



**Primary care physicians in Switzerland:  
state of play and future directions**

## IMPRESSUM

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### **Note on terminology**

The definition of the term "primary care physicians" varies across different countries and even within Switzerland. Primary care physicians may encompass general practitioners, family doctors, general internists, and paediatricians. This diversity in interpretations creates complexities, making it hard to pinpoint a singular definition. In addition, data need to be interpreted and compared with caution, considering the specific definition used.

This report uses the following terms:

- Primary care physicians (PCPs): Physicians with postgraduate training in either general internal medicine (GIM) or paediatrics and working in an outpatient private practice.
- Family physicians: Physicians with postgraduate training in GIM and working in outpatient, private practice (i.e., PCPs providing care for adult patients).
- Practicing physician (D: Praktischer Arzt / F: médecin praticien): Physicians having completed the mandatory three-year postgraduate training (plus the postgraduate examination in general internal medicine) to be licenced to practice independently, but without having obtained the specialist title in GIM.
- Resident in medical practice (D: Praxisassistenz / F: médecin assistant en cabinet): Physician in training in an outpatient medical practice (usually a primary care practice) under the supervision of a trained physician.
- Medical practice assistant (D: Medizinische Praxisassistenz / F: assistante médicale): Person having completed a three-year vocational training and completing the following tasks under the supervision of a physician: reception and scheduling of patients, administrative work, assisting the attending physicians, and laboratory and X-ray work.

## Executive summary

As the Swiss population continues to grow and age, health care needs will increase accordingly. Epidemiological trends affecting both old and young will also contribute to this increase, chief among them the burden of mental health disorders as well as the long-term consequences of multimorbidity on both physical and mental health. As the proportion of people 65 and over increases, health care needs will grow accordingly and with them the needs for PCPs. Indeed, managing the multiple health vulnerabilities that come with age requires regular follow-ups, longer consultation time and time to coordinate with other health professionals (nurses, physical therapists, other specialist physicians,...).

To meet this increase in healthcare needs, primary care physicians (PCPs) will play a key role. Indeed, research shows that ensuring an adequate supply of and access to PCPs leads to better population health, optimized use of secondary and tertiary care, and more efficient use of resources. Primary care physicians can take care of most health care needs at a fraction of the cost of more specialized care: while healthcare provided by PCPs represents only 8% of overall healthcare costs, these medical professionals can take care of 90% of healthcare needs without referral. In most cases, they are the first point of contact for medical care and provide a wide range of medical services, including prevention, coordination of care, and referral to specialists. As a result, they are the medical providers of reference.

To fulfil these roles, Switzerland must ensure that the number of PCPs is sufficient to meet primary care needs. However, in Switzerland like in all EU countries, if the density of medical doctors has increased between 2010 and 2020, the share of PCPs has decreased. While the density of specialists has increased over the last 10 years, the density of primary care physicians has plateaued at around 0.8 per 1,000 inhabitants. As more and more physicians are aspiring to a better work-life balance and reduce their hours, the density of family physicians calculated as FTE is low, at 0.54 for 1,000 inhabitants in 2021. With an aging population of PCPs (mean age of 55 in 2020), the desire for a better work-life balance and difficulties in attracting general internal medicine and pediatrics graduates towards primary care practice, there are signs that a shortage of PCPs is already a reality.

PCPs role in coordinating complex care may become increasingly important. To fulfil this role, the curriculum needs to be adapted to enhance interprofessional training, and new ways of working, particularly with other physicians or as part of interprofessional primary care teams, need to be developed. These interprofessional primary care teams would most likely include physician assistants, advanced practice nurses, as well as case managers. These new ways of working are still in their infancy in Switzerland. Consequently, support to bring pilot programs to scale as well as allocation of sustained financial resources towards expanding the PCPs workforce and supporting the practice of family medicine will allow PCPs to fulfill their role as leader and coordinator of high-quality primary health care.

To avoid shortages that could undermine access to primary care, the federal government and the cantons have made significant investments in the recent years, but these need to be maintained and strengthened to achieve long-term results for primary care supply. These include investments to bolster the number of physicians trained in Switzerland, to further strengthen teaching in primary care medicine at both undergraduate and postgraduate level alongside logistical and financial support to make long-term training placements in primary care settings an essential part of physician education. Once trained, the conditions in which PCPs practice need to be more attractive with support to lighten the burden of administrative tasks, provision of efficient information systems and the financial revalorization of primary care practices.

## Résumé

La population suisse continue de croître et de vieillir, et les besoins en soins de santé vont augmenter en conséquence. Les tendances épidémiologiques qui touchent à la fois les jeunes et les personnes âgées contribueront également à cette augmentation, notamment le fardeau des troubles psychiques et les conséquences à long terme de la multimorbidité sur la santé physique et mentale. À mesure que la proportion de personnes âgées de 65 ans et plus augmentera, les besoins en matière de soins de santé s'accroîtront en conséquence, de même que les besoins en médecins de premier recours (MPR). En effet, la prise en charge des multiples atteintes à la santé liées à l'âge nécessite un suivi régulier, des consultations plus longues ainsi que du temps dédié à la coordination avec les autres professionnels de santé (infirmiers·ères, physiothérapeutes, autres médecins spécialistes, ...).

Pour répondre à cette augmentation des besoins en matière de soins, les médecins de premier recours sont appelés à jouer un rôle clé. En effet, la recherche montre qu'assurer un accès adéquat aux médecins de premier recours permet d'améliorer la santé des populations, d'optimiser le recours aux soins secondaires et tertiaires et d'utiliser les ressources de manière plus efficace. Les médecins de premier recours peuvent répondre à la plupart des besoins en soins de leurs patients pour une fraction du coût des soins dispensés par des spécialistes : alors que les soins fournis par les médecins de premier recours ne représentent que 8 % du coût total de la santé, cette catégorie de médecins peut répondre à 90 % des problèmes de santé sans référer leurs patients à un spécialiste. Dans la plupart des cas, ils sont le premier point de contact pour les soins et fournissent un large éventail de services médicaux, y compris la prévention, la coordination des soins et l'orientation vers des spécialistes. Ils sont donc les prestataires médicaux de référence.

Pour remplir ces fonctions, la Suisse doit veiller à ce que le nombre de médecins de premier recours soit suffisant pour répondre aux besoins en matière de soins primaires. Or, en Suisse comme dans tous les pays de l'UE, si la densité de médecins a augmenté entre 2010 et 2020, la proportion des médecins de premier recours a diminué. Alors que la densité en spécialistes s'est accrue au cours des dix dernières années, celle en médecins de premier recours s'est stabilisée autour de 0,8 pour 1 000 habitants. Comme de plus en plus de médecins aspirent à un meilleur équilibre entre vie professionnelle et vie privée et réduisent leurs heures de travail, la densité en médecins de famille, calculée en équivalent plein temps, est faible. Elle s'établit à 0,54 pour 1 000 habitants en 2021. Avec le vieillissement de la population des médecins de famille (âge moyen de 55 ans en 2020), le désir d'un meilleur équilibre entre vie professionnelle et vie privée et les difficultés à attirer les diplômés en médecine interne générale et en pédiatrie vers la médecine de premier recours, certains signes indiquent qu'une pénurie de médecins de famille est d'ores et déjà une réalité.

Le rôle des médecins de premier recours dans la coordination des soins complexes pourrait devenir de plus en plus important. Pour remplir ce rôle, le programme d'études doit être adapté afin d'améliorer la formation interprofessionnelle. De nouveaux modes de travail, notamment en collaboration avec d'autres médecins ou dans le cadre d'équipes interprofessionnelles de soins primaires, doivent être développés. Ces équipes incluraient très probablement des assistantes médicales, des infirmiers·ères en pratique avancée, ainsi que des gestionnaires de cas (case manager). Ces nouvelles méthodes de travail n'en sont qu'à leurs débuts en Suisse. Par conséquent, le soutien à la mise en place à plus grande échelle des programmes pilotes existants ainsi que l'allocation de ressources financières durables pour développer les effectifs des médecins de premier recours et soutenir la pratique de la médecine de famille permettront aux médecins de premier recours de remplir leur rôle de leader et de coordinateur de soins de santé primaires de haute qualité.

Pour éviter les pénuries qui pourraient compromettre l'accès aux soins primaires, le gouvernement fédéral et les cantons ont réalisé d'importants investissements ces dernières années. Cependant, ceux-ci doivent être maintenus et renforcés afin de garantir ces résultats sur le long terme en matière d'offre de soins primaires. Il s'agit notamment d'investissements ayant pour but d'augmenter le nombre de médecins formés en Suisse, de renforcer l'enseignement de la médecine de premier recours au niveau pré- et post-gradué, et d'apporter un soutien logistique et financier pour que les stages pratiques en médecine de premier recours deviennent un élément essentiel de la formation des médecins. Une fois formés, les médecins de premier recours doivent bénéficier de conditions d'exercice plus attrayantes, avec un soutien pour alléger le fardeau des tâches administratives, la mise à disposition de systèmes d'information efficaces et la revalorisation financière des soins de premier recours.

## Zusammenfassung

Das Wachstum und die Alterung der Schweizer Bevölkerung wird den Bedarf in der Gesundheitsversorgung steigern. Epidemiologische Trends betreffen sowohl alte als auch junge Menschen und werden ebenfalls zu diesem Anstieg beitragen, allen voran die Belastung durch psychische Erkrankungen sowie die langfristigen Folgen der Multimorbidität für die körperliche und psychische Gesundheit. Da der Anteil der über 65-Jährigen zunimmt, wird auch der Bedarf an medizinischer Versorgung entsprechend steigen und damit auch der Bedarf an Hausärzten. Die Bewältigung der vielfältigen altersbedingten gesundheitlichen Probleme erfordert regelmässige Untersuchungen, längere Sprechzeiten und Zeit für die Koordinierung mit anderen Gesundheitsfachkräften (Pflegefachpersonen, Physiotherapeutinnen, anderen Fachärzten usw.).

Die Hausärzte haben eine Schlüsselrolle in der Deckung dieses zunehmenden Bedarfs an medizinischer Versorgung. Forschungsergebnisse zeigen, dass die Sicherstellung eines angemessenen Angebots an und des Zugangs zu Hausärztinnen zu einer besseren Gesundheit der Bevölkerung, einer optimierten Inanspruchnahme der Sekundär- und Tertiärversorgung und einer effizienteren Nutzung der Ressourcen führt. Hausärzte können die meisten Gesundheitsbedürfnisse zu einem Bruchteil der Kosten einer spezialisierten Versorgung abdecken: Während die von Hausärztinnen erbrachte Gesundheitsversorgung nur 8 % der gesamten Gesundheitskosten ausmacht, können sie sich um 90 % der Gesundheitsbedürfnisse ohne Überweisung kümmern. In den meisten Fällen sind sie die erste Anlaufstelle für gesundheitliche Probleme und bieten eine breite Palette medizinischer Dienstleistungen an, einschliesslich Prävention, Koordination der Versorgung und Überweisung an Spezialisten. Sie sind somit eine der wichtigsten Ansprechpersonen im medizinischen Bereich.

Dafür braucht es in der Schweiz eine ausreichende Anzahl an Hausärzten, um den Bedarf in der Primärversorgung zu decken. In der Schweiz, wie auch in allen anderen EU-Ländern, hat die Ärztedichte zwischen 2010 und 2020 zwar zugenommen, der Anteil der Hausärztinnen ist jedoch gesunken. Während die Dichte der Fachärzte in den letzten 10 Jahren zugenommen hat, stagniert die Dichte der Hausärzte bei etwa 0,8 pro 1.000 Einwohner. Da immer mehr Ärztinnen eine bessere Work-Life-Balance anstreben und ihre Arbeitszeit reduzieren, ist die Dichte der Hausärzte, berechnet als Vollzeitäquivalent, mit 0,54 pro 1.000 Einwohnern im Jahr 2021 gering. Angesichts der alternden Bevölkerung (Durchschnittsalter von 55 Jahren im Jahr 2020), des Bedürfnisses nach einer besseren Vereinbarkeit von Beruf und Familie und der Schwierigkeiten, Absolventen der Fachrichtungen Allgemeine Innere Medizin und Pädiatrie für die hausärztliche Tätigkeit zu gewinnen, gibt es Anzeichen dafür, dass ein Mangel an Hausärzten bereits Realität ist.

Die Rolle der Hausärzte bei der Koordinierung von komplexen Fällen wird immer wichtiger. Dafür muss der Inhalt der Lehre angepasst werden, um die interprofessionelle Ausbildung zu verbessern. Neue Arbeitsmodelle müssen entwickelt werden, insbesondere mit anderen Ärzten oder als Teil von interprofessionellen Teams, die insbesondere auch medizinische Praxisassistentinnen, Pflegefachpersonen sowie Case Manager gehören. Diese neuen Arbeitsmodelle stecken in der Schweiz noch in den Kinderschuhen. Damit die Hausärztinnen ihre Rolle in der Leitung und Koordination einer qualitativ hochwertigen medizinischen Grundversorgung erfüllen können, müssen Pilotprogramme in grösserem Umfang unterstützt werden. Es braucht nachhaltige finanzielle Mittel für die Erhöhung der Anzahl von Hausärzten und die Unterstützung der Hausarztpraxen.

Um Engpässe zu vermeiden, die den Zugang zur Grundversorgung erschweren könnten, haben der Bund und die Kantone in den letzten Jahren erhebliche Investitionen getätigt. Diese müssen erhöht werden, um die Grundversorgung langfristig zu stärken. Dazu gehören Investitionen zur Erhöhung der Zahl der in der Schweiz ausgebildeten Ärztinnen und Ärzte, zur weiteren Stärkung der Lehre in

Hausarztmedizin sowohl auf der Ebene des Studiums als auch auf der Ebene der Weiterbildung, sowie logistische und finanzielle Unterstützung, um langfristige Praktika in der Grundversorgung zu einem wesentlichen Bestandteil der ärztlichen Ausbildung zu machen. Nach der Ausbildung müssen die Arbeitsbedingungen der Hausärzte attraktiver werden: die Belastung durch administrative Aufgaben muss verringert, der Informationsaustausch effizienter und die finanzielle Aufwertung von Hausarztpraxen gefördert werden.

## Introduction

The last few years have seen a proliferation of headlines about healthcare shortages in both the outpatient and inpatient sectors. While the COVID crisis and its aftermath have certainly played a role, the tensions affecting the Swiss healthcare system seem to have reached an unprecedented level. These tensions have been felt in most high-income countries, and indeed the situation in Switzerland is very similar to that in the rest of Europe.

Strengthening the role of primary care is one of the key strategies for effective, efficient, and equitable health systems that can respond effectively to the population's evolving health needs, which are increasingly related to chronic diseases and multimorbidity. Two factors are important to achieve this: maintaining high-quality primary care services and ensuring that the population has access to a sufficient number of primary care physicians (PCPs)<sup>1</sup>. One of the major trends across Europe is the increasing proportion of specialists relative to PCPs, suggesting that primary care might be a less attractive career choice compared to specialised medical practice. This is combined with the widespread observation of an aging PCP workforce and younger physicians' desire for a better work-life balance (and thus shorter working hours), increasing the risk of PCP shortages even more. In addition to workforce shortages, imbalances in the geographical distribution of PCPs are increasing, with populations in rural and peripheral areas potentially encountering problems to access primary care.

There is some evidence of effective strategies to improve the attractiveness of primary care to medical students and physicians, including interventions in medical education, improvements in working conditions (especially remuneration and overall quality of work), effective workforce planning systems, and more attractive models of primary care (e.g., multidisciplinary care models)<sup>2</sup>. New models of care that are different from the classical single-practice physician are currently one of the most promising policy developments discussed in many countries. They are focused on improving the access to effective care and patients with complex needs such as multiple chronic diseases. Economic incentives are also needed to encourage PCPs to work in teams, focus on prevention and continuity of care, and coordinate care in complex situations<sup>3</sup>.

Switzerland's healthcare system is considered one of the best in the world: the population has access to a wide range of services, satisfaction is high, and life expectancy is among the highest in the world. However, it is heavily based on inpatient and specialized care and may therefore not be optimal to care for the growing number of people suffering from chronic diseases. Healthcare costs are also rising steadily and have been at the centre of political debate in recent decades. Strengthening primary care in such a system implies a paradigm shift and strong involvement of political decision-makers. Swiss PCPs have fuelled this process in the first decade of the millennium by launching a federal initiative, resulting in the publication of the Federal Council's strategy to strengthen primary care in 2011. A Masterplan set the basis for concrete measures to improve training of future PCPs, promote academic primary care (notably through the creation of the Swiss Academy of Family Medicine or SAFMED), and adjust the financial remuneration of PCPs.

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<sup>1</sup> Quality in primary health care. World Health Organization, 2018. Available from: <https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.54>

<sup>2</sup> Kroezen M, Rajan D, Richardson E. Strengthening primary care in Europe: How to increase the attractiveness of primary care for medical students and primary care physicians? European Observatory on Health System and Policies, Policy Brief 55, 2023

<sup>3</sup> OECD (2020), Realising the Potential of Primary Health Care, OECD Health Policy Studies, OECD Publishing, Paris. <https://doi.org/10.1787/a92adee4-en>

Since then, over a decade has passed. The purpose of the present report is to take stock of how the primary care situation has evolved in Switzerland, to outline possible future developments, and to suggest priorities for action. It presents relevant public health and research data to support advocacy in favour of strengthening primary care in Switzerland.

