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Healthcare expenditure projections for Switzerland up to 2060: ageing and reforms

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Contents

Abstract

- The growing burden of healthcare expenditure on health insurance premium payers and taxpayers is a central issue in social and fiscal policy reform debates. To highlight the need for reforms in the health sector, this report presents new expenditure projections for Switzerland up to 2060.

- The projections offer insights into the long-term expenditure dynamics in the health sector. They are based on the 2025 population scenarios and incorporate the recently adopted healthcare financing reforms, including the uniform financing of outpatient and inpatient services as well as care (EFAS), and the requirement for cantons to provide a minimum contribution to premium reductions.

- The projections show, first, that structural cost drivers, such as population ageing, rising incomes and medical advances, as well as Baumol's cost disease, will continue to exert sustained pressure on health spending. Based on the underlying assumptions, total expenditure in the health sector is projected to rise from 11.2% of GDP in 2023 to 15.3% of GDP by 2060. While ageing primarily affects expenditure growth in long-term care, non-demographic factors are the main drivers of expenditure growth in healthcare.

- Second, the recent financing reforms lead to shifts in financing between compulsory health insurance and public budgets. Public budgets are expected to face greater pressure in healthcare while experiencing some relief in long-term care. Once these financing reforms have been implemented in the early 2030s, health expenditures for premium payers and taxpayers will grow proportionally.

- Third, for the first time, the projections attempt to capture the shift from inpatient to outpatient healthcare through a more differentiated analysis by type of healthcare service. Because outpatient treatments are, on average, less costly, this shift is expected to reduce growth in healthcare expenditure.

- To account for uncertainty surrounding the cost drivers, alternative scenarios are considered. These scenarios highlight that changes in the assumptions regarding ageing and morbidity, migration, income and medical advances, as well as Baumol's cost disease, can significantly influence expenditure development.

- From a health policy perspective, sustained expenditure growth risks undermining broad access to healthcare for the population. From a fiscal policy perspective, persistently high expenditure growth in healthcare and long-term care absorbs an increasing share of budgets at federal, cantonal and communal levels, thereby crowding out other public expenditure. Furthermore, sustained expenditure growth is likely to intensify calls for greater tax-based financing of the health system, which could also affect the division of responsibilities between the Confederation and the cantons. This, in turn, poses risks to the overall sustainability of public finances.

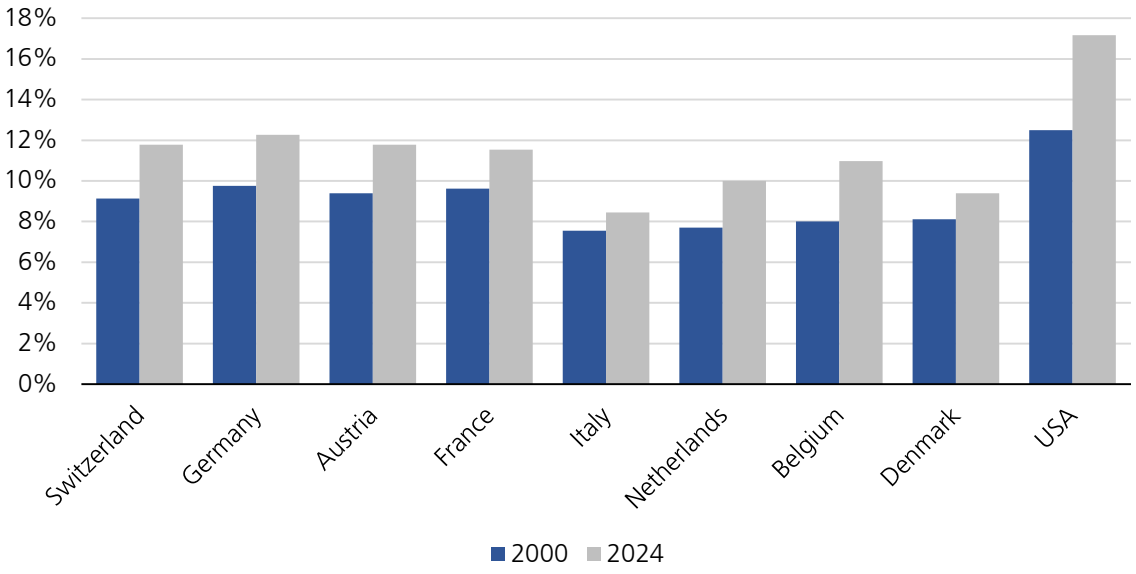
- Against this background, further measures to improve efficiency and contain expenditure growth are necessary. Key approaches include binding cost targets to strengthen cost accountability among healthcare stakeholders and improved hospital planning to reduce overcapacity. In addition, policies should focus on strengthening outpatient flat-rate payments, prevention and health promotion, implementing an effective Health Technology Assessment, improving the coordination and integration of healthcare provision (for example by reducing coordination costs through digitalisation), and pursuing a forward-looking healthcare personnel policy.

1 Introduction

Even after the COVID-19 pandemic, the health sector continues to face major challenges. High-quality healthcare services must remain accessible to the population, while the system needs to deliver care efficiently and remain resilient to health crises. At the same time, healthcare financing must be sustainable over the long term.

The growing burden of healthcare expenditure on health insurance premium payers and taxpayers is one of the greatest concerns of the Swiss population (UBS, 2025). Rising healthcare expenditure is a central issue in social and fiscal policy reform debates. Similar trends can be observed internationally (OECD, 2025). Over recent decades, health sector expenditure has increased sharply in many developed countries (Figure 1). In Switzerland, health spending as a share of gross domestic product (GDP) rose from just over 9% in 2000 to more than 11% in 2024. In 2025, total expenditure in the health sector is likely to have exceeded CHF 100 billion (Anderes and Gersbach, 2025).

Figure 1: Total health expenditure in an international comparison (in % of GDP)

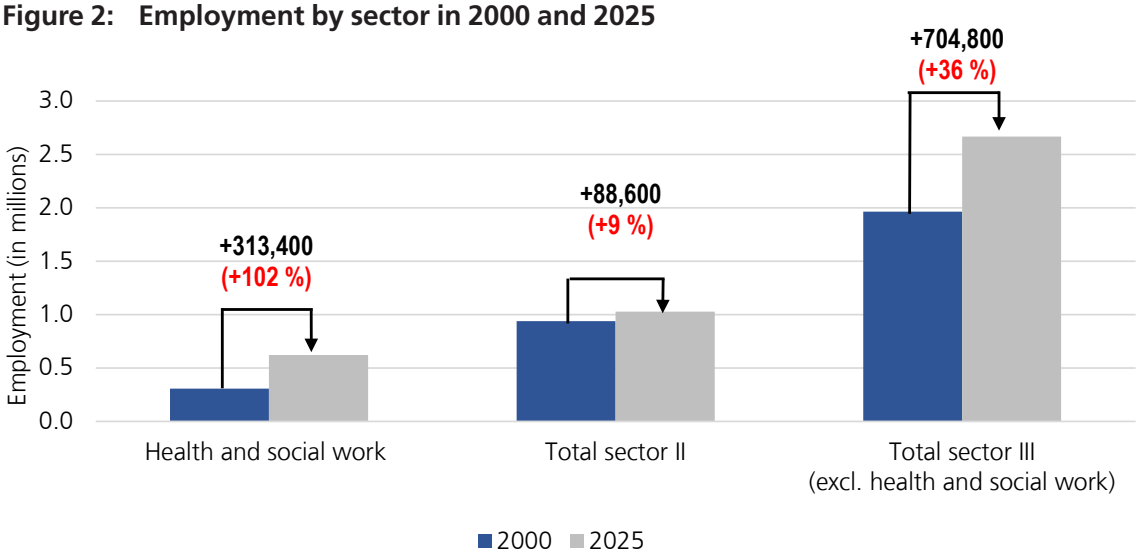


Notes: Preliminary OECD forecasts for 2024.

Source: OECD

The strong expenditure growth in the health sector also has broader macroeconomic implications. In Switzerland, the sector's expansion has been accompanied not only by rising value added but also by substantial employment growth in health and social work, which has become increasingly important for the economy as a whole. Over the past 25 years, employment in this sector has more than doubled, creating more than 300,000 additional full-time equivalent jobs (Figure 2). Over the same period, employment growth in the secondary and tertiary sectors (excluding health and social work) amounted to only 9% and 36% respectively. Current sectoral scenarios also indicate that the health sector will continue to grow in the future (Federal Chancellery, 2025).

Figure 2: Employment by sector in 2000 and 2025



Notes: Changes in employment in absolute and relative (%) terms from Q1/2000 to Q3/2025. Sector II comprises economic branches 5–43 under the General Classification of Economic Activities (NOGA). Sector III comprises branches 45–96. Health and social work comprise branches 86-88.

Source: Federal Statistical Office

An important element of forward-looking policy is ensuring sustainable financing of the health sector. The present expenditure projections for Switzerland up to 2060 make an important contribution in this regard. They provide guidance on the medium- to long-term expenditure dynamics in the health sector, improve the understanding of the underlying cost drivers, and highlight the ongoing pressure for reform.

From a fiscal policy perspective, the central question is how expenditure growth can be contained so that public health spending does not absorb an ever-larger share of the budgets of the cantons and the Confederation. At federal level, for example, rapidly increasing spending on social welfare (e.g. old-age provision and premium reduction), which is mostly tightly earmarked, tends to crowd out less earmarked and more easily adjustable expenditure within the rule-based budget process (Federal Council, 2024). Closely related to this, a key challenge from a social and health policy perspective is how to curb the strong growth in health spending without jeopardising broad access to care, while ensuring the provision of high-quality healthcare services. If healthcare expenditure continues to grow, calls for greater tax-based financing of the health system are also likely to increase, which may in turn affect the division of responsibilities between the Confederation and the cantons.

The expenditure projections are based on the population scenarios of the Federal Statistical Office (Federal Statistical Office, 2025a) and follow a macro-cohort approach. The projection framework is aligned with the methodologies of the OECD (Lorenzoni et al., 2024; OECD, 2025) and the European Commission (AWG, 2024). The projections incorporate the foreseeable effects of the healthcare financing reforms adopted in 2024. These reforms include the introduction of a uniform financing scheme for outpatient and inpatient services as well as care (EFAS), and the requirement for cantons to provide a minimum contribution towards premium reductions from 2026.

The projections consider several structural cost drivers. On the one hand, demographic ageing plays a key role, as an older population demands more healthcare services and has a greater need for long-term care. Beyond the direct effects of ageing, changes in health status (morbidity) associated with rising life expectancy also influence expenditure developments. On the other hand, non-demographic factors are also important. First, the projections account for the relationship between national income growth and healthcare expenditure growth. This relationship reflects both demand-side and supply-side factors, such as rising expectations of the population regarding healthcare services and medical advances. In addition, prices in the health sector have tended to grow faster than in the rest of the economy. This can be attributed to inefficiencies in the health system, shortage of skilled labour, and Baumol's cost disease. The latter describes the phenomenon whereby productivity gains in the labour-intensive health sector are lower than in other sectors of the economy, leading to relatively stronger wage growth and, consequently, higher cost growth.

Additional factors also contribute to higher health spending. In particular, insurance coverage can create incentives to raise expenditure (moral hazard or behavioural hazard). Moreover, asymmetric information between patients and physicians can lead to market failure in the health sector. Because physicians possess superior information and knowledge regarding treatment options, this asymmetry may result in supplier-induced demand, whereby the volume of treatments exceeds what is medically necessary. These factors – together with the large number of stakeholders with partly conflicting interests – contribute to the high degree of complexity in the health sector.

The projections show, first, that ageing, rising incomes and medical advances, as well as Baumol's cost disease will continue to exert sustained pressure on the health sector, both on healthcare and long-term care. In the reference scenario, total expenditure in the health sector is projected to increase from 11.2% of GDP in 2023 to 15.3% by 2060, thus growing considerably faster than the economy.

Non-demographic factors are the main drivers of expenditure growth in healthcare, while population ageing and the associated increase in care needs primarily affect expenditure growth in long-term care. From a financing perspective, the additional burden will fall largely on public budgets and compulsory health insurance (CHI). In the reference scenario, public expenditure on health rises from 3.5% in 2023 to 5.0% of GDP by 2060. More than two-thirds of public health spending is borne by the cantons.

Second, the projections show that the recent reforms lead to shifts in financing between compulsory health insurance and public budgets. Public budgets – particularly those of the cantons – are expected to face a greater financial burden in the healthcare sector from 2028 onwards under the uniform financing scheme (EFAS), as they will also contribute to the financing of outpatient services. From 2032, the cantons and communes are expected to experience some relief on their expenditure on long-term care. Once the financing reforms have been fully implemented in the early 2030s, expenditure on premium- and tax-financed health services under the Federal Act on Health Insurance (HIA) is projected to grow proportionally. Furthermore, the introduction of new minimum cantonal contributions to individual premium reductions (IPR) leads to additional financial burdens for the cantons. The federal budget is affected primarily through its contribution to the financing of IPR, which is set at 7.5% of gross CHI expenditure.

Third, the ongoing shift from inpatient to outpatient healthcare is reflected for the first time through a more differentiated analysis of expenditure dynamics by type of healthcare service. Under the assumptions adopted, expenditure on outpatient healthcare services is projected to increase more strongly relative to GDP between 2023 and 2060 than expenditure on inpatient healthcare services (+2.1 versus +0.7 percentage points of GDP). Since outpatient treatments are, on average, less costly, the continued shift towards outpatient care is expected to slow expenditure growth in the overall healthcare sector.

Moreover, alternative scenarios show the sensitivity of the projections to the assumptions regarding ageing and morbidity, migration, income, as well as Baumol's cost disease. In the scenarios with a more pronounced Baumol's cost disease or a higher income elasticity, total health expenditure rises to 16.7% and 16.3% of GDP respectively by 2060. By contrast, in the scenario with a lower income elasticity, total health expenditure is projected to reach 14.5% of GDP by 2060.

The projections should not be interpreted as forecasts. Rather, they represent an extrapolation of long-term trends and their potential effects on health spending. As such, they do not indicate the exact level that health spending will reach in the future. Instead, they address the following question: how might health spending evolve under the stated assumptions if – apart from the reforms already adopted – no additional policy measures are implemented?

The projections provide guidance on the long-term expenditure dynamics in the health sector and highlight the urgency of further reforms. They build on the 2024 fiscal sustainability report for Switzerland (Federal Department of Finance, 2024) and illustrate the additional burden on premium payers and taxpayers in light of the recent reforms in healthcare financing.

Further measures to improve efficiency and contain expenditure growth are warranted. Important starting points include binding cost targets that strengthen cost accountability among stakeholders in the healthcare system, as well as improved hospital planning to reduce overcapacity. In addition, policies should focus on strengthening outpatient flat-rate payments, prevention and health promotion, implementing an effective Health Technology Assessment, and improving the coordination and integration of healthcare services (e.g. by reducing coordination costs through digitalisation). Finally, a forward-looking personnel policy in the health sector also needs to be pursued.

Despite the focus on the costs of healthcare, it is important to emphasise that a well-functioning health sector generates substantial benefits, as it maintains and improves the health of the population. Better health can also support economic growth (Ridhwan et al., 2022; Fumagalli et al., 2024) – for example through improved utilisation of the labour force potential due to fewer illness-related absences, and through stronger incentives to invest in education, which in turn contributes to higher productivity and innovation.

Section 2 outlines the projection framework. Section 3 presents expenditure projections for the health sector as a whole, for services under the Federal Act on Health Insurance (HIA), as well as for premium payers and for public budgets. Section 4 compares the projections with those of the predecessor study and with projections from other countries. Section 5 concludes by discussing fiscal policy implications.

2 Projection framework

This section presents the key elements of the underlying macro-cohort approach. Section 2.1 decomposes total health expenditure by sector (healthcare and long-term care) and by financing entity (compulsory health insurance and public sector). Section 2.2 introduces the main cost drivers of health expenditure. These cost drivers are incorporated into the projection scenarios described in Section 2.3. Section 2.4 then presents the assumptions regarding demographic and economic developments. Section 2.5 describes the expenditure profiles for the health system. Finally, Section 2.6 discusses how recent financing reforms (EFAS and cantonal minimum contribution to IPR) are incorporated into the projections.

2.1 Health expenditure data

Health expenditure data are primarily drawn from the statistics on "Health care costs and financing" from the Federal Statistical Office (FSO). For the public sector, data from the public finance statistics are used (Federal Finance Administration, 2025). At the time the expenditure projections were prepared, data were available up to 2023 and 2024 for the Confederation (including old-age and survivors' insurance, AHV, and disability insurance, IV) and up to 2023 for cantons and communes. For compulsory health insurance (CHI) data, statistics on compulsory health insurance from the Federal Office of Public Health (FOPH) are used.

The base year for the expenditure projections is generally 2023. However, due to the recent reforms considered in the projections, and the use of the most up-to-date information – including estimates of healthcare expenditure for 2024 to 2026 – the long-term projections using the macro-cohort approach begin in 2027.[1]

Total health expenditure is divided into the two sectors of healthcare and long-term care. Within each sector, expenditure is further differentiated by outpatient and inpatient services.

