ESPN Thematic Report on Challenges in long-term care

Switzerland

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European Social Policy Network (ESPN)

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The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary

The Swiss long-term care (LTC) system is highly decentralised. Competencies for LTC regulation, financing, and provision are separated between the federal government, the cantons, and the municipalities. According to the OECD, Switzerland spent 2.3 per cent of its GDP on LTC in 2015. This is considerably more than the OECD average (1.3 per cent). There is no specific LTC insurance. Health insurance funds, pension funds, taxpayers, and patients finance LTC services, which can be provided either in nursing homes, or at home by professional care services or relatives. Due to the decentralised LTC system, the mix of LTC provision varies between cantons.

The main challenges for the Swiss LTC system are equity in access as well as employment-related issues. For example, the health insurance system pays for medical services but not for non-medical services in LTC, such as household work. Patients need to cover these expenses out of their own pocket, through supplementary payments from the public old-age and/or invalidity insurance pension funds, or by social assistance for which cantons and municipalities pay. Thus, there is a risk of cost-shifting to the weakest party, i.e. patients.

The second challenge concerns employment, notably maintaining and expanding the workforce of professionals, but also creating flexible solutions that either compensate working caregivers with dependent relatives for their care work, or that guarantee flexibility in job arrangements, for example to take leave or have flexible working hours. The national government has taken steps to address employment-related concerns by investing in more qualification options in the LTC sector and assessing the need for informal care workers who take care of dependent relatives.

1 Description of the main features of the country's LTC system(s)[1]

1.1 Organisation and scope

The Swiss long-term care (LTC) system is very decentralised. At the national level, the most important institutions in the policy field are health insurance funds. They finance ambulatory LTC if it is related to sickness but not to old age. Other services, such as household assistance, activity therapy, or stays in nursing homes are billed to the patient directly. Patients who cannot cover these expenses from private assets or retirement income from public or occupational pension funds can apply for supplementary payments from the national public old-age (AHV) and invalidity (IV) insurance schemes, or for social assistance from municipal governments. Switzerland spends over 2 per cent of its GDP on LTC. This is almost double the OECD average (1.4 per cent in 2014). The reasons for the higher expenditure on LTC in Switzerland are partly the large part of the population aged over 65 in Switzerland (17.1 per cent in 2011) relative to the OECD average (12.2 per cent in 2011). It is also related to the fact that the Swiss health system is overall comparatively expensive (OECD 2014). Nevertheless, expenditure on LTC has grown less in Switzerland than the OECD average during more recent years.

Table 1: Long-term Care Expenditure in Switzerland (% of GDP)

	2000	2005	2010	2014	2015
Long-term Care Expenditure % of GDP	1.7	2.0	2.0	2.2	2.3
OECD Average	0.8	1.0	1.1	1.3	1.3

Note: The number of countries for which data are available varies. We report always the average values for the available countries.
Source: OECD 2017

In 2015, LTC services accounted for 19.5 per cent of the overall health expenditure in Switzerland. The biggest share of these expenditures is for LTC services in nursing homes (2015: 16.6 per cent of national health expenditure). LTC services at home make up a considerably smaller part of the expenditure (2015: 2.9 per cent of national health expenditure). Nevertheless, the data provided for home care concerns only LTC services in the "narrower" sense, i.e. formal health care services such as nursing or physiotherapy. These services increased by 8.5 per cent compared with 2014 (from 2.8 to 2.9 per cent of national health expenditure).[2] Additional and non-medical home care services, such as household assistance (meals, shopping), need to be added to that. In 2016, 340,000 individuals received home care services (*Spitex*, acronym for the German phrase *Spitalexterne Hilfe und Pflege* – care services provided out of hospitals), which can entail formal health care services as well as additional non-medical services. This was an increase of 10 per cent compared with 2015. Conversely, the number of residents in nursing homes declined.[3]

[1] This part of the report is based on the ESPN Country profile on Switzerland: (Bonoli and Trein 2018).

