Switzerland Country Profile

Hospital-Substituting Acute Somatic Care at Home – Regulatory-Incentive Framework

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Short Summary

- **Terminology & model:** Switzerland uses terms like Hospital at Home (HaH), Hospitalisation à Domicile (HaD), patient@home for delivery of substitutes of acute care episodes that is traditionally provided by hospitals. Care at Home (Care@home) is another term used for care models in which diagnostics and therapy are provided in patient homes that is traditionally provided by hospitals or elsewhere but expands beyond acute care episodes.
- **Legal status / regulation:** HaH[1] services are not covered as part of the mandatory health insurance scheme or home care service tariffs. Hospital tariffs may not be applied outside brick-and-mortar structures such that coverage is limited to ambulatory tariffs for pharmacy, physician and home care services required to treat patients at home.
- **Program scale:** HaH is not nationwide and only exists in selected cantons with ongoing pilot programs by selected providers. The Canton of Geneva maintains a legacy hospital at home project since the early 1990s that covers complex cases treated at home which expanded to the Canton of Vaud. However, within some cantons, HaH services are offered only within a defined perimeter (not across the whole canton).
- **Maturity / typology:** Switzerland is in a pilot-to-expansion stage, with about 14 active projects across 10 cantons. Most cantons are experimenting or have no HaH services at all.
- **Institutional anchoring:** HaH is primarily anchored in hospitals (Basel Landschaft, Zurich, Bern). Geneva is the main example of a cantonal community anchored program. Hospital at Home AG in Zurich represents a hybrid approach.
- **Funding source(s):** Programs are funded mainly through cantonal supplementary funds during pilot stages.
- **Reimbursement model and payment basis:** Fee-for-service tariffs for ambulatory care and minute-based tariffs for home care. Pilot programs are set up to match approximately hospital-based tariffs for acute care episodes based on SwissDRG. HaH has no national tariff. Cantons provide mostly lump-sum co-financing schemes for pilot programs to cover hospital substituting services. The Canton of Bern provides co-financing with health insurances to top up ambulatory care tariffs.
- **Integration (long-term):** Because hospitals cannot apply SwissDRG tariffs outside the hospital and coordination between hospital and ambulatory care providers including home care to set up integrated programs is challenging, long-term integration and scalability remain uncertain. While the Federal Council supports the development of HaH models and the upcoming equal financing of hospital and ambulatory care services (EFAS) support HaH integration, there is no national integration architecture. Long-term integration depends entirely on cantonal authorities and remains inconsistent.
- **Drivers:** HaH is driven by expected efficiency gains from shifting traditional hospital care into ambulatory and home-based settings, the expected potential of telemedicine and digitization, and expected workforce shortages, as well as patient-centered aims such as treating suitable patients in a familiar home environment and reducing disruption for patients and caregivers (where clinically appropriate).

[1] HaH is used for convenience. Here and in the following, under HaH we mean acute somatic care provided in home settings substituting hospital care.

- **Common challenges:** Key barriers include diverging incentive structures among hospital, ambulatory and home care providers, lack of national standards, and limited incentives for coordinated cross-sector implementation. Adoption remains slow where governance is decentralized. Ensuring a patient-centered pathway—shared decision-making, clear communication, and seamless coordination across hospitals, HaH providers, and Spitex/caregivers—is an additional implementation requirement.