Subsequently, expenditure on health services under the Federal Act on Health Insurance (HIA services) is identified, as these services will gain importance with the implementation of EFAS. The shares of CHI and public budgets in health financing are then determined, taking into account government transfers such as individual premium reductions (IPR).

By sector, total expenditure in the health sector in 2023 is composed as follows (Figure 3, Panel A):

- 79% corresponds to expenditure on healthcare and 21% is expenditure on long-term care;
- Within healthcare, 54% of expenditure is attributable to outpatient treatment in physicians' practices, hospitals and therapists, while 29% relates to inpatient hospital treatments. The remaining 17% consists of expenditure on administration, education and research, prevention, and dental treatment;
- Within long-term care, 78% of expenditure is attributable to inpatient services in care homes and 22% to outpatient services provided by non-residential care (Spitex).

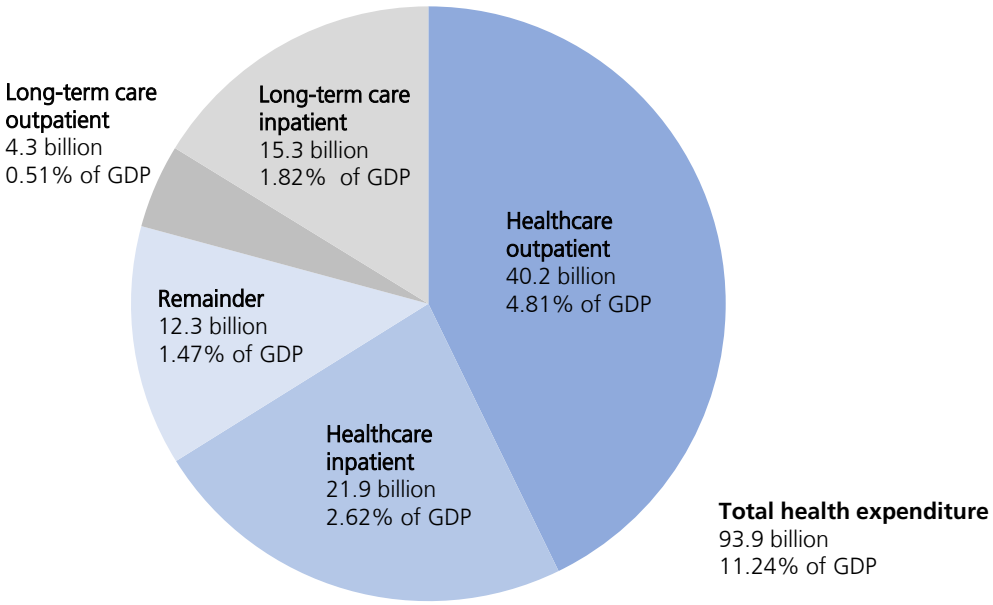
1 Table A1 in the appendix provides an overview of the underlying sources and assumptions for expenditure growth by sector and financing entity for the years 2023 to 2026.

By financing entity, total health expenditure in 2023 can be broken down as follows (Figure 3, Panel B):

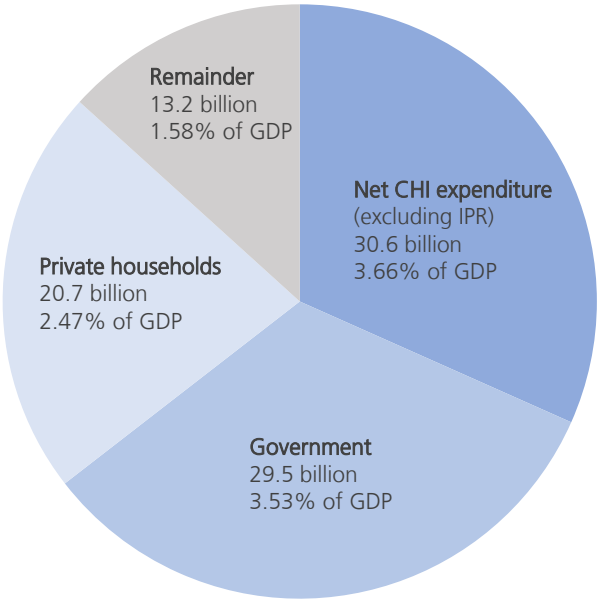
- Net expenditure of CHI (defined as gross CHI expenditure including administrative costs, minus cost sharing by private households and individual premium reductions) accounts for 33% of total expenditure in the health sector;
- Public budgets finance 31% of total health expenditure. Of this amount, 67% is financed by the cantons, 12% by the Confederation, 11% by communes, and 10% by AHV and IV contributions, including expenditure for helplessness allowances and for medical services and therapeutic apparatus;
- Private households cover 22% of total health expenditure, including cost sharing under CHI, out-of-pocket payments and supplementary insurance;
- The remaining 14% is financed by other sources, including compulsory accident insurance, private supplementary insurance and private foundations.

Figure 3: Health expenditure by sector and financing entity in the base year 2023
(in CHF billions and in % of GDP)

Panel A: Expenditure by sector



Panel B: Expenditure by financing entity



Notes: Net CHI expenditure corresponds to gross CHI expenditure, minus cost sharing by private households and expenditure on IPR. IPR is attributed to the general government sector, i.e. public expenditure.

Source: Federal Finance Administration, Federal Statistical Office, Federal Office of Public Health

2.2 Cost drivers in the health sector

The literature discusses several structural factors as key drivers of healthcare expenditure in developed economies. These include population ageing, the population's health status (morbidity), income growth, medical advances, changes in the relative prices for health services compared with the rest of the economy, and institutional factors, such as the extent of insurance coverage. More recently, the link between climate change and health expenditure has also received increasing attention (see Box 1). However, the strength and nature of the relationship between the individual factors and healthcare expenditure is often unclear. The structural cost drivers are explained in more detail below.

2.2.1 Ageing and morbidity

Population ageing influences health expenditure, as older people use more healthcare services on average. As the share of older persons in the population increases, the demand for healthcare and long-term care services rises accordingly, leading to higher health expenditure.[2]

Besides the direct effects of ageing, changes in the population's health status (morbidity) are also relevant. This raises the question of how health evolves as life expectancy increases. The literature discusses three different hypotheses.

2 Some studies suggest that rising healthcare expenditure is explained less by ageing per se and more by proximity to death, also known as the «red herring» hypothesis (Zweifel et al., 1999; Seshamani and Gray, 2004; Werblow et al., 2007; Costa-Font and Vilaplana-Prieto, 2020). This thesis is, however, disputed and is increasingly being questioned (Colombier and Weber, 2011; Panczak et al., 2017; Breyer and Lorenz, 2021; Milkovska et al., 2024). For these reasons, it is not taken into account in the present expenditure projections.

First, an increase in life expectancy may be associated with a pure expansion of morbidity ("pure ageing"). Under this hypothesis, the additional years of life gained are not spent in good health (Gruenberg, 1977), implying a deterioration in the overall health of the population. The second hypothesis assumes a relative decline in morbidity ("healthy ageing"). The time spent in illness or in need of care remains unchanged, while the additional years of life are spent in good health (Manton, 1982). In the third hypothesis, morbidity decreases as life expectancy increases (Fries, 1980; 1989). Advances in medical technology and improved prevention reduce the time spent in illness or in need of care, so that the number of healthy life years increases more than overall life expectancy.

Since the relationship between rising life expectancy and changes in health status remains uncertain, the projections include scenarios with alternative assumptions on the future development of morbidity.

2.2.2 Income growth and medical advances

The first non-demographic structural factor considered in the projections is income growth. Numerous studies show that income growth is a key driver of expenditure growth in the health sector (Nghiem and Connelly, 2017). As incomes rise, healthcare expenditure typically increases as well. For Switzerland, as in many other developed countries, the income elasticity of health expenditure is estimated to be around one or below (De la Maisonneuve and Martins, 2014; Hartwig and Sturm, 2014; Baltagi et al., 2017; Colombier, 2018; AWG, 2024; Lerch et al., 2025). This relationship captures both demand-side and supply-side effects. On the demand side, higher incomes may improve access to healthcare services and raise expectations regarding the quality of healthcare. On the supply side, income growth is also associated with medical advances that expand treatment possibilities. Since the direct effect of medical advances on health expenditure is difficult to isolate empirically (Marino and Lorenzoni, 2019; Lorenzoni et al., 2024), the projections capture it indirectly through national income growth (Smith et al., 2009).

2.2.3 Baumol's cost disease and wage pressure

The second non-demographic factor considered in the projections relates to changes in the relative prices for health services compared with the rest of the economy.

In health economics, Baumol's cost disease is widely regarded as an important supply-side explanation for rising expenditure in the health sector (Baumol, 1967; Bates and Santerre, 2013; Hartwig, 2008; Hartwig and Sturm, 2014; Colombier, 2017). The underlying mechanism is that cost pressures tend to increase more in labour-intensive sectors such as healthcare than in other sectors of the economy, as they benefit less from technological progress. As a result, productivity growth in the health sector is lower than in the economy as a whole. However, given the relatively price-inelastic demand for health services, wages for healthcare workers must rise at the same rate as wages in the rest of the economy to maintain the attractiveness of employment in the sector. This dynamic can generate wage pressures and, consequently, cost pressures in the health sector. Baumol's cost disease is considered particularly relevant for labour-intensive long-term care (Celebi et al., 2025). By contrast, productivity gains are more likely in the more capital- and technology-intensive hospital sector.

Several factors may reinforce this trend. For example, shortages of skilled labour, which may be exacerbated by population ageing, can increase cost pressures. On the supply side, the relative size of the working-age population is declining, while on the demand side, the need for long-term care personnel is increasing (Obsan, 2025b). In addition, supply-side inefficiencies in the healthcare system – such as insufficient coordination between service providers or misaligned incentives in tariff structures – can further increase cost pressures.

In the following, Baumol's cost disease is used as a parsimonious proxy for these supply-side factors, capturing relative price effects that cannot be separately identified in the available data.

2.2.4 Factors not included

Institutional and regulatory conditions also influence the development of health expenditure. Examples include the remuneration and tariff systems for service providers, as well as policy instruments such as family doctor models and cost-sharing arrangements. However, deriving clear empirical estimates of their cost effects is often difficult, as these factors have primarily been analysed through cross-country comparisons (De la Maisonneuve et al., 2016). Moreover, major institutional differences are generally more relevant for international comparisons than for country-specific projections, which typically rely on a "no policy change" assumption.

Furthermore, certain structural trends such as the shift in care of older persons from family members to institutional care (Spitex and nursing homes) – for example due to the greater labour force participation of women – are not considered. Likewise, changes in tariffs and prices for treatments and pharmaceuticals are not modelled explicitly. Assumptions about such developments over the projection horizon to 2060 would be subject to considerable uncertainty.

Box 1: The effects of climate change on health

The health consequences of climate change are receiving increasing attention in the literature. Epidemiological studies already show that heatwaves have significant effects on mortality and morbidity (Gasparrini et al., 2015; Haines and Ebi, 2019). As climate change progresses, the frequency and intensity of heatwaves are likely to increase further, placing additional burden on the health sector. This effect may be amplified by population ageing, as older individuals are particularly vulnerable to heat stress, air pollution and climate-related infectious diseases (AWG, 2024). Despite these concerns, empirical research on the link between climate change and healthcare expenditure remains limited.

For the United States, a recent study by ETH Zurich estimates that global warming of 2.5 degrees Celsius above pre-industrial levels could increase public healthcare expenditure by around 3 percentage points of GDP by 2050 (Barrage, 2024). Similar findings are reported for the EU (Socol et al., 2023). With rising temperatures and an ageing population, the number of individuals potentially affected by climate-related health problems could roughly double by 2050 (Falchetta et al., 2024; Holzhausen et al., 2024).

The Intergovernmental Panel on Climate Change (IPCC), the World Health Organization (WHO) and the European Environment Agency (EEA) point out that Europe is among the regions globally facing the highest climate-related risks (IPCC, 2022; WHO, 2022; Kazmierczak et al., 2022). In Switzerland as well, the health consequences of climate change are becoming

increasingly relevant. The National Centre for Climate Services has examined the effects of increasing future heat stress on healthcare costs (NCCS, 2025). A 2019 study shows that climate change is likely to increase both heat-related mortality from cardiovascular and respiratory diseases, and productivity losses among the labour force (Voehringer et al., 2019). Another study estimates that heat-related mortality in Switzerland could rise from around 300 deaths per year today to approximately 1,900 by 2060 (de Schrijver et al., 2023).

2.3 Scenarios

The expenditure projections are based on "if-then" propositions and should not be interpreted as forecasts of future health expenditure developments. Instead, health expenditure is projected into the future using a model-based approach under different scenarios that reflect key structural cost drivers. Because the cost drivers vary across different health sectors, the scenarios are estimated separately for healthcare and long-term care. Each of these sectors is further subdivided into outpatient and inpatient services.

Healthcare expenditure includes spending on outpatient treatment (e.g. services provided by doctors' practices and hospitals, physiotherapy, psychotherapy, pharmaceuticals, therapeutic devices, and support services such as laboratory services), inpatient treatment in hospitals (e.g. hospitals and psychiatric clinics, pharmaceuticals, therapeutic devices, and support services such as transport and rescue), as well as expenditure on administration, education and research, prevention and dental treatment. Long-term care expenditure includes spending on inpatient services in care homes and outpatient services provided by non-residential care (Spitex).

For the first time, the present expenditure projections explicitly account for the ongoing shift from inpatient to outpatient healthcare services. This trend is driven, for example, by the increasing use of minimally invasive procedures and other treatments that, due to medical advances, no longer require inpatient care (Obsan, 2025a). In Switzerland, the introduction of EFAS is expected to further reinforce this development (Polynomics, 2022).

The projections are subject to uncertainty regarding future economic developments, the magnitude of cost effects, and the modelling of non-demographic factors in the health sector, particularly medical advances. To reflect these uncertainties, alternative scenarios are presented alongside a reference scenario. Table 1 summarises the key assumptions underlying the different scenarios, which are described in the following two subsections.

2.3.1 Reference scenario

The reference scenario is based on population projections up to 2060 from the Federal Statistical Office's medium population scenario (A-00-2025). At the same time, the population's health status improves as life expectancy increases. In the macro-cohort model, the improvement in morbidity is represented by an age shift. This implies that, for example, a 50-year-old individual in the future is healthier than a 50-year-old individual in the base year 2023. In the reference scenario, we assume that for every additional year of life expectancy, each cohort is effectively half a year younger in health terms – and thus healthier – than in 2023.

Within healthcare, expenditure is assumed to increase more than proportionately with rising incomes. The income elasticity is 1.2 for outpatient services and 1.0 for inpatient services. These assumptions reflect the population's rising expectations regarding health services (demand-side effect), as well as medical and technological advances, and increases in service volumes that are not medically indicated (supply-side effects). For inpatient services, the elasticity is somewhat lower due to their higher capital intensity, which makes them benefit more from efficiency gains arising from medical advances. Moreover, the higher income elasticity for outpatient services reflects the ongoing shift from inpatient to outpatient care, which tends to intensify with medical advances.

Regarding prices in healthcare, it is assumed that these exceed general inflation by 50% for outpatient services and by 25% for inpatient services. This above-average inflation can be attributed in part to Baumol's cost disease. The difference in price developments between outpatient and inpatient services is attributable to the higher capital intensity for inpatient services.

For long-term care, the same assumptions regarding demographic development and morbidity apply as for healthcare, reflecting the population's need for care. However, Baumol's cost disease is particularly pronounced in long-term care (Celebi et al., 2025). For this reason, prices in this sector are assumed to grow 75% faster than in the economy as a whole. This magnitude is consistent with the high share of personnel costs in the care home sector (Credit Suisse, 2015).

Table 1: Scenarios for the expenditure projections

Scenario	Healthcare				Long-term care	Morbidity	FSO scenario
	Income elasticity		Wage pressure		Wage pressure		
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient/inpatient		
Reference	1.2	1.0	0.50	0.25	0.75	0.50	A-00-2025
Healthy ageing	1.2	1.0	0.50	0.25	0.75	**1.00**	A-00-2025
Pure ageing	1.2	1.0	0.50	0.25	0.75	**0.00**	A-00-2025
Wage pressure	1.2	1.0	**0.75**	**0.50**	**1.00**	0.50	A-00-2025
Cost pressure	**1.5**	**1.3**	0.50	0.25	–	0.50	A-00-2025
Cost containment	**0.9**	**0.7**	0.50	0.25	–	0.50	A-00-2025
High migration	1.2	1.0	0.50	0.25	0.75	0.50	**A-05-2025**
Low migration	1.2	1.0	0.50	0.25	0.75	0.50	**A-06-2025**

Notes: The values shown in bold indicate the hypothesis by which the respective alternative scenario differs from the reference scenario. It is assumed for simplicity that the need for care, and thus long-term care expenditure, does not depend on income. The wage pressure factor indicates the extent to which a wage increase in the health sector contributes to an increase in per capita expenditure. A value of 0.5 means, for example, that a 1% wage increase raises per capita expenditure by 0.5 percentage points. The morbidity factor indicates how an increase in life expectancy, differentiated by age and gender, translates into a change in the health status or the need for care respectively. A value of 1.0 means, for example, that the period of life spent in good health and the period of life spent without the need for care rise proportionally to life expectancy.