[2] Federal Office for Statistics [https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/kosten-finanzierung/kosten.html], last accessed February 9, 2018.

[3] Federal Office for Statistics [https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/gesundheitswesen/hilfe-pflege-hause.assetdetail.3842154.html], last accessed February 9, 2018.

1.2 Financing of services

As in the case of health care, the organisation of LTC is decentralised. The responsibility for LTC is with the cantons, which have the option to delegate this responsibility to the municipalities or private organisations – an option that they use frequently (Kocher 2010; OECD 2011). Health insurance funds, cantons, and municipalities finance directly about 40 per cent of LTC costs. The remaining 60 per cent is covered by households. However, to ease financial pressure on families and individuals, social benefits such as invalidity allowances and supplementary benefits for the elderly from the public old-age insurance scheme (*Ergänzungsleistungen*) cover another 24 per cent of the total expenditure, so that households have to cover 36 per cent of the costs of LTC (OECD 2011). These supplementary payments come from the public old-age and invalidity insurance funds; individuals can apply for additional payments if they fulfil the eligibility criteria, such as having a legal claim to a public old-age or invalidity pension, being a resident in Switzerland and having Swiss or EU/EFTA citizenship, or being a foreign resident of Switzerland for at least ten consecutive years before claiming the benefits (five years for refugees and stateless persons). Benefits are calculated on the basis of a person's actual income and wealth, as well as their living situation (single, married, number of children etc.). In addition to allowances for basic living costs, claimants can receive additional reimbursements for health care services and health insurance costs. The funding schemes are national but the cantons administer them and they have some freedom in adjusting the exemption limits for deducting personal assets from these supplementary payments.[4] Further schemes are means-tested social municipal social assistance programmes. There are no cash benefits that are linked to LTC explicitly, and patients compensate for this through the other types of reimbursement mentioned. Direct financing of LTC services by the health insurance system is limited to medical services. In other words, to receive reimbursement for medical-related LTC services by the health insurance system, a doctor needs to prescribe these services (Portenier et al. 2015, 298). If health insurance funds do not approve these services, patients can turn to the organisation *Pro Senectute* for legal and financial help.[5] Furthermore, there is a risk that cantons shift costs towards patients, since patients might move between cantons and it is unclear which canton has to support the patient financially. A recent parliamentary initiative regulated that the canton of residence remains responsible for supplementary payments, even if LTC services are provided in a different canton.[6]

1.3 Provision of services

The provision of care occurs either in medical nursing homes, nursing departments for old age, disability homes, or on an ambulatory basis. Nursing homes are either operated by public providers only, receive private subsidies, or are run privately. In general, the number of nursing homes varies greatly between cantons, and most nursing homes are either privately run or receive subsidies from private organisations.[7] Quality criteria are defined in the federal health insurance law but implementation is in the hands of the cantons and municipalities (Mösle 2015). The *Spitex* is responsible for the provision of ambulatory care (Gmür and Steiner 2015). Until recently, the *Spitex* had a quasi-monopoly for providing home care services through non-profit contractors at the municipal level but the number of private for-profit providers of home care services has

[4] AHV/IV 2018 [https://www.ahv-iv.ch/p/5.01.d], last accessed on March 26, 2018.

[5] SRF 2012 [https://www.srf.ch/sendungen/puls/gesundheitswesen/spitex-wie-man-zur-hilfe-kommt-was-sie-kostet], last accessed on March 26, 2018.

[6] Federal Assembly of Switzerland, Parliamentary Initiative Egerszegi-Obrist Christine. Amend the financing regime for LTC, Nr. 14.417. [https://www.parlament.ch/de/ratsbetrieb/amtliches-bulletin/amtliches-bulletin-die-verhandlungen?SubjectId=41217#votum1], last accessed on March 26, 2018.