This report starts with the presentation of demographic and epidemiological trends affecting the Swiss population's health care needs (Chapter 1). We felt it was necessary to emphasise and reaffirm the benefits of primary care on population health and the effectiveness of high-quality primary care (Chapter 2). Chapter 3 outlines the main trends in the primary care workforce as a basis for workforce planning. Finally, we outline recent efforts to strengthen primary care in undergraduate and postgraduate education (Chapter 4), and what is needed for long-term retention of physicians in primary care practice.

Wherever possible, we placed the situation in Switzerland in a wider context by providing data from other countries and from international scientific studies.

## 1. Explaining health care needs increase: demographic and epidemiological trends in Switzerland

Switzerland is experiencing the same demographic trends as most high-income countries. These demographic changes encompass both population growth and population aging. Additionally, epidemiological trends will impact the burden of disease in Switzerland. While much of this increased burden is directly related to the growing proportion of people aged 65 years and over, some of these trends will also affect younger people. Primary care physicians will play a crucial role in preventing, detecting, and treating these conditions to safeguard the long-term health of the population.

### *a. A sustained population growth – a projected 10 million Swiss residents by 2040*

The Swiss population has increased by almost a million people between 2010 and 2021; thus, the number of people potentially accessing the primary care sector increased by 11.4% in only one decade. This growth is expected to continue (see Table 1.1). According to the reference scenario, the Swiss population is expected to increase by almost 2 million by 2050.

	1990	2000	2010	2021	2030	2040	2050
Swiss population	6 673 850	7 164 444	7 785 806	8 670 300	9 430 802	10 015 412	10 440 621
<b>Variation (absolute numbers)</b>		+490 594	+884 494		+584 610		
		+621 362		+760 502		+425 209	
<b>Variation (%)</b>		+7.4%	+11.4%		+6.2		
		+8.7%		+8.8%		+4.2%	

**Table 1.1 Evolution of the Swiss population from 1990 to 2021 and population projection until 2050\***

\*Projection numbers are from the reference scenario

Source: OFS, Scénarios pour la Suisse [page internet]

<https://www.bfs.admin.ch/bfs/fr/home/statistiques/population/evolution-future/scenarios-suisse.html>

### *b. An aging population – people 80 years old or over to triple between 2020 and 2050*

Demographic trends in all high-income countries point to a significant aging of the overall population. In Switzerland, both the absolute number and percentage of people aged 65 years and over will increase dramatically. In particular, the number of people aged over 80 years will almost triple in just 30 years (Table 1.2). Whereas the proportion of people under the age of 20 years is expected to remain stable at around 20%, the absolute number of this population is expected to increase by almost 300'000 between 2020 and 2050. The need for child and adolescent primary care will therefore also increase.

	2020	2050
<b>Permanent resident population (total)</b>	8 688 200	10 440 600
<b>People under 20 years of age (n)</b>	<b>1 733 000</b>	<b>2 015 700</b>
<b>People under 20 years of age (%)</b>	<b>20%</b>	<b>19.3%</b>
<b>People aged 20 to 64 years old (n)</b>	5 314 300	5 752 300
<b>People aged 20 to 64 years old (%)</b>	61.2%	55.1%
<b>People aged 65 or over (n)</b>	<b>1 640 900</b>	<b>2 672 600</b>
<b>People aged 65 or over (%)</b>	<b>18.9%</b>	<b>25.6%</b>
<b>People aged 80 or over (n)</b>	<b>460 000</b>	<b>1 110 000</b>
<b>People aged 80 or over (%)</b>	<b>5.3%</b>	<b>10.6%</b>

**Table 1.2 Evolution of the Swiss population structure by age - population projection until 2050\***

\*Projection numbers are from the reference scenario

Source: OFS, Evolution future [page internet]

<https://www.bfs.admin.ch/bfs/fr/home/statistiques/population/evolution-future.html>

The specific healthcare needs of this older population will affect the demands placed on the health care system in the future<sup>4</sup>:

- Older adults are more likely to suffer from long-term and chronic illnesses (e.g., cancer, heart disease, diabetes) than younger people (**Figure 1.1**). According to the 2017 Swiss Health Survey, about half of the population aged 65 and over reported at least two chronic diseases, and about a quarter reported three or more<sup>5</sup>.
- Older adults have more limitations in performing activities of daily living than younger people, due to higher rates of physical and cognitive disability. In 2017, 3.5% of people aged 35 to 44 reported that their daily activities were severely limited by health problems, compared with 6.6% aged 65 to 74 and 9.9% of people aged 75 and over<sup>6</sup>.
- Older adults need more care in all sectors (outpatient, inpatient, nursing home, and home-based care). In 2017, 2.5% of 45 to 54 years old reported being hospitalized for 6 days or more, compared with 11% in people aged 75 or over<sup>7</sup>. When asked how many times they had visited a PCP in the last 12 months, 10.9% of 45–54-year-olds and 20.9% of people aged 75 and over reported 5 or more visits<sup>8</sup>.

**The 2017 Swiss Health Survey thus showed that although a high proportion of the Swiss population rate their health as good or very good<sup>9</sup>, this proportion declines with age (Figure 1.1).**

<sup>4</sup> McGinnis SL, Moore J. The impact of the aging population on the health workforce in the United States--summary of key findings. *Cah Sociol Demogr Med*. 2006;46(2):193-220.

<sup>5</sup> OFS, Enquête suisse sur la sante 2017. Tableau standard. Maladie chroniques ou problèmes de santé de longue durée, 2012, 2017. <https://www.portal-stat.admin.ch/sgb2017/files/fr/O2b.xml>

<sup>6</sup> OFS, Enquête suisse sur la sante 2017. Tableau standard Limitation dans les activités habituelles, 2012, 2017. <https://www.portal-stat.admin.ch/sgb2017/files/fr/O2b.xml>

<sup>7</sup> OFS, Enquête suisse sur la sante 2017. Tableau standard Nombre de jours d'hospitalisation. <https://www.portal-stat.admin.ch/sgb2017/files/fr/O2c.xml>

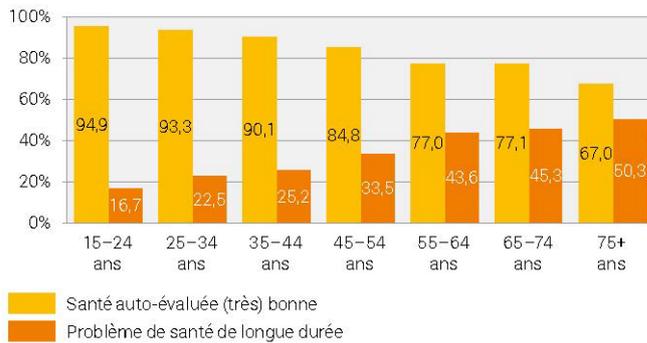
<sup>8</sup> OFS, Enquête suisse sur la sante 2017. Tableau standard Nombre de consultations chez un médecin généraliste. <https://www.portal-stat.admin.ch/sgb2017/files/fr/O2c.xml>

<sup>9</sup> OFS, Enquête suisse sur la santé 2017. Vue d'ensemble. OFS, 2018. <https://www.bfs.admin.ch/asset/fr/6426303>

## Santé auto-évaluée et problème de santé de longue durée, en 2017

Population de 15 ans et plus vivant en ménage privé

G11



Source: OFS – Enquête suisse sur la santé (ESS)

© OFS 2018

**Figure 1.1 Self-rated health and long-term health problems by age**

Source : Enquête suisse sur la santé 2017 Vue d'ensemble. OFS, 12.2018 (version corrigée)

<https://www.bfs.admin.ch/bfs/fr/home/statistiques/sante/etat-sante.assetdetail.6426303.html>

**The healthcare needs in the older population are best addressed in a coordinated and efficient primary care system.** Managing the multiple health vulnerabilities that come with age requires regular follow-ups, longer consultation time and time to coordinate with other health professionals (nurses, physical therapists, specialist physicians). Numerous health care institutions and actors are involved in providing care to this population. Consequently, if healthcare is delivered in silos with no or insufficient communications and coordination between the professionals involved (physicians, pharmacists, nursing homes, etc.), quality of care may suffer, notably because of discontinuities in care and missed opportunities for early intervention and prevention. PCPs are ideally placed to coordinate care in these situations.

**Overall life expectancy is an indicator of general population health and living conditions. Another – often overlooked – indicator is healthy life expectancy, which focuses on the number of years an individual can expect to live in good health without experiencing significant disability or illness; it thus considers health-related quality of life.**

**While life expectancy at birth in Switzerland is among the highest in the world<sup>10</sup>, healthy life expectancy suggests that there is room for improvement in terms of health in the older population<sup>11</sup> (Table 1.3), especially in comparison to Sweden and Norway, the two best performing countries. Healthy life expectancy is closely linked to characteristics of the healthcare system: a well-functioning healthcare system that provides access to quality care, emphasizes prevention, and addresses both acute and chronic health needs can contribute significantly to a population's overall health and the extension of healthy life expectancy. Improving life expectancy in good health can reduce the economic risks associated with an aging population and contribute to the sustainability of health systems by limiting the increase in healthcare needs of the elderly<sup>12</sup>.**

<sup>10</sup> In 2021, Life expectancy at birth for men is 81.6 years; for women it is 85.7 years. Source: OFS, *Espérance de vie* <https://www.bfs.admin.ch/bfs/fr/home/statistiques/population/naissances-deces/esperance-vie.html>

<sup>11</sup> Stéphanie Monod. *La santé, cette oubliée du débat*. Le Temps, 1 February 2023.

<sup>12</sup> European Commission Health and Consumer Protection Directorate-General, *Healthy aging: keystone for a sustainable Europe*, 2007. [https://ec.europa.eu/health/archive/ph\\_information/indicators/docs/healthy\\_ageing\\_en.pdf](https://ec.europa.eu/health/archive/ph_information/indicators/docs/healthy_ageing_en.pdf)

	Switzerland		Sweden		Norway	
	Women	Men	Women	Men	Women	Men
<b>Life expectancy at age 65 years</b>	23 years	20.3 years	22.1 years	19.6 years	21.9 years	19.6 years
<b>Life expectancy in good health at age 65 years</b>	10.5 years	11.2 years	16.6 years	15.9 years	15.8 years	15.8 years
<b>Years of ill health at end of life</b>	12.5 years	9.1 years	5.5 years	3.7 years	6.1 years	3.8 years

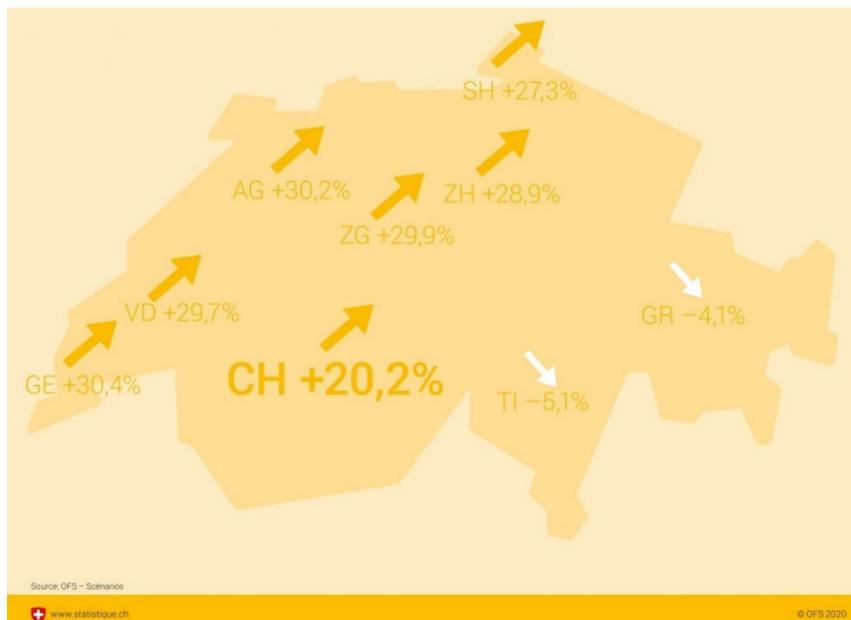
**Table 1.3 Life expectancy and life expectancy in good health at 65 in Switzerland, Sweden, and Norway (2019 or nearest year)**

Source: Health at a Glance 2021: OECD Indicators. Life expectancy and healthy life expectancy at age 65.  
<https://www.oecd-ilibrary.org/sites/82ca511d-en/index.html?itemId=/content/component/82ca511d-en>

*c. Demographic trends will not affect regions and cantons homogeneously*

The demographic trends described above are not homogeneously distributed throughout Switzerland and will thus affect the evolution of care needs in different ways according to cantonal variations. For example, the cantons of Geneva and Ticino have very different projected evolutions until 2050 (Figure 1.2). While in Geneva, the population is expected to increase by 30%, in Ticino it will decrease by 5% during the same period. The proportion of the population aged 65 years and over will increase in Ticino to reach 34% of its population, while in Geneva, it will represent 20% of the population<sup>13</sup>. For the canton of Ticino, this scenario is worrying, because it may lead to a significant increase in healthcare needs with their associated costs and needs for an appropriate primary care workforce. Along with the heterogeneous distribution of primary care physicians (see below), it may become challenging to guarantee adequate access to primary care services to all parts of the population.

<sup>13</sup> For more information regarding the projections by cantons, further information is available on the Swiss Federal Office of Statistics:  
<https://www.bfs.admin.ch/bfs/fr/home/statistiques/population/evolution-future/scenarios-cantons.html>



**Figure 1.2 Population evolution for selected cantons 2020-2050\***

\*Projection numbers are from the reference scenario

Source: OFS, Evolution future [page internet]

<https://www.bfs.admin.ch/bfs/fr/home/statistiques/population/evolution-future.html>

#### *d. The burden of mental health disorders in the Swiss population and its impact on primary care physicians*

**As mentioned at the beginning of this chapter, demographic trends will be the driving factor behind the increase in demand for primary care. Epidemiological trends across different age groups may also affect primary care needs.**

**One such trend is the increasing burden of disease linked to mental health conditions.** A Swiss Health Observatory<sup>14</sup> (OBSAN) report highlighted that whereas most people rate their quality of life as good or excellent (91.7% in 2017), **some indicators show a deterioration of mental health status, as testified by an increase in depressive symptoms (Table 1.4). This was accompanied by a decrease of factors known to be protective for mental health: only 37% of respondents reported a good sense of control over their lives (the lowest proportion since 2002), while 38% reported feeling lonely often or sometimes, the highest proportion in 20 years.**<sup>15</sup>

It is important to note that such surveys tend to underestimate the burden of mental disorders or vulnerabilities in the general Swiss population.<sup>16</sup>

<sup>14</sup> The Swiss Health Observatory (OBSAN) provides reliable, independent analyses of the health system in Switzerland for the Confederation and the cantons.

<sup>15</sup> Schuler, D., Tuch, A. & Peter, C. (2020). La santé psychique en Suisse. Monitoring 2020 (Obsan Rapport 15/2020). Neuchâtel: Observatoire suisse de la santé. <https://www.obsan.admin.ch/fr/publications/2020-la-sante-psychique-en-suisse>

<sup>16</sup> This underestimation can be explained by two facts: people living in health institutions or similar institutions are generally excluded from the survey population, and people suffering from mental health disorders are less likely to answer this type of survey.

	Mild depressive symptoms	Moderate depressive symptoms	Severe depressive symptoms
2012	22.2	4.6	1.9
2017	25.9	5.9	2.8
<b>Diagnosed with depression in the last 12 months</b>			
2012	4.2		
2017	5.4		
<b>Suicidal thoughts</b>			
2012	6.4%		
2017	7.8%		

**Table 1.4 Evolution of selected mental health indicators in the Swiss population, 2012-2017**

Source: Schuler, D., Tuch, A. & Peter, C. (2020). La santé psychique en Suisse. Monitoring 2020 (Obsan Rapport 15/2020). Neuchâtel: Observatoire suisse de la santé.

<https://www.obsan.admin.ch/fr/publications/2003-la-sante-psychique-en-suisse>

The report notes that between 2000 and 2020, once diagnosed, patients have increasingly been treated by mental health specialists (psychiatrists or psychologists), with 85% of treatments for mental health disorders being provided by these specialists in 2017 (58% in 1997). **While this trend is encouraging, it masks the fact that the burden of managing mental health disorders (i.e., prevention, diagnosis and first line of treatment) is certainly largely shouldered by primary care physicians<sup>17</sup>.** This apparent contradiction is explained by what is known as the treatment gap – the fact that most people experiencing common mental disorder symptoms do not seek treatment and/or are not recognised as having a health problem by the healthcare professionals with whom they come into contact<sup>18</sup>.