2.3.2 Alternative scenarios

Ageing and morbidity

To account for uncertainty regarding how the health status changes as life expectancy increases, two alternative scenarios are considered in which it evolves more or less favourably than in the reference scenario. In the healthy ageing scenario, the population spends all the additional years of life in good health (factor of 1 instead of 0.5, as in the reference scenario). In the pure ageing scenario, by contrast, the additional years of life are assumed to be spent in poor health (factor of 0).

Increasing wage pressure

Uncertainty also surrounds how wages in the health sector will evolve relative to the rest of the economy, particularly in light of Baumol's cost disease, shortages of skilled labour and potential inefficiencies in the health sector. This uncertainty is reflected in the wage pressure scenario, which assumes a price differential that is 25 percentage points higher than in the reference scenario for both outpatient and inpatient services. In long-term care, this implies a relative inflation of 100%. In other words, in this scenario, productivity growth is lower for healthcare than in the reference scenario, while no productivity growth is assumed in long-term care.

Higher income elasticity

Furthermore, there is uncertainty regarding the extent to which future income growth will affect healthcare expenditure. In the cost pressure scenario, income-related, non-demographic cost drivers – such as medical advances or rising expectations of the population regarding health services – lead to stronger expenditure growth. In this scenario, the income elasticity is 1.5 for outpatient services and 1.3 for inpatient services.

Lower income elasticity

Conversely, empirical estimates suggest that the income elasticity in Switzerland has weakened since the 1990s, with values in some cases below 1 (Lerch et al., 2025). Possible explanations include efficiency gains resulting from medical advances, which could be further enhanced in the future through digitalisation and the use of artificial intelligence in the health sector (Prognos, 2025). In addition, once a certain level of economic development and income has been reached, increases in the population's demand for health services may become more moderate (Baltagi et al., 2017).

A lower income elasticity in the future could also result from several recently adopted reforms whose effects will only materialise in the coming years. These include the regular adjustment of physicians' tariffs (e.g. the introduction of TARDOC from 1 January 2026), the introduction – and possible further development – of cost and quality targets (see amendment of Article 54 of the HIA, SR 832.10)[3] and other measures aimed at improving efficiency gains and strengthening cost containment (e.g. cost containment package 2).

The ongoing shift of healthcare services towards outpatient care may also dampen expenditure growth, as treatments are increasingly moved from the cost-intensive inpatient sector to the comparatively less expensive outpatient sector (Polynomics, 2022). This trend is driven both by technological progress and the introduction of EFAS, which reduces distortions created by the previously differing financing arrangements for outpatient and inpatient services. However, both the duration of this trend and the magnitude of the resulting savings remain uncertain.

3 By the end of 2026, the Federal Council will, for the first time, set cost growth targets for the period 2028 to 2031, based on medical needs and taking into account efficiency and quality of care. In addition, it has established the Federal Commission for Cost and Quality Monitoring, which tracks expenditure developments across service areas and issues recommendations on measures to ensure compliance with the targets.

To capture the potential effects of these developments and policy measures, the projections include a stylised cost containment scenario, in which the income elasticity is assumed to be 0.9 for outpatient healthcare services and 0.7 for inpatient healthcare services.

For long-term care, by contrast, the need for care is assumed to be independent of income. Consequently, the cost pressure and cost containment scenarios are not applied to long-term care.

Migration scenarios

A further significant – yet difficult to estimate – factor shaping population developments in a small open economy such as Switzerland is immigration. To capture the associated uncertainty, we use the Federal Statistical Office's population scenarios with high and low net migration (A-05-2025 and A-06-2025). Because immigration mainly occurs among working-age individuals – and the foreign working-age population is therefore, on average, younger than the domestic population – higher immigration slows the ageing process and supports economic growth. Conversely, lower immigration accelerates population ageing and slows economic growth. Through these demographic effects, immigration also influences the development of health expenditure.

For the sake of simplicity, the projections do not account for differences in utilisation of health services by domestic and foreign persons. The empirical evidence suggests that foreign individuals tend to use fewer health services than the domestic population (Giuntella and Mazzonna, 2015; Kennedy et al., 2015; Federal Statistical Office, 2025b). The projections also do not consider the potential impact of immigration on labour supply and thus on shortages of skilled labour in the health sector (Obsan, 2025b).

2.4 Assumptions on demographic and economic developments

Demographic developments in the projections are based on the Federal Statistical Office's reference population scenario (A-00-2025) for the period 2025–2060. This horizon allows for a comprehensive assessment of ageing-related health costs, particularly those associated with the retirement of the baby-boomer generation.

According to the Federal Statistical Office's projections, Switzerland's population will increase from just under 9 million in 2023 to 10.6 million in 2060, corresponding to an average annual growth rate of 0.45%. Population growth is expected to moderate over time: while a cumulative increase of 11.2% is projected up to 2040, it moderates to 5.8% between 2040 and 2060.

Overall, population ageing continues to advance, driven by an assumed persistently low fertility rate of around 1.4 children per woman and rising life expectancy. Between 2023 and 2060, life expectancy is projected to increase from 82.2 to 85.9 years for men and from 85.8 to 88.9 years for women. As a result, the old-age dependency ratio – defined as the population aged 65 and over relative to the working-age population (20–64 years) – is projected to rise from around 32% in 2023 to over 46% in 2060.

The alternative migration scenarios (A-05-2025 and A-06-2025) project population levels of 11.4 and 9.8 million, respectively, by 2060 – around 800,000 higher and lower than in the reference scenario. These differences are attributable to the higher and lower assumed net immigration in each case. Under these scenarios, the old-age dependency ratio in 2060 stands at 43% and 50% respectively.

In addition to demographic assumptions, the expenditure projections also require assumptions about future economic developments. In this context, we distinguish between short-term forecasts and long-term projections. Actual GDP developments are used up to 2024, while forecasts from the Federal Expert Group are applied for the period 2025-2027. Beyond this horizon, GDP is projected in line with the scenario approach of the State Secretariat for Economic Affairs (as of December 2025). Under these assumptions, real GDP grows at an average annual rate of 1.35% from 2023 to 2027. From 2030 onwards, GDP growth is determined in line with the approach of the State Secretariat for Economic Affairs (SECO), as the product of assumed macroeconomic productivity gains (1.15% per year) and the development of the working-age population in full-time equivalents (FTEs), based on the population scenarios of the Federal Statistical Office. This yields an average annual real GDP growth rate of 1.3% for the period 2030-2060. Table A2 in the appendix summarises the key assumptions on demographic and economic developments.

2.5 Expenditure profiles for the health sector

In the macro-cohort approach, alongside population scenarios, expenditure profiles for healthcare and long-term care constitute a key input. These profiles describe the per capita spending on healthcare and long-term care by age and sex in the base year 2023.

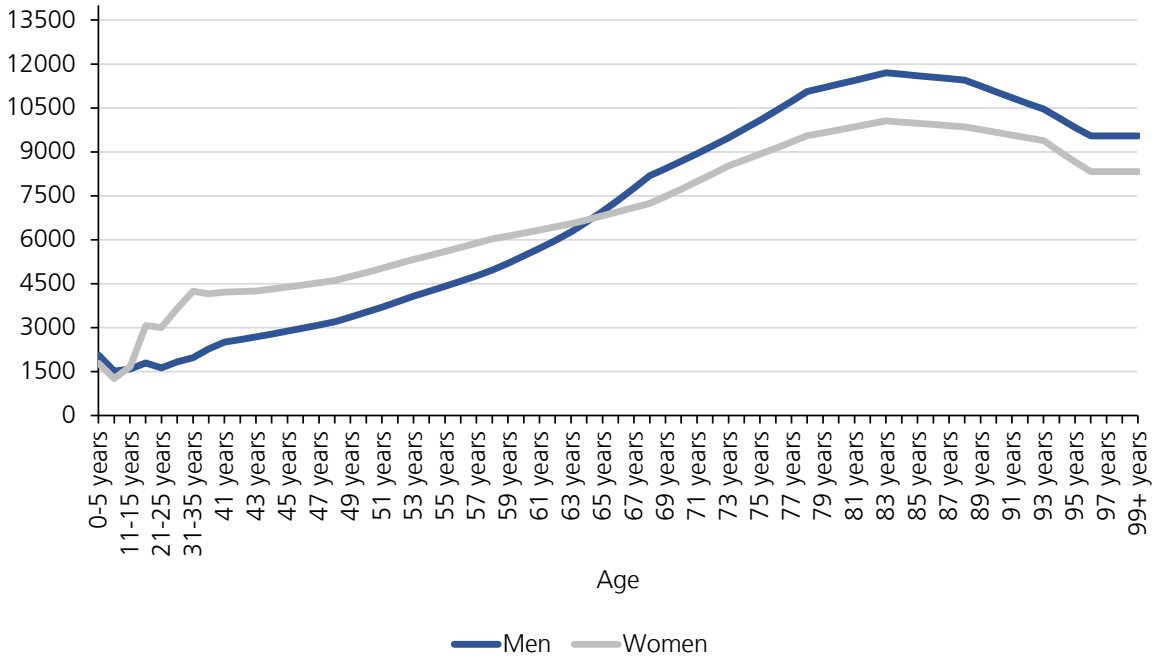
The Federal Statistical Office provides these profiles in 5-year age cohorts. To adequately capture changes in the health status (morbidity) in the projections, the data are annualised by assuming that the average expenditure of each 5-year age cohort corresponds to the expenditure at the cohort's midpoint age.[4,5]

Given substantial differences in life expectancy and morbidity between women and men, as well as between outpatient and inpatient health services, the expenditure profiles are further differentiated by gender and type of service. Figure 4 illustrates, by way of example, the average expenditure on outpatient healthcare services by age and sex for 2023.

4 A more precise analysis of morbidity effects would require information on the probability of illness and the need for care for each birth cohort. As such data are not available, changes in per capita expenditure are used as a proxy for changes in morbidity.

5 Since per capita health expenditure for individuals under 41 years and per capita long-term care expenditure for individuals under 61 years vary little with age, morbidity effects are only modelled from age 41 onwards for healthcare and from age 61 onwards for long-term care. From age 96, per capita expenditure is assumed to remain constant.

Figure 4: Healthcare expenditure for outpatient services by gender in 2023 (in CHF)



Source: Federal Statistical Office, Federal Finance Administration

We quantify the impact of demographic change – particularly shifts in population size and age structure – on health expenditure by multiplying per capita expenditure in 2023 for each age cohort by the projected population development in the corresponding cohorts.

Per capita expenditure can be decomposed into the price of services and the volume of services per capita. Demographic change is assumed to affect neither the service prices nor utilisation rates within age cohorts. Instead, these components are influenced by assumptions regarding morbidity trends and non-demographic cost drivers, such as medical advances or Baumol's cost disease.

For instance, if the population's health status improves over the projection horizon, per capita expenditure within each age cohort decreases and the expenditure profile shifts to the right (Figure A1 in the appendix). This reflects a lower probability of illness or need for care, leading to reduced service utilisation per capita. By contrast, cost pressures arising from medical advances increase per capita expenditure within each cohort. As non-demographic cost drivers are assumed to affect all age cohorts uniformly, the expenditure profile shifts upward overall (Figure A1). Such increases in expenditure may result from higher unit costs, more intensive use of services per patient, or a combination of both.[6,7]

6 In the case of price increases driven by medical advances, it is difficult to determine to what extent they reflect genuine price effects as opposed to improvements in the quality of care. Ideally, such quality gains would need to be netted out to identify the actual price increase. However, this is already challenging when analysing past expenditure trends and lies beyond the scope of the present approach.

7 A detailed description of the projection methodology is provided in Colombier (2012) and Brändle and Colombier (2022).

2.6 Inclusion of recent health financing reforms

The projections assume that the policy framework in the health sector remains unchanged relative to the current status ("no policy change"). This includes the reforms adopted in 2024 – namely the introduction of uniform financing for outpatient and inpatient health services as well as care (EFAS), and the cantonal minimum contributions to the financing of IPR – even though these measures will only take effect in the coming years.[8]

Uniform financing of outpatient and inpatient services as well as care (EFAS)

On 24 November 2024, the electorate approved the reform introducing the uniform financing of outpatient and inpatient health services as well as care (EFAS) under the Federal Act on Health Insurance (HIA), which was adopted by Parliament in December 2023. The reform covers both inpatient and outpatient HIA services for healthcare and long-term care, which are jointly financed by compulsory health insurance (CHI) and by cantons and communes (Federal Office of Public Health, 2024a).

HIA services are financed by CHI (premium payers), cantons and communes (taxpayers), and through cost sharing by private households under CHI. Together, these components constitute the gross HIA services under EFAS, which amounted to around CHF 52 billion in 2023 – equivalent to 6.2% of GDP and 55% of total health expenditure.

Services financed exclusively by premium payers and taxpayers are referred to as net HIA services. In 2023, these amounted to CHF 46.5 billion, corresponding to 5.6% of GDP and 49% of total health expenditure.

EFAS aims to promote the shift from more costly inpatient treatments to more cost-effective outpatient treatment, to strengthen cooperation among service providers – for example, between physicians in private practices and hospitals, as well as between general practitioners and specialists (coordinated care) – and to ensure sustainable financing of long-term care services (Federal Office of Public Health, 2024b). At the same time, the shift from inpatient to outpatient services should no longer be borne solely by health insurance premium payers, but is to be co-financed by cantonal taxpayers (Federal Office of Public Health, 2024c).

Under the current system, CHI fully finances outpatient HIA healthcare services, while inpatient hospital services – remunerated through case-based lump sums (SwissDRG) – are financed at least 55% by cantons and up to 45% by CHI. In long-term care, the Federal Office of Public Health estimated that 46% of HIA expenditure in 2022 was financed by cantons and communes and 54% by CHI. Based on the financing shares between 2016 and 2019, a cost-neutral financing key for EFAS was established between cantons and communes (taxpayers) and CHI (premium payers), ensuring that the overall burden remains unchanged relative to that period (Infras, 2021; Federal Office of Public Health, 2024c).

8 An exception to the "no policy change" assumption is the cost-containment scenario, which assumes a lower income elasticity. This is intended to capture potential efficiency gains that arise from future medical advances, the ongoing shift from inpatient to outpatient health services, and possible additional reforms.

EFAS will be introduced in two stages (Federal Office of Public Health, 2024a). In a first step, from 2028, the financing of outpatient and inpatient HIA services in healthcare will be unified. At that stage, taxpayers will cover at least 24.5% of healthcare expenditure and premium payers at most 75.5%. In a second step, from 2032, HIA services in long-term care will also be integrated. Thereafter, taxpayers will cover at least 26.9% of total expenditure on net HIA services, and premium payers at most 73.1%.

The projections apply this financing key to net HIA services and incorporate EFAS from 2028 onwards.[9] To this end, public health expenditure is disaggregated into spending on HIA services and other services and transfers, such as IPR or supplementary benefits under AHV for long-term care.

Cantonal minimum contribution to the financing of premium reductions

Following the rejection of the SP's premium relief initiative (maximum 10% of income for health insurance premiums), voters approved the Federal Council's indirect counter-proposal on the reform of cantonal individual premium reductions (IPR) on 9 June 2024. This reform, which entered into force on 1 January 2026, is also incorporated in the expenditure projections.[10]

The reform requires cantons to finance a minimum share of between 3.5% and 7.5% of cantonal gross CHI expenditure (Federal Office of Public Health, 2024e; Article 65 para. 1ter-1octies of the HIA). The minimum contribution depends on the premium burden faced by the 40% lowest-income households in the respective canton. If the burden of these households is below 11% of their taxable income, the canton must contribute at least 3.5% of cantonal gross CHI costs through IPR. The minimum share increases progressively with the premium burden on the 40% lowest-income households – up to 7.5%, when the burden on taxable income is 18.5% or higher. Given that over the long term household incomes have, on average, grown more slowly than CHI expenditure, it can be expected that every canton will eventually reach the highest minimum contribution rate of 7.5%.

The Federal Office of Public Health determines cantonal minimum contributions in accordance with the Ordinance on Cantonal and Federal Contributions to Premium Reduction in Health Insurance (HIPRO), which entered into force on 1 January 2026. Currently, some cantons already contribute more than the highest minimum contribution rate of 7.5%, while a smaller group falls below the statutory minimum of 3.5%. Most cantons lie within the range of 3.5% and 7.5%.

This classification forms the basis for the projections of cantonal IPR contributions. As CHI expenditure is expected to grow faster than the income of the 40% lowest-income households, the premium burden on this group will continue to rise. We assume that all cantons will reach the minimum share of 7.5% by 2033. For cantons that already exceed this threshold, we assume that their current contribution rates will remain unchanged. Over the medium term, this yields an average cantonal IPR contribution of 8.5% of gross CHI expenditure.