[7] Federal Office for Statistics [https://www.bfs.admin.ch/bfs/de/home/statistiken/kataloge-datenbanken/tabellen.assetdetail.3802575.html], last accessed on March 28, 2018.

increased in recent years and these providers demand more political influence.[8] There is no legal limit to eligibility for access to services: however, as noted above, reimbursement for medical services needs to be prescribed by a doctor. In addition to formal care services, informal care also plays an important role in Switzerland. The distribution of the types of service varies between cantons. There are important geographical variations concerning the mix of LTC service provision. In the western and mostly French-speaking part of Switzerland (cantons: Geneva, *Jura, Neuchatel, Ticino*, and *Vaud*), the majority of LTC services are home care services provided by the *Spitex*. Patients spend only a limited time in nursing homes, mostly at the end of their lives. In the central part of Switzerland (cantons: *Glarus, Luzern, Niedwalden, Obwalden, Schwyz* and *Uri*), the provision of LTC services occurs in nursing homes. Patients spend a longer period in nursing homes and have a lower need of care than in the model of western Switzerland, where patients arrive at a later stage in nursing homes. The other cantons have a mixed model of LTC services that combines the *Spitex* and services in nursing homes (except for the canton *Valais*, which does not fit into this classification) (Obsan 2016). Interestingly, services by the *Spitex* are rather financed by social insurance schemes (health insurance and supplementary benefits by the public old-age and invalidity insurance) and the state, whereas residents pay for stays in nursing homes to a larger share with private assets. This implies that cantons with a higher share of LTC home care services finance these services with more public money than cantons with mostly nursing home-based services do (Jolanda and Künzi 2014).

The majority of the personnel in the care (health and LTC) sectors work in hospitals (46 per cent, in 2014). One third (36 per cent) work in nursing homes and the remaining 18 per cent work for home care services, notably the *Spitex* which also provides household services, such as assistance with cleaning, cooking, or shopping. In the coming ten years, experts expect a considerable increase in the demand for personnel in the health care sector in general, including LTC (Dolder and Grüning 2016). At the same time, there are demands for a better quality of jobs in the LTC sector. The largest Swiss union, UNIA, conducted a survey amongst 1000 LTC workers and reports a rather high degree of dissatisfaction due to long working hours and low pay. Apparently, more than half of the respondents were considering leaving the profession due to increasing pressure and less time for patients.[9]

1.4 Home care and informal care

Home care and care by individuals for their dependent relatives are an important element of the Swiss system of LTC (Zumbrunn and Bayer-Oglesby 2015; Trein 2016). For example, about 40 per cent of old-aged persons in need of care receive home care, many of them by relatives of working age. But there is also a large number of younger persons, for example children and adults with disabilities, who receive care from their relatives. Against this background, the Swiss system of support for persons of working age with dependent relatives is underdeveloped. For example, only a few cantons and municipalities provide financial benefits for those who take care of dependent persons at home. The benefits that exist are not income-replacement benefits, but rather a recognition for the services provided by volunteers. Regarding benefits in kind, there are more offers available, such as counselling or information and training services (Trein 2016). Cantons, municipalities, and non-government organisations (NGOs) provide support to persons with dependent relatives. Nonetheless, these services are not well coordinated and do not entail many measures to improve work-life balance for persons of working age with dependent relatives (Trein 2016). Due to the high cost of LTC services, the fragmented system of coverage for costs, and the lack of support for persons of working age with dependent relatives, there are strong incentives for households to

[8] NZZ, December 12, 2015.

[9] SRF (Swiss National Radio and TV), February 10, 2016 [https://www.srf.ch/news/schweiz/viel-arbeit-fuer-wenig-lohn-das-pflegepersonal-ist-unzufrieden], last accessed February 9, 2018.

