home-ownership has increased somewhat since 1970, mainly thanks to the rapid increase in condominium-style flat-ownership (SFSO, 2005).

7.1.1.10 Housing standards/ conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

Radio and TV consumption
in minutes per day

	1990			2003		
	G	F	I	G	F	I
TV[4]	113	129	128	141	168	175
Radio[5]	...	...	...	111	105	106
Reading[6]	29	22	32	31	29	29

[4] Per person over 3, daily average Mon-Sun
[5] Per person over 15, daily average Mon-Fri
[6] Per person over 15, daily average Mon-Sun

G: German, F: French, I: Italian

SFOS, 2005

7.2 Examples of good or innovative practices in support services

Provide brief descriptions of the good practices or innovations listed under section 3.1.

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Some more websites on the Swiss Health care System:

Swiss Federal Organisations

Croix-Rouge suisse (CRS)	www.redcross.ch
Conférence des gouvernements cantonaux (CdC)	www.kdk.ch
Conférence des directeurs de l'instruction publique (CDIP)	www.edk.ch
Conférence des directeurs des affaires sociales (CDAS)	www.sodk-cdas-cdos.ch
Conférence des directeurs des finances (CDF)	www.fdk-cdf.ch
Conférence suisse des directrices et directeurs cantonaux de santé (CDS)	www.gdk-cds.ch
Conférence universitaire suisse (CUS)	www.shk.ch
Office fédéral de la santé publique (OFSP)	www.bag.admin.ch

Most recent health care financing proposal
http://www.bag.admin.ch/kv/projekte/f/vernhml_pflegefinanzierung_230604.pdf

Office fédéral de la statistique (OFS)	www.statistik.admin.ch
Office fédéral de la formation professionnelle et de la technologie (OFFT)	www.bbt.admin.ch
Bureau d'intégration	www.europa.admin.ch
Administration fédérale	www.admin.ch
Parlement fédéral	www.parlament.ch
Promotion Santé Suisse	www.promotionsante.ch
Plate forme "Politique nationale suisse de la santé"	www.santenationale.ch
Observatoire suisse de la santé (obsan)	www.obsan.ch
Institution commune LAMal	www.kvg.org

More organisations dealing with health care

http://files.hplus.ch

http://www.santesuisse.ch

http://www.zmt.ch

http://www.preisueberwacher.ch

http://www.tarmedsuisse.ch

http://www.fmh.ch/ww/en/pub/welcome.htm