9 The financing key for gross HIA services is calculated equivalently and therefore results in the same allocation of financing shares between premium payers and taxpayers (Infras, 2021).

10 To this end, the Ordinance on the Federal Contribution to Premium Reduction in Health Insurance (HIPRO, SR 832.112.4) was fully revised and the Health Insurance Ordinance (HIO, SR 832.102) was amended accordingly.

3 Results of the health expenditure projections

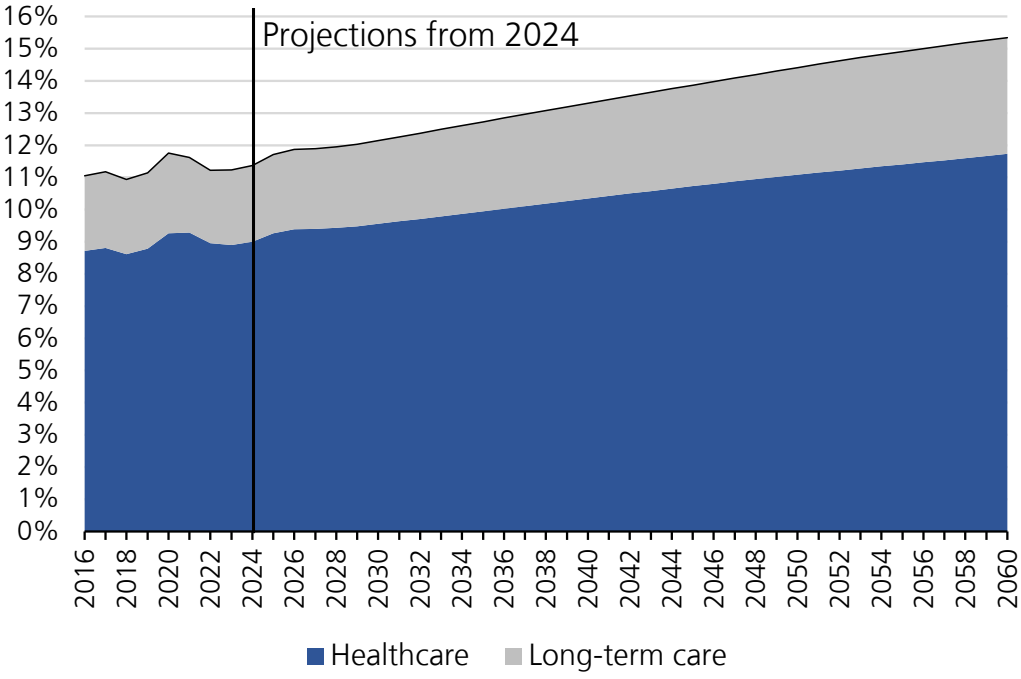
This section presents the results of the health expenditure projections from various perspectives. Section 3.1 provides an overview of the development of total health expenditure up to 2060 in the reference scenario and in the alternative scenarios. Section 3.2 focuses on expenditure for HIA services, which will gain importance under EFAS, and differentiates between premium- and tax-financed expenditure. Section 3.3 analyses the evolution in compulsory health insurance premiums. Section 3.4 examines public health expenditure, focusing on the developments across different levels of government. A comprehensive overview of the projection results is provided in Table A3 in the appendix.

3.1 Total expenditure in the health sector up to 2060

3.1.1 Health expenditure in the reference scenario

As shown in Figure 5, total health expenditure remained relatively stable between 2016 and 2019 at around 11.0% of GDP. During the COVID-19 pandemic, it rose temporarily to 11.8% of GDP, before declining again to 11.2% of GDP in the subsequent years, including the base year 2023 (CHF 93.9 billion). Over the projection horizon, we project total health expenditure to grow markedly, reaching 15.3% of GDP in 2060 in the absence of additional reforms. This increase reflects the fact that health expenditure grows faster than GDP, with an average annual (nominal) growth rate of 3.2%, compared to around 2.3% for GDP (Table A2).

Figure 5: Total health expenditure by sector between 2016–2023 and in the reference scenario (in % of GDP)



Notes: For the years 2024 to 2026, the calculations are based on estimates.

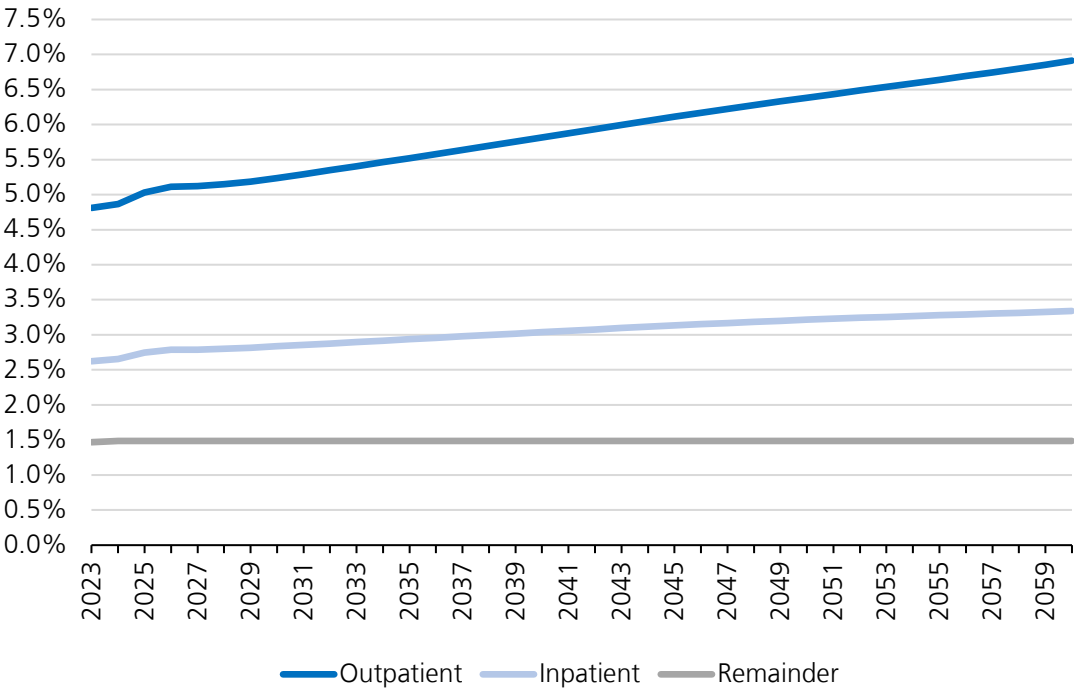
Source: Federal Statistical Office, Federal Office of Public Health, Federal Finance Administration, State Secretariat for Economic Affairs

Expenditure on healthcare increases from 8.9% of GDP in 2023 to 11.7% of GDP in 2060.[11] Over the same period, expenditure on long-term care increases from 2.3% to 3.6% of GDP. Long-term care expenditure thus grows more dynamically, increasing its share of total health expenditure from around 21% to over 23%.

Figure 6 illustrates the projected development of expenditure on outpatient and inpatient services in healthcare and long-term care. In 2023, expenditure on outpatient and inpatient healthcare services amounted to around 4.8% and 2.6% of GDP. By 2060, they are projected to rise to 6.9% and 3.3% of GDP. Expenditure on outpatient services thus grows more strongly, increasing by 2.1 percentage points of GDP, compared with 0.7 percentage points for inpatient services. This pattern reflects the ongoing shift from inpatient to outpatient care. As outpatient treatments are, on average, less costly, this trend contributes to moderating total expenditure growth in the health sector.

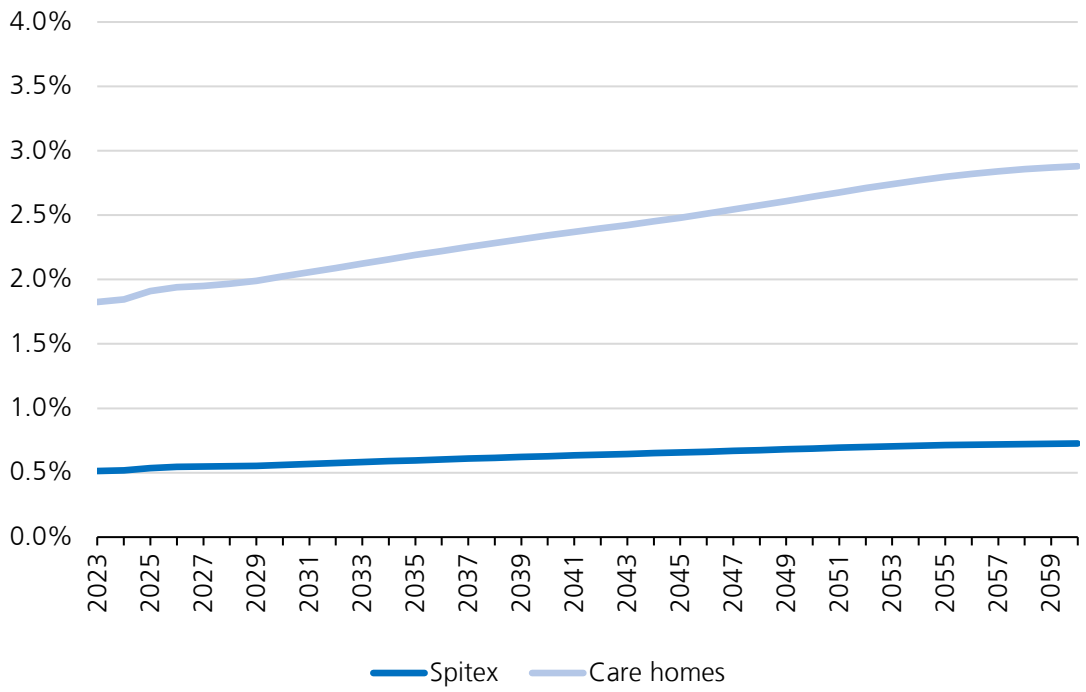
Figure 6: Health expenditure by sector and type of service (in % of GDP)

Panel A: Expenditure on healthcare



11 Expenditure on administration, education and research, prevention and dental treatment is projected proportional to GDP growth, as these areas are not subject to the same cost drivers as the other areas in the health sector.

Panel B: Expenditure on long-term care



Notes: Expenditures falling under the "Remainder" category include administration, education and research, prevention and dental treatment.

Source: Federal Finance Administration

In long-term care, expenditure on outpatient services (Spitex) amounted to 0.5% of GDP in 2023 and is projected to rise to 0.7% by 2060. Expenditure for inpatient services (nursing and care homes) increases from 1.8% to 2.9% of GDP over the same period. In contrast to healthcare, expenditure for inpatient services in long-term care grows more strongly than for outpatient services. The divergence from the shift towards outpatient services observed in healthcare can be explained, among other factors, by the assumption of no income effect in long-term care. While medical advances may also enable a greater provision of long-term care services in outpatient settings, this effect is less pronounced than in healthcare due to the higher labour intensity in the sector. In addition, Baumol's cost disease also has a stronger impact in long-term care than on healthcare.

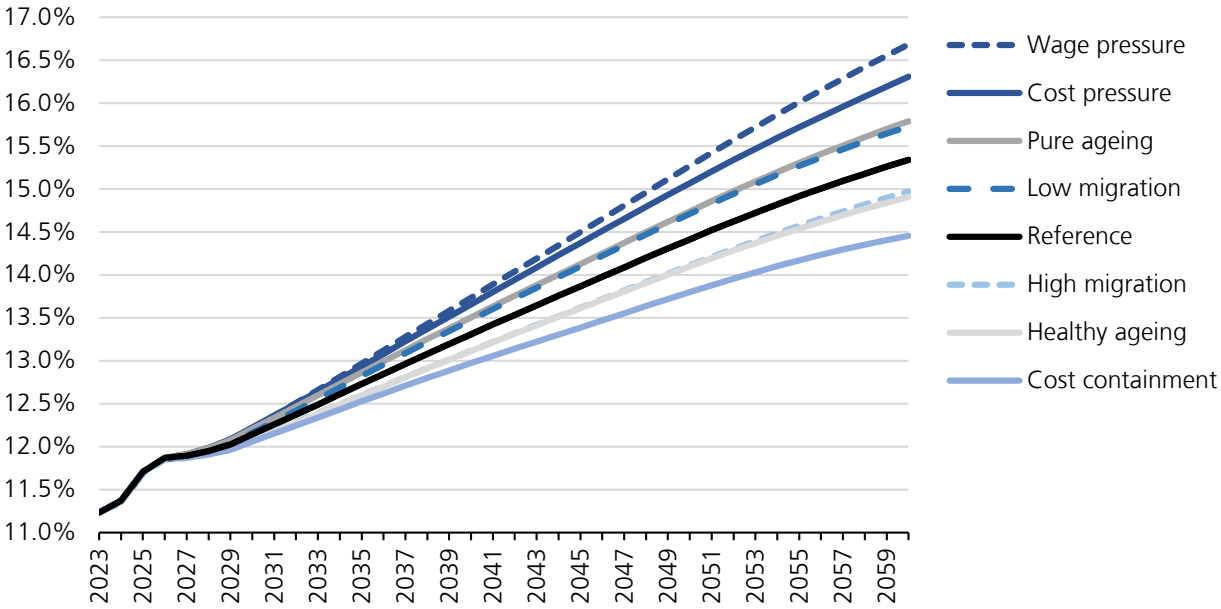
3.1.2 Health expenditure in the alternative scenarios

Figure 7 presents the expenditure projections under the different scenarios. The development of total health expenditure is particularly sensitive to non-demographic cost drivers, especially assumptions regarding wage pressure (e.g. from Baumol's cost disease, shortages of skilled labour, and inefficiencies in the health system) and the income elasticity (e.g. from increased supplier-induced demand or the approval of new, cost-intensive therapies). Under the wage and cost pressure scenarios, health expenditure is projected to reach 16.7% and 16.3% of GDP by 2060.

In the cost containment scenario, health expenditure continues to grow faster than the economy up to 2060, but increases more moderately, reaching 14.5% of GDP by 2060. Such a development could be supported by medical advances, digitalisation, the use of artificial intelligence, or new

reforms aimed at curbing expenditure growth, thereby partially decoupling health expenditure from income growth.

Figure 7: Total health expenditure under alternative scenarios (in % of GDP)



Source: Federal Finance Administration

The scenarios also illustrate the importance of demographic assumptions for the development of health expenditure. If additional years of life are predominantly spent in poor health (pure ageing), health expenditure rises to 15.8% of GDP by 2060. Conversely, if these additional years are spent in good health (healthy ageing), expenditure growth is moderated, reaching 14.9% of GDP in 2060.

Assumptions about immigration also play a role. According to the projections, a high net immigration tends to dampen growth in health expenditure relative to GDP. This is because immigrants are, on average, younger, thereby slowing population ageing while simultaneously supporting economic growth. In the low migration scenario, health expenditure rises to 15.7% of GDP by 2060, whereas in the high migration scenario it increases more moderately, reaching 15.0%.

3.1.3 Contributions of cost drivers to health expenditure growth

The relative contributions of cost drivers to health expenditure growth vary across sectors and scenarios (Figure 8). In the reference scenario, ageing accounts for around 35% of healthcare expenditure growth (Panel A). As half of the additional years of life gained are spent in good health (morbidity effect), the impact of ageing is slightly mitigated (-3%). Overall, demographic change explains roughly one third of the projected expenditure increase in healthcare.

Income growth, reflecting the population's rising expectations regarding healthcare services and fostering medical advances, is the most important cost driver in healthcare, accounting for around

46% of the expenditure increase. Baumol's cost disease accounts for slightly more than one fifth of the growth in healthcare expenditure.

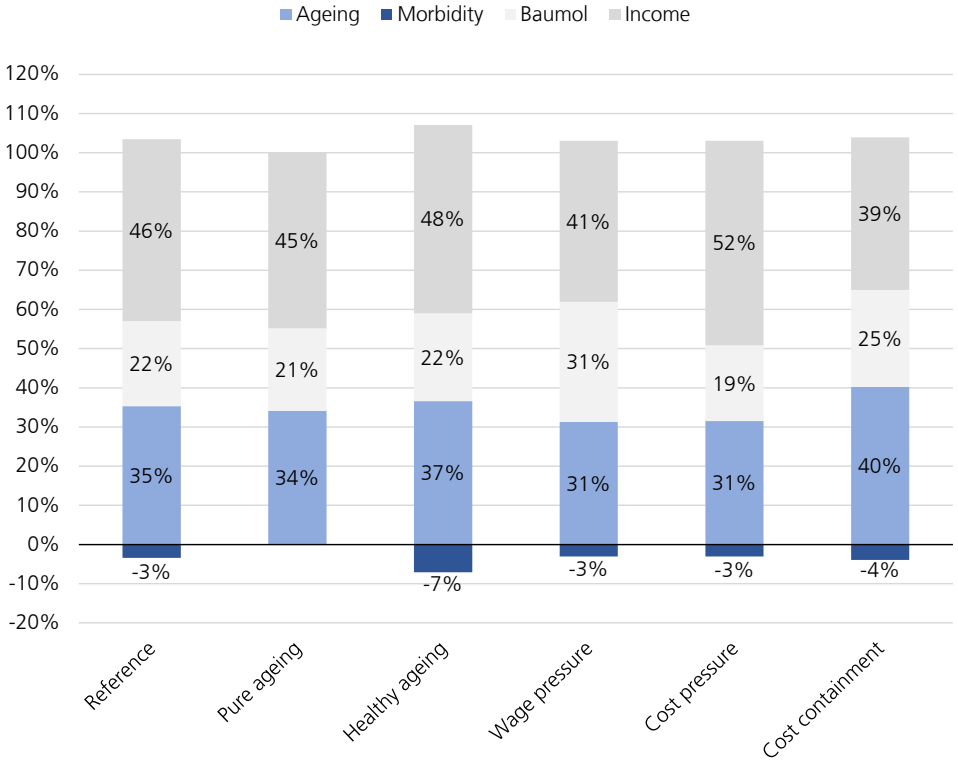
In the alternative scenarios, the relative importance of these factors shifts in line with the underlying assumptions (Table 1). In the pure ageing scenario, the demographic effect is more pronounced than in the reference scenario. In the healthy ageing scenario, by contrast, the improved health status further dampens the impact of ageing. In the wage pressure scenario, Baumol's cost disease becomes more important than in the reference scenario, while in the cost pressure scenario, the income effect gains significance. Conversely, the role of income growth diminishes in the cost containment scenario.