recruit carers outside the formal sector. Thus, in recent years, the number of hired but informal care personnel has increased considerably. Especially since the extension of the free movement of people to eight new EU members in 2011, care migration has increased, mostly from eastern Europe. It is rather easy to hire someone in Switzerland to assist with the care of a dependent relative, as there are no strict regulations. As there are considerable differences in income levels between Switzerland and other EU countries, such an arrangement is attractive for care migrants because they can reach a significant income, as well as for Swiss citizens, since they can get 24-hour care services at a much lower rate than the market price (Van Holten et al. 2013).[10] Nevertheless, there are some problems with this form of informal care: care migrants are not protected by Swiss labour law, and do not have formal qualifications for dealing with ailments such as dementia, or the demanding context of full-time care services. Furthermore, they do not have social contacts in Switzerland who can assist them in case of problems (Lehmann 2017). Thus, they are vulnerable to exploitation. Recently, the Swiss national parliament[11] and cantonal administrations, such as St. Gallen (Lehmann 2017), have begun to attend to these problems.

1.5 Future need for LTC

In the future, experts anticipate a rising demand for LTC services in Switzerland. The main reason for this is that the baby boomers' generation is growing older and will retire soon. Experts estimate that the number of individuals in need of LTC will increase from 125,000 to 185,000 between 2010 and 2030. This number depends on the development of morbidity rates. If these cohorts remain in good health for a longer time, then the need for additional LTC services might not increase so much (Höpflinger et al. 2011). Nevertheless, the prevalence of certain conditions such as dementia is very likely to increase. All this will entail a steep rise in expenditure on LTC (NZZ, July 15, 2016).

2 Analysis of the main LTC challenges in the country and the way in which they are tackled[12]

2.1 Assessment of the challenges in LTC

Access and adequacy challenge: In Switzerland, access to LTC depends largely on private assets (Höpflinger et al. 2011). Health insurance funds pay for part of the cost of ambulatory LTC services by the *Spitex* if a doctor prescribes them. The insurance contribution is comprised of a daily rate for basic care, but patients have to top this up out of their own pockets. In cases where an individual cannot raise the out–of–pocket contributions, there is the possibility to apply for supplementary benefits from the old-age and invalidity insurance schemes. If the schemes do not pay for the services a patient needs and if there are no private means available, those in need can apply for social assistance (Mösle 2015).[13]

In the Swiss population, income and wealth are most unequally distributed in the group that is over 60 years old. Every 7th couple in this group has a fortune of over 1 million

[10] Tagesanzeiger, December 19, 2012.

[11] Federal Assembly of Switzerland, Parliamentary Initiative Schmid-Federer Barbara. Protect care migrants in private households by the national labour legislation, Nr. 17.472. [https://www.parlament.ch/de/ratsbetrieb/suche-curia-vista/geschaeft?AffairId=20170472], last accessed on March 26, 2018.

[12] This part of the report is based on the ESPN Country profile on Switzerland: (Bonoli and Trein 2018).

[13] In 2016, health insurances paid 41.2 per cent of stays in nursing homes, pensions (AHV and IV) 41 per cent, and 17.8 per cent patients out of their own pockets. Federal Office for Statistics [https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/gesundheitswesen/alters-pflegeheime.assetdetail.3863802.html], last accessed February 13, 2017.

Swiss Francs (CHF), whereas every 10th couple has less than CHF 10,000 in cash. Individuals with an income (salary, pension, other) below CHF 28,700 per year are considered poor according to the government definition (Pilgram and Seifert, 2009). However, living costs, such as health insurance contributions, tend to increase faster than pensions. Therefore, interest groups, such as *ProSenectute*, demand to raise complementary services for the elderly and adapt them to rent and energy prices, as well as more tax reliefs for the poorest seniors. If we take a comparative perspective, in Switzerland the rate of poor elderly (+65) was at 26.5 per cent of the age group, which is rather high compared with other European countries (Austria, Denmark, EU25/27/28, France, Finland, Germany, Italy, Netherlands, Norway, Spain, Sweden, UK) (Braun and Thomschke 2017, 18). At the same time, the poverty threshold is higher in Switzerland than in the other countries. For example, the risk of poverty would double among elderly people in Germany if Swiss standards were applied (Braun and Thomschke 2017, 19).