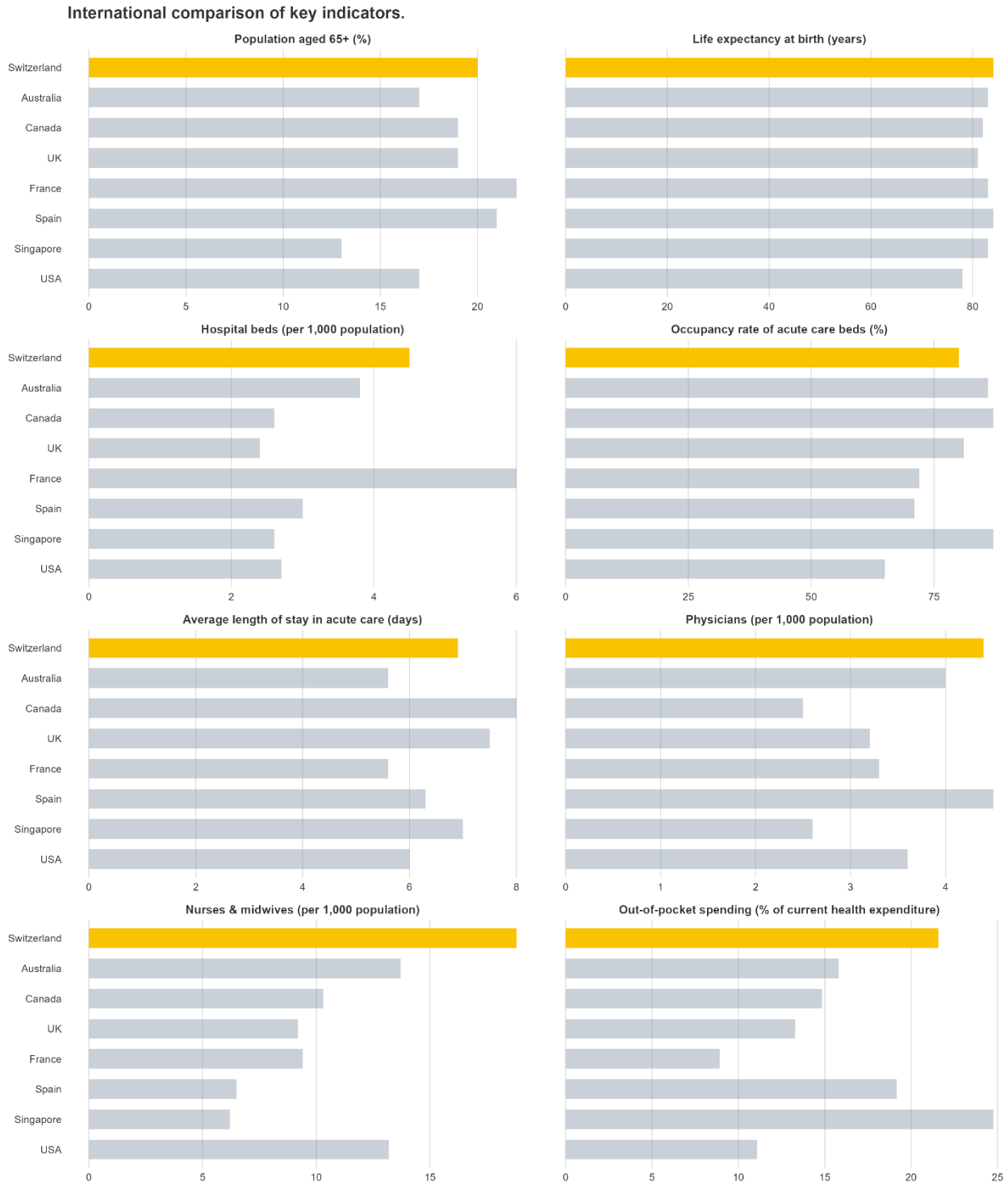
1. Country & health system overview

Dimension	Health system summary
Type / Universal coverage	**Mandatory health insurance (MHI)** provided by competing private (non-profit) insurers operating under federal rules (1,2). A decentralized, universal system with mandatory health insurance for all residents (since 1996), purchased from private nonprofit insurers; cantons provide premium subsidies for people on low incomes (1,2).
Financing model	Funded through community-rated individual premiums (no employer contribution); general taxes (mostly cantonal), social insurance contributions, and out-of-pocket payments (2).
Organization & governance	**Federal:** Regulation of system financing; assurance of quality and safety of pharmaceuticals and medical devices; oversight of public health, research, training. **Cantons**: regulation of provider oversight; capacity planning; financing through subsidies (institutions and individual premiums); health promotion activities. **Local**: Organization and provision of long-term care and social supports (2). → **Highly decentralized** -- 26 Cantons are independently responsible for providing health care (2). Health and accident insurance (including tariffs for reimbursement), research on humans, drug approval, transplant medicine, antibiotic resistance and infectious diseases are managed and regulated on the national level. Sub-national (i.e., cantonal and municipal) government spending on health care accounts for more than 85% of total public health spending, and the Swiss federal government (SFG) is responsible for less than 20% of health care decisions, illustrating the high degree of autonomy of cantonal authorities (3,4).
Payer structure	Universal multiple-payer system (where non-profit insurers cover the population and compete with each other) (5). All residents are legally required to hold mandatory health insurance (OKP) from one of competing non-

	profit insurers. The insured benefit (LKV) is defined uniformly in federal law, so coverage is universal and the basket is standardized.
Hospital funding	Reimbursement for inpatient care is financed by the cantons and the compulsory insurance. Cantons pay 55% and 45% is covered by compulsory insurance, by coinsurance, and copayments from patients (2). The distribution between cantonal and compulsory insurance funding is subject to change in the future due to the EFAS initiative that has been accepted in 2024, becoming effective in 2028. In addition to reimbursement for inpatient services hospitals can receive *Gemeinwirtschaftliche Leistungen* by the cantons. These are paid out for services such as educational services and vary heavily depending on type and location of hospitals.
Ownership & inpatient payment method	Public and private. While there are more private hospitals than public ones, public ones have more beds in total. Case-based DRG payments for inpatient care (SwissDRG) (2,6). Hospital-based physicians are normally paid a salary (2).
Ambulatory care financing & payment	Mainly financed via mandatory health insurance and reimbursed predominantly as fee-for-service under the national TARMED (TARDOC and ambulatory care bundles starting from January 2026) tariff, with patient cost-sharing through the deductible plus typically 10% coinsurance (capped annually) (2).
Home-based care financing & payment	Home-based nursing care is financed through compulsory health insurance, patient cost-sharing, and public contributions by cantons and/or municipalities. The compulsory insurance pays a fixed amount (per *Krankenpflege-Leistungsverordnung*, KLV); individuals may contribute up to a maximum of 20% of costs (canton-dependent; in some cantons zero (e.g., parts of Romandie) or below the cap (CH expert)), and the canton and/or municipality covers the public share based on KLV *Normkosten* (standard costs) (arrangement varies by canton) ((7) and CH expert). Nursing care tariffs are defined on a minute-basis based on KLV (*Krankenpflege-Leistungsverordnung*).

2. Key indicators relevant for adoption of hospital-substituting acute somatic care at home

Domain	Indicator	Value (year, source)
Demand & demographic pressure	Population (total)	8.9 million in 2023 (8)
	65+ (%)	20% in 2023 (8)
	Life expectancy (years)	84 in 2023 (8)
Hospital capacity pressure	Hospital beds / 1,000 people	4.5 in 2020 (8)
	Occupancy rate of curative acute care beds	81% in 2023 (9)
	Average length of stays for all causes in acute hospital beds (ALOS)	6.9 days in 2023 (9)
Workforce capacity	Physicians / 1,000 people	4.4 in 2021(8)
	Nurses & midwives / 1,000 people	18.8 in 2021(8)
Financing context	Health expenditure (% GDP)	11.71% in 2022 (8)
	Out-of-pocket (% of current health expenditure)	24.74% in 2022 (8)



Note: Latest available year (years may vary).