In long-term care, ageing is the dominant factor (Panel B). Although the assumption that half of the additional years of life gained are spent in good health reduces its impact somewhat (-9%), demographic change still accounts for around two thirds of the expenditure growth. The remaining third is attributable to wage pressure associated with Baumol's cost disease and other supply-side factors (e.g. labour shortages and inefficiencies). While the relative contributions of the cost drivers in long-term care vary somewhat across scenarios, ageing remains the dominant determinant.

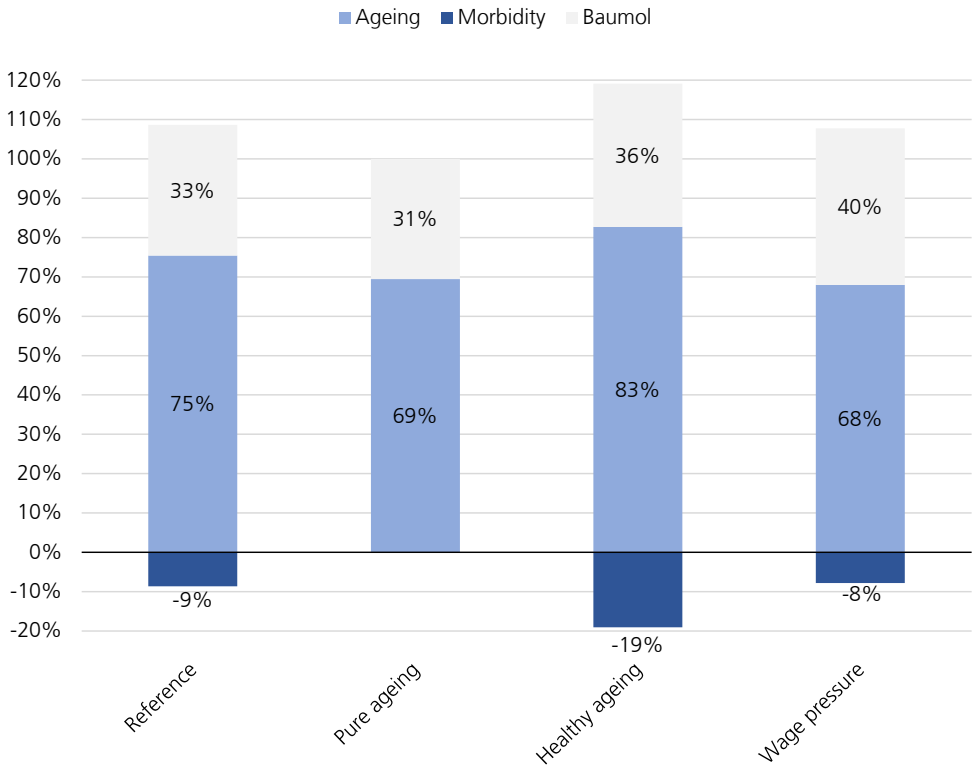
The morbidity factor refers to the relationship between the increase in life expectancy and the degree of the population's need for care. As the demand for care services is assumed to be independent of income, income growth does not contribute to the expenditure growth in long-term care.

Figure 8: Relative contributions of cost drivers to health expenditure growth by sector (2023–2060, shares in %)

Panel A: Healthcare expenditure



Panel B: Long-term care expenditure



Notes: Baumol includes supply-side factors that influence price developments, such as Baumol's cost disease, the shortage of skilled labour and other inefficiencies in the health sector. The migration scenarios assume a different population development and are not directly comparable with the other scenarios for the purpose of analysing relative contributions to health expenditure growth.

Source: Federal Finance Administration

3.2 Expenditure on health services under the Federal Act on Health Insurance

With the introduction of EFAS, the focus will shift from a premium-based perspective to health services covered under the Federal Act on Health Insurance (HIA), jointly financed by compulsory health insurance (CHI) and the cantons.

3.2.1 Expenditure on HIA services by financing entity and sector in the reference scenario

In 2023, expenditure on net HIA services amounted to 5.6% of GDP (Panel A), or CHF 46.5 billion, corresponding to approximately half of total health expenditure (11.2% of GDP). Around three quarters of expenditure on HIA services is financed through premiums (4.1% of GDP), while one quarter is tax-financed (1.4% of GDP).[12] Figure 9 shows the projected financing shares of premium payers (CHI) and taxpayers (cantons and communes) in the reference scenario, taking into account the phased introduction of EFAS between 2028 and 2032.[13]

12 In line with EFAS, this analysis focuses on the direct financing of health services. Tax-financed expenditure on IPR is not considered at this point, as it represents a transfer.

13 In the projections, the financing share of premium payers corresponds to expenditure on net CHI services. The financing share of taxpayers comprises cantonal and communal expenditure on healthcare and long-term care services under the HIA (FOPH, 2024d).

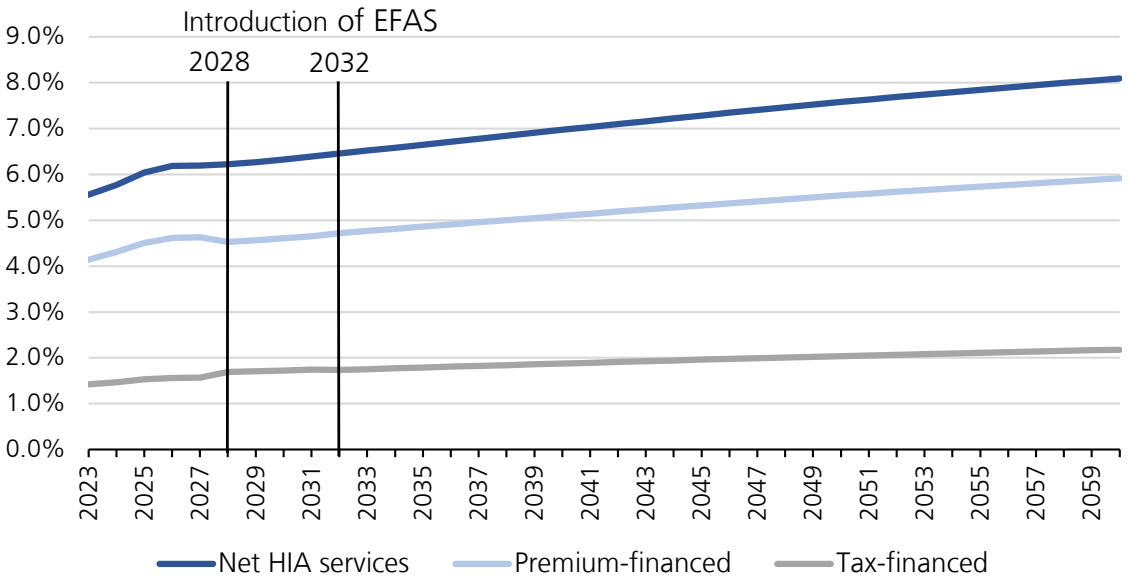
With the introduction of EFAS in the healthcare sector from 2028, the burden shifts partly from premium payers to taxpayers (Figure 9, Panel B). This reflects the fact that cantons will also contribute to the financing of outpatient services. As a result, the share of HIA expenditure on healthcare services borne by premium payers declines from 4.17% of GDP in 2027 to 4.07% in 2028, while the tax-financed share increases from 1.20% to 1.32% of GDP.

By contrast, the inclusion of long-term care in EFAS leads to a shift in the opposite direction (Panel C). However, the resulting relief for taxpayers in long-term care does not offset the additional burden in the healthcare sector. According to the projections, expenditure on HIA services in long-term care financed by premium payers increases from 0.48% of GDP in 2031 to 0.64% in 2032 – an increase of around one third – while for taxpayers it declines from 0.39% to 0.24% of GDP.

From 2032 onwards, expenditure shares evolve in parallel, reflecting the fixed EFAS financing key, under which 73.1% of net HIA services are financed by premium payers and 26.9% by taxpayers. By 2060, total expenditure on net HIA services is projected to reach 8.1% of GDP (Panel A), with the premium-financed share rising to around 5.9% of GDP and the tax-financed share to 2.2%.

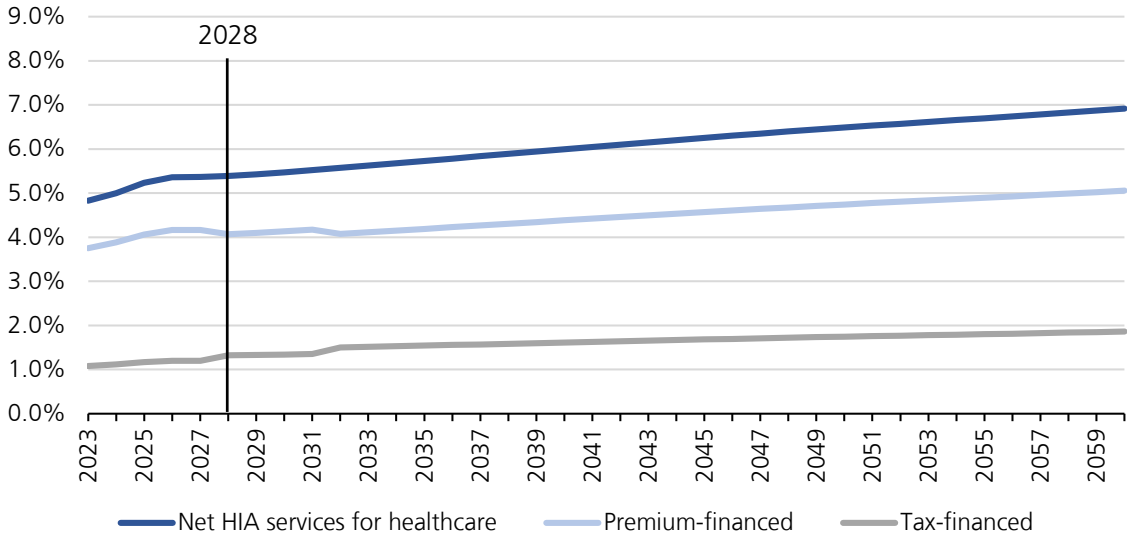
Figure 9: Health expenditure on net HIA services by financing entity and sector
(in % of GDP)[14]

Panel A: Total net HIA services

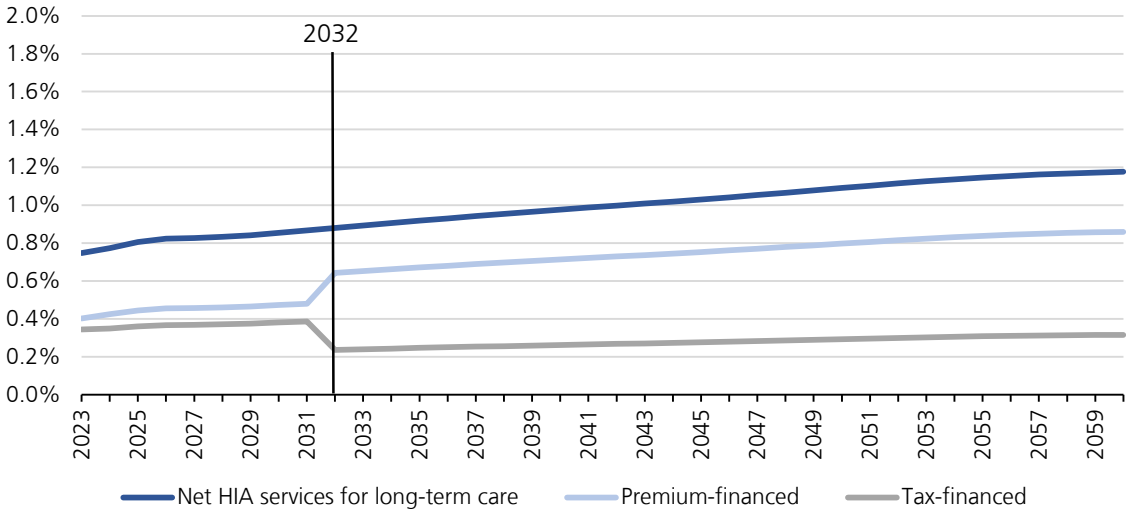


14 For the transitional period during the introduction of EFAS (2028-2031), the projections assume that the tax-financed share of cantons and communes in net HIA expenditure is set at the minimum level of 24.5% (FOPH, 2024c).

Panel B: Net HIA services for healthcare



Panel C: Net HIA services for long-term care

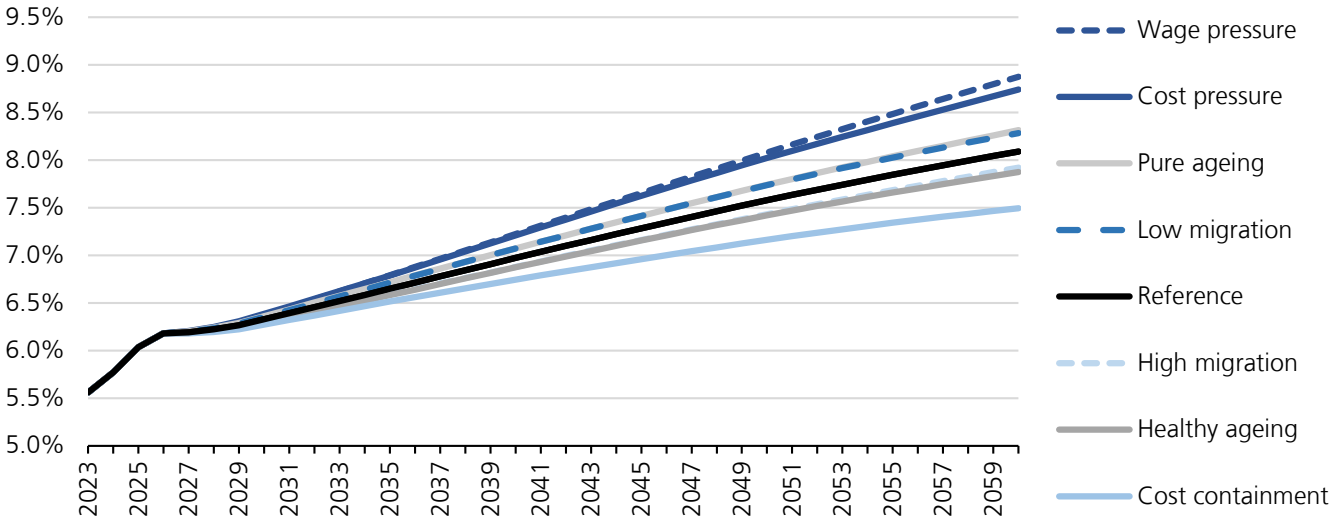


Source: Federal Office of Public Health, Federal Finance Administration

3.2.2 Expenditure on HIA services in the alternative scenarios

Figure 10 shows the development of net HIA expenditure in the alternative scenarios. As with total health expenditure, HIA expenditure is particularly sensitive to non-demographic factors, in particular to the assumptions on wage pressure and income elasticity. Under the wage and cost pressure scenarios, HIA expenditure increases to 8.9% and 8.7% of GDP by 2060. In contrast, under the cost containment scenario, HIA expenditure grows more moderately, reaching 7.5% of GDP by 2060 – below the level projected in the reference scenario (8.1% of GDP).