Research from Germany<sup>19,20</sup> and Switzerland (Bern)<sup>21</sup> suggests that most people with mental health problems are not receiving care from mental health specialists. The Bern Epidemiological At Risk (BEAR) study found that 93% of 16–40-year-olds with mental health problems were not receiving psychiatric or psychological treatment at the time of the survey<sup>22</sup>. Many people only seek help when their mental illness impairs their ability to function<sup>23</sup>. **According to a recent estimate, 13.8% of the Swiss population would need psychiatric or psychological therapy, but that only 6% receive it<sup>24</sup>. This means that an estimated 7.8% of the Swiss population, or 0.7 million people, would need psychiatric or psychotherapeutic care, but are not receiving it. This treatment gap is seen throughout the world: it is estimated that even in high income countries, nearly 50% of people with depression do not get treatment<sup>25</sup>.**

<sup>17</sup> Nelly Zilber, High users of primary care services - How are their mental health problems recognized and addressed? Bulletin du Centre de recherche français à Jérusalem [Online], 7 | 2000. <http://journals.openedition.org/bcrfj/2472>

<sup>18</sup> Mental Health in Primary Care: Illusion or Inclusion, Technical series on primary health care, WHO, 2018.

<sup>19</sup> Mack, S., Jacobi, F., Gerschler, A., Strehle, J., Höfler, M., Busch, M.A. et al. (2014). Self-reported utilization of mental health services in the adult German population--evidence for unmet needs? Results of the DEGS1-Mental Health Module (DEGS1-MH) International Journal of Methods in Psychiatric Research, 23(3): 289-303.

<sup>20</sup> Rommel, A., Bretschneider, J., Kroll, L.E., Prütz, F. & Thom, J. (2017). Inanspruchnahme psychiatrischer und psychotherapeutischer Leistungen – Individuelle Determinanten und regionale Unterschiede. Journal of Health Monitoring, 2(4).

<sup>21</sup> Michel, C., Schnyder, N., Schmidt, S.J., Groth, N., Schimmelman, B.G. & Schultze-Luttera, F. (2018). Functioning mediates help seeking for mental problems in the general population. European Psychiatry, 54: 1–9.

<sup>22</sup> Michel, C., Schnyder, N., Schmidt, S.J., Groth, N., Schimmelman, B.G. & Schultze-Luttera, F. (2018). Functioning mediates help seeking for mental problems in the general population. European Psychiatry, 54: 1–9.

<sup>23</sup> Schuler, D., Tuch, A. & Peter, C. (2020). La santé psychique en Suisse. Monitoring 2020 (Obsan Rapport 15/2020). Neuchâtel: Observatoire suisse de la santé.

<sup>24</sup> Künzi, K., Stocker, D. & Schläpfer, D. (2020). Volkswirtschaftlicher Nutzen des Anordnungsmodells und damit eines niederschwelligeren Zugangs zu ambulanter Versorgung bei psychischen Erkrankungen. Bern: Föderation der Schweizer Psychologinnen und Psychologen

<sup>25</sup> Mental Health in Primary Care: Illusion or Inclusion, Technical series on primary health care, WHO, 2018.

This treatment gap means that there is in effect a lack of mental health specialists in Switzerland. While this fact has been predicted a decade ago<sup>26</sup>, the mental health workforce is still largely insufficient to fulfil the mental health care needs in the population. This gap is partly filled by PCPs: due to their position as the first point of contact for many patients within the healthcare system, they are often well positioned to detect, diagnose, and manage a wide range of mental health conditions, as they have a comprehensive understanding of a patient's medical history, lifestyle, and social context. They can also improve access to appropriate mental health services.

#### *e. Morbidity in young people: epidemiological trends likely to raise primary care needs*

Childhood, adolescence, and young adulthood are periods of vulnerability, but also of great potential regarding preventive and health-promoting measures<sup>27</sup>. Most young people report high ratings in terms of quality of life and health status. **However, increasing mental health problems are a major concern in this population. A 2022 report on mental health noted that among children, adolescents, and young adults, worrying trends included high levels of psychological distress, an increase in hospital admissions for mental health morbidities and for attempted suicides, particularly among girls and young women up to the age of 18<sup>28</sup>.** These trends are particularly worrisome given that the early onset of mental disorders can have a significant impact on an individual's personal and professional development.

**Increases in the prevalence of mental health issues have been reported by other key recent publications:**

- The proportion of 11–15-year-olds suffering from multiple psycho-emotional disorders (sadness, bad mood, nervousness, fatigue, anxiety, irritability, and difficulty falling asleep) increased between 2002 and 2018. Fatigue and difficulty falling asleep are on the rise.<sup>29</sup>
- In a survey of 14–19-year-olds conducted in the summer of 2021 in Switzerland and Liechtenstein, about one third reported mental health problems<sup>30</sup>. Although the COVID pandemic probably played a role, the prevalence rate was higher than that reported in other studies on similar populations in Switzerland or in other countries. Only about half of the participants reporting symptoms of mental health distress had seen a mental health professional in the 12 months prior to the survey. The authors hypothesise that while the stigma associated with mental health care may explain this low proportion, another explanation may be that treatment is not sought because young people in distress are not identified early enough.

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<sup>26</sup> Giacometti-Bickel G., Landolt K, Bernath C., Seifritz E., Haug A., Rössler W. (2013). Bulletin des médecins suisses 2013;94:8

<sup>27</sup> Observatoire suisse de la santé, Claudio Peter, Monika Diebold, Marina Delgrande Jordan, Julia Dratva, Ilona Kickbusch, Susanne Stronski (Ed.), La santé en Suisse – Enfants, adolescents et jeunes adultes. Rapport national sur la santé 2020

<sup>28</sup> Schuler, D., Tuch, A., Sturny, I. et Peter, C. (2022). Santé psychique. Chiffres clés et impact du COVID-19 (Obsan Bulletin 02/2022). Neuchâtel: Observatoire suisse de la santé. [https://www.obsan.admin.ch/sites/default/files/2022-04/Obsan\\_BULLETIN\\_2022\\_02\\_f.pdf](https://www.obsan.admin.ch/sites/default/files/2022-04/Obsan_BULLETIN_2022_02_f.pdf)

<sup>29</sup> Observatoire suisse de la santé, Claudio Peter, Monika Diebold, Marina Delgrande Jordan, Julia Dratva, Ilona Kickbusch, Susanne Stronski (Ed.), La santé en Suisse – Enfants, adolescents et jeunes adultes. Rapport national sur la santé 2020

<sup>30</sup> Barrense-Dias Y, Chok L, Surís JC. A picture of the mental health of adolescents in Switzerland and Liechtenstein. Lausanne, Unisanté – Centre universitaire de médecine générale et santé publique, 2021 (Raisons de santé 323). <https://doi.org/10.16908/issn.1660-7104/323>

The mental health treatment gap mentioned in reference to the adult population thus also exists in the youth population and has been documented in young Swiss adults (17-21 years old)<sup>31</sup>.

Although most school-age children and young people are in good physical health, most of them see a primary care physician at least once per year. Thus, PCPs are an important point of entry to the health system for this population, especially because there might be less stigma associated with seeing a PCP than seeing a mental health professional. It will thus be essential to consider these mental health needs when planning the primary care workforce and the training of future PCPs.

The role of PCPs in identifying and treating mental health disorders is important in a context where the provision of psychiatry and psychotherapy for children and adolescents has been shown to be largely inadequate by a 2016 report commissioned by the Federal Office of Public Health to obtain a clearer picture of the shortcomings in the treatment of mental illness in Switzerland<sup>32</sup>.

Childhood and youth are also life periods where risk factors for future chronic diseases develop, such as overweight/obesity, cigarette smoking, and dietary habits. Although these are public health issues that need to be addressed on a population level, PCPs can address these questions in an individualized way and reinforce public health messages<sup>33</sup>. For example, **the high prevalence of overweight and obesity in children is a continuing concern in many countries**. For children 6 to 12 years old, a recent study showed a small but significant downward trend in the prevalence of overweight (including obesity), but not of obesity alone, between 2012 and 2017/18<sup>34</sup>. Despite these encouraging results, the authors noted that ‘at nearly 16%, the prevalence of overweight, including obesity, remains a public health concern’. PCPs providing paediatric care play a central role in these preventive efforts because of their long-term follow-up of families allowing them to identify risk factors early on.

#### *f. The impact of the Covid-19 pandemic*

The Covid-19 pandemic has placed unprecedented strain on the Swiss health care system and has the potential to significantly affect the future health care needs of the Swiss population. The long-term physical and mental health effects of the pandemic are still not fully understood, but it is likely that they will further increase the demand for primary health care. The pandemic has led to an increase in mental health disorders such as anxiety and depression, as well as long-term physical health issues, known as long-covid symptoms, in those who have recovered from the virus. Much of the management of these sequelae will be carried out by PCPs.

In summary, demographic and epidemiological trends in Switzerland indicate a significant increase in health care needs over the coming decades. An aging population, the growing prevalence of chronic diseases and multimorbidity, increasing mental health problems among young people, and the impact of the Covid-19 pandemic are all contributing to increasing demand for primary health care services. This growing demand will put significant pressure on the PCP workforce, requiring a proactive and coordinated approach to effectively manage these challenges.

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<sup>31</sup> Werlen L, Puhon MA, Landolt MA, Mohler-Kuo M. Mind the treatment gap: the prevalence of common mental disorder symptoms, risky substance use and service utilization among young Swiss adults. *BMC Public Health*. 2020;20(1):1470. Published 2020 Sep 29. doi:10.1186/s12889-020-09577-6

<sup>32</sup> Zitiervorschlag: Stocker, D., Stettler, P., Jäggi, J., Bischof, S., Guggenbühl, T., Abrassart, A, Rüesch, P., & Künzi, K. (2016). Versorgungssituation psychisch erkrankter Personen in der Schweiz. Bern: Bundesamt für Gesundheit.

<sup>33</sup> Tissot H, Pfarrwaller E, Haller DM. Primary care prevention of cardiovascular risk behaviors in adolescents: A systematic review. *Prev Med*. 2021 Jan;142:106346. doi: 10.1016/j.ypmed.2020.106346. Epub 2020 Dec 1. PMID: 33275966.

<sup>34</sup> Isabelle Herter-Aeberli. BMI, waist circumference and body fat measurements as well as NCD risk factors in 6- to 12-year-old children in Switzerland. Final report for the attention of the Federal Office of Public Health (BAG), 2018

## 2. Benefits of primary care for the health care system

There is now solid evidence from several decades of research that healthcare systems with a strong primary care base perform better: the population is healthier, the healthcare system is more cost-effective, and there are economic benefits beyond the healthcare system itself. These observations apply to all countries in the world, regardless of their economic level. The central role of primary care was already recognized by the international community in 1978 in the World Health Organization's Declaration of Alma Ata, which stated that primary care was the key element in ensuring health for all. This vision was reiterated in the 2018 Astana Declaration<sup>35</sup>.

In Switzerland, the importance of primary care was politically recognized following demands and actions from the PCP community, especially their popular initiative<sup>36</sup>. The Federal Council's subsequent counterproposal included several measures. In addition to a modification of the constitution to explicitly mention primary care as an essential component of basic medical care, a Masterplan laid out concrete measures in three areas: (1) the mandatory integration of primary care into under- and post-graduate training programmes via a revision of the law on the medical professions, (2) measures to promote academic primary care, and (3) adjustments to tariffs to better remunerate PCPs.

### The core functions of primary care

Primary care is the ideal gateway to the healthcare system for a large proportion of the population. PCPs can take care of most health problems, offering person-centred care and ensuring continuity over time with, where necessary, coordination with other partners in the healthcare system. The core functions of primary care, first introduced by Barbara Starfield<sup>37</sup> based on her health systems research and subsequently updated by organizations such as the WHO, are an essential framework to understand why primary care has such important benefits for population health (**Table 2.1**). High-quality primary care builds on these core functions and is particularly well suited to caring for patients suffering from chronic diseases, which is one of the main challenges of healthcare systems in high-income countries.

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<sup>35</sup> Declaration of Astana, Global Conference on Primary Health Care: Astana, Kazakhstan, 25 and 26 October 2018  
Institute of Medicine (US) Committee on the Future of Primary Care, Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. Primary Care: America's Health in a New Era. Washington (DC): National Academies Press (US); 1996.  
National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care, Robinson SK, Meisner M, Phillips RL Jr., McCauley L, eds. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington (DC): National Academies Press (US); May 4, 2021.

<sup>36</sup> Conseil Fédéral, Stratégie pour lutter contre la pénurie de médecins et encourager la médecine de premier recours, Novembre 2011.

<sup>37</sup> Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502. doi: 10.1111/j.1468-0009.2005.00409.x. PMID: 16202000; PMCID: PMC2690145.

- **First contact accessibility** creates a strategic entry point for and improves access to health services.
- **Continuity** promotes the development of long-term personal relationships between a person and a health professional or a team of providers.
- **Comprehensiveness** ensures that a diverse range of promotive, protective, preventive, curative, rehabilitative, and palliative services are provided.
- **Coordination** organizes services and care across levels of the health system and over time.
- **People-centred care** ensures that people have the education and support needed to make decisions and participate in their own care.

**Table 2.1. Five Core Functions of Primary Care**

Source: WHO, Primary Care [internet page]

<https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care>

### *a. The link between supply of primary care physicians and population health outcomes*

Research on whether and how the density of primary care physicians contributes to health outcomes has been conducted mainly in the last two decades of the 20<sup>th</sup> the beginning of the 21<sup>st</sup> century. **These studies have provided a strong evidence base for the consensus that an adequate supply of PCPs is important to achieve better population health. A higher density of PCPs is associated with better health outcomes<sup>38</sup>**, including all-cause mortality, mortality attributed to cancer, heart disease, and acute myocardial infarction, stroke, mortality attributed to avoidable causes, acute hospital admissions, infant mortality, low birth weight, life expectancy, and self-rated health<sup>39,40</sup>. **Indeed, primary care is the only medical discipline where a greater supply produces improvements in population health, longer lives, and greater health equity<sup>41</sup>. A 2003 study<sup>42</sup> conducted on data from 18 OECD countries analysing the link between characteristics of these countries' primary care system and health outcomes showed that the strength of the country's primary care system was negatively associated with all-cause mortality, all-cause premature mortality and cause-specific premature mortality (asthma and bronchitis, emphysema and pneumonia, cardiovascular disease, and heart disease).** Thus, strong primary care system and practice characteristics such as geographic regulation, longitudinal coordination and community orientation were associated with improved population health. **An increase of one PCP per 10,000 population has been estimated to decrease mortality by 5 to 6%<sup>43,44</sup>.** The policy impact of these findings is considerable. In the USA, a 5.3 percent reduction in all-cause mortality in 2000 would translate into 127,617 deaths potentially averted.

<sup>38</sup> Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly* 2005; 83(3):457-502.

<sup>39</sup> Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv*. 2007;37(1):111-126. doi:10.2190/3431-G6T7-37M8-P224

<sup>40</sup> Gulliford MC, Jack RH, Adams G, Ukoumunne OC. Availability and structure of primary medical care services and population health and health care indicators in England. *BMC Health Serv Res*. 2004;4(1):12. Published 2004 Jun 11. doi:10.1186/1472-6963-4-12

<sup>41</sup> National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

<sup>42</sup> Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. *Health Serv Res*. 2003 Jun;38(3):831-65. doi: 10.1111/1475-6773.00149. PMID: 12822915; PMCID: PMC1360919.

<sup>43</sup> Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv*. 2007;37(1):111-126. doi:10.2190/3431-G6T7-37M8-P224

<sup>44</sup> Gulliford MC. Availability of primary care doctors and population health in England: is there an association? *J Public Health Med*. 2002;24(4):252-254. doi:10.1093/pubmed/24.4.252

An example illustrating the impact of regionally increasing PCP density on a health outcome parameter is a Norwegian policy from 1992, using financial incentives to attract PCPs to remote municipalities suffering from a long-standing physician shortage. This initiative led to a significant decrease in perinatal mortality and increased birth weights<sup>45</sup>.

### *b. Improving access to primary care physicians to decrease use of emergency services*

Switzerland, like many other countries, is faced with the relatively new problem of overcrowding in emergency services, which regularly receives high-profile media coverage<sup>46,47</sup>. When emergency services cannot see patients in a timely manner because of overcrowding, consequences can be serious as delays in admissions from the emergency room to inpatient services are linked to an increase in mortality<sup>48</sup>. Robust primary care services can contribute to alleviate the strain on emergency departments, ensuring that they can focus on critical, life-threatening cases: by offering timely and accessible healthcare at the community level, PCPs can address minor ailments and manage chronic conditions, reducing the frequency of emergencies stemming from untreated or poorly managed health issues. Although the reasons for overcrowding are multifactorial<sup>49,50</sup>, research has highlighted the link between levels of access to primary care services and the use of emergency services.

A multinational survey conducted in 34 countries (including Switzerland) found that better accessibility of primary care services was associated with a decrease in emergency department use: patients who had a PCP who knew them on a personal level were less likely to visit emergency rooms<sup>51</sup>. Only a third of patients who went to the emergency room explained that the main reason for their visit was that their problem could not be handled by a PCP. This association has also been observed in older patients (65 and older) in a Canadian study<sup>52</sup>: patients who had no PCP or who described low or medium (versus high) levels of continuity of care with a PCP had increased rates of emergency department use, after adjusting for age, sex, and comorbidity.