Acute somatic care programs provided at home substituting hospitalization

3. Design & operations

Dimension	Evidence summary
Terminology	Hospital at home (German-speaking cantons) (10), Hospitalisation à Domicile (French-speaking cantons), patient@home, Care@home (11).
Representative body	Swiss Hospital at Home Society is working to establish HaH as a recognized, scalable Swiss care model by shaping framework conditions and standards, building a network of HaH providers, supporting research/quality measurement (incl. a minimal dataset), and advancing policy, education, and IT guidance to enable broader implementation. The complimentary Swiss Center for Care@home (SCC), Canton of Bern, supports development and implementation through pilot projects and research (11,12).
Year of Introduction	2021 with pilot programs across multiple cantons and institutions, local program in Geneva (Hospitalisation à Domicile running since 1991 for complex care).
Main programs (names & regions)	14 programs across 10 cantons (AG, BL, BS, BE, GE, GR, LU, SZ, VD, ZH, TI) were operating as of January 2026. Models range from hospital-driven (Klinik Arlesheim (BL), Visit Zollikerberg (ZH), Kantonsspital Baselland (KSBL)) to ambulatory-centered (IMAD Geneva (GE, VD), established 1991) and hybrid approaches (Hospital at Home AG (ZH), AdvantAGE Basel (BS)) (13).
Delivery model	**Hospital-driven models** (e.g., Klinik Arlesheim; Visit) deliver home treatment via hospital teams and coordinate with GPs; relatives may be involved in decisions, hospitals hold clinical accountability for home treatment of patients (14–16). **Community-driven models** (e.g., IMAD Geneva) operate on a physician mandate (the doctor remains the prescriber/clinical lead) and, as a separate home-care/ambulatory provider, coordinate with the treating physician and other care-network partners (17–20). **Hybrid/network-based models** (e.g., Hospital at Home AG) receive patient referrals from hospitals and physician practices and operate similar to community-driven models as a separate home-care/ambulatory provider. They integrate physicians, advanced practice nurses (APN), and nursing services as a backbone of operations in their own care team, while at the same time coordinating with Spitex, GPs and other care-network partners under the premise “the provider nearest to the patient’s home” delivers the service (CH expert).

Type of program (conditions & services)	**Conditions:** acute internal medicine conditions (e.g., pneumonia, decompensated heart failure, COPD exacerbation, soft tissue infections, febrile pyelonephritis, viral respiratory infections like SARS-CoV-2/RSV/influenza, gastroenteritis, hypertensive crisis, MS relapse, dehydration, wound infections, various other moderate infections and inflammations) (21,22). **Services:** EKG/ultrasound/blood tests, IV meds/infusions/oxygen, catheter management, small interventions (e.g., pleural/ascites puncture) and telemedical monitoring if needed (21). IMAD/SITEX: IV treatments such as antibiotics/chemo/pain treatment/hydration/parenteral nutrition; blood transfusions; nasogastric tubes; VAC dressings; peritoneal dialysis; palliative care linkages; plus pediatric HAD including oncology, transplants, rare diseases, prematurity, diabetes (23,24). **Age:** Kantonsspital Baselland (KSBL) HaH program is aimed at older people (25); IMAD/SITEX, Zollikerberg: all ages (23,24,26); Hospital at Home AG treats patients of various ages (e.g., youngest was 18, the oldest was 102, average was 71 years old) (CH expert).
Regulatory authority	Programs are delivered under existing healthcare governance arrangements; there is no dedicated HaH-specific regulatory authority or oversight body. Hospital planning and oversight are primarily organized at cantonal level.
Legal status & regulation	**HaH/Care@home is generally treated as ambulatory care** for tariff purposes: SwissDRG tariffs apply to in-hospital inpatient care and cannot be billed for treatment delivered at home. The Federal Council has stated that treatment at home does not in itself constitute a need for hospitalization; therefore, inpatient tariffs cannot be used (27). **Cantonal legal basis varies:** Some cantonal hospital laws explicitly allow cantonal contributions to hospital-linked ambulatory and intermediate services when tariffs do not cover economically efficient provision, and may include innovation/experimental clauses that can support new models such as HaH (e.g., Basel-Landschaft §16 SpiVG (28); Bern BSG 812.11 – SpVG, Art. 62, 139, 150 (29); Zürich §11 LS 813.20 – SPFG (30)). In cantons with more inpatient-oriented hospital laws, HaH-type programs may need to rely on *Gemeinwirtschaftliche Leistungen* (GWL)[2] (public-service obligations / services of general economic interest), service contracts

[2] GWL (*Gemeinwirtschaftliche Leistungen*): In Switzerland, cantons can pay hospitals or other providers for public-interest services that standard health-care tariffs do not fully finance. These payments are often used to maintain necessary capacity (e.g., emergency readiness), support training, or fund services that are important for the population but not cost covering under regular reimbursement. GWL is often described as "public service obligations" or "services of general economic interest."

	(*Leistungsverträge*[3]), or other special legal bases (e.g., Lucerne §5/§6d SRL 800a – SpiG (31); Aargau §17b SAR 331.200 – SpiG (32); Schaffhausen Art. 2 SpG (33)). ***Implication**: In the absence of a dedicated national HaH tariff, cantons may use these legal instruments to fund or pilot HaH programs.* **Current reimbursement structure (status quo):** home nursing services under KLV (patient contribution, if applied, capped and canton-dependent; may be zero); physician services under TARMED/TARDOC; inpatient hospital services under SwissDRG (in hospital only). HaH is compatible with the *Krankenversicherungsgesetz* (KVG) framework but is not reimbursed as inpatient hospital treatment; policy discussions emphasize avoiding cost-increasing duplication alongside existing inpatient structures (27,34). **EFAS reform (effective 01.01.2028):** unified financing of ambulatory and inpatient services; expected to strengthen incentives for shifting appropriate care to ambulatory settings, potentially including acute care delivered at home.
Program scale	Not national, local pilots, supported by cantonal funding: As of January 2026, 14 initiatives in acute care to avoid admissions or promote early supported discharge / transfer were active.
Maturity / typology	Early-stage and fragmented: HaH is in a pilot-to-expansion phase, with ~14 active initiatives across ~10 cantons (as of Jan 2026) and no national standardized scheme or tariff. Service availability can remain sub-cantonal, i.e., offered only within defined local perimeters rather than canton-wide coverage (CH expert). The dominant operational variant is hospital-anchored acute substitution in which hospitals retain clinical responsibility and coordinate with Spitex/ambulatory services; smaller shares of ambulatory/community-anchored and hybrid models coexist. A key exception is IMAD Geneva (and later Vaud), a long-running, comparatively mature *hospitalisation-à-domicile* service since 1991, operating within existing ambulatory/home-care tariffs rather than a dedicated national HaH payment route, suggesting that HaH-type delivery can, in some settings, be embedded in existing tariffs without a separate pilot payment route.
Institutional anchoring	**Hospital-driven dominance**: Represents majority of pilots since 2021. Most common model is where hospitals maintain control of acute episodes, supplemented in some pilots with Spitex/ambulatory services.