Figure 10: Net HIA expenditure under alternative scenarios (in % of GDP)



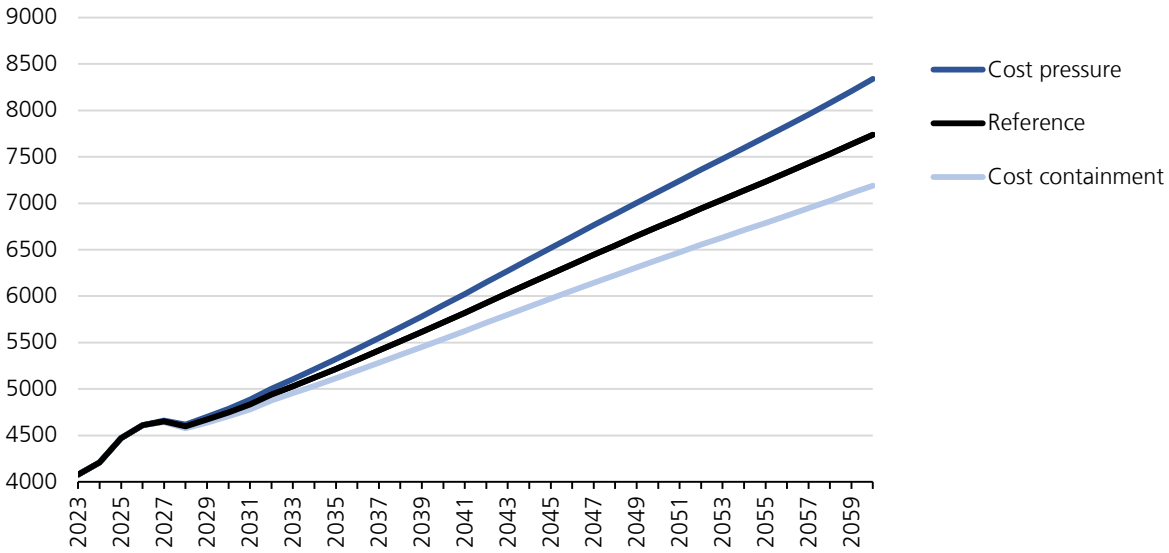
Source: Federal Finance Administration

3.3 Compulsory health insurance premiums

Figure 11 illustrates the development of net CHI expenditure per capita between 2023 and 2060 in Swiss francs (at 2023 prices). In the long term, net CHI expenditure per capita corresponds to the average health insurance premium (Federal Office of Public Health, 2024f).

In 2023, average annual net CHI expenditure per capita amounted to CHF 4,080 (4.4% of GDP per capita). In the reference scenario, it increases in real terms to CHF 7,740 by 2060 (6.2% of GDP per capita), corresponding to an average annual real growth rate of 1.75%. Two alternative scenarios are shown for comparison. In the cost pressure scenario, CHI expenditure per capita increases further to CHF 8,339 by 2060 (6.6% of GDP per capita), roughly doubling relative to 2023. In the cost containment scenario, net CHI expenditure per capita also increases markedly, but more moderately, reaching CHF 7,191 in 2060 (5.7% of GDP per capita).

Figure 11: Net CHI expenditure per capita under alternative scenarios (CHF, at 2023 prices)



Note: The net CHI expenditure shown in this figure corresponds to expenditure on gross CHI services excluding the cost-sharing contributions of private households.

Source: Federal Finance Administration

3.4 Public health expenditure

Public health expenditure covers a broader scope than tax-financed HIA services. It includes all contributions by the Confederation, cantons, communes and social security funds to the financing of the Swiss health system. In the financial statistics, this comprises expenditure classified under the "Health" function, as well as health-related spending under "Social security", such as expenditure on IPR, care home, and illness and disability costs reimbursed by supplementary benefits under AHV and IV (Federal Finance Administration, 2025).

Around three quarters of total public health expenditure is attributable to the healthcare sector – in particular hospitals – along with IPR, and public spending on prevention, supplementary benefits under AHV for long-term care, care homes, and Spitex services.[15]

3.4.1 Public health expenditure by level of government in the reference scenario

In 2023, total public expenditure in the health sector amounted to 3.5% of GDP, or CHF 29.5 billion (Figure 12, Panel A). Of this, 1.4% of GDP was attributable to net HIA services subject to EFAS. A further 0.7% of GDP was spent on IPR, while the remaining 1.4% of GDP covered other expenditure, including research and education, health prevention, and cantonal contributions to hospitals, as well as AHV/IV spending on helplessness allowances and medical services (see also Table A3 in the appendix).

15 For a detailed presentation, see Figure 5 in Brändle and Colombier (2022).

In the reference scenario, public health expenditure rises to 5.0% of GDP by 2060. The introduction of EFAS in the healthcare sector in 2028 leads to a one-off increase in public expenditure of around 6.2% (+0.13 percentage points of GDP).

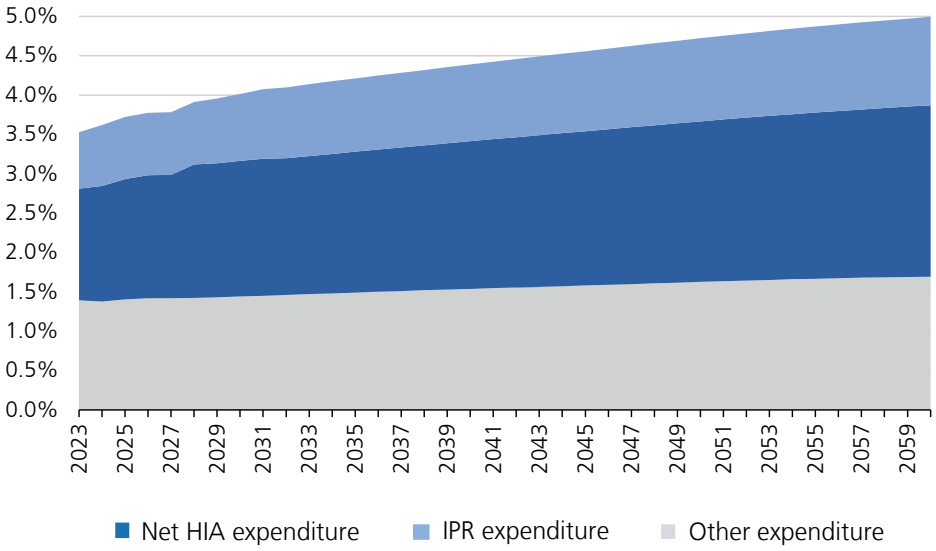
Cantons account for around two thirds of public health expenditure and thus play a central role in financing. Their expenditure increases from 2.4% of GDP in 2023 to 3.6% of GDP in 2060 (Figure 12, Panel B). This increase is attributable to structural cost drivers, as well as the introduction of EFAS and the cantonal minimum contributions to IPR. With the implementation of EFAS, cantonal expenditure rises on a one-off basis by 8.1% between 2027 and 2028.[16]

The Confederation, communes and social security funds are significantly less involved in the financing of the health sector. In 2023 their expenditure amounted to 0.44%, 0.38% and 0.33% of GDP. However, health expenditure is also projected to increase for these levels of government in the coming decades. The increase is most pronounced for the Confederation, whose expenditure is projected to rise by around one third to 0.58% of GDP by 2060, reflecting the fact that federal contributions to IPR are directly tied to CHI costs (7.5%) and therefore grow proportionally.

For communes, whose contributions include long-term care, inpatient healthcare services and IPR, expenditure growth is more moderate, reaching around 0.43% of GDP in 2060. With the inclusion of long-term care in EFAS in 2032, communes experience a one-off decline in health-related expenditure of around 19% between 2031 and 2032. Health-related expenditure of social security funds – which contribute to supplementary benefits under AHV/IV – is projected to reach around 0.38% of GDP by 2060.

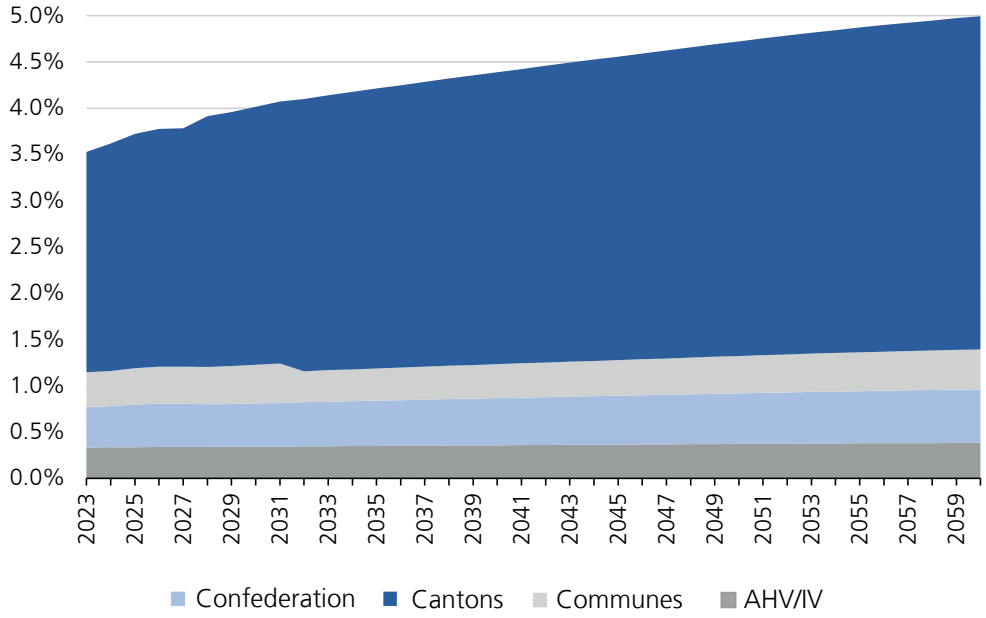
Figure 12: Public health expenditure by HIA services and level of government
(in % of GDP)

Panel A: Public health expenditure for HIA services, IPR and other expenditure



16 In response to Postulate 20.4257 Würth, the impact of population ageing on public expenditure in the areas of health and education was analysed for cantons particularly affected by demographic change, using the methodology presented here (Federal Council, 2023).

Panel B: Public health expenditure by level of government



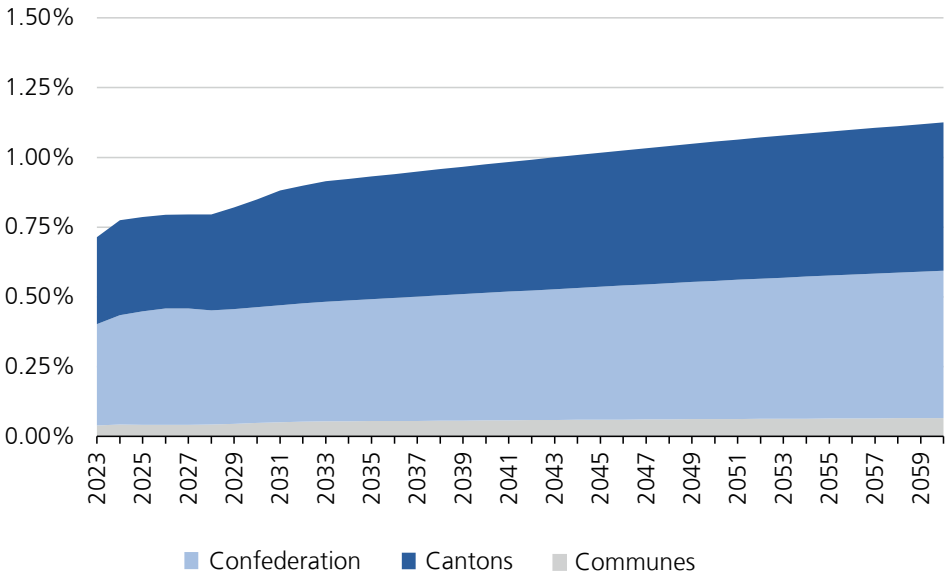
Source: Federal Finance Administration

Figure 13 focuses on expenditure on IPR – which increases from 0.7% to 1.1% of GDP between 2023 and 2060 – and provides a breakdown by level of government. Federal expenditure on IPR rises from 0.36% of GDP in 2023 to 0.53% in 2060. With the introduction of EFAS, CHI expenditure rises only marginally in 2028, which is reflected in the modest change in the trajectory of IPR expenditure. From 2032, when long-term care is also partially financed through CHI, expenditure increases more strongly, leading to a corresponding rise in federal IPR expenditure. A similar pattern is observed at the cantonal level.

At the same time, the introduction of cantonal minimum contributions to premium reductions leads to greater cantonal participation in financing gross CHI expenditure. As gross CHI expenditure is assumed to grow faster than the incomes of the 40% lowest-income households, all cantons are expected to eventually reach the minimum IPR contribution rate of 7.5% of gross CHI costs. From 2033, cantonal IPR expenditure grows proportionally to CHI expenditure. As a result, it increases from 0.31% of GDP in 2023 to 0.53% in 2060.

Some communes also contribute to cantonal IPR financing. However, their share is small, rising only modestly from 0.04% of GDP in 2023 to just over 0.07% in 2060.

Figure 13: Expenditure on IPR by level of government (in % of GDP)



Source: Federal Finance Administration

3.4.2 Public expenditure for healthcare and long-term care

Figure 14 illustrates the projections of public expenditure by level of government and health sector. Panel A disaggregates total public expenditure by healthcare, long-term care, and IPR.[17] Panels B and C show public expenditure by level of government in the sectors of healthcare and long-term care separately.

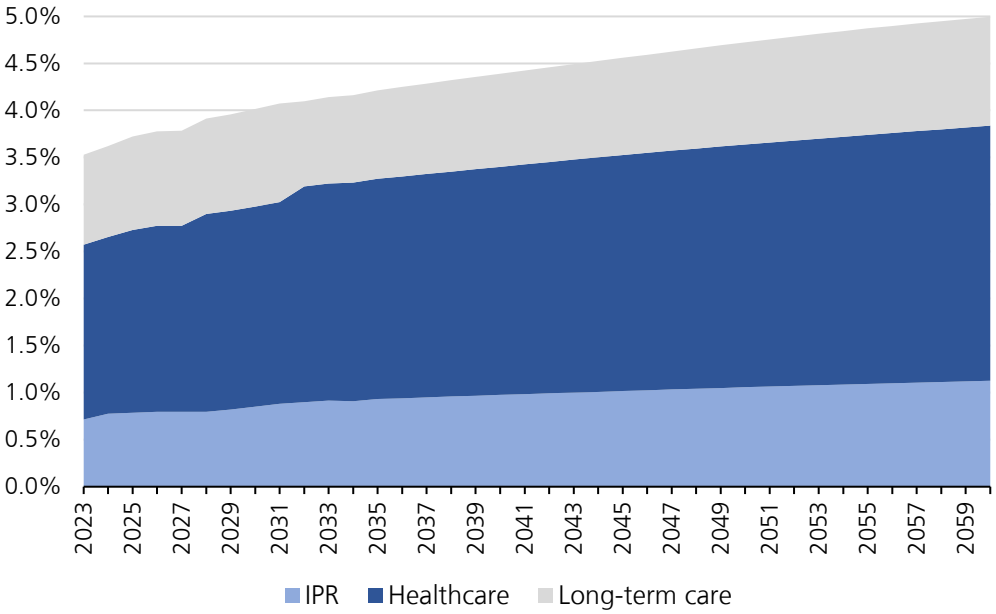
In 2023, public expenditure in healthcare and long-term care amounted to 1.9% and 1.0% of GDP. By 2060, they are projected to increase to 2.7% and 1.2% of GDP respectively. The stronger increase in healthcare expenditure is attributable to EFAS, under which cantons will contribute also to the financing of outpatient services, which exhibit more dynamic growth (Figure 14, Panel B). By contrast, their contribution to long-term care expenditure is expected to decline somewhat, a pattern that also applies to communes (Figure 14, Panel C).

Apart from its role in financing IPR, the Confederation's involvement in financing the health sector remains limited. Social security funds, by contrast, contribute to both healthcare and long-term care, for example through benefits in kind and cash transfers under AHV/IV, including helplessness allowances.

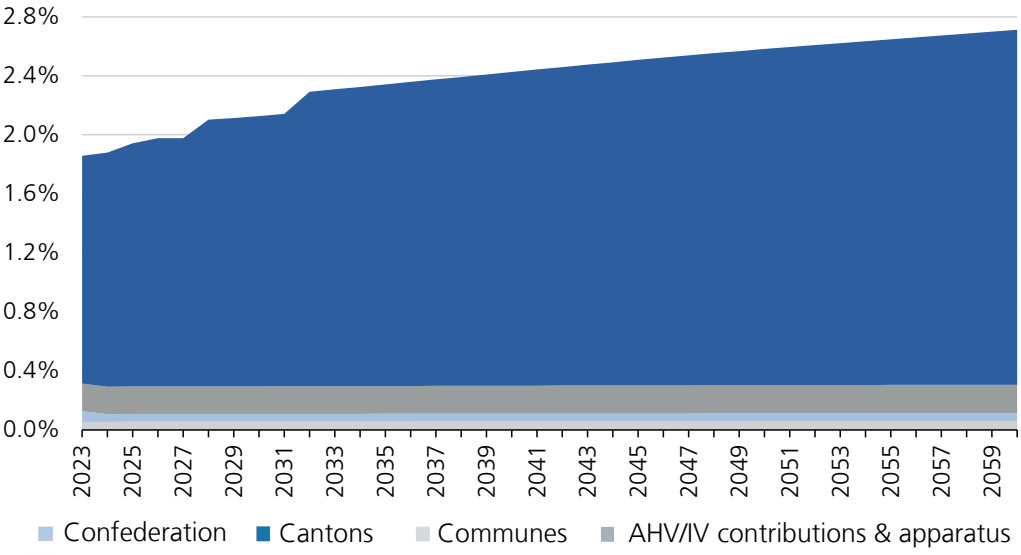
17 Public expenditure on IPR consists of public transfers and cannot be attributed specifically to either healthcare or long-term care.