**One of the main challenges is to set up effective services to respond to out-of-hours care needs (evening and weekends in particular) and for which emergency department care is not appropriate. Some countries, such as the USA, UK and New Zealand, have established urgent care centres. Where these structures have been instituted, the number of emergency room visits decreased: in a US-based**

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<sup>45</sup> Kinge JM, Grytten J. The impact of primary care physician density on perinatal health: Evidence from a natural experiment. *Health Econ*. 2021;30(12):2974-2994. doi:10.1002/hec.4426

<sup>46</sup> «Le personnel des Urgences finit par s'épuiser». *Le Matin Dimanche*. 14 janvier 2023. <https://www.24heures.ch/le-personnel-des-urgences-finit-par-sepuiser-937813350656>

<sup>47</sup> Les urgences sont "au bord de l'effondrement", selon des médecins. *RTS info* 15 janvier 2023. <https://www.rts.ch/info/suisse/13703042-les-urgences-sont-au-bord-de-leffondrement-selon-des-medecins.html>

<sup>48</sup> Jones S, Moulton C, Swift S, Molyneux P, Black S, Mason N, Oakley R, Mann C. Association between delays to patient admission from the emergency department and all-cause 30-day mortality. *Emerg Med J*. 2022 Mar;39(3):168-173. doi: 10.1136/emermed-2021-211572. Epub 2022 Jan 18. PMID: 35042695.

<sup>49</sup> Morley C, Unwin M, Peterson GM, Stankovich J, Kinsman L. Emergency department crowding: A systematic review of causes, consequences and solutions. *PLoS One*. 2018 Aug 30;13(8):e0203316. doi: 10.1371/journal.pone.0203316. PMID: 30161242; PMCID: PMC6117060.

<sup>50</sup> Martigny : cas isolé ou cas d'école? *Bull Med Suisses*. 2023;104(1415):18. 5 avril 2023. DOI: <https://doi.org/10.4414/bms.2023.21492>

<sup>51</sup> van den Berg MJ, van Loenen T, Westert GP. Accessible and continuous primary care may help reduce rates of emergency department use. An international survey in 34 countries. *Fam Pract*. 2016 Feb;33(1):42-50. doi: 10.1093/fampra/cm082. Epub 2015 Oct 28. PMID: 26511726.

<sup>52</sup> Ionescu-Ittu R, McCusker J, Ciampi A, Vadeboncoeur AM, Roberge D, Larouche D, Verdon J, Pineault R. Continuity of primary care and emergency department utilization among elderly people. *CMAJ*. 2007 Nov 20;177(11):1362-8. doi: 10.1503/cmaj.061615. PMID: 18025427; PMCID: PMC2072991.

study, open urgent care centres significantly reduced the total number of emergency room visits by 17.2%. Thus, urgent care centres seem to attract patients who would have otherwise gone to an emergency department. This shift potentially decreases health care expenses.

### *c. Economic benefits of strengthening primary care*

A strong primary care basis has long-term benefits that go beyond the health care system. The World Health Organisation outlined three ways through which primary care exerts long-term economic benefits<sup>53</sup>:

1. Improved health outcomes,
2. Improved health care system efficiency,
3. Improved health care system equity.

**Switzerland's health care costs are the second highest in the world<sup>54</sup>.** Possible cost-reducing measures include those that increase the efficiency of the health care system, including eliminating incentives for unnecessary services, concentration of highly specialized care, and improved quality of care through better coordination. **Some studies have demonstrated that increasing the density of PCPs is associated with reduction in health care expenses<sup>55</sup>.** Although these findings have not been consistently confirmed, studies that also account for indirect costs (e.g. loss of productivity due to chronic illness) have concluded that there are long-term economic benefits in healthcare systems that are strongly based on primary care.

The main reason for the greater efficiency of primary care when compared with specialized care is the lower use of resources (e.g., diagnostic tests, medicine prescriptions, procedures)<sup>56</sup>. In the longer term, people with access to and/or a long-term relationship with a PCP receive more recommended care and are less likely to be hospitalised, particularly from complications of chronic disease.

**In Switzerland, recent studies have shown that PCPs deal with most health care demands while accounting for only about 8% of total health care costs<sup>57</sup>.**

A 2015 study by the Institute of Family Medicine in Zurich showed that **PCPs can effectively deal with 94.3% of their patients' health problems without referring them to other specialists<sup>58</sup>.** Another study<sup>59</sup> by the Centre for Family Health Care in Basel found that **PCPs provided 67% of all medical consultations** (compared with 46% for secondary care and 6% for tertiary care). **The authors noted that although the healthcare needs of the Swiss population were largely met by PCPs, the proportion**

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<sup>53</sup> WHO, Building the economic case for primary health care: a scoping review. Technical Series on Primary Health Care. 2018

<sup>54</sup> The Commonwealth Fund. International Health Care System Profiles: Switzerland. <https://www.commonwealthfund.org/international-health-policy-center/countries/switzerland>

<sup>55</sup> Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. *Health Aff (Millwood)*. 2010;29:766–72.

<sup>56</sup> Harrold LR, Field TS, Gurwitz JH. Knowledge, patterns of care, and outcomes of care for generalists and specialists. *J Gen Intern Med*. 1999;14:499–511.

<sup>57</sup> Swiss Health Observatory, OBSAN BULLETIN 11 / 2016 La médecine de famille en Suisse – Perspectives - Analyse sur la base des indicateurs du programme SPAM (Swiss Primary Care Active Monitoring). [https://www.obsan.admin.ch/sites/default/files/2021-08/obsan\\_bulletin\\_2016-11\\_f.pdf](https://www.obsan.admin.ch/sites/default/files/2021-08/obsan_bulletin_2016-11_f.pdf)

<sup>58</sup> Tandjung R, Hanhart A, Bärtschi F, Keller R, Steinhauer A, Rosemann T, Senn O. Referral rates in Swiss primary care with a special emphasis on reasons for encounter. *Swiss Med Wkly*. 2015 Dec 28;145:w14244. doi: 10.4414/smw.2015.14244. PMID: 26709751.

<sup>59</sup> Giezendanner S, Bretschneider W, Fischer R, Diaz Hernandez L, Zeller A. The ecology of medical care in Switzerland: prevalence of illness in the community and healthcare utilisation in Switzerland. *Swiss Med Wkly*. 2020 May 4;150:w20221. doi: 10.4414/smw.2020.20221. PMID: 32365218.

of PCPs was relatively low<sup>60,61</sup> (between 28% and 43%), highlighting a mismatch between needs and physician specialties.

The benefits of primary care on the efficiency of the healthcare system can be explained by its cardinal functions (see above). Studies comparing different countries have shown that the element most strongly associated with a beneficial impact on health indicators was comprehensive care (comprehensiveness, i.e., the breadth of services offered in primary care)<sup>62</sup>. Integrating preventive activities into care makes an important contribution to improving its effectiveness, particularly as these activities prevent the onset and complications of chronic diseases. These effects seem to be greater in disadvantaged socio-economic populations, indicating that primary care could help reduce social inequalities in health.

**The higher cost of specialized care can be explained by the training system.** Specialist physicians are usually trained in hospitals (often university hospitals), which care for patients suffering from very specific health problems. These patients are not representative of the general population and thus have a higher prevalence of certain diseases. This influences the characteristics of diagnostic tests in terms of specificity, sensitivity, and predictive value. If hospital-trained specialists care for patients from a general population without prior triage, they will tend to overestimate the probability of certain diseases, which leads to overuse of diagnostic tests and unnecessary treatments, increasing the risk of side-effects and iatrogenic conditions.

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<sup>60</sup> OECD. Health policy in Switzerland 2017. <https://www.oecd.org/els/health-systems/Health-Policy-in-Switzerland-July-2017.pdf>.

<sup>61</sup> Senn N, Ebert S, Cohidon C. Analyse et perspectives sur la base des indicateurs du programme SPAM. OBSAN Dossier 55. Neuchâtel: Schweizerisches Gesundheitsobservatorium (Obsan); 2016.

<sup>62</sup> Kringos D, Boerma W, Bourgueil Y, et al. The strength of primary care in Europe: an international comparative study. *Br J Gen Pract*. 2013;63(616):e742-e750. doi:10.3399/bjgp13X674422

### 3. Primary care physicians in Switzerland – the state of play in 2023

**Switzerland has more physicians per capita than most OECD countries, but the share of primary care physicians is relatively low compared to other countries<sup>63</sup>, suggesting that the development of an appropriate primary care workforce should be a priority to achieve a better balance between PCPs and specialists.** As described in the previous chapters, this is one of the key points in ensuring that our health system can respond effectively to the needs of an aging population and an increasing burden of chronic diseases.

This chapter highlights key aspects of the demography of primary care physicians in 2023 and how this demography is expected to evolve. To this end, the main findings of the report published by OBSAN in 2022, "Projections of needs and numbers of specialists in Switzerland", will be presented.

Nota bene: The varied definitions of the term "primary care physician" pose a significant challenge when attempting to compare data internationally and even across national studies. Please refer to the *Terminology section* at the beginning of this report for the definition of different subgroups of PCPs.

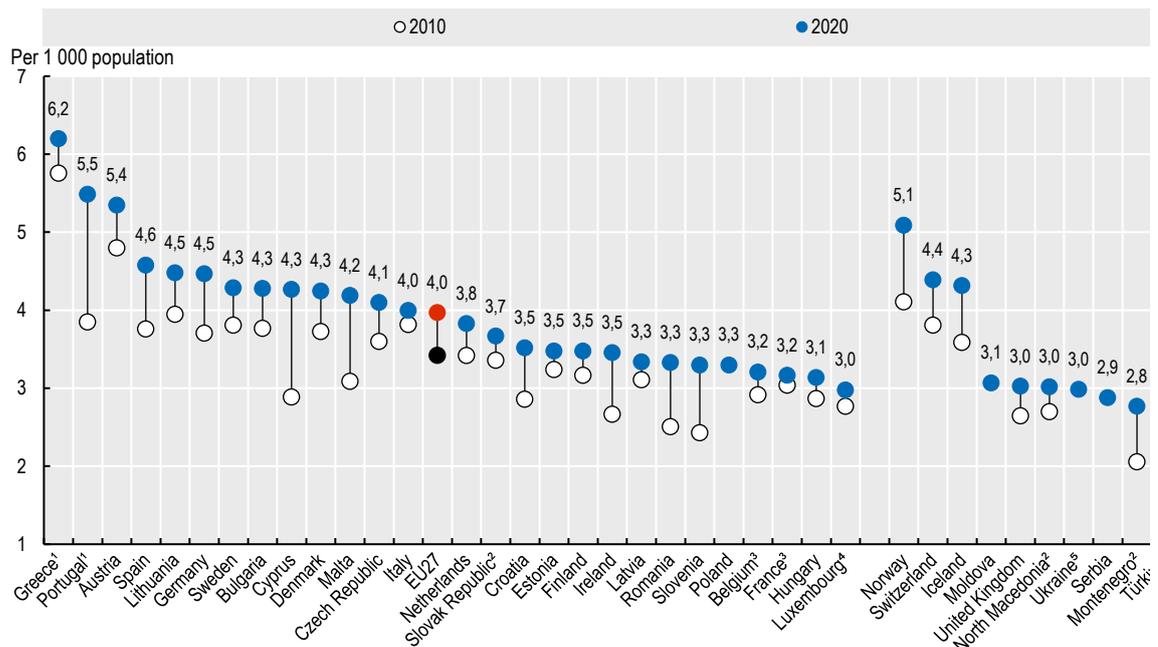
#### *a. Number, density and ratio of PCPs to other specialties*

**According to the latest FMH statistics, there were 40,002 practising physicians in 2022 (+2% compared to 2021), corresponding to 34,688 full-time equivalent (FTE) positions. Most physicians are male, but the proportion of female physicians is steadily growing<sup>64</sup>. In comparison to the OECD average, Switzerland has a relatively high physician density of 4.6 per 1,000 inhabitants (all types of physicians).** This is similar to the density in neighbouring countries such as Germany, France or Italy (**Figure 3.1**).

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<sup>63</sup> Health Policy in Switzerland. OECD, July 2017. <https://www.oecd.org/els/health-systems/Health-Policy-in-Switzerland-July-2017.pdf>

<sup>64</sup> Hostettler S., Kraft E. Faible densité de généralistes et forte dépendance de l'étranger. Bull Med Suisse. 2023;104(12):2. <https://doi.org/10.4414/bms.2023.21657>; 4-29



**Figure 3.1 Practising doctors per 1,000 population, 2010 and 2020 (or nearest year)**

Source: OECD Health Statistics 2022; Eurostat Database; WHO National Health Workforce Accounts for Moldova and Ukraine

[https://www.oecd-ilibrary.org/fr/social-issues-migration-health/health-at-a-glance-europe-2022\\_d0057e82-en](https://www.oecd-ilibrary.org/fr/social-issues-migration-health/health-at-a-glance-europe-2022_d0057e82-en)

Note: The EU average is unweighted. 1. Data refer to all doctors licensed to practice, resulting in a large over-estimation of the number of practising doctors (e.g. of around 30% in Portugal). 2. Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors). 3. Medical interns and residents are not included. 4. The latest data refer to 2017 only. 5. The latest data refer to 2014 only.

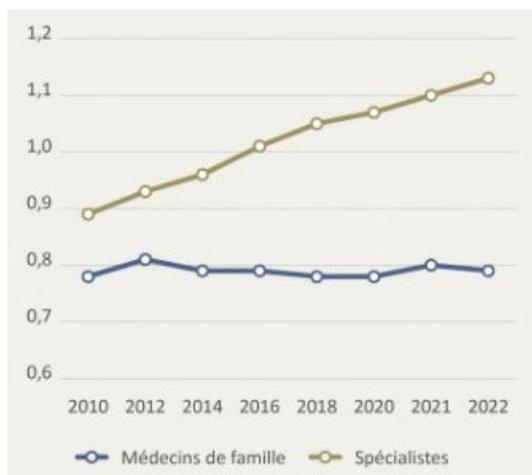
PCPs represent 42% of the Swiss physician population (Figure 3.3; here, PCPs include general internists, paediatricians, and medical practitioners). Between 2016 and 2022, the absolute number of specialists has increased by 20% (+2057), a much higher increase than the one observed in PCPs (increase by 8.9% or absolute number of 784) (Figure 3.3).

Since 2010, the overall physician density in Switzerland and most OECD countries has increased, but the proportion of PCPs has decreased<sup>65</sup>. On average in OECD countries, only one in five physicians was a PCP in 2020 (Figure 3.4). In terms of the proportion of PCPs, Switzerland's situation is comparable to that of its neighbours and close to the OECD average (Figure 3.4; please note that only family physicians are considered PCPs in the OECD statistics).

The density of PCPs in Switzerland has remained unchanged in the last decade, whereas the density of specialists practicing in the outpatient setting has increased (Figure 3.2). In comparison, Australia has a PCP density of 1.77 per 1,000 inhabitants, the Netherlands 1.83, while Italy and the UK have similar densities of 0.82 and 0.81 respectively<sup>66</sup>.

<sup>65</sup> OECD/European Union (2022), Health at a Glance: Europe 2022: State of Health in the EU Cycle, OECD Publishing, Paris, <https://doi.org/10.1787/507433b0-en>.

<sup>66</sup> OECD.Stat. Healthcare Resources: Physicians by categories. General Medical Practitioners. Density per 1000 population, results for 2021. <https://stats.oecd.org/index.aspx?queryid=30173>

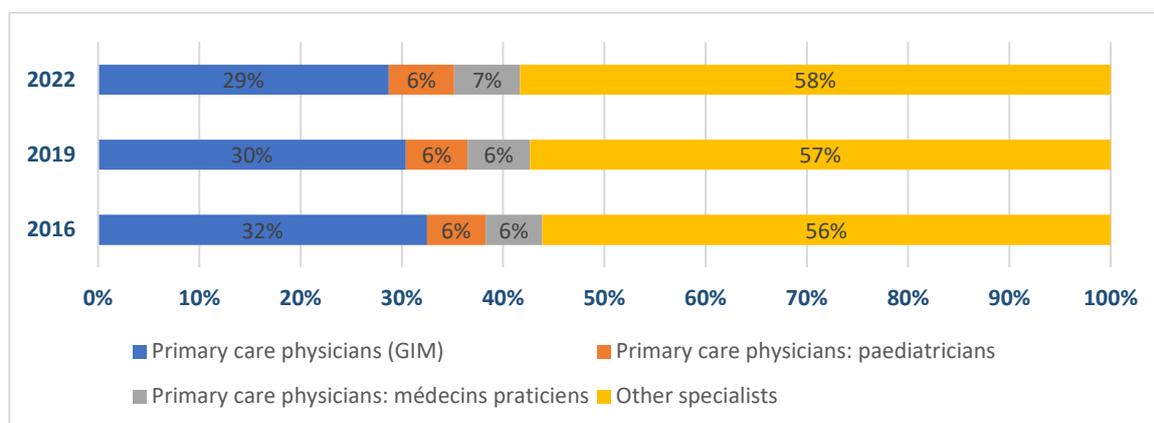


**Figure 3.2 Density of family doctors<sup>a</sup> and specialists in full-time equivalents per 1000 inhabitants (ambulatory sector) according to FMH medical statistics**

Source: Hostettler S., Kraft E. Faible densité de généralistes et forte dépendance de l'étranger. Bull Med Suisse. 2023;104(12):2.

<https://bullmed.ch/article/doi/bms.2023.21657>

a. the term family doctor does not include paediatricians.