[3] *Leistungsverträge* (service contracts / performance agreements): Cantons also use formal contracts with providers to define which services must be delivered, to whom, with what quality requirements, and how much public funding will be paid. These are essentially service delivery contracts (sometimes called performance agreements) and can be used to fund activities that are not adequately covered through national tariffs.

	Examples: Arlesheim (BL), Zollikerberg, Kantonsspital Baselland (KSBL), Universitätsspital Basel (USB) (partial), Biel, Chur, LUKS, CHUV (2 programs). **Ambulatory/Community-driven**: less common but includes longest-standing program (IMAD in Geneva / Vaud since 1991); centers on home care (Spitex)/ambulatory care infrastructure; supplements with hospital services as needed. Examples: IMAD Geneva, we4you Schwyz. **Hybrid models**[4]: Combination approaches explicitly integrate hospital and community resources. Examples: USB AdvantAGE (APN model), Hospital at Home AG in Zurich (collaborates with hospitals that refer patients to the provider; the provider coordinates care across a regional network including public and private Spitex partners, positioning itself as a regional coordination hub (platform model) rather than a single-hospital program).

[4] Hybrid (= platform/hub): provider-led model pooling cases from multiple hospitals and coordinating delivery across multiple Spitex partners; may include own employed physicians/nurses. Hybrid/hub models may be scalable because only some hospitals will be able to build standalone HaH programs; regional ambulatory HaH hubs could allow hospitals to connect and hand over eligible cases (CH expert).

4. **Financing & reimbursement**

Dimension	Evidence summary
Funding source(s)	All pilot programs run using cantonal support and regular funding schemes: Mandatory health insurance pays medical services; cantons co-finance inpatient care substitutes provided at home and infrastructure; patients pay deductibles and co-payments; home care (Spitex) financing is typically shared between mandatory health insurance, patient cost-sharing (capped; canton-dependent and may be zero), and public contributions from cantons and/or municipalities (depending on the canton), often based on regulated standard/normative costs (*Normkosten*) rather than full residual actual costs ((35–38) and CH expert). The feasibility and legal route for cantonal co-funding varies by canton, reflecting differences in cantonal hospital/health laws (explicit ambulatory/intermediate contribution clauses and/or innovation clauses in some cantons vs. reliance on general GWL/*Leistungsverträge* in others). Additional cantonal funding covers excess cost for providing hospital-substituting services at home and program evaluation (Source: exchange with programs and experts). Cantonal supplementary funding is most frequent, e.g., in AG, BL (Klinik Arlesheim & KSBL), BS, ZH (Hospital at Home AG & Visit). Amounts range from CHF 500K to CHF 10M. No extra funding: SZ (we4you), GE (legacy project since 1991), VD (in cooperation with GE since 2020) operate within existing tariffs (39). Cantonal / health insurance mark-up for hospital-substituting ambulatory care episodes: canton (BE) and health insurers match ambulatory care tariffs to SwissDRG reimbursement level – committed cost-saving (40). Additional projects in pilot stage with unconfirmed cantonal funding source: GR, LU; TI (HospiHome).
Reimbursement model	HaH services are reimbursed through standard ambulatory fee-for-service tariffs (TARMED/TARDOC for physician services, nursing care ordinance (KLV) minute-based rates for nursing care) with patient co-payments, as federal law prohibits applying hospital DRG tariffs (SwissDRG) outside brick-and-mortar facilities. Most cantonal pilots receive supplementary funding through negotiated flat rates, lump-sum co-financing, or canton-insurer top-up arrangements to approximate hospital-level reimbursement (ranging from 10% to 100% of SwissDRG rates depending on the canton), though Geneva's legacy program operates entirely within standard ambulatory frameworks. No national HaH tariff exists, and long-term reimbursement pathways remain undefined beyond pilot-stage cantonal funding mechanisms that expire in 2025-2026.