Figure 14: Public health expenditure by sector and level of government (in % of GDP)

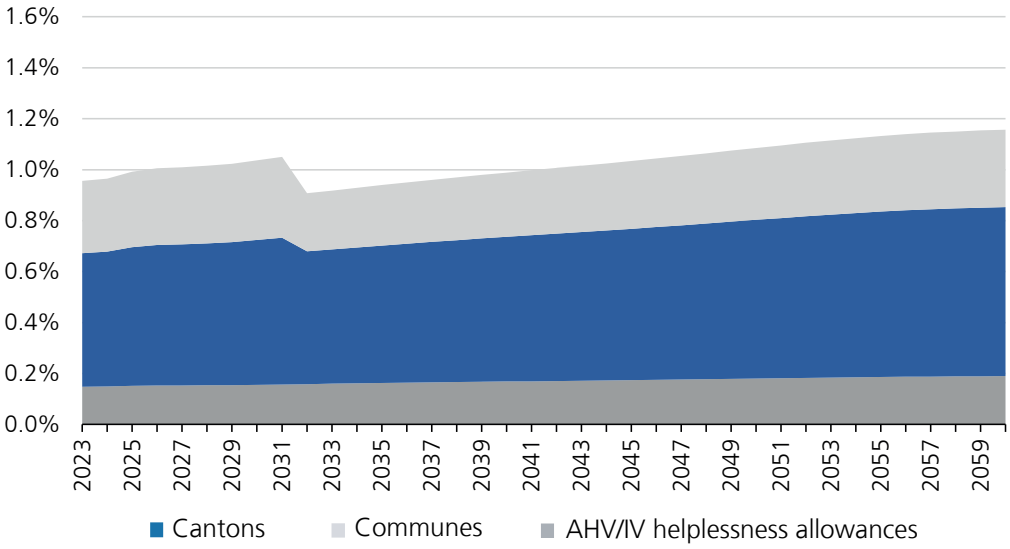
Panel A: Public expenditure by sector and IPR



Panel B: Public expenditure on healthcare by level of government



Panel C: Public expenditure on long-term care by level of government



Source: Federal Finance Administration

3.4.3 Public health expenditure in the alternative scenarios

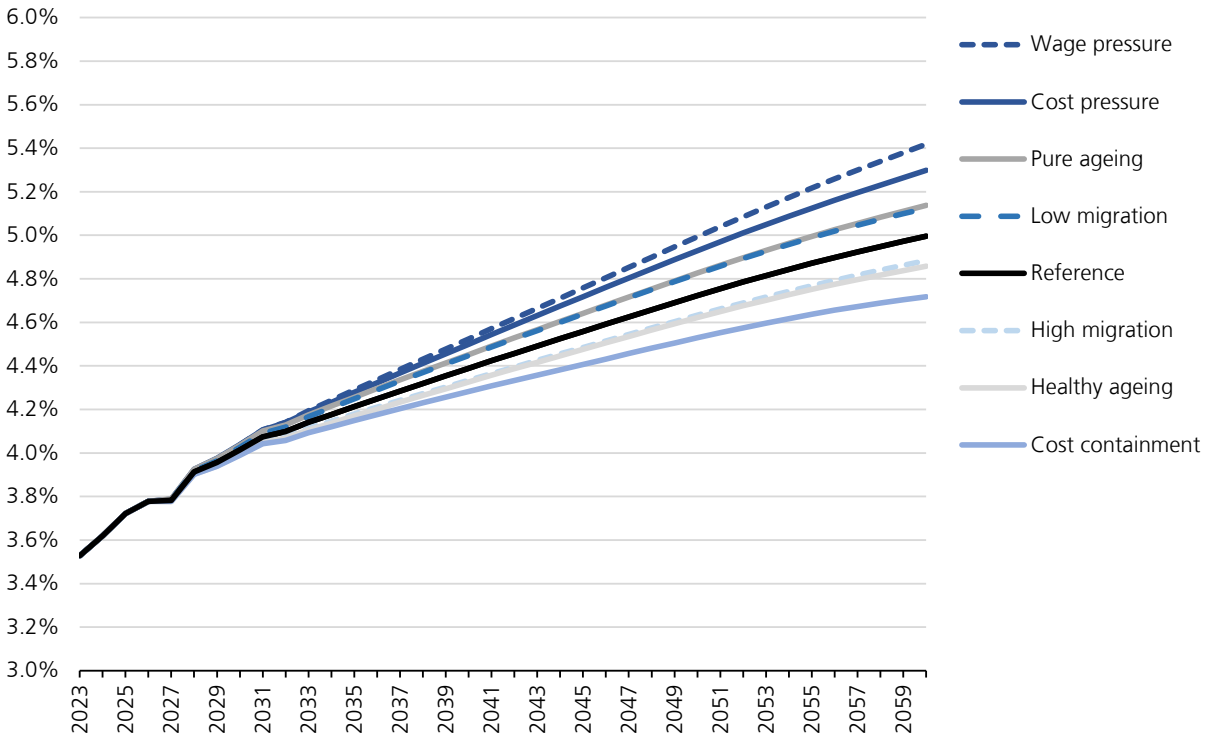
Figure 15 shows that public health expenditure is particularly sensitive to non-demographic factors (Figure 15, Panel A). The effects of the wage pressure scenario are especially pronounced in long-term care (Figure 15, Panel C), while in healthcare the cost pressure scenario also has a substantial impact (Figure 15, Panel B).

Under the wage pressure and cost pressure scenarios, public expenditure rises to 5.4% and 5.3% of GDP by 2060 (reference scenario: 5.0%). These are followed by the pure ageing and low migration scenarios, both reaching around 5.1% of GDP. This reflects the fact that less favourable health developments alongside rising life expectancy, as well as lower immigration – which accelerates population ageing and slows economic growth – both contribute to stronger health expenditure growth relative to GDP.

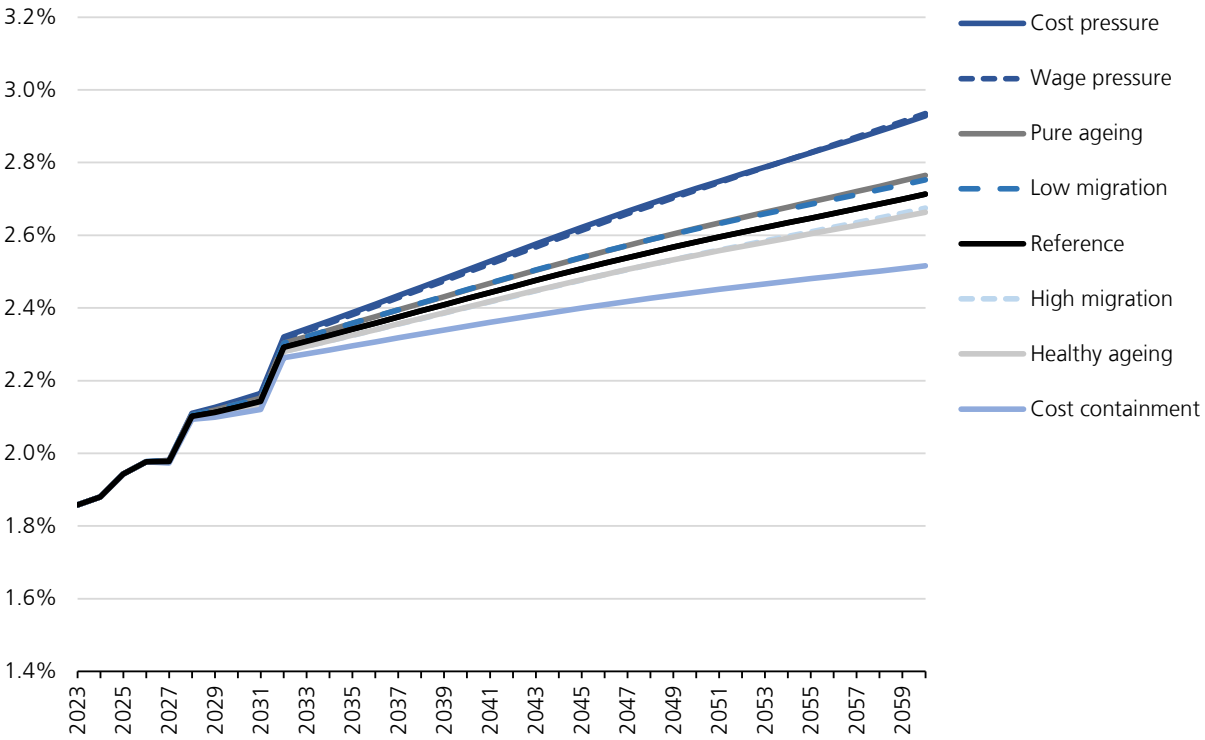
By contrast, expenditure growth is more moderate in the cost containment scenario, under which public health expenditure reaches around 4.7% of GDP by 2060. The healthy ageing and high migration scenarios also yield slightly lower expenditure levels than the reference scenario, at around 4.9% of GDP in 2060. This can be explained by improved health outcomes as life expectancy rises, and by higher immigration – which somewhat dampens the ageing process and contributes to economic growth – thereby attenuating health expenditure growth relative to GDP.

Figure 15: Public health expenditure by sector and scenario (in % of GDP)

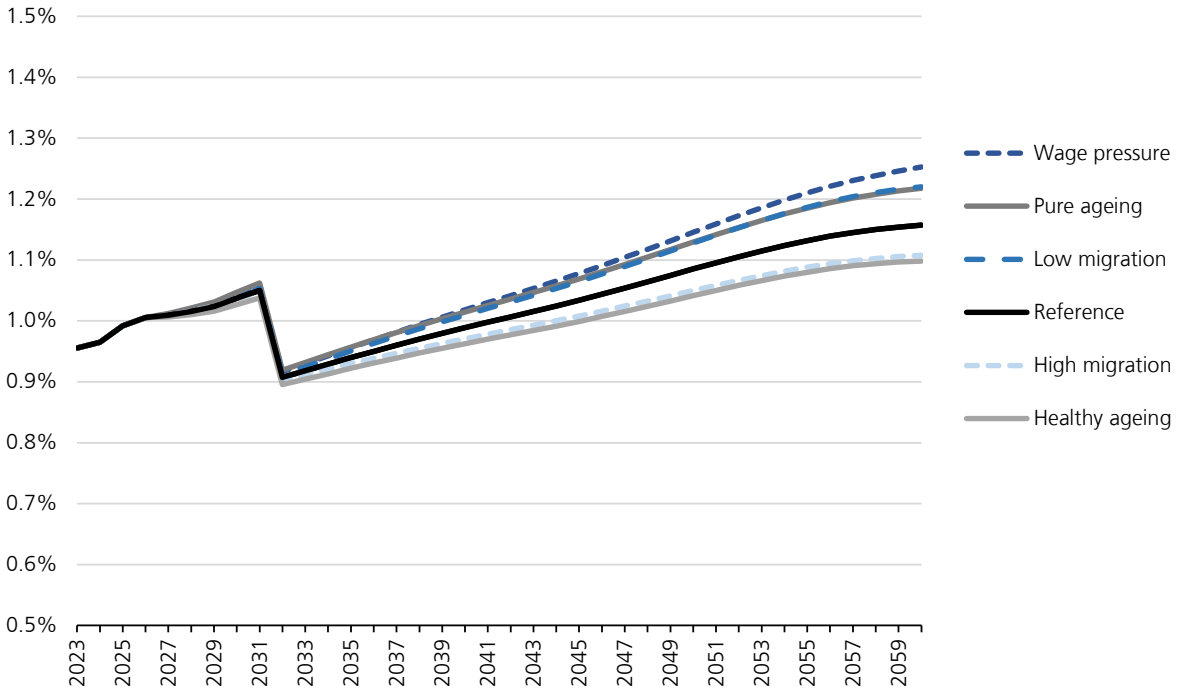
Panel A: Total public health expenditure



Panel B: Public expenditure on healthcare



Panel C: Public expenditure on long-term care



Source: Federal Finance Administration

4 Comparison with other studies

This section compares the present results with those of the 2022 expenditure projections and places them into context through an international comparison.

4.1 Healthcare expenditure projections from 2022

The previous healthcare expenditure projections were shaped by the effects of the COVID-19 pandemic (Brändle and Colombier, 2022). The current projections incorporate several important updates. They are based on the latest population scenarios of the Federal Statistical Office, which assume less pronounced ageing dynamics than the 2020 scenarios. This is attributable, in particular, to more moderate gains in life expectancy and higher net immigration. The expenditure projections also reflect the latest revision of the national accounts (September 2025), the recent financing reforms (EFAS and the cantonal minimum contribution to the financing of IPR), and the ongoing shift from inpatient to outpatient care. This shift is explicitly incorporated for the first time by assuming a higher income elasticity for outpatient than for inpatient services (Table 1). Similarly, Baumol's cost disease is now modelled in a more differentiated manner across types of services. In contrast, the 2022 projections assumed a uniform income elasticity of 1.1 for healthcare, and Baumol's cost disease was set at 50% for healthcare and at 75% for long-term care in the reference scenario.

Overall, the current projections indicate similar health expenditure dynamics over the comparable period 2027–2050, when using the macro-cohort approach, as those from 2022. However, the projected increase in expenditure is lower, amounting to 2.5% of GDP compared with 3.0% of GDP in the previous edition. This difference is primarily attributable to two factors. First, the most recent population scenarios project less pronounced population ageing in the coming decades. Second, the present projections account for the shift from inpatient to outpatient services. Both assumptions dampen health expenditure growth. The recent financing reforms, on the other hand, primarily lead to a shift in the financing burden between premium payers and taxpayers, rather than affecting overall health expenditure growth.

4.2 International comparison

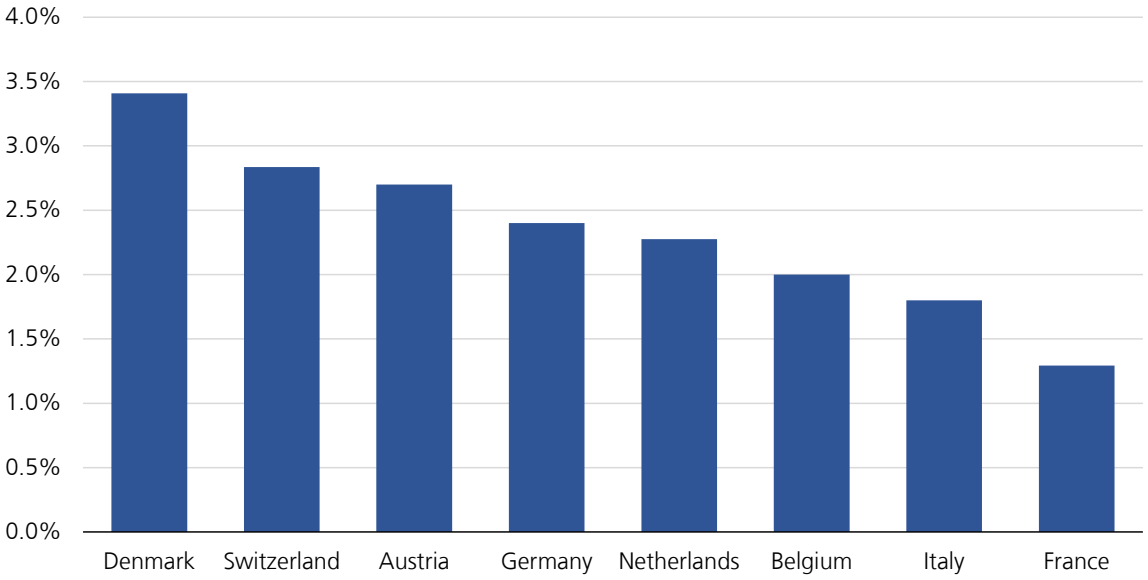
Rising healthcare expenditure poses an economic policy challenge in most advanced economies (OECD, 2025). Accordingly, several finance ministries and the European Commission regularly produce expenditure projections to highlight the ongoing need for reform.

Figure 16 compares projected increases in public health expenditure, expressed as a percentage of GDP between the mid-2020s and 2060 for selected countries. These projections are based, where available, on publications from national finance ministries and on the 2024 Ageing Report of the Working Group on Ageing Populations and Sustainability (AWG) of the Economic Policy Committee of the European Commission (AWG, 2024).

According to the present projections, Switzerland's public health expenditure (including compulsory health insurance) is expected to rise by 2.8 percentage points of GDP between 2023 and 2060. In international comparison, this represents the second-largest increase in public health expenditure after Denmark, and places Switzerland slightly ahead of Austria (+2.7 percentage points), followed by Germany (+2.4 percentage points) and the Netherlands (+2.3 percentage points).

In countries such as Belgium, Italy and France, the projected increase remains below 2 percentage points. Nevertheless, even in these countries, health expenditure is expected to grow faster than the overall economy.