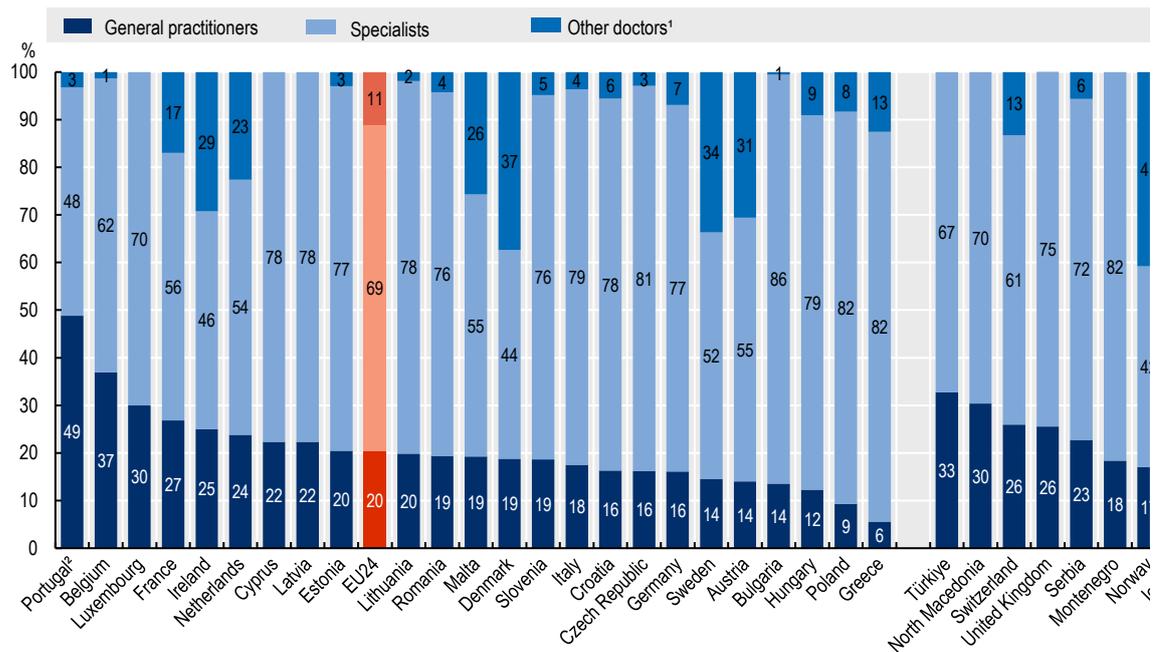


	Primary care physicians: family physicians	Primary care physicians: paediatricians	Primary care physicians: practicing physicians	Other specialists
<b>2016</b>	5950	1060	1028	10285
<b>2019</b>	5923	1186	1201	11174
<b>2022</b>	6078	1366	1378	12342

**Figure 3.3 Proportion and numbers of primary care physicians and other specialists in Switzerland 2016-2022**

Source : FMH Statistiques médicales, indicateurs disciplines

<https://www.fmh.ch/fr/themes/statistique-medicale/indicateurs.cfm>



**Figure 3.4 Share of different categories of doctors, 2020 (or nearest year)**

Source: Health at a glance Europe 2022.

[https://www.oecd-ilibrary.org/fr/social-issues-migration-health/health-at-a-glance-europe-2022\\_d0057e82-en](https://www.oecd-ilibrary.org/fr/social-issues-migration-health/health-at-a-glance-europe-2022_d0057e82-en)

Note: The EU average is unweighted.

1. The category "Other doctors" includes non-specialist doctors working in hospital, recent medical graduates who have not yet started post-graduate specialty training, as well as any other doctors not further defined.

2. In Portugal, only about 30% of doctors employed by the public sector work as GPs in primary care – the other 70% work in hospitals.

Source: OECD Health Statistics 2022; Eurostat Database.

It is important to note that physicians are not uniformly distributed across Switzerland. In rural regions, PCP densities tend to be lower. These regions also tend to have more difficulties attracting younger physicians; thus, the geographical distribution needs to be considered when deciding how to address physicians' shortage or oversupply. **Also, it is important to consider the frequent part-time activity of PCPs: their density is even lower when expressed in full-time equivalents (Table 3.1).**

	Family physicians	Practicing physicians	Family physicians + Practicing physicians	Paediatricians
GE	0.76	0.18	0.94	0.22
BS	0.79	0.08	0.87	0.19
GR	0,67	0,06	0.73	0.08
AI	0.64	0.09	0.73	*
BE	0.63	0.1	0.73	0.1
ZH	0.59	0.1	0.69	0.1
BL	0.62	0.04	0.66	0.11
UR	0.58	0.03	0.61	0.01
CH	<b>0.54</b>	<b>0.12</b>	<b>0.66</b>	<b>0.12</b>
SG	0.54	0.19	0.73	0.09
ZG	0.52	0.12	0.64	0.01
GL	0.51	0.12	0.63	0.06
TI	0.51	0.1	0.61	0.12
VD	0.5	0.22	0.72	0.21
SO	0.49	0.08	0.57	0.07
LU	0.49	0.12	0.61	0.12
NW	0.48	0.1	0.58	0.05
VS	0.46	0.12	0.58	0.11
SZ	0.45	0.08	0.53	0.07
JU	0.44	0.21	0.65	0.09
TG	0.44	0.18	0.62	0.06
SH	0.43	0.11	0.54	0.06
AR	0.43	0.27	0.7	0.04
NE	0.42	0.2	0.62	0.08
OW	0.41	0.09	0.5	0.03
AG	0.39	0.08	0.47	0.07
FR	0.35	0.11	0.46	0.13

**Table 3.1 Weighted density (x for 1000 inhabitants) of primary care physicians, practicing physicians and paediatricians in private practice in Switzerland by canton, 2021. Results are expressed in full-time equivalents.**

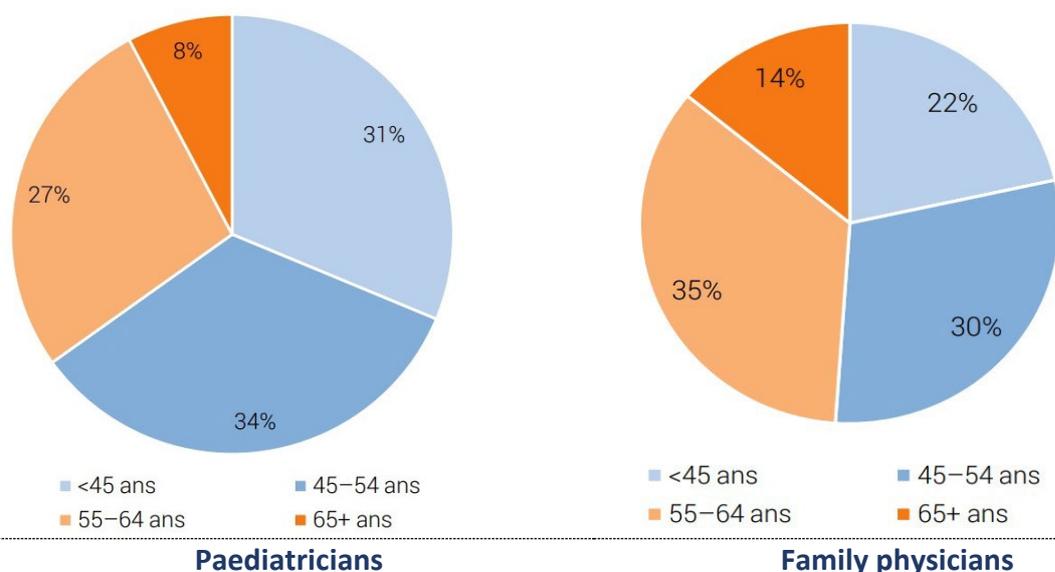
Source: Données structurelles des cabinets médicaux et des centres ambulatoires (MAS), Office fédéral de la statistique, 2021

### *b. Key demographic indicators*

**The PCP population in Switzerland is an aging workforce:** their mean age increased from 51 years in 2015 to 55 years in 2020<sup>67</sup>. **This is mainly a problem in the family physician (general internist) population, where almost half (49%) are at least 55 years old and will therefore reach retirement age in the next ten years<sup>68</sup>. In paediatricians, this proportion is lower (figure 3.4).**

<sup>67</sup> Zeller A, Giezendanner S, 4eme enquête Workforce: les résultats. Primary and Hospital Care – Médecine Interne Générale. 2020 ;20(11) :325-328. <https://primary-hospital-care.ch/fr/article/doi/phc-d.2020.10311>

<sup>68</sup> The proportion is similar to the one reported in the 2022 International Health Policy Survey of Primary Care Physicians. Pahud, O. & Dorn, M. (2023). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2022 der amerikanischen Stiftung Commonwealth Fund (CWF)



**Figure 3.5 Primary care physicians in private practice, age distribution, Switzerland, 2018**

Source: Projections des besoins et des effectifs de médecins spécialistes en Suisse. Partie 1 : Total des domaines de spécialité, médecine de premier recours, pédiatrie, psychiatrie et psychothérapie et orthopédie, OBSAN rapport 04/2022, 2022, Neuchâtel : Observatoire suisse de la santé.

[https://www.obsan.admin.ch/sites/default/files/2022-05/Obsan\\_04\\_2022\\_RAPPORT.pdf](https://www.obsan.admin.ch/sites/default/files/2022-05/Obsan_04_2022_RAPPORT.pdf)

In addition, many PCPs are planning career changes in the short or medium term, as shown in the analysis of the 2022 International Health Policy Survey (Table 3.2). Many PCPs over the age of 55 years want to reduce their clinical activity in the next three years or are anticipating retirement. This means that if these physicians cannot be replaced, the PCP workforce will soon become insufficient to answer the health-related needs of the population.

Planning to	Age groups				Total
	<44	45-54	55-64	>=65	
Reduce clinical activity	21.6	28.5	56.8	69.1	41.6
Quit working	1.2	2.2	19.5	61.3	16.5
Change career	7.2	8.3	4.0	6.2	6.4

**Table 3.2 Career development intentions of primary care physicians<sup>a</sup> by age group (%)**

Source: Pahud, O. & Dorn, M. (2023). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2022 der amerikanischen Stiftung Commonwealth Fund (CFW) im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 01/2023). Neuchâtel: Schweizerische Gesundheitsobservatorium.

<https://www.obsan.admin.ch/de/publikationen/2023-aerztinnen-und-aerzte-der-grundversorgung-situation-der-schweiz-und-im>

a. in this survey, primary care physicians included the following specialties: GIM, paediatricians, practicing physicians

One of the most important developments over the last three decades has been the aspiration of both established and junior PCPs to reduce their working hours. The 4<sup>th</sup> workforce survey of PCPs (2020) showed a steady decrease in the mean numbers of working hours since 2015 (Figure 3.6). This intention to reduce working time is shared by postgraduate trainees and junior doctors working in

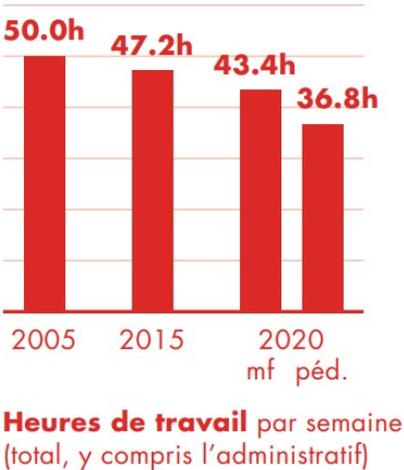
im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 01/2023). Neuchâtel: Schweizerisches Gesundheitsobservatorium.

hospital settings, with 86% of respondents wanting to work 42 hours or less per week<sup>69</sup>. These young hospital doctors are an important source for the future primary care workforce.

**Although currently two thirds of the family physician workforce are males (Table 3.3), these will likely be replaced by a majority of younger women, as the proportion of females obtaining a postgraduate specialist title in general internal medicine has remained around or above 60% over the last 10 years. The mean activity rates of female PCPs are lower than those of male PCPs (Figure 3.7).** Respondents in the 4<sup>th</sup> Workforce survey confirmed this trend, reporting a median working time of 9 half-days per week in male family physicians and of 7 half-days per week in female family physicians; in paediatricians, the trend is similar. Thus, the aging and predominantly male PCP workforce will need to be replaced by a higher absolute number of younger physicians.

	Women	Men
Paediatricians	58%	42%
Family physicians (GIM)	32%	68%
Practicing physicians	42%	58%

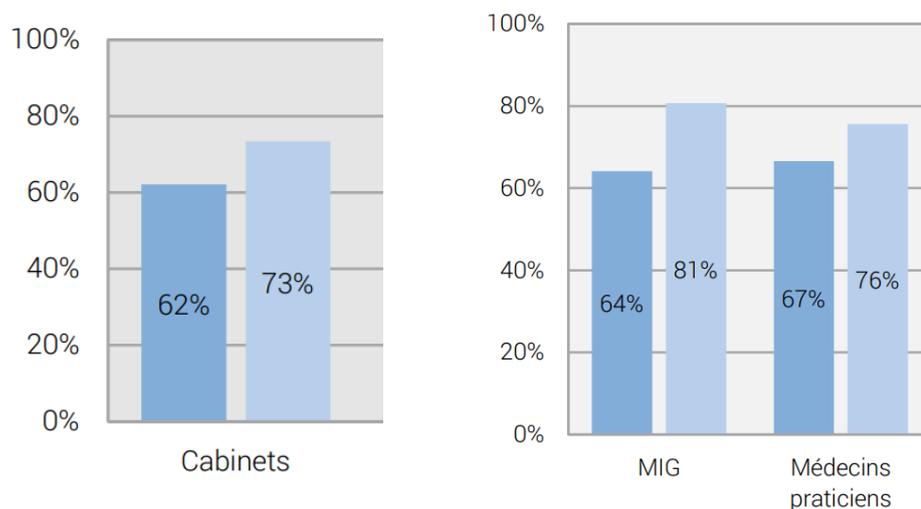
**Table 3.3 Paediatricians and family physicians’ distribution by sex, Switzerland, 2018 (proportions calculated in FTE)**



**Figure 3.6 Paediatricians and family physicians in private practice, mean numbers of hours worked a week (including administrative tasks), 2005-2020, Switzerland**

Source: 4<sup>ème</sup> enquête Workforce, Centre universitaire de médecine de premier recours Bâle, Suisse <https://www.medecinsdefamille.ch/media/communiqués-aux-medias/détail/étude-workforce-sur-la-médecine-de-base-pénurie-de-médecins-de-famille-mais-une-lueur-a-l'horizon>

<sup>69</sup> VSAO/ASMAC. Situation de travail des médecins-assistant(e)s et chef(fe)s de clinique - Sondage auprès des membres 2023 – Rapport. <https://vsao.ch/wp-content/uploads/2023/05/Mitgliederbefragung-VSAO-2023-Chartset-FR.pdf>



■ Femmes ■ Hommes  
**Paediatricians** **Family and practicing physicians**

**Figure 3.7 Paediatricians and family physicians in private practice, mean activity rate by sex, Switzerland, 2018**

Source: Projections des besoins et des effectifs de médecins spécialistes en Suisse. Partie 1 : Total des domaines de spécialité, médecine de premier recours, pédiatrie, psychiatrie et psychothérapie et orthopédie, OBSAN rapport 04/2022, 2022, Neuchâtel : Observatoire suisse de la santé

### *c. Heavy dependence on foreign doctors*

**Switzerland relies heavily on foreign doctors to meet the healthcare needs of its population. In 2022, 39,5% of doctors practicing in Switzerland were trained partially or totally in another country (Figure 4.1).** Of these, the highest proportion (38.6%) were trained in Germany, followed by Italy (13,0%), Austria (10,2%), France (7,6%), and Greece (4,3%).

**In contrast, only 31% of new doctors specialising in primary care medicine (family physicians, paediatricians, and practicing physicians) had been trained abroad<sup>70</sup>.**

The reliance on foreign graduates is felt at undergraduate and postgraduate levels<sup>71</sup>. This dependence is risky: if working conditions and salaries were to improve in their country of origin, the number of physicians willing to work in Switzerland would most likely decrease. Also, relying on such a high share of foreign physicians poses an ethical problem, because this will in turn increase workforce problems in their countries of origin.

### *d. Risks of insufficient PCP workforce to cover population health needs*

The growing imbalance between the supply of PCPs and the growing healthcare needs of the population has implications for access to timely and comprehensive healthcare services, including longer waiting times for appointments, limited access to preventive care, and heavy reliance on

<sup>70</sup> Nora Wille, Yvonne Gilli, Pénurie de médecins : il n'y a pas que l'énergie qui vient d'ailleurs, Bulletin des médecins suisses, 2023;104(1-2):30-32)

<sup>71</sup> Nora Wille, Yvonne Gilli, Pénurie de médecins : il n'y a pas que l'énergie qui vient d'ailleurs, Bulletin des médecins suisses, 2023;104(1-2):30-32)

emergency departments for non-urgent health concerns. Furthermore, this imbalance exacerbates health disparities, with rural areas being disproportionately affected.