Payment basis	In hospital and hybrid models that started in 2021, mainly fee-for-service TARMED (TARDOC and ambulatory care bundles from 2026) for ambulatory care/ nursing care ordinance (KLV) for home care with additional funding matched to meet levels comparable to SwissDRG, either equal or somewhat lower (source: exchange with programs and experts). Geneva introduced a special tariff for pharmacy services provided at home in the early 1990s (41,42). For home care, patient co-payment is reduced from CHF 15.95 to 10.00 per day (39).
Patient cost-sharing	Hospital-based pilots (e.g., KSBL, Spital Zollikerberg), and also Hospital at Home AG: The costs are covered by the health insurance company under basic insurance, just like with a traditional hospital stay (21). Compared to a conventional treatment in the hospital, a patient does not incur any additional costs (14). Participation in AdvantAGE is currently free for patients (37). For reha@home, patient cost-sharing follows the standard mandatory insurance rules—patients pay their annual deductible (Franchise) plus a 10% co-insurance (Selbstbehalt) up to CHF 700 per calendar year (15).
Cost impact	At present, **no peer-reviewed economic evaluations** are identified. A Basel-Landschaft parliamentary proposal (Landrat Vorlage LRV 2025/185, 6 May 2025; to expand Hospital at Home under "Gesundheit BL 2030", incl. legal basis §16 SpiVG) reports an internal 2024 controlling/tariff-based comparison from Klinik Arlesheim (111 cases): ~19.6% lower tariff-based billed amounts/payments for HaH versus an inpatient comparator. The difference is mainly attributed to a ~10% lower HaH case payment relative to the hospital base rate and a lower average case-mix index; interpretation should consider potential patient selection effects (16). Expert feedback (unpublished): One provider argues that if inpatient DRGs under-cover hospital effective costs by ~10% for comparable cases, then even DRG-equivalent reimbursement for HaH could still imply ≥10% cost differences versus inpatient effective costs; with scale-up, they expect potential differences of ~20%, but quantified results are not yet available (CH expert).
Coding & activity counting	Presently, no national coding/reporting expectations.
Integration (long-term)	Federal Council clarified that HaH models should be aligned with ambulatory fee-for-service payments (27,43). TARDOC and ambulatory care bundles could serve as a starting point. Currently, there is no long-term integration strategy. However, the Geneva/IMAD model illustrates a pathway that is less dependent on time-limited pilot top-ups, as it is largely embedded in existing tariffs.

5. **Drivers & barriers/risks**

Drivers	Barriers/Risks
– **Cost efficiency and system transformation**: C@h/HaH models can lead to cost reductions through lower follow-up costs, more targeted resource deployment, and avoidance of costly hospital construction. Shifting care to home settings can mitigate negative impacts of hospital closures and free up capacity for urgent hospitalizations.	– **Lack of legal and tariff framework**: Most programs only function through subsidies, as standard financing in the outpatient sector is insufficient. A federal tariff appendix under the KVG is missing, as is a uniform national definition of hospital-substituting acute somatic care at home services, which prevents scaling and sustainable implementation (44).
– **Patient perspective:** Potential benefits include receiving acute treatment in a familiar environment, reduced disruption for patients and caregivers, and improved experience for suitable patients—provided appropriate safety, monitoring, and support are ensured.	– **Fragmentation at system and actor levels**: Institution-oriented thinking (hospitals vs. Spitex vs. general practitioners) rather than service-oriented perspectives hinder integration. Fragmented cantonal planning without interregional coordination and lack of Spitex integration in care planning impede coherent system design.
– **Growing stakeholder collaboration and pilot projects**: Declining mistrust between hospitals, Spitex organizations, and insurers promotes the development of integrated care models. Ongoing pilot projects with provisional financing enable experience gathering and evidence building for future standard financing.	– **Legal limitations on role assignment**: The existing KVG framework (Art. 33/34) limits initial patient contact and direct service provision by non-physician health professionals (APN, physiotherapy). Unclear definition of family caregiver roles and inadequate reimbursement for coordination services obstruct integrated care models.
– **Digitalization for improved coordination**: Digital solutions for communication, coordination, and billing between service providers create the technical foundation for efficient episode-based care. This supports overcoming fragmentation between inpatient and outpatient sectors.	– **Risk of one-sided cost focus**: There is a danger of viewing C@h/HaH primarily as a cost-cutting measure, thereby neglecting patient and staff benefits. Incorrect pricing levels (too low → project abandonment; too high → overutilization) and building parallel systems instead of need-driven design endanger quality.
– **Political window of opportunity and regulatory openness**: Increasing openness in federal government responses regarding applications under the Health Insurance Act (KVG) and the upcoming unified financing reform (EFAS) create favorable framework conditions. The enhancement of professional roles (particularly APN/clinical nurse specialist	– **Stakeholder conflicts and regulatory uncertainty**: Fear of loss among various stakeholders leads to lack of mutual understanding and guarded behavior by key actors (particularly cantons). Future regulatory interventions could create unequal competitive conditions if different institutions are granted different permissions or tariffs.

(CNS)) and new role distributions increase attractiveness for healthcare professionals.

Synthesis: Narrative summary

Switzerland operates a fragmented and largely pilot-based Hospital at Home (HaH) landscape, with no national regulatory framework or reimbursement model. The Canton of Geneva established the country's first program in 1991 through IMAD (*Institution genevoise de maintien à domicile*), providing complex acute care at home using standard ambulatory tariffs, and later expanded to Vaud. Since 2021, approximately 14 additional pilot projects have emerged across 10 cantons, driven by expected efficiency gains, workforce shortages, the potential of telemedicine, and patient-centeredness, i.e., providing appropriate acute care in the home environment and reducing disruption for patients and caregivers, provided safety and clinical suitability are ensured.

These programs operate outside Switzerland's standard reimbursement frameworks. Federal law classifies care delivered at home as ambulatory, prohibiting the application of hospital DRG tariffs (SwissDRG) outside brick-and-mortar structures. Consequently, HaH services are reimbursed through standard fee-for-service ambulatory tariffs (TARMED/TARDOC for physician services, minute-based nursing care ordinance (KLV) for nursing care), supplemented by cantonal pilot funding ranging from CHF 500,000 to CHF 10 million. Most programs are hospital-anchored (9 of 14), where hospitals maintain control of acute episodes while coordinating with home care (Spitex) providers. Three programs are ambulatory-anchored (Geneva's IMAD, SITEX, and Schwyz's we4you), and two operate as hybrid models integrating hospital and community resources.