Figure 16: Increase in public health expenditure in an international comparison, 2023–2060 (in percentage points of GDP)



Notes: For better international comparability, for Switzerland, health expenditure includes both public spending and expenditure financed through compulsory health insurance. The starting year of the projections varies by country, ranging from 2023 to 2025. In the starting year, health expenditure financed through compulsory contributions, as a percentage of GDP, was: 10.1% in Denmark, 7.2% in Switzerland, 9.4% in Austria, 9.1% in Germany, 9.6% in the Netherlands, 8.0% in Belgium, 7.9% in Italy, and 10.2% in France. For Germany, the projections for 2060 correspond to the average of the optimistic and pessimistic scenarios. For Belgium, the projections for 2060 correspond to the interpolated value between 2050 and 2070.

Source: Own representation based on data from the Federal Finance Ministries of Germany, Austria, Italy and Belgium (BMF, 2024; BMF/ÖBR, 2025; MEF, 2024; CSF, 2024), and data from the AWG (2024) for Denmark, the Netherlands and France.

The international comparison provides useful indications of the expected financing burden in the health sector across countries. However, its comparability is limited. The projections for individual countries are based on differing demographic and economic developments, and the institutional arrangements in the health system also vary considerably. For Switzerland, it is important to note that health expenditure as a share of GDP is already high by international standards. The projections further suggest a comparatively strong expenditure dynamic if no additional policy measures are taken.

5 Fiscal policy conclusions

Why are the expenditure projections important?

An important element of forward-looking policy is ensuring the sustainable financing of the health sector. The expenditure projections for Switzerland up to 2060 provide an important contribution in this regard. They offer insights into the medium- to long-term expenditure dynamics in healthcare and long-term care, deepen the understanding of the underlying cost drivers and highlight the urgency of reforms aimed at improving efficiency and containing expenditure growth.

What are the key results?

First, the projections show that structural cost drivers such as ageing, rising incomes, medical advances and Baumol's cost disease will continue to exert sustained pressure on the health system. Under the baseline assumptions, total health expenditure in the reference scenario increases from 11.2% in 2023 to 15.3% of GDP in 2060. While expenditure growth in healthcare is driven primarily by non-demographic factors, expenditure growth in long-term care is largely shaped by ageing and the rising prevalence of care needs. From a financing perspective, the substantial additional burden will be borne by CHI and public budgets.

Second, recent healthcare reforms will shift financing responsibility between CHI and public budgets. The introduction of a uniform financing scheme for outpatient and inpatient services (EFAS) is expected to increase the burden on public budgets in healthcare more than it alleviates them in long-term care. In addition, the introduction of cantonal minimum contributions to premium reductions is likely to further increase the financial burden on cantons, while relieving premium payers accordingly. Once these reforms are fully implemented in the early 2030s, expenditure dynamics for premium payers and taxpayers will grow proportionally.

Third, the projections account for the shift from inpatient to outpatient care services by providing a more differentiated analysis of expenditure dynamics across health sectors. Under the baseline assumptions, spending on outpatient services will grow more rapidly than spending on inpatient services. As outpatient treatments are, on average, less costly, this trend has the potential to moderate overall expenditure growth in the health sector. The requirement for certain services to be provided on an outpatient basis has been in force since 2019. The introduction of EFAS could reinforce this trend by removing incentives that favour inpatient over outpatient treatment. Continued medical advances are also expected to support this development.

What are the fiscal policy implications?

From a fiscal policy perspective, persistently high expenditure growth implies that the health sector will claim an increasing share of the budgets of the Confederation, cantons, and communes, possibly crowding out other expenditure. Moreover, further demands for greater tax-based financing of the health system are likely to arise, potentially affecting the division of responsibilities between the Confederation and the cantons. The projections thus suggest growing pressure on the sustainability of public finances, alongside continued increases in insurance premiums. Against this backdrop, further measures to enhance efficiency and contain expenditure growth are necessary.

One concrete measure is the systematic implementation of criteria of efficacy, appropriateness and cost-effectiveness of health services set out in Article 32 of the HIA through Health Technology Assessment (HTA). HTA involves the in-depth evaluation of services reimbursed by compulsory health insurance. A recent postulate report shows that HTA at federal level has generated savings while simultaneously improving the quality of services (Federal Council, 2026a). At the same time, additional potential for improvement has been identified, particularly with regard to the selection of topics, the scope of assessments, and implementation.

Digitalisation also offers considerable efficiency gains. It can reduce coordination costs, avoid duplicate examinations, and improve both the quality of care services and the pace of medical innovations through more effective and secure information flows – for example through the use of artificial intelligence and telemedicine. The "DigiSanté" programme for the digital transformation of healthcare is an important step in this direction (Federal Office of Public Health, 2023).

In addition to efficiency-enhancing measures, prevention plays a key role. Promoting healthy diets and physical activity, as well as strengthening health literacy, can help prevent chronic and musculoskeletal diseases. Targeted interventions can improve the health of the population as life expectancy increases, thereby moderating expenditure growth in both healthcare and long-term care.

Forward-looking personnel policy is equally important. The retirement of the baby-boomer generation, high dropout rates, particularly in the care sector, a growing demand for healthcare personnel, and long training periods all point to emerging shortages. Addressing these challenges can mitigate risks of undersupply and strongly rising wage costs (Obsan, 2025b). In this context, measures to improve working conditions in healthcare and long-term care – such as those currently discussed under the implementation of the nursing care initiative – are particularly relevant (Federal Office of Public Health, 2024g).

Alongside these ongoing efforts, the cost and quality targets approved by voters in 2024 constitute an important policy lever. They increase transparency and strengthen incentives for cost accountability. Over time, this instrument should be made more binding to encourage more cost-conscious behaviour among all stakeholders. Greater accountability through overarching cost targets may also increase the attractiveness of managed care models with budget responsibility, thereby supporting better integration and coordination of care. In addition, the new tariff system – comprising TARDOC and outpatient flat-rate payments in force since the beginning of 2026 – can help curb medically unnecessary volume expansion (Federal Office of Public Health, 2025).

Finally, improved hospital planning remains a key area for reform. A recent postulate report indicates that significant overcapacity persists in the inpatient sector. While efforts have been made to harmonise cantonal hospital planning and to address the multiple roles of cantons as regulators, owners, and co-financiers, further potential for improvement remains. This includes, in particular, stronger intercantonal coordination through cross-cantonal care regions and joint hospital planning (Federal Council, 2026b).

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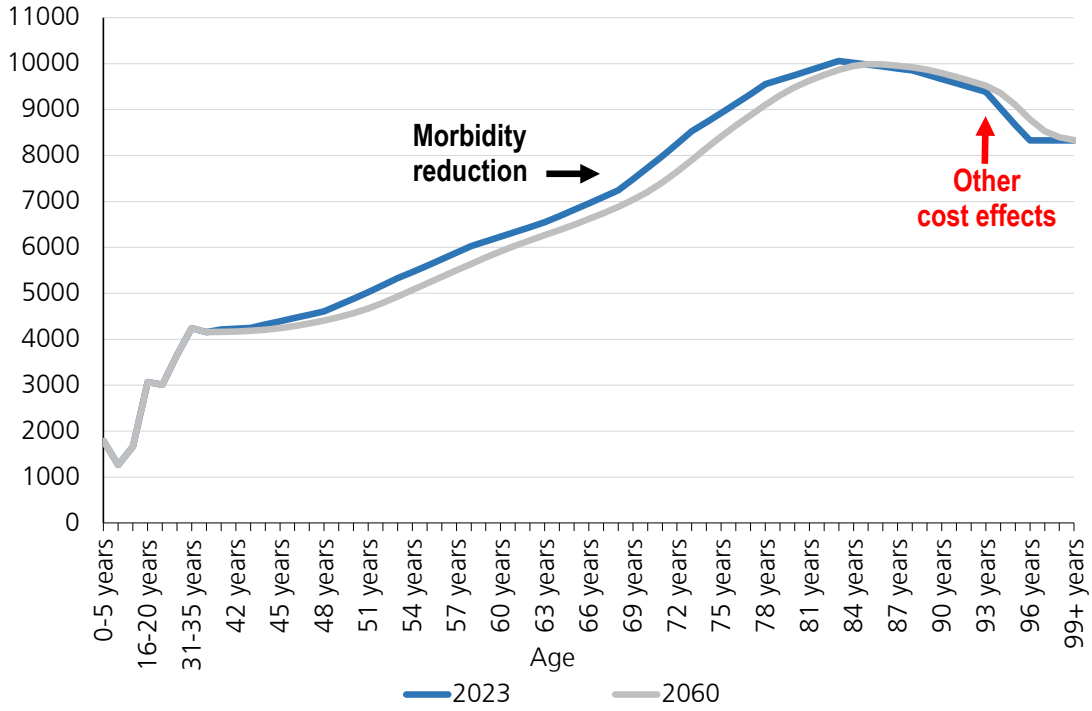
Appendix

Figure A1: Healthcare expenditure for outpatient services per woman for 2023 and 2060 using the healthy ageing scenario (in CHF)



Source: Federal Finance Administration

Table A1: Data sources and assumptions on expenditure by financing entity and sector for 2023 to 2026

Financing entity & sector	2023	2024	2025	2026
Confederation, health expenditure excl. IPR	Financial statistics		Projections using GDP	
Confederation, expenditure on IPR	Financial statistics		State financial statements 2025	FFA budget figures (autumn 2025)
Cantons & communes, expenditure on HIA services	Financial statistics and HIA expenditure based on FOPH estimates for 2022	Extrapolation of health expenditure on inpatient services using CHI expenditure; extrapolation of remaining HIA expenditure using total health expenditure growth		
Cantons & communes, expenditure outside the HIA	Financial statistics	Extrapolation using total health expenditure growth		Projections using the macro-cohort approach
Cantons, expenditure on IPR	Financial statistics	FOPH calculation pursuant to IPR reform (HIA, HIPRO)	Extrapolation using gross CHI expenditure and adjustment of the average cantonal minimum contribution to IPR (HIPRO)	
Compulsory health insurance (CHI)	CHI statistics		FOPH and state financial statements 2025	FOPH estimate based on gross CHI expenditure (HIPRO) and FFA budget figures for IPR

Notes: This table presents the sources and assumptions on health expenditure for the years 2023–2026. From 2027, the projections of the macro-cohort approach apply. The data are as of the end of December 2025. List of abbreviations: CHI: compulsory health insurance; FFA: Federal Finance Administration; FOPH: Federal Office of Public Health; IPR: individual premium reduction; HIA: Federal Act on Health Insurance; HIPRO: Ordinance on the Federal Contribution to Premium Reduction in Health Insurance

Table A2: Key figures for population and economic development

Population development (FSO scenario A-00-2025)	**2023**	**2040**	**2060**
Permanent resident population (in millions)	8.96	9.97	10.59
Net migration[1]	89,200	45,000	45,000
Average number of children per woman	1.33	1.41	1.42
Life expectancy at birth (in years)			
Men	82.2	84.5	85.9
Women	85.9	87.7	88.9
Old-age dependency ratio (in %)[2]	31.8	40.9	46.4
Real old-age dependency ratio (in %)[3]	39.6	48.6	54.7
Youth dependency ratio (0-19 years, in %)[4]	32.9	31.5	31.8
Labour force participation rate in FTEs (>15–64 years; in %)	84.6	86.2	86.1
Labour force in FTEs (in millions)	4.37	4.87	5.04
Economic growth (mean, p. a. in %)[5]		**2030–2060**	
Nominal GDP		2.3%	
Real GDP		1.3%	
Labour productivity		1.15%	
Real wages		1.15%	
Labour force		0.3%	
Inflation		1.0%	

Notes:
1 Net migration in 2023 does not include persons with protection status S from Ukraine.
2 Old-age dependency ratio: number of people aged over 65 years relative to the working-age population (20-64).
3 Real old-age dependency ratio: number of people over 65 years relative to the labour force (in full-time equivalents, FTEs).
4 Youth dependency ratio: number of people under 20 years relative to the working-age population.
5 For the years 2025 to 2027, the forecast of the Federal Expert Group of 12 December 2025 is assumed. Up to 2029, values from the key figures of the Financial Plan 2027-29 are also used. For the long-term development of GDP, the scenarios of the State Secretariat for Economic Affairs published on 12 December 2025 serve as the baseline, in particular regarding the assumptions on labour productivity and the development of working hours in FTEs, as well as the working-age population according to the population projections of the Federal Statistical Office.

Source: Federal Finance Administration, State Secretariat for Economic Affairs, Federal Statistical Office

Table A3: Health expenditure in the reference scenario by sector, HIA services and financing entity (in % of GDP)

Health expenditure by sector, HIA services and financing entity	2023	2032		2060	
	Level	Level	*Change 2023–2032*	Level	*Change 2032–2060*
Total health expenditure by area	11.2	12.4	+1.14	15.3	+2.97
Healthcare	8.9	9.7	+0.81	11.7	+2.02
Long-term care	2.3	2.7	+0.33	3.6	+0.94
Breakdown by HIA services					
Gross HIA expenditure[1]	6.2	7.2	+0.96	9.0	+1.81
Net HIA expenditure[2]	5.6	6.5	+0.90	8.1	+1.64
Premium-financed (CHI)	4.1	4.7	+0.58	5.9	+1.20
Tax-financed	1.4	1.7	+0.32	2.2	+0.44
Cantons	1.2	1.6	+0.38	2.0	+0.39
Communes	0.2	0.1	-0.07	0.2	+0.05
Healthcare	4.8	5.6	+0.74	6.9	+1.34
Premium-financed (CHI)	3.8	4.1	+0.32	5.1	+0.98
Tax-financed	1.1	1.5	+0.42	1.9	+0.36
Long-term care	0.7	0.9	+0.13	1.2	+0.30
Premium-financed (CHI)	0.4	0.6	+0.24	0.9	+0.22
Tax-financed	0.3	0.2	-0.11	0.3	+0.08
Cost sharing by private households (CHI)	0.6	0.7	+0.06	0.9	+0.18
Breakdown by financing entity[3]					
Government (incl. social insurance)[4]	3.5	4.1	+0.57	5.0	+0.90
Confederation	0.4	0.5	+0.04	0.6	+0.10
Cantons	2.4	2.9	+0.56	3.6	+0.66
Communes	0.4	0.3	-0.04	0.4	+0.09
AHV/ IV[5]	0.3	0.3	+0.01	0.4	+0.04
Healthcare	1.4	1.8	+0.45	2.3	+0.42
Cantons	1.4	1.8	+0.45	2.2	+0.41
Communes	0.0	0.0	+0.00	0.0	+0.00
Long-term care	0.5	0.4	-0.09	0.5	+0.13
Cantons	0.2	0.2	-0.03	0.2	+0.06
Communes	0.3	0.2	-0.06	0.3	+0.08
Transfers[6]	1.4	1.6	+0.23	1.9	+0.35
Individual premium reductions (IPR)	0.7	0.9	+0.18	1.1	+0.23
Confederation	0.4	0.4	+0.06	0.5	+0.10
Cantons	0.3	0.4	+0.11	0.5	+0.11
Communes	0.0	0.1	+0.01	0.1	+0.01
Cantonal supplementary benefits for care homes, illness & disability costs	0.3	0.3	+0.03	0.4	+0.09
Supplementary benefits for AHV	0.2	0.2	+0.03	0.3	+0.09
Supplementary benefits for IV	0.1	0.1	+0.00	0.1	+0.00
AHV helplessness allowances & contributions	0.1	0.1	+0.01	0.1	+0.03
Compulsory health insurance (net expenditure excluding IPR)[7]	3.7	4.1	+0.40	5.0	+0.97
Private households[8]	2.5	2.6	+0.17	3.7	+1.10
Remaining expenditure[9]	1.6	1.6	+0.00	1.6	+0.00

Notes: The temporal breakdown of the results is guided by the introduction of EFAS. The values may contain rounding differences.

1 Gross HIA expenditure includes services for healthcare and long-term care, according to EFAS.
2 Net HIA expenditure represents gross HIA expenditure minus cost sharing financed by private households for CHI.
3 The sum of expenditure by the financing entities government (incl. social security), CHI (net expenditure minus IPR), private households and remaining expenditure corresponds to total health expenditure.
4 This item captures total public health expenditure, including also government expenditure with health-related AHV/IV expenditure and remaining public healthcare expenditure not explicitly shown, e.g. for prevention, rescue services, research & development and dentists.
5 AHV/IV helplessness allowances, AHV/IV contributions to medical services and therapeutic apparatus.
6 This item includes IV contributions to medical services and therapeutic apparatus and IV helplessness allowances, which amount to 0.2% of GDP.
7 Net CHI expenditure is gross CHI expenditure including administrative expenditure, excluding cost sharing by private households and excluding the public budgets' contribution in form of IPR, which is attributed to the government sector.
8 CHI cost sharing, out-of-pocket payments and cost sharing under private supplementary insurance.
9 "Remaining expenditure" includes expenditure of compulsory accident insurance, private supplementary insurance and private foundations.

Source: Federal Finance Administration