The 2011 Federal Council report on strategies to encourage primary care (Stratégie pour lutter contre la pénurie de médecins et encourager la médecine de premier recours) estimated that without any measures to counter the PCP shortage, 40% of necessary primary care consultations could not be covered by 2030. It stated that there was mostly a shortage of physicians trained in Switzerland rather than a general physician shortage<sup>72</sup>. As a result, the number of medical students was increased, and measures were introduced to raise the profile of primary care. It seems that the measures taken to support PCPs have meant that this prediction has not passed. However, the changes in medical demography outlined above, including the tendency to work less, mean that each PCP retiring or leaving the profession will need to be replaced by more than one physician, even more so considering the growing healthcare needs related to chronic diseases.

**While available data is inconclusive regarding whether there currently is a shortage of PCPs in Switzerland, some studies indirectly point to existing regional shortages.** In 2021, the consumers' association FRC (Fédération Romande des Consommateurs) evaluated access to PCPs in the French-speaking part of Switzerland through a survey about patients' experiences of finding a new PCP (Table 3.4). The results show that patients have difficulties finding a PCP or even reaching primary care practices by phone, especially in rural regions, as many practices do not accept new patients.

	Geneva rural area	Delémont	Fribourg	Le Locle	Martigny	Vallée de Joux	Yverdon les Bains
Mean number of calls to reach a practice	1,75	1,31	2.13	2,40	1.87	3,88	2.08
Mean number of calls to book an appointment	2,29	14.48	30,54	2,92	19.76	5,76	12,62
%age of practices refusing new patients	50%	65.63%	58.97%	60%	68,09%	50%	75.51%
% of practices indicating limited availability	50%	34.47%	41,03%	40%	31,91%	50%	24,5%

**Table 3.4 Results from the FRC survey on how to find a primary care physician**

Source: FRC internet website. Recherche médecin désespérément. <https://enquetes.frc.ch/medecins>

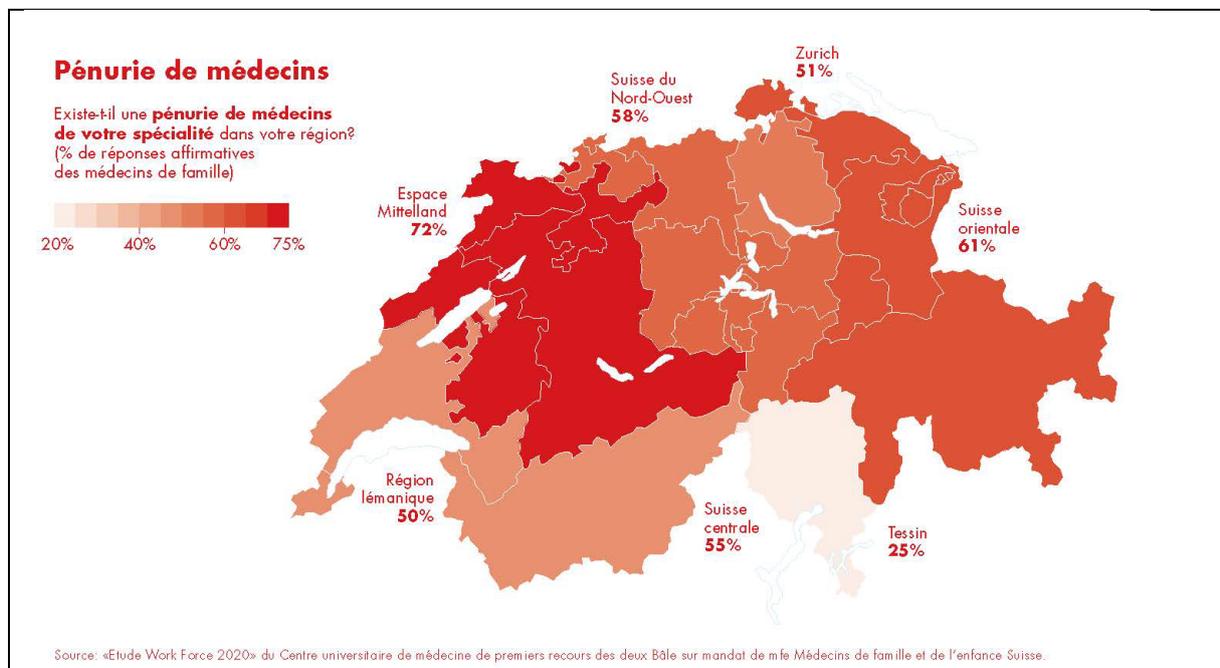
<sup>72</sup> Stratégie pour lutter contre la pénurie de médecins et encourager la médecine de premier recours Rapport du Conseil fédéral en réponse à la motion 08.3608 de la Conseillère nationale Jacqueline Fehr « Stratégie pour lutter contre la pénurie de médecins et encourager la médecine de premier recours » du 2 octobre 2008, 2011. <https://www.bag.admin.ch/bag/fr/home/berufe-im-gesundheitswesen/medizinalberufe/medizinische-grundversorgung/strategie-gegen-aerztmangel.html>

A national survey concludes that almost a quarter of primary care practice do not accept new patients<sup>73,74</sup>, and a few studies document a similar trend in some cantons for both family physicians and paediatricians (Table 3.6).

Canton			
<b>Bern</b>	60% of primary care physicians (inc. paediatricians) have partially (47%) or completely (13%) stopped to take new patients	66% of PCPs considered there was a lack of family physicians in their region; 79% of paediatricians estimate that there was a lack of paediatricians in their region	Stierli et al. 2021 <sup>75</sup>
<b>Valais</b>	12% of physicians <sup>76</sup> do not accept new patients	29% of physicians estimate that care needs will be insufficiently met in 5 years	Gloor et Chiolero, 2019 <sup>77</sup>

**Table 3.5 Data from physicians' survey indicating a lack of access to primary care physicians or unmet care needs**

In some regions, when asked if there is a shortage of primary care specialists in their area, a majority of PCPs say there is (Figure 3.8).



**Figure 3.8 Proportion of primary care physicians stating that there is a shortage of in their specialty in their region**

Source: «Etude Work Force 2020» du Centre universitaire de médecine de premiers recours des deux Bâle sur mandat de mfe Médecins de famille et de l'enfance Suisse.

<https://www.medecinsdefamille.ch/media/communiqués-aux-medias/détail/etude-workforce-sur-la-medecine-de-base-pénurie-de-medecins-de-famille-mais-une-lueur-a-l'horizon>

<sup>73</sup> Pahud, O. (2019). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2019 der amerikanischen Stiftung Commonwealth Funds im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 15/2019). Neuchâtel : Observatoire suisse de la santé

<sup>74</sup> In the 2019 IHP survey of primary care physicians, the following categories of PCPs were surveyed family physicians (GIM specialist in private practice), practicing physicians and paediatricians.

<sup>75</sup> Stierli, R., Rozsnyai, Z., Felber, R., Jörg, R., Kraft, E., Exadaktylos, AK., Streit, S. (2021). Primary Care Physician Workforce 2020 to 2025 - a cross-sectional study for the Canton of Bern. *Swiss Med Wkly.*,10;151

<sup>76</sup> The physicians surveyed were all physicians with a license to practice independently in Valais.

<sup>77</sup> Gloor, V. & Chiolero, A. (2019). Enquête sur l'activité des médecins en Valais, 2018. Sion : Observatoire valaisan de la santé (OVS).

Finally, the conclusions of the report<sup>78</sup> published by OBSAN in April 2022 indicate that although the simulation model used in the report does not allow to conclusively determine that there is a shortage of PCPs, expert opinion and the results of some studies suggest that supply is insufficient. As a result, the report recommends increasing the number of physicians trained in Switzerland (at both undergraduate and post-graduate level). The same report points out that existing databases do not allow us to make a precise estimate of the number of doctors in practice or of the actual healthcare needs. It recommends that the response rate to the MAS survey needs to increase.

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<sup>78</sup> Burla, L., Widmer, M. & Zeltner, C. (2022). Projections des besoins et des effectifs de médecins spécialistes en Suisse. Partie 1: Total des domaines de spécialité, médecine de premier recours, pédiatrie, psychiatrie et psychothérapie et orthopédie. Rapport final de l'Obsan et du comité «Coordination de la formation postgrade des médecins» sur mandat du dialogue «Politique nationale suisse de la santé» (Obsan Rapport 04-2022). Neuchâtel: Observatoire suisse de la santé. [https://www.obsan.admin.ch/sites/default/files/2022-05/Obsan\\_04\\_2022\\_RAPPORT.pdf](https://www.obsan.admin.ch/sites/default/files/2022-05/Obsan_04_2022_RAPPORT.pdf)

## 4. Training the future primary care physicians

Primary care workforce planning must consider that the use of health care services will increase over the next few decades because of a growing and aging population and increased comorbidity, whereas the number of PCPs per capita is expected to drop because of the difficulties to replace the aging PCP workforce. The strong dependency of the Swiss healthcare system on foreign medical graduates and physicians, together with a projected shortage of physicians in general and PCPs in particular, led the Federal government to allocate CHF100 million towards increasing the number of training places for medical students at Swiss universities over the period of 2017-2020 to reach a target of 1'200 to 1'300 medical students obtaining their master's in medicine. **To increase the number and proportion of PCPs, more new graduates must choose to train in primary care specialties and to practice in private outpatient settings. To make primary care an attractive career choice, interventions should target both under- and postgraduate levels: If medical students perceive primary care as an attractive career choice, they will be more motivated to pursue postgraduate training in a primary care specialty – high-quality postgraduate training programmes focused on primary care practice will help maintain them in this field in the long term.**

### *a. Primary care postgraduate training in Switzerland*

Postgraduate training in both general internal medicine and paediatrics takes at least 5 years. Although postgraduate training programmes now acknowledge the specificities of training for physicians who want to practice in primary care settings, training is heavily hospital-based and specific primary care practice is recommended, but not mandatory. Although postgraduate training programmes are structured into two parts (foundation training and secondary training), trainees have great flexibility in the organisation of their training. Consequently, in general internal medicine, the average length of postgraduate training is 7 to 8 years and the average age at which GIM physicians receive their postgraduate degree is 35 years<sup>79</sup>.

**In international comparison, this required training period of 5 years for family physician is among the longest in Europe (Table 4.1).**

France	Germany	Italy	Netherlands	United Kingdom	Denmark	Spain
4 years	5 years	3 years	3 years	3 years	5 years	4 years

**Table 4.1 Duration of training to become a family physician (GIM) in selected European countries**

Source: European Academy of Teachers in General Practice/Family Medicine, Online European Training Database.

<https://euract.woncaeurope.org/specialist-training-database>

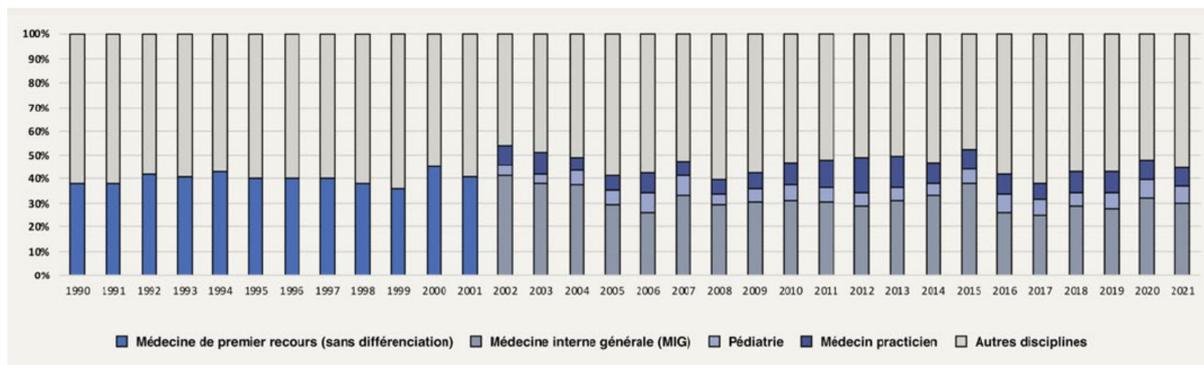
### *b. The attractiveness of primary care during postgraduate training*

A relatively high proportion of graduates train in one of the primary care specialties, and this proportion has remained stable (Figure 4.1). **In 2022, 36% of all awarded postgraduate training diplomas were in a primary care specialty (31% in general internal medicine, 5% in paediatrics)<sup>80</sup>.**

<sup>79</sup> OFSP, Médecins 2021, Avril 2022. <https://www.bag.admin.ch/bag/fr/home/zahlen-und-statistiken/statistiken-berufe-im-gesundheitswesen/statistiken-medizinalberufe1/statistiken-aerztinnen-aerzte.html>

<sup>80</sup> OFSP, Statistiques médecins, Tableau de données brutes de titres postgradués fédéraux 2022. Available at: <https://www.bag.admin.ch/bag/fr/home/zahlen-und-statistiken/statistiken-berufe-im-gesundheitswesen/statistiken-medizinalberufe1/statistiken-aerztinnen-aerzte.html>

More women than men trained in these specialties (60% of women in general internal medicine, 86% in paediatrics).



**Figure 4.1 Proportion of postgraduate degrees delivered in primary care specialties (GIM, Paediatrics, Practicing physicians) vs other medical specialties, 1990-2021**

Source: Nora Wille, Yvonne Gilli, Pénurie de médecins : il n’y a pas que l’énergie qui vient d’ailleurs, Bulletin des médecins suisses, 2023;104(1–2):30–32

However, as these postgraduate training programmes are not specific to primary care, these physicians will not necessarily practice as PCPs. Some will train in a subspecialty or another specialty, others will practice in hospital settings. A report by OBSAN predicts that if only 25% of GIM physicians choose to practice family medicine, there will be a shortage by 2030; this situation could be avoided if 50% choose to practice as family doctors<sup>81</sup>.

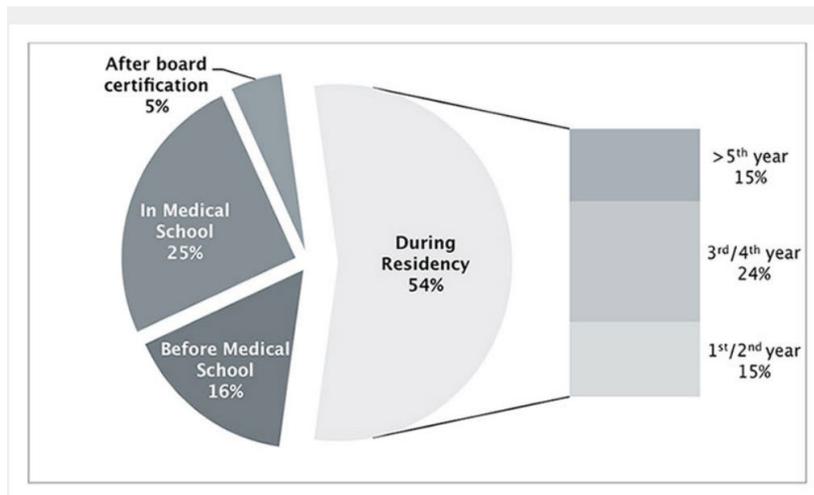
A study conducted in 2013<sup>82</sup> suggested that most PCPs in Switzerland had decided to pursue a career in primary care during their postgraduate training (Figure 4.2). This has important implications for the content, structure, and setting of postgraduate training in general internal medicine. Training as a resident in primary care practice was an important influence on the choice of pursuing a career in primary care.

#### Three elements were identified:

- 1) The length of training in primary care (9–12 months vs. 6 months of full-time training),
- 2) The availability of part-time training,
- 3) The trainee’s feeling of being competent at the end of the training, reflecting the quality of training.

<sup>81</sup> Burla L, Widmer M. Détermination des besoins futurs en médecins par spécialité : modèle de simulation (en allemand) incl. résumé en français. Rapport III de l’Observatoire suisse de la santé, dans le cadre du groupe thématique «Coordination de la formation des médecins». Obsan, Neuchâtel, 20.09.2018. <https://www.bag.admin.ch/bag/fr/home/berufe-im-gesundheitswesen/medizinalberufe/plattform-zukunft-aerztliche-bildung/koordination-aerztl-weiterbildung.html>

<sup>82</sup> Studerus, L., Ahrens, R., Häuptle, C. *et al.* Optional part-time and longer GP training modules in GP practices associated with more trainees becoming GPs – a cohort study in Switzerland. *BMC Fam Pract* 19, 5 (2018). <https://doi.org/10.1186/s12875-017-0706-1>



**Figure 2**

Time of decision to become a general practitioner.

**Figure 4.2 Time of decision to become a general practitioner**

Source: Tandjung R, Senn O, Marty F, Krauss L, Rosemann T, Badertscher N. Career after successful medical board examination in general practice--a cross-sectional survey. *Swiss Med Wkly.* 2013;143:w13839. Published 2013 Jun 25. doi:10.4414/smw.2013.13839

These findings have been confirmed by the results of programmes that have been set up and evaluated in Bern<sup>83</sup>, Solothurn<sup>84</sup> and St Gallen<sup>85</sup>. For example, in Bern, 81% of trainee physicians who had completed a residency in primary care subsequently became PCPs; in Solothurn, the proportion was 77%. These findings suggest that ensuring wider access to this type of training could be a key factor in addressing the shortage of PCPs<sup>86</sup>.