Institutional anchoring varies by design. Hospital-driven models (Basel-Landschaft, Zurich, Bern, Lucerne, Graubünden, Vaud) typically receive negotiated flat rates or top-up payments to approximate SwissDRG reimbursement levels, though actual amounts and mechanisms differ by canton and are largely unknown. Geneva's ambulatory-centered model operates entirely within standard minute-based KLV and fee-for-service TARMED frameworks without special reimbursement, relying on high care intensity per patient and canton subsidization of patient co-payments (reduced from the federal maximum of CHF 15.95 to CHF 10.00 per day). This is a notable exception indicating that HaH delivery can, in some settings, be organized within existing ambulatory/home-care tariffs—though transferability to other cantons and models remains uncertain. The Canton of Bern has experimented with canton-insurer co-financing to bridge ambulatory tariffs toward hospital-level reimbursement.

Long-term sustainability remains uncertain. Most pilot funding expires in 2025-2026 and continuation depends on positive evaluation results and cantonal willingness to establish permanent financing mechanisms. The upcoming EFAS reform (effective January 2028), which unifies financing of ambulatory and inpatient services, may create opportunities for HaH integration, but no national architecture exists. The Swiss Hospital at Home Society (SHAHS), founded recently as an interprofessional organization, aims to structure and harmonize HaH nationally, but implementation authority rests entirely with cantonal governments, creating risk of uncoordinated development and geographic inequity. The Swiss Center for Care at Home at Bern University of

Applied Sciences and funded by the Canton of Bern aims to support development and evaluation of home-centered treatment pathways, also outside acute care settings.

Switzerland's highly decentralized health system—where cantons independently regulate provider oversight, capacity planning, and financing—prevents standardization. Switzerland has no dedicated HaH classification, no national coding requirements, and no consistent reimbursement pathway. The Federal Council has acknowledged HaH models but deferred decisions to cantonal authorities and ordinary ambulatory payment mechanisms. This makes Switzerland an example of a decentralized, pilot-stage system where innovation occurs locally, but scalability and equity depend on cantonal capacity and political will rather than national policy.

6. Regulatory-incentive framework

This regulatory–incentive framework summarizes, in a structured way, how the Swiss regulatory and financing environment enables or constrains hospital-substituting acute care at home across nine dimensions.

Category	Dimension	Status	Scope	Evidence notes	Implication
Rule clarity and eligibility/entitlement	Legal status / regulatory anchoring	Not defined / ad hoc	National (KVG interpretation: care at home treated as ambulatory; SwissDRG not applicable at home)	HaH is legally ambulatory care and SwissDRG tariffs do not apply outside brick-and-mortar structures; the Federal Council position is that treatment at home does not indicate hospital need, therefore inpatient tariffs cannot be used.	Switzerland has a clear restriction (no inpatient tariff at home), but no explicit national HaH entitlement/operational framework for hospital-substituting episodes—leaving implementation dependent on local arrangements.
	Governance clarity (steering & roles)	Not defined / ad hoc	National framework absent; governance occurs at cantonal/program level	No dedicated regulatory authority or oversight for HaH; hospital planning/oversight is organized at cantonal level, and implementation authority rests with cantons, with no national standards.	Steering and oversight are fragmented (cantonal/program-specific), increasing transaction costs and reducing consistency for scaling and evaluation.
	Anchoring of service delivery & accountability	Pilot/program-based (bounded)	By pilot/model (hospital-led dominant; some community-led/hybrid)	Institutional anchoring varies: most pilots are hospital-driven (hospitals retain control/clinical responsibility), but community-driven models (e.g., IMAD) and hybrid approaches exist, with accountability described at the program level rather than standardized nationally.	Accountability can be clear within pilots, but system-wide clarity is limited and varies by model—making routinized contracting/roles harder across cantons.
Payment pathway and incentive alignment	Defined payment pathway (tariff/contract)	No dedicated payment pathway	National; pilots rely on component ambulatory billing + cantonal supplements	HaH has no national tariff and services are reimbursed through standard ambulatory FFS (TARMED/TARDOC) and KLV minute-based nursing tariffs, with many pilots using cantonal supplementary funding/top-ups to approximate hospital-level reimbursement.	The "episode" is not represented by a routinized tariff—providers must piece together components and/or negotiate supplements, which limits scalability and comparability.
	Revenue neutrality under substitution (provider incentives)	Financial penalty / misaligned incentives	Standard rules nationally; some pilots partially offset via cantonal co-financing/top-ups	Because SwissDRG cannot be applied at home, hospital substitution cannot be billed like an inpatient stay; pilots seek to match approximately hospital-based tariffs based on SwissDRG via cantonal funding/co-financing arrangements rather than a national rule.	Under standard financing rules, substitution is not revenue-neutral for hospitals; pilots can reduce the penalty locally, but incentives remain inconsistent and canton-dependent.
	Financing stability & long-term integration	Time-limited / uncertain financing	Cantonal pilots (often time-limited); EFAS as future enabler	A pilot-to-expansion landscape funded mainly through cantonal supplementary funds, and long-term integration/scalability is uncertain; EFAS (01.01.2028) potentially supportive but there is no current national integration architecture.	The model is not yet on durable, rule-based financing, so investments/workforce build-out remain risky and uneven; continuity depends on cantonal decisions and pilot horizons.

Operational enablers and safeguards for routine care	Data, coding & reporting/monitoring	Not identifiable in routine data	National	No national coding/reporting expectations.	Without standardized identifiers, HaH episodes are hard to track, benchmark, and monitor consistently across cantons/programs.
	Program scale-up & geographic coverage	Partial scale / uneven coverage	Selected cantons only (≈14 initiatives across ≈10 cantons as of Jan 2026)	HaH is not nationwide, exists as selected pilots, ~14 programs across ~10 cantons (Jan 2026).	Availability is patchy and canton-dependent, limiting diffusion and making national learning/comparisons more difficult.
	Equity & access	Equity risks / uneven access	Geography-driven (cantonal variation)	Decentralization and the risk of inconsistent, uncoordinated development with geographic inequity, given cantonal authority and lack of national architecture.	Access likely varies by canton/program presence rather than need alone; without national safeguards, equity depends on cantonal capacity and policy choices.