The regional distribution of care affects access and the adequacy LTC. In the cantons of central Switzerland, individuals spent more short periods in LTC nursing homes than in the French-speaking and Italian-speaking cantons (Obsan 2016). These figures imply that in cantons with a lower amount and usage of nursing home places, more individuals as a consequence depend on care at home. These services can be provided by the ambulant care services (*Spitex*) but the situation results also in a higher involvement of relatives in the provision of care services for their dependent relatives (Obsan 2016). Shortages of beds and limited capacity in residential homes are not pressing problems in Switzerland.

Quality challenge: The structural fragmentation in the provision of LTC services complicates the implementation of regional, not to speak of national, quality control measures in Swiss LTC. The main responsibility for quality control is with the cantons, which use their public services to implement quality controls. However, health insurance funds and health care providers also implement quality control measures. Health insurers are mostly concerned with controlling the cost efficiency of health insurance. Providers of care, such as *CURAVIVA* (Association of Swiss Nursing Homes), also implement quality control measures (Gobet et al. 2009). A recent national representative survey on the quality of care – Residents' Perspectives of Living in Nursing Homes in Switzerland (RESPONS) – concluded that the quality of care in Swiss nursing homes is high and that patients are satisfied overall with the care they receive (Sommerhalder et al. 2015).

One specific problem related to quality assurance in LTC relates to the workforce. For example, in nursing homes a large part of the personnel do not have a professional education that spans several years of training in institutions of higher education. As a consequence, many members of the workforce pursue their job for altruistic reasons that are not career and money related. This helps to keep costs low but is challenging for implementing complex and strict quality assessment policies (Mösle 2015, 327). Particularly in the informal care sector, such as care provided by migrant workers, quality controls are difficult to implement. There are also some empirical results that indicate concerns with the quality of care in Switzerland. A 2010 report on late-age care quality, notably palliative care, ranked Switzerland at 30 out of 40 European countries, whereas relative availability of palliative care was evaluated rather well. The federal government responded to this problem with reform initiatives in 2010 (De Pietro et al. 2015, 194). Furthermore, there are measures available for family carers, although these are mostly benefits in kind, such as information and training opportunities (cf. Trein 2016 for details).

Employment challenge: The above-mentioned increase in potential demand for LTC services brings with it an employment challenge. To put it most simply, there is a need for LTC personnel because we can expect a rising number of beneficiaries in the coming years. Nevertheless, a recent report by the Swiss Observatory for Health Policy (OBSAN) reports that the education sector could increase the supply of graduates to LTC-related professions. The additional demand can also be compensated for by recruitment from abroad: this is unlikely to change as long as working conditions in the Swiss LTC sector

remain rather good compared with other countries, such as Germany, which is a large neighbouring country to Switzerland (Obsan 2014). In Germany, the working conditions are difficult and pay is very low compared with other professions in the health sector.[14] Therefore, it is attractive for personnel to move to Switzerland, especially to the German-speaking part of Switzerland. Furthermore, the lack of support for persons of working age with dependent relatives creates another employment challenge, with individuals who take care of a dependent relative working less without adequate financial compensation. Consequently, they often depend on other working persons in their family. Most problematically, due to a lack of alternatives, women often decide to reduce their workload in order to care for dependent relatives without adequate financial compensation or guarantees of professional reintegration after the period of care (Trein 2016). Statistical information supports this point. In Switzerland, in 2016, 32.7 per cent of women who were inactive in the labour market did not work for family/care responsibility reasons (compared with 25 per cent in the EU28). In 2007, 45.5 per cent of inactive women did not work due to caring responsibilities.[15] On the other hand, the proportion of women who were in part-time work because they cared for a child or incapacitated adult was 20.2 per cent in 2016 (compared with 27.4 in the EU28), but the rate of those who work part-time for another personal or family-related reason was at 24.2 per cent (compared with 15.3 in the EU28).[16] Regulating care migration, notably to ensure protection of workers' rights, is another challenge (cf. above).