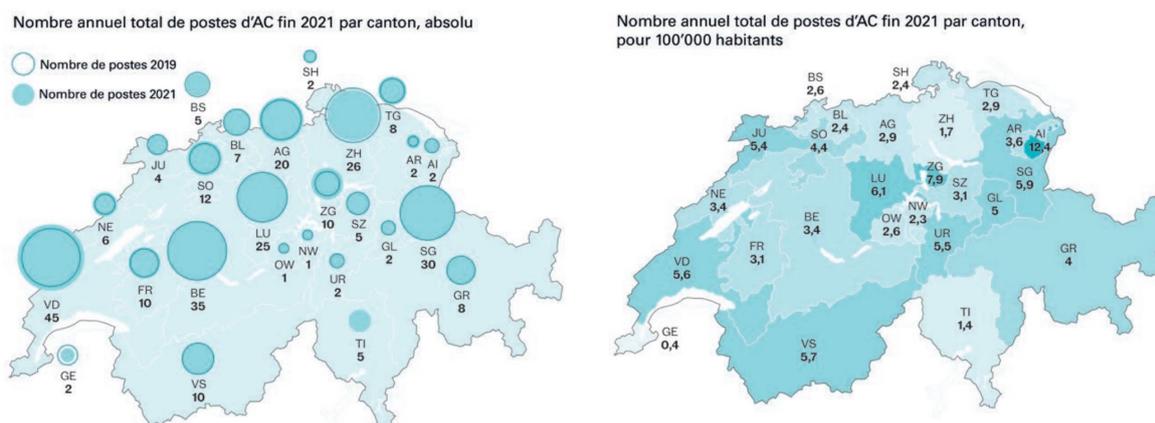
Training positions for residents in primary care practices have been extended in the last decade. By the end of 2021, every canton had postgraduate training positions in primary care practices, with a total of 285 positions available annually (up from 258 positions available in 2019; +9%). However, availability remains heterogeneous across cantons and the total number of available positions remains largely insufficient if all future PCPs were to benefit from this type of training. **The way in which this training is financed would also benefit from financial investment, particularly from the cantons, to harmonise the funding of training positions in hospital and private practice. Efforts to establish training positions in primary care practices have demonstrated the effectiveness of such programmes in attracting postgraduates to family medicine. These programmes need to be expanded more rapidly to ensure that enough postgraduates choose a career in family medicine. At present, these efforts are not ambitious enough to guarantee such an outcome.**

<sup>83</sup> Rozsnyai Z, Diallo B, Streit S. 10 Jahre Praxisassistentenprogramm im Kanton Bern. *Schweiz Arztsch.* 2019;100(19):642–3.

<sup>84</sup> Zimmerli L, Fluri M, Droste P, Cina C, Leupold F, Streit S. Erfolgreiche Nachwuchsförderung. *Schweiz Arztsch.* 2020;101:948–9

<sup>85</sup> Häuptle C. Weiterbildung zur Hausärztin und zum Hausarzt im Kanton St. Gallen. *Prim Hosp Care Allg Inn Medizin.* 2019;19(9):271–4.

<sup>86</sup> Gerber T. et al, Assistanat au cabinet médical en Suisse : aperçu dans les cantons, Primary and Hospital Care – Médecine Interne Générale 2022 ; 22(11) :331-334



**Figure 4.3 Number of residency position in primary care practices in Switzerland cantons – total available number and number per 100'000 inhabitants, per canton**

Source: Gerber T. et al, Assistanat au cabinet médical en Suisse : aperçu dans les cantons, Primary and Hospital Care – Médecine Interne Générale 2022 ; 22(11) :331-334

### *c. Primary care in the undergraduate medical curriculum: Recent developments*

Extrapolating from a study carried out in the canton of Bern<sup>87</sup>, Switzerland would need to train between 584 (working 7.5 days a week, 20% of the workforce coming from abroad) and 845 (working 6.5 days a week, 0% of the workforce coming from abroad) family physicians per year. To reach this number, between 48 and 70% of medical graduates would have to become PCPs (based on 1209 federal diplomas of medicine delivered in 2022). To reach such long-term goals, the place of primary care in the undergraduate curriculum will need to be re-thought.

The content and teaching modalities of primary care at Swiss medical faculties have changed considerably in the last couple of decades. From the early 2000s, committed physicians launched initiatives in several medical faculties with the aim of integrating PCPs more actively into undergraduate teaching and making this profession more visible to students. The Federal Council's Masterplan has promoted and strengthened these initiatives. The foundation of the Swiss Academy of Family Medicine (SAFMED) in 2013 was one of the consequences of the Masterplan and contributed largely to promote primary care in all Swiss medical faculties.

Previously, university institutes of family medicine existed in Basel, Bern, Geneva, Lausanne, and Zurich. With the creation of SAFMED, additional resources were made available, and this initial funding enabled the development of various joint research and teaching projects. In 2017, the newly created institutes of family medicine of St Gallen, Freiburg and Luzern joined the SAFMED<sup>88</sup>. In 2023, the Università della Svizzera Italiana (USI) created its own Institute of Family Medicine, which started operating in Lugano in October.

<sup>87</sup> Stierli R, Rozsnyai Z, Felber R, Jörg R, Kraft E, Exadaktylos AK, Streit S. Primary Care Physician Workforce 2020 to 2025 - a cross-sectional study for the Canton of Bern. Swiss Med Wkly. 2021 Sep 10;151:w30024. doi: 10.4414/SMW.2021.w30024. PMID: 34499438.

<sup>88</sup> <https://safmed.ch/>

A 2013 report on the activities of these institutes identified the need for further investment in the following areas<sup>89</sup>:

- (1) creation of a chair professorship in each family medicine institute<sup>90</sup>;
- (2) homogeneous and specific teaching competencies adapted to ambulatory primary care;
- (3) development of research skills among PCPs and support to the development of academic careers in primary care.

Since the publication of the report, the proposed recommendations have been taken on board with the following developments:

- Creation of professorship positions in Lausanne, Freiburg, Berne, Geneva, Basel, Lucerne and St Gallen;
- Development and extension of dedicated family medicine teaching modules and placements in primary care practices;
- Creation of mentoring programmes and funding for postgraduate training positions in primary care practices;
- Development of research projects specific to primary care.

#### *d. Increasing the attractiveness of primary care in the undergraduate curriculum*

Career choice during undergraduate medical education – and more specifically primary care career choice – has been studied for several decades. In parallel, medical faculties' growing awareness of their role for population health has given rise to the international consensus of social accountability: medical faculties have a “moral duty” to train future physicians in line with the health needs of the society. Several literature reviews have summarized the growing body of research about what determines primary care career choice in medical students<sup>91,92,93,94</sup>. Some influences are linked to students' personal characteristics (e.g., female gender or older age), personal background (e.g., growing up in a non-urban area), and personal motivations (e.g., interest in a diverse patient population or low importance of prestige or income). The exposure to primary care in the curriculum has been increasingly recognized as a crucial influence, in terms of quantity (e.g., numbers of weeks of placements in primary care) and quality (e.g., the teaching quality associated with primary care

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<sup>89</sup> Johanna Sommer, Catherine Ritter, Etat des lieux des activités des instituts de médecine générale/premier recours Bestandesaufnahme / Ist-Analyse Institute für Hausarztmedizin Schweiz Dans le cadre du projet Masterplan « médecine de premier recours et médecine de base », Faculté de Médecine de Genève, 2013

<sup>90</sup> At the time of the report, the Zurich institute was the only one with a full professorship in family medicine attached.

<sup>91</sup> Bland CJ, Meurer LN, Maldonado G. Determinants of primary care specialty choice: a non-statistical meta-analysis of the literature. *Acad Med.* 1995;70(7):620-41.

<sup>92</sup> Senf JH, Campos-Outcalt D, Kutob R. Factors related to the choice of family medicine: a reassessment and literature review. *J Am Board Fam Pract.* 2003;16(6):502-512. doi:10.3122/jabfm.16.6.502

<sup>93</sup> Campos-Outcalt D, Senf J, Watkins AJ, Bastacky S. The effects of medical school curricula, faculty role models, and biomedical research support on choice of generalist physician careers: a review and quality assessment of the literature. *Acad Med.* 1995;70(7):611-9. doi: 10.1097/00001888-199507000-00012.

<sup>94</sup> Bennett KL, Phillips JP. Finding, recruiting, and sustaining the future primary care physician workforce: a new theoretical model of specialty choice process. *Acad Med.* 2010;85(10 Suppl):S81-8. doi: 10.1097/ACM.0b013e3181ed4bae.

teaching).<sup>95,96,97</sup> Studies conducted in Switzerland underlined the motivating impact of one-to-one practical tutoring in primary care<sup>98</sup> and the benefit of a continuous, structured primary care teaching programme<sup>99</sup> on students' interest in primary care careers.

**Despite the evidence supporting a more prominent place of primary care in the curriculum, it may be difficult to know how to act effectively.**

**A systematic review of interventions in the undergraduate curriculum suggested that longitudinal teaching programmes were the only strategy to significantly increase the proportion of students choosing a primary care specialty at graduation.**<sup>100</sup> Additionally, the quality of clinical placements in primary care was found to be fundamental to the attractiveness of primary care – and mediocre quality placements could have a dissuasive effect on students. Based on the analysis of the characteristics of successful interventions, the authors proposed a series of recommendations for curriculum design (**Table 4.2**). These recommendations, along with further research<sup>101</sup>, informed developments in primary care teaching in several Swiss medical faculties.<sup>102</sup>

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<sup>95</sup> Harding A, Rosenthal J, Al-Seedy M, et al. Society for Academic Primary Care (SAPC) Heads of Teaching Group. Provision of medical student teaching in UK general practices: a cross sectional study. *Br J Gen Pract* 2015; DOI: <https://doi.org/10.3399/bjgp15X685321>.

Zink T, Center B, Finstad D, et al. Efforts to graduate more primary care physicians and physicians who will practice in rural areas: examining outcomes from the University of Minnesota–Duluth and the Rural Physician Associate Program. *Acad Med* 2010; 85(4): 599–604.

<sup>96</sup> Hepworth J, Davis A, Harris A, et al; and CAFM Four Pillars Taskforce. The four pillars for primary care physician workforce reform: a blueprint for future activity. *Ann Fam Med*. 2014;12(1):83–87

<sup>97</sup> Defined as sessions spent in clinical placements in general practice and teaching sessions delivered by general practice teachers

<sup>98</sup> Buddeberg-Fischer B, Stamm M, Marty F. Family medicine in Switzerland: training experiences in medical school and residency. *Fam Med*. 2007;39(9):651-5.

<sup>99</sup> Chung C, Maisonneuve H, Pfarrwaller E, Audetat MC, Birchmeier A, Herzig L, et al. Impact of the primary care curriculum and its teaching formats on medical students' perception of primary care: a cross-sectional study. *BMC Fam Pract*. 2016;17(1):135. doi: 10.1186/s12875-016-0532-x.

<sup>100</sup> Pfarrwaller E, Sommer J, Chung C, et al. Impact of Interventions to Increase the Proportion of Medical Students Choosing a Primary Care Career: A Systematic Review. *J Gen Intern Med*. 2015;30(9):1349-1358. doi:10.1007/s11606-015-3372-9

<sup>101</sup> Pfarrwaller E, Audetat MC, Sommer J, Maisonneuve H, Bischoff T, Nendaz M, et al. An Expanded Conceptual Framework of Medical Students' Primary Care Career Choice. *Acad Med*. 2017;92(11):1536-42. doi: 10.1097/ACM.0000000000001676.

<sup>102</sup> Pfarrwaller E, Sommer J, Héritier F, Rodondi PY, Haller DM. [From theory to practice: innovations in the family medicine curriculum in Swiss French-speaking universities]. *Rev Med Suisse*. 2019;15(650):958-64.

General recommendations	Features of successful programmes
Establish longitudinal primary care programs, combining diverse learning experiences.	Preclinical preceptorship: repeated sessions in a primary care physician’s office Lectures or seminars on population-based health Clinical clerkships in family medicine or general practice Community-based research or public health project work Electives for interested students
Establish high-quality clinical clerkships in general practice or family practice. When possible, include the clerkship in a longitudinal program (see above). Ensure high-quality clerkship	Active, hands-on experiences (no sitting in the corner watching) Good relationship with the preceptor and the practice team (feeling welcome) Opportunity to see a variety of patients and to be able to follow them over time Structured teaching and good-quality feedback from preceptors

**Table 4.2 Recommendations for Curricular Interventions to Increase the Proportion of Medical Students Choosing Primary Care**

Source: Pfarrwaller E, Sommer J, Chung C, et al. Impact of Interventions to Increase the Proportion of Medical Students Choosing a Primary Care Career: A Systematic Review. *J Gen Intern Med.* 2015;30(9):1349-1358. doi:10.1007/s11606-015-3372-9

The investments in raising the profile of primary care in Swiss medical faculties appear to have yielded results: a 2017 survey of medical students enrolled in a master’s programme in human medicine found that 20% of students were committed to a career in primary care while 40% were interested<sup>103</sup>. In comparison, only 10% of medical students were interested in a career in primary care in a similar survey conducted in 2005<sup>104</sup>.

<sup>103</sup> Diallo B, Rozsnyai Z, Bachofner M, et al. Wer strebt am Ende des Medizinstudiums eine Hausärztekariere an? Umfrage unter Schweizer Studierenden. *Praxis (Bern 1994).* 2019;108(12):779-786. doi:10.1024/1661-8157/a003300

<sup>104</sup> Halter U, Tschudi P, Isler R, et al.: Berufsziel von Medizin-studierenden. *PrimaryCare* 2005; 5: 468–472

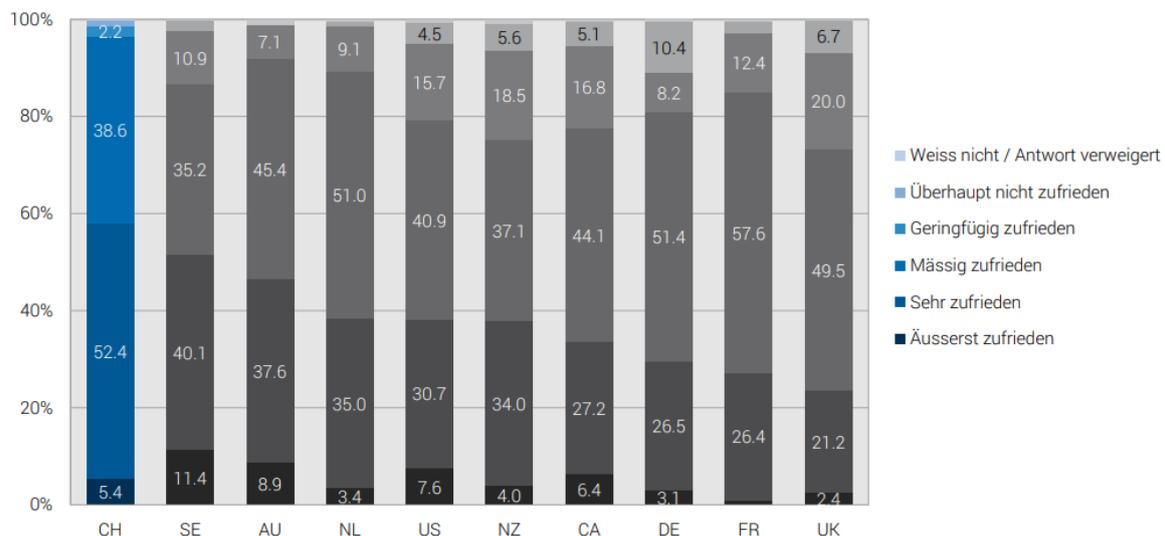
## 5. Retaining primary care physicians in practice

Efforts to make primary care careers more attractive in undergraduate and postgraduate training only have long-term impact if trained PCPs encounter the working conditions that motivate them to continue to practice primary care. However, some PCPs in Switzerland consider a change of career or a reduction in working time, even at a relatively young age (see Table 3.3). It is therefore crucial to understand the factors that contribute to retaining PCPs in practice and thus guaranteeing a stable PCP workforce.

### a. Primary care physicians' professional satisfaction

The Workforce survey of PCPs in Switzerland has been conducted every 5 years since 2000 and aims to collect data on working hours, professional habits, motivations, and plans in terms of occupation rates. The latest survey was conducted in 2020 and included paediatricians for the first time<sup>105</sup>. It showed that 71% of PCPs were satisfied with their professional situation, a significantly higher proportion than in 2005 (55%). Compared with family physicians, paediatricians reported significantly higher satisfaction levels (82%)<sup>1</sup>. This high level of satisfaction was confirmed by the results of the 2022 International Health Policy Survey of Primary Care Physicians conducted by the Commonwealth Fund (Figure 5.1); Swiss PCPs reported the highest level of satisfaction compared to PCPs of the 10 countries surveyed.

G 4.5 Allgemeinen Zufriedenheit mit der ärztlichen Tätigkeit, internationaler Vergleich, 2022



Quelle: Commonwealth Fund – International Health Policy Survey 2022

© Obsan 2023

**Figure 5.1 General satisfaction with professional activity among primary care physicians, international comparison, 2022**

Source: Pahud, O. & Dorn, M. (2023). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2022 der amerikanischen Stiftung Commonwealth Fund (CFW) im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 01/2023). Neuchâtel: Schweizerisches Gesundheitsobservatorium

<sup>105</sup> Zeller, Andreas & Giezendanner, Stéphanie. (2020). 4e enquête Workforce: les résultats. Primary and hospital care: médecine interne générale. 10.4414/phc-f.2020.10311.