How to read: Status uses standardized labels and Scope indicates applicability (payer/model/region/time). Evidence notes are profile-based; Implication provides interpretation. Standardized Status label definitions are provided in the Country Profiles Annex (Annex C).

Synthesis: Regulatory-incentive lens narrative summary

Switzerland's regulatory-incentive environment for hospital-substituting acute care at home is characterized less by an enabling national framework than by a clear national constraint: treatment delivered at home is classified as ambulatory, and SwissDRG inpatient tariffs may not be applied outside brick-and-mortar hospital structures (Federal Council position: treatment at home does not indicate hospital need, so inpatient tariffs cannot be used). This creates a situation where the "rules of the game" are defined mainly by what cannot be done nationally, while a routinized national entitlement, eligibility architecture, and oversight model for HaH episodes is not established; governance and operationalization therefore default to cantonal and program-level arrangements.

On the incentive side, the absence of a dedicated national HaH payment route means hospital-substituting episodes are financed through fragmented ambulatory components—physician services via TARMED/TARDOC, home nursing via minute-based KLV tariffs—with many pilots relying on cantonal supplementary funding, flat rates, or canton–insurer top-ups intended to approximate hospital-level reimbursement. The practical implication is uneven revenue neutrality: under baseline rules, substitution is not financially neutral for hospitals, while pilot "bridging" mechanisms vary by canton and are often time-limited, making the business case and operational integration contingent on local negotiations rather than standardized incentives. EFAS (effective 01.01.2028) is described as potentially supportive for shifting care, but there is no national integration architecture in place today.

Operationally, the framework remains weakly instrumented for routine scaling: no national coding/reporting expectations, making HaH activity hard to identify consistently in routine data and limiting benchmarking, monitoring, and comparability across cantons. Combined with decentralized authority and pilot-stage financing, this produces uneven geographic coverage (selected cantons only) and an inherent risk of unequal access, as availability depends on cantonal priorities and local implementation capacity rather than a uniform national pathway.

7. Traffic-light table for cross-country comparison

The following table enables cross-country comparison across 9 dimensions.

Category	Dimension	Traffic light (with qualifier)
Rule clarity & eligibility/entitlement	Legal status / regulatory anchoring	🔴 (national: hospital-substituting acute care at home classified as ambulatory; inpatient SwissDRG tariffs cannot be applied at home; no routinized HaH entitlement/pathway)
	Governance clarity (steering & roles)	🔴 (national: no dedicated HaH regulatory authority/oversight; governance/planning occurs at cantonal level)
	Anchoring of service delivery & accountability	🟡 (model-specific: majority hospital-anchored pilots; smaller ambulatory/community-anchored and hybrid models)
Payment pathway & incentive alignment	Defined payment pathway (tariff/contract)	🔴 (national: no HaH tariff; episode paid via fragmented ambulatory components & cantonal pilot top-ups/flat rates in many cantons; Geneva legacy program within standard ambulatory tariffs)
	Revenue neutrality under substitution (provider incentives)	🟡 (🔴 baseline: hospitals cannot bill SwissDRG at home → substitution not revenue-neutral; 🟡 where cantons/insurers top-up toward SwissDRG levels, varying by canton)
	Financing stability & long-term integration	🟡 (pilot-stage cantonal supplementary funding; long-term pathway undefined; funding often time-limited/expiring 2025–2026; EFAS from 01.01.2028 noted as potential enabler but not a current architecture)
Operational enablers & safeguards	Data, coding & reporting/monitoring	🔴 (national: no national coding/reporting expectations; not routinely identifiable)
	Program scale-up & geographic coverage	🟡 (partial/uneven: not nationwide; ~14 initiatives across ~10 cantons as of Jan 2026)
	Equity & access	🟡 (geography-dependent: availability varies by canton/pilot presence; decentralized implementation implies uneven access)

Note: For definitions and the traffic-light derivation rules used in the cross-country synthesis, see the Country Profiles Annex (Annex B–D).

8. References

1. Switzerland: Health system review. Copenhagen: World Health Organization (WHO) / European Observatory on Health Systems and Policies; 2015. p. 1–288. (Health Systems in Transition). Report no.: 18.

2. Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton G, editors. International Profiles of Health Care Systems 2020 [Internet]. The Commonwealth Fund; 2020. Available from: https://www.commonwealthfund.org/international-health-policy-center/system-profiles

3. Burger MMRL, Large KE, Liu Y, Coyle MC, Gamanya CT, Etter JF. Future Strategic Priorities of the Swiss Decentralized Healthcare System: A COVID-19 Case Study. Epidemiologia. 2022 May 16;3(2):250–68. doi:10.3390/epidemiologia3020020 PubMed PMID: 36417256; PubMed Central PMCID: PMC9620901.

4. Special Issue on Health. OECD J Budg. 2019;19(3). doi:https://doi.org/10.1787/045f5902-en

5. Siciliani L, Brekke K, Kifmann M, Straume OR. Public Health Care [Internet]. 1st ed. Cambridge University Press; 2025 [cited 2025 May 6]. Available from: https://www.cambridge.org/core/product/identifier/9781108652537/type/element doi:10.1017/9781108652537

6. Stationäre Tarifstrukturen [Internet]. [cited 2025 Dec 1]. Available from: https://www.bag.admin.ch/de/stationaere-tarifstrukturen

7. Krankenversicherung: Pflegeleistungen [Internet]. [cited 2025 Dec 1]. Available from: https://www.bag.admin.ch/de/krankenversicherung-pflegeleistungen

8. World Bank Open Data [Internet]. [cited 2025 Oct 8]. World Bank Open Data. Available from: https://data.worldbank.org

9. OECD. Health at a Glance 2025: OECD Indicators [Internet]. Paris: OECD Publishing; 2025 [cited 2025 Nov 13]. (Health at a Glance). Available from: https://doi.org/10.1787/8f9e3f98-en doi:10.1787/8f9e3f98-en