Financial sustainability challenge: As in many other developed democracies, the sustainability of LTC services is one of the biggest challenges in health policy, because the share of those aged over 65 in the population will increase steeply in the future. Projections of the expected increase in health expenditures assume that the cost of LTC will triple by 2060. Cantons are especially affected, as they currently finance over 60 per cent of public expenditure on healthcare. The expected increase in LTC expenditure affects also the budgets of municipalities, as well as the disability and survivors' insurance schemes. Conversely, the cost pressure on the federal government is smaller, as it is mostly engaged in the co-financing of insurance premium reductions (Colombier 2012; Bonoli and Trein 2018).

The financial sustainability challenge for the Swiss LTC sector is related to two other problems. Firstly, health insurers reimburse the cost of LTC services that are prescribed by a doctor. Health insurance premiums are rising steeply in Switzerland. Therefore, the cost containment challenge that exists for the Swiss health care sector overall also affects the LTC sector (Bonoli and Trein 2018; Trein 2018). Secondly, there are vertical coordination problems. Notably, the federal government tries to shift the costs of LTC to lower levels of government. For example, in 1998, four years after the adoption of the national health insurance law, the federal government reformed the LTC payment system so as to reduce the burden on insurers and shift costs to the cantons and municipalities – which, however, hived the costs off to patients as much as possible (Mösle 2015, 329-330).

2.2 Recent or planned reforms

In recent years, the following reforms have been carried out in the LTC sector:

- By 2010 the federal government had already put in place a national strategy to improve palliative care quality, which it renewed until 2015. Palliative care aims to improve quality of life for patients with incurable chronic illnesses. It comprises medical care and nursing, as well as psychological, social and spiritual support, over a shorter or longer period, depending on the course of disease. In the

[14] Spiegel Online [http://www.spiegel.de/wirtschaft/soziales/altenpflege-ich-kann-den-pflegeraeten-nur-raten-organisiert-euch-a-1169165.html], last accessed February 12, 2018.

[15] Eurostat, variable lfsa_igar. Accessed March 28, 2018.

[16] Eurostat, variable lfsa_epgar. Accessed March 28, 2018.

strategy, the federal government and the cantons aim at implementing palliative care in all sectors of the health system that need to participate in it.[17] This reform is a response to concerns regarding the quality of LTC services.

- The federal government, specifically the federal office for public health, has provided a new dataset on LTC institutions in Switzerland. It contains new information on the number of patients in nursing homes, time of residence, number of personnel per occupant as well as the share of qualified LTC nurses. Additional variables measure the cost per day, the intensity of care that is delivered for each patient as well as the cost-effectiveness of the institution. The data are aimed at providing more information for providers and patients, creating more transparency, and helping to monitor access and personnel in the Swiss LTC sector. According to the federal government, the information will be updated every year.[18]
- The federal government has decided to take an initiative to increase personnel in LTC-related jobs. Starting in 2018, the federal government aims to launch an initiative that is designed to improve the image of jobs in the LTC sector. The goal is to motivate more individuals to enter training and to take up a job in the LTC sector, in order to deal with the problem of high demand for personnel in the sector.[19]
- In February 2017, the federal government put in place a programme to support persons who care for dependent relatives. The goal of this initiative is to do more research on the situation of persons of working age with dependent relatives and to create support measures at the cantonal, the municipal, and the private level (NZZ, February 1, 2017).[20]

2.3 Policy recommendations

Policy recommendations concern two areas of LTC in Switzerland:

1. The first recommendation is about keeping costs under control. Currently, the costs of LTC services are largely hived off to health insurance and pension funds, and to a lower but still noteworthy extent to patients. The dynamics of these hidden costs need to be taken into account, to avoid cost-shifting dynamics that create unequal access and low service quality, either by offloading costs onto patients/claimants or by undermining quality due to excessive cost-containment measures. Therefore, costs need to be distributed equally amongst providers, health insurers, pension funds, generations, and families/patients. This entails guaranteeing enough affordable and good-quality services, which allow patients a certain freedom of choice. One possible option would be to deal with this in the context of existing insurance schemes (pension and health care). Another option is an LTC insurance (NZZ, November 10, 2010, NZZ, October 19, 2011), which Swiss policymakers have debated occasionally but which is currently not a high priority on the political agenda.