**Factors found to be associated with higher satisfaction** were practicing in a group practice rather than an individual practice (75% vs 67%) and being involved in training of primary care residents<sup>106</sup>.

The most frequent reason for dissatisfaction was related to workload, followed by time spent with patients and income, which was a more frequent source of dissatisfaction in older physicians (**Table 5.1**).

Dissatisfaction (not very or not at all satisfied) with (%)	Age groups				Overall
	<44	45-54	55-64	>=65	
Income	7.2	14.1	14.6	15.6	12.9
Time spent with patients	21.4	22.5	18.1	8.9	18.7
Workload	25.4	29.4	26.8	11.3	24.8

**Table 5.1: reasons for dissatisfaction among PCPs by age group**

Source: Pahud, O. & Dorn, M. (2023). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2022 der amerikanischen Stiftung Commonwealth Fund (CWF) im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 01/2023). Neuchâtel: Schweizerisches Gesundheitsobservatorium

**Another reason for dissatisfaction is the burden of administrative tasks**, which in turn affect the time spent with patients, and can be significant. **In Switzerland, physicians estimate dedicating around 20% of their time to administrative tasks. In an international comparison, this is similar to estimates in Germany, but slightly higher than in France (15%)<sup>107</sup>.** According to the results of the 2022 IPH survey, **more than two thirds (68.0%) of Swiss physicians consider the time spent on administrative activities related to insurance or billing to be a major problem<sup>108</sup>**; this proportion increased compared to 2019 (60.7%). This puts Switzerland in first place internationally, ahead of Sweden (62.3%), Germany (59.9%) and the USA (51%). **In terms of specific sub-tasks, almost half (45.4%) see the production of clinical or quality data for government agencies or health insurers as a major problem**, second only to Germany (51.8%) and ahead of the Netherlands (39.7%). In most of the countries surveyed, this share is at or below one fifth, and in a comparison over time, Switzerland's share and ranking have remained unchanged since 2019.

**Research has shown that the burden of administrative tasks is related to increased stress and burnout in physicians<sup>109,110</sup>** Although the proportion of Swiss PCPs who are extremely or very stressed is the second lowest in an international comparison, it has increased significantly from **37.1% to 43.1% between 2019 and 2022<sup>111</sup>**. Regarding burnout, **13.4% of PCPs in Switzerland report**

<sup>106</sup> Zeller, Andreas & Giezendanner, Stéphanie. (2020). 4e enquête Workforce: les résultats. Primary and hospital care: médecine interne générale. 10.4414/phc-f.2020.10311.

<sup>107</sup> Pahud, O. & Dorn, M. (2023). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2022 der amerikanischen Stiftung Commonwealth Fund (CWF) im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 01/2023). Neuchâtel: Schweizerisches Gesundheitsobservatorium

<sup>108</sup> Pahud, O. & Dorn, M. (2023). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2022 der amerikanischen Stiftung Commonwealth Fund (CWF) im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 01/2023). Neuchâtel: Schweizerisches Gesundheitsobservatorium

<sup>109</sup> Erickson SM, Rockwern B, Koltov M, McLean RM; Medical Practice and Quality Committee of the American College of Physicians. Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians. *Ann Intern Med.* 2017;166(9):659-661. doi:10.7326/M16-2697

<sup>110</sup> Friedberg MW, Chen PG, Van Busum KR, Aunon F, Pham C, Caloyeras JP, et al. Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. Santa Monica, CA: RAND; 2013.

<sup>111</sup> Pahud, O. & Dorn, M. (2023). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2022 der amerikanischen Stiftung Commonwealth Fund (CWF) im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 01/2023). Neuchâtel: Schweizerisches Gesundheitsobservatorium

**symptoms, and 4.4% report being completely exhausted and burnt out**<sup>74</sup>. These percentages are low compared to other countries in the IPH survey. However, they still mean that **almost 20% of PCPs may be facing serious emotional challenges or psychological problems**<sup>74</sup>. These various sources of stress and dissatisfaction may explain why a small proportion of PCPs are considering changing or ending their careers (see Table 3.3).

### *b. Supporting primary care physicians to limit attrition*

Maintaining PCPs' professional satisfaction should be part of the strategy to guarantee a stable workforce. In Switzerland, the main sources of stress and dissatisfaction are administrative burden and income.

#### **Lightening the burden of administrative tasks**

As mentioned above, most PCPs in Switzerland report that the time spent on administrative tasks is a major problem, diverting time and focus from more clinically important activities and increasing the risk of burnout. Possible solutions may include the following elements:

- Shifting administrative tasks that are not strictly related to patient care to other professionals, such as practice assistants or medical secretaries (e.g., obtaining medical records from other health professionals, organizational tasks, documentation)<sup>112</sup>;
- Administrative tasks that cannot be eliminated must be regularly reviewed and revised by all involved stakeholders, with the aim of reducing redundancy and complexity<sup>113</sup>;
- More generally, structured and systematic interprofessional approaches (such as multiprofessional team practices) can reduce the professional workload and streamline communication processes between involved stakeholders<sup>114</sup>.

Electronic health records may also be a key element to solving the problem of administrative burden if stakeholders agree on using the same data elements and reporting formats. The use of a shared electronic health record has the potential to facilitate information exchange and coordination of care between caregivers within the same structure and when referring patients from primary care to specialists or hospitals and back. Although the challenges of implementing such electronic records are important, it seems essential to continue its development as quickly as possible<sup>115</sup>.

#### **Valuing the specificities of primary care through PCPs' income**

While income is not the main reason for PCPs' dissatisfaction, the structure of the outpatient billing catalogue TARMED has long been criticized by PCPs for failing to recognize the value and specificities of primary care. TARMED values technical procedures and investigations more than primary care-specific clinical practices, such as preventive care, personal interactions with patients, social care and coordination tasks. The proposal for the new billing catalogue TARDOC better reflects these specificities through a separate chapter on primary care, integrating key services such as palliative care

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<sup>112</sup> Castioni, J., et al. Délégation des tâches médico-administratives : perspectives croisées entre médecins assistants et secrétaires. Rev Med Suisse. 2017; 3 (584): 2048–2051.

<sup>113</sup> Shari M. Erickson, Brooke Rockwern, Michelle Koltov, et al; for the Medical Practice and Quality Committee of the American College of Physicians. Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians. Ann Intern Med.2017;166:659-661. [Epub 28 March 2017]. doi:10.7326/M16-2697

<sup>114</sup> Cohidon, C., et al. Quels professionnels travaillent dans les cabinets de médecine de famille ? Panorama dans différents pays. Rev Med Suisse. 2023; 9 (826): 889–891.

<sup>115</sup> Senn, N., Ebert, ST. & Cohidon, C. (2016). La médecine de famille en Suisse. Analyse et perspectives sur la base des indicateurs du programme SPAM (Swiss Primary Care Active Monitoring) (Obsan Dossier 55). Neuchâtel: Observatoire suisse de la santé

and chronic disease management. It could thus play an important role in maintaining PCP job satisfaction and in generally raising the value attributed to primary care in our health care system.

### *c. Interprofessional practice models may contribute to a more sustainable primary care workforce*

Two of the key evolutions in terms of practice and work organization in the last 20 years are the desire of most PCPs to work less hours and the move from individual to group practice. The proportion of PCPs working in solo practice and putting in long working weeks (45 hours or more) has thus decreased continuously since 2012. As the proportion of doctors working in group practices has increased, it is the possibility of working part-time (less than 45 hours a week) that seems to make group practices attractive<sup>116</sup>. Studies show that another advantage of group practice is an increase in earnings by lowering marginal costs<sup>117</sup>. In this context, the consideration of models of integrated or coordinated care outlined in the seminal 2011 report commissioned by the Swiss Confederation<sup>118</sup> are still relevant. One option would be to develop primary care teamwork, as is already the case in some Western countries notably in the US and Canada<sup>119,120</sup>. Studies on integrated care suggest that an interprofessional team-based structure can help meet the chronic and preventive care needs of the population<sup>121,122</sup>. In Switzerland, a change in the legislation would be needed for interprofessional teamwork reimbursed by health insurance.

#### **Organisation - Development of teamwork**

In the countries where this development has been going on the longest, discussions are now focusing on the ideal composition of structures in terms of the number and distribution of professionals<sup>123</sup>. In many countries, however, there is still a debate (also justified from a legislative point of view) about task transfer versus task delegation<sup>124</sup>. Task transfer means that the medical professional performing the task is independent and fully responsible for the task, whereas in the case of task delegation, the medical professional performing the task is mandated to do so by a doctor, who remains legally responsible for the care provided. In both configurations, there are aspects of communication and team management that PCPs need to understand and implement. Experiences from countries having successfully implemented such models show that team-based primary care practice increases patient

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<sup>116</sup> Pahud, O. & Dorn, M. (2023). Ärztinnen und Ärzte in der Grundversorgung – Situation in der Schweiz und im internationalen Vergleich. Analyse des International Health Policy (IHP) Survey 2022 der amerikanischen Stiftung Commonwealth Fund (CWF) im Auftrag des Bundesamtes für Gesundheit (BAG) (Obsan Bericht 01/2023). Neuchâtel: Schweizerisches Gesundheitsobservatorium

<sup>117</sup> O Baudier, F. et al. 2010 : La dynamique de regroupement des médecins généralistes libéraux de 1998 à 2009. Institut de recherche et documentation en économie de la santé. Mojon-Azzi, S.M. (2001) : Gruppenpraxen - ihre Vor- und Nachteile. Bulletin des médecins suisses 2001; 82: n° 22.

<sup>118</sup> Stratégie pour lutter contre la pénurie de médecins et encourager la médecine de premier recours, rapport du Conseil fédéral, 23.11.2011. <https://www.bag.admin.ch/bag/fr/home/berufe-im-gesundheitswesen/medizinalberufe/medizinische-grundversorgung/strategie-gegen-aerztmangel.html>

<sup>119</sup> Wagner EH, LeRoy L, Schaefer J, Bailit M, Coleman K, Zhan C, et al. How Do Innovative Primary Care Practices Achieve the Quadruple Aim? J Ambul Care Manage. 2018;41(4):288-97.

<sup>120</sup> Ghorob A, Bodenheimer T. Sharing the care to improve access to primary care. N Engl J Med. 2012;366(21):1955-7.

<sup>121</sup> Jabbarpour Y, Jetty A, Dai M, Magill M, Bazemore A. The Evolving Family Medicine Team. Journal of the American Board of Family Medicine : JABFM. 2020;33(4):499-501.

<sup>122</sup> National Academies of Sciences and Medicine. Implementing High-Quality Primary Care: Rebuilding the foundation of Health Care. Washington, DC: The National Academies Press.; 2021.

<sup>123</sup> Sinsky CA, Bodenheimer T. Powering-Up Primary Care Teams: Advanced Team Care With In-Room Support. Annals of family medicine. 2019;17(4):367-71.

<sup>124</sup> Ghorob A, Bodenheimer T. Sharing the care to improve access to primary care. N Engl J Med. 2012;366(21):1955-7.

and professional satisfaction, facilitates the use of healthcare services, and improves clinical outcomes<sup>125,126</sup>.

In most countries, funding is the major obstacle to the development of interprofessional models in primary care. Primary care funding models must therefore evolve to allow for the time devoted to interprofessional care.

### Implementing integrated care in Switzerland: options and projects

One of the main questions around teamwork is the type of professionals to be included in these primary care teams. **Nowadays, in Switzerland, there are two professional bodies that can address this issue: medical assistants and nurses.** Swiss primary care practices have long been based on a doctor and medical assistant tandem. The recent creation of an additional diploma for medical assistants, in the form of a certificate of qualification as a coordinator in outpatient medicine with an administrative or clinical orientation, is a step in the direction of task sharing and should be encouraged. The clinically oriented training should enable more shared management of patients suffering from chronic illnesses. Trained medical assistants could plan future care, stimulate patients' autonomy and self-care skills, and support care provided by relatives. They could also coordinate the various services provided by the local authorities. Other countries, where the use of medical assistants is less widespread, are also considering the development of medical assistants<sup>127</sup>. In Switzerland, the acceptance of the TARDOC could increase the recognition of this profession.

The large-scale integration of nurses into primary care structures is currently limited by the lack of a legislative framework and, above all, of billing for nursing acts in this context. There are, however, pilot schemes in Switzerland with encouraging results (Mocca)<sup>128</sup>. In addition, the recent creation of an advanced practice diploma for nurses offers a perspective for the introduction of this professional group into outpatient primary care structures.<sup>129,130</sup>

Apart from these new health professions, new functions are also developing in primary care structures. For example, the role of case and/or care manager, which provides close support for the care pathways of chronically ill patients, is particularly interesting, both from a clinical point of view for patients and for the healthcare system<sup>131,132, 133</sup>.

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<sup>125</sup> Saint-Pierre C, Herskovic V, Sepúlveda M. Multidisciplinary collaboration in primary care: a systematic review. *Family practice*. 2018;35(2):132-41.

<sup>126</sup> Schepman S, Hansen J, de Putter ID, Batenburg RS, de Bakker DH. The common characteristics and outcomes of multidisciplinary collaboration in primary health care: a systematic literature review. *Int J Integr Care*. 2015;15:e027.

<sup>127</sup> Chapman SA, Blash LK. New Roles for Medical Assistants in Innovative Primary Care Practices. *Health services research*. 2017;52 Suppl 1(Suppl 1):383-406.

<sup>128</sup> Schütz, M., Senn, N. & Cohidon, C. (2020). Le projet pilote MOCCA : une nouvelle organisation des cabinets de médecine de famille dans le canton de Vaud, Suisse. *Revue française des affaires sociales*,337-350. <https://doi.org/10.3917/rfas.201.0337>

<sup>129</sup> Altermatt-von Arb R, Stoll H, Kindlimann A, Nicca D, Lauber E, Staudacher S, et al. Daily practices of advanced practice nurses within a multi-professional primary care practice in Switzerland: a qualitative analysis. *BMC Prim Care*. 2023;24(1):26.

<sup>130</sup> Gysin S, Sottas B, Odermatt M, Essig S. Advanced practice nurses' and general practitioners' first experiences with introducing the advanced practice nurse role to Swiss primary care: a qualitative study. *BMC family practice*. 2019;20(1):163.

<sup>131</sup> Karam M, Chouinard MC, Poitras ME, Couturier Y, Vedel I, Grgurevic N, et al. Nursing Care Coordination for Patients with Complex Needs in Primary Healthcare: A Scoping Review. *International journal of integrated care*. 2021;21(1):16.

<sup>132</sup> Challis D, Hughes J, Berzins K, Reilly S, Abell J, Stewart K, et al. Implementation of case management in long-term conditions in England: survey and case studies. *Journal of health services research & policy*. 2011;16 Suppl 1:8-13.

<sup>133</sup> Hudon C, Chouinard MC, Aubrey-Bassler K, Muhajarine N, Burge F, Bush PL, et al. Case Management in Primary Care for Frequent Users of Health Care Services: A Realist Synthesis. *Ann Fam Med*. 2020;18(3):218-26.

## CONCLUSION AND TAKE HOME MESSAGES

The Swiss population is growing; by 2050, people over 65 years old will represent at least a quarter of the population. Although the population in Switzerland is generally in very good health, there is room for improvement: half of the population over 65 suffers from at least two chronic diseases, and a comparatively low healthy life expectancy suggests that preventive care could be strengthened. There is solid evidence from several decades of research that primary care is a cost-effective and efficient way to address chronic health problems and multimorbidity. An insufficient density of PCPs increases mortality, unnecessary hospitalizations, and emergency consultations.

The current Swiss primary care workforce is aging. An important part of PCPs plan to reduce their working hours or to quit practice in the coming years. Younger physicians place high priority on favourable working conditions and work-life balance, thus increasing the total number of PCPs that are necessary to renew the retiring workforce. In the absence of measures, retiring PCPs will be increasingly difficult to replace. This shortage is already a reality for the population, demonstrated by the difficulty finding a family physician.

Considering this growing imbalance between the evolving health care needs of the population and the decreasing primary care workforce, there is urgency to implement actions to maintain an adequate primary care offer. Primary care needs to become a more attractive career choice for undergraduate medical students. Postgraduate training in primary care should be promoted, and residencies in primary care practices should be increased. Trained primary care physicians need to be supported in several fields to maintain professional satisfaction and limit attrition.

To build and maintain a resilient and sustainable primary care system in Switzerland, investments are necessary to achieve the following goals:

1. Increase the number of medical graduates projecting to train in primary care specialties (general internal medicine and paediatrics): Decrease the dependency on foreign medical graduates by increasing the number of medical students at Swiss medical faculties; support existing and future University institutes of family medicine/primary care to strengthen academic primary care and promote high-quality research and teaching; extend existing practical learning experiences in primary care for all medical students.
2. Increase the number of physicians in training projecting to practice primary care: Create a stronger focus on training in primary care practices during postgraduate training in general internal medicine and paediatrics, mainly by extending the availability of residency positions in primary care; support young and future PCPs through mentoring and coaching.
3. Decrease the number of PCPs leaving their profession early: Enhance the value of primary care practice by adapting remuneration to the specificities of primary care; support new models of interprofessional team-based medical practice to improve collaboration and cooperation, distribute administrative burden among more professionals, and improve physician's motivation and satisfaction.