[17] Federal Office of Public Health (FOPH) [http://www.bag.admin.ch/themen/gesundheitspolitik/13764/index.html?lang=de], last access, October 10, 2013.

[18] FOPH [https://www.news.admin.ch/message/index.html?lang=de&msg-id=52164], last access, June 1, 2015.

[19] FOPH [https://www.admin.ch/gov/de/start/dokumentation/medienmitteilungen.msg-id-64883.html], last access February 14, 2017.

[20] FOPH [https://www.bag.admin.ch/bag/de/home/themen/strategien-politik/nationale-gesundheitspolitik/foerderprogramme-der-fachkraefteinitiative-plus/foerderprogramme-entlastung-angehoerige.html?_organization=317], last access June 17, 2017. FOPH [https://www.bag.admin.ch/bag/de/home/themen/strategien-politik/nationale-gesundheitspolitik/foerderprogramme-der-fachkraefteinitiative-plus/foerderprogramme-entlastung-angehoerige.html], last access January 13, 2018.

2. The second recommendation concerns labour market and employment related measures. Notably, there is a demand for qualified and trained personnel in the LTC sector and for the professional tasks that are associated with LTC services, such as medical-related aspects. On the other hand, there is a demand for flexible solutions for informal care workers, such as giving financial compensation for their services and ensuring flexibility in jobs, such as full-time or part-time leave from work in order to take care of their dependent relatives. Currently, the national government is working on a legislative project to support carers with dependent relatives (cf. previous section). Eventually, dealing with the situation of care migrants is another important challenge for Swiss policymakers. Particularly, care migrants need to be protected against exploitation by employers (families or middlemen and companies). Therefore, not only the federal government but also the cantons should act, for example by extending Swiss labour law to informal carers from abroad and by creating contact points for care migrants in need.

3 Analysis of the indicators available in the country for measuring LTC

The National Statistical Office of Switzerland (BfS) provides a range of specific information on the financing and provision of LTC services at the national and the cantonal level. Regarding the quality of care, there is less information available. Subnational data is sometimes available and sometimes not. The following table points to the main categories of statistical data available:

Table 2: Data on health and LTC in Switzerland

Indicator	Definition	Source	Frequency and years	Website
Health expenditure and financing (*Kosten und Finanzierung des Gesundheitswesens 2015: Definitive Daten*)	Various health and LTC spending indicators by provider and services	BfS	1960/1996-2015, yearly	https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/kosten-finanzierung.gnpdetail.2017-0083.html
Health determinants (*Gesundheits-determinanten*)	Indicators on health determinants, such as risk factors	BfS	1960/1996-2015, yearly	https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/determinanten.html
State of population health (*Gesundheitszustand*)	Indicators on the state of population health	BfS	various-2015, decade and yearly	https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/gesundheitszustand.html
Health and LTC service structure (*Gesundheitswesen*)	Service provision infrastructure in the health care and LTC sectors	BfS	various-2015, decade and yearly	https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/gesundheitswesen.html
Employment and working time (*Erwerbstätigkeit und Arbeitszeit*)	Employment statistics	BfS	various-2015, decade and yearly	https://www.bfs.admin.ch/bfs/de/home/statistiken/arbeit-erwerb.html?dyn_pageIndex=0
Residents' Perspectives of Living in Nursing Homes in Switzerland (RESPONS) (Lebens- und Pflegequalität im PflegeheimBeschreibende Ergebnisse der	Report on the perceived quality of LTC	College of Higher Education (*Berner Fachho*		https://www.curaviva.ch/files/BFJKEKD/ergebnisse_der_studie_respons.pdf

Befragung von Bewohnerinnen und Bewohnern in Pflegeheimen in der Schweiz)		*chschul e*) Bern		

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