10. Pöchtrager S. Hospital at Home. Inf Rzt. 2024 Dezember;14(12). doi:https://doi.org/10.23785/ARZT.2024.12.005

11. Thilo FJS, Kim SI. Strategie 2025-2030 Swiss Center for Care@home SCC [Internet]. Bern: Berner Fachhochschule; 2024 Dec [cited 2026 Jan 8]. Available from: https://www.bfh.ch/dam/jcr:faf1def7-8179-4838-b354-d16a3db5d8a6/Strategie_Swiss%20Center%20for%20Care@home%20SCC_d.pdf

12. Bürkle T, Cignacco E, Karadeniz S, Kim SI, Kunz S, Schmid T, et al. Jahresbericht Swiss Center for Care@home 2024 [Internet]. Bern: Berner Fachhochschule; 2025 Feb [cited 2026 Jan 8]. Available from: https://www.bfh.ch/dam/jcr:22a9d7d6-185b-43e0-bcc3-a40887f90faf/Jahresbericht%202024%20SCC.pdf

13. Donzé R. das Spital der Zukunft findet in den eigenen vier Wänden statt. Neue Zürcher Zeitung [Internet]. 2023 Jun 3 [cited 2026 Jan 22]. Available from: https://www.nzz.ch/schweiz/das-spital-der-zukunft-findet-in-den-eigenen-vier-waenden-statt-ld.1779191

14. Visit – Spital Zollikerberg Zuhause® | Spital Zollikerberg [Internet]. [cited 2026 Jan 26]. Available from: https://spitalzollikerberg.ch/de/fachbereiche/visit

15. Kosten und Finanzierung - reha@home. Therapien, Spitex Pflege und Betreuung [Internet]. [cited 2026 Jan 26]. Available from: https://rehaathome.ch/ueber-uns/kosten/

16. Regierungsrat des Kantons Basel-Landschaft. Gesundheit BL 2030 – Ausweitung Hospital at Home; Ausgabenbewilligung [Internet]. Liestal; 2025 May [cited 2026 Jan 26]. Report LRV 2025/185. Available from: https://baselland.talus.ch/de/dokumente/geschaeft/9f119a051dd149ab884373becc968d8e-332

17. Hospitalisation à domicile · imad - Aide et soins à domicile du canton de Genève. imad - Aide et soins à domicile du canton de Genève [Internet]. [cited 2026 Jan 26]. Available from: https://www.imad-ge.ch/prestations/hospitalisation-a-domicile/

18. Magazine Aide et soins à domicile [Internet]. 2023 [cited 2026 Jan 26]. Magazine Aide et soins à domicile - Compétences et intensité d'une hospitalisation, à domicile. Available from: https://spitexmagazin.ch/fr/article/competences-et-intensite-dune-hospitalisation-a-domicile/

19. imad - institution genevoise de maintien à domicile | Ville de Genève - Site officiel [Internet]. [cited 2026 Jan 26]. Available from: https://www.geneve.ch/imad-institution-genevoise-maintien-domicile

20. Mission et objectifs · imad - Aide et soins à domicile du canton de Genève. imad - Aide et soins à domicile du canton de Genève [Internet]. [cited 2026 Jan 26]. Available from: https://www.imad-ge.ch/organisation/mission-et-objectifs/

21. Angebot M. Aufenthalt & Besuch [Internet]. [cited 2026 Jan 26]. Hospital at Home (im Laufental). Available from: https://www.ksbl.ch/de/leistungen/hospital-at-home/

22. Hospital at Home AG. Hospital@Home [Internet]. [cited 2026 Jan 26]. Available from: https://hospitalathome.ch

23. imad. Nos prestations [Internet]. imad – institution genevoise de maintien à domicile; 2025 Jun. Available from: https://www.imad-ge.ch/wp-content/uploads/2025/05/imad_brochure_prestations.pdf

24. Hospitalisation à domicile (HAD). SITEX [Internet]. [cited 2026 Jan 27]. Available from: https://www.sitexsa.ch/hospitalisation-a-domicile/

25. «Hospital at Home Laufen»: Kanton unterstützt temporäres Gesundheitsangebot für Laufentaler Bevölkerung [Internet]. [cited 2026 Jan 26]. Available from: https://www.baselland.ch/politik-und-behorden/regierungsrat/medienmitteilungen/hospital-at-home-laufen-kanton-unterstuetzt-temporaeres-gesundheitsangebot-fuer-laufentaler-bevoelkerung

26. Visit – Spital Zollikerberg Zuhause® | Spital Zollikerberg [Internet]. [cited 2026 Jan 26]. Available from: https://spitalzollikerberg.ch/de/fachbereiche/visit

27. Hospital at home : un concept problématique ? [Internet]. Bern; 2024 [cited 2025 Aug 29]. Available from: https://www.parlament.ch/fr/ratsbetrieb/suche-curia-vista/geschaeft?AffairId=20247460

28. Der Landrat des Kantons Basel-Landschaft. Spitalversorgungsgesetz (SpiVG) [Internet]. 2018. Available from: https://www.lexfind.ch/tolv/237750/de

29. BSG 812.11 - Spitalversorgungsgesetz - Kanton Bern - Erlass-Sammlung [Internet]. [cited 2026 Feb 18]. Available from: https://www.belex.sites.be.ch/app/de/texts_of_law/812.11

30. Der Kantonsrat Zürich. Spitalplanungs- und -finanzierungsgesetz (SPFG), LS 813.20 [Internet]. 2011 [cited 2026 Feb 18]. Available from: https://www.notes.zh.ch/appl/zhlex_r.nsf/WebView/1FA52449D0C2E45EC12588DE0029DD82/$File/813.20_2.5.11_119.pdf

31. Der Grosse Rat des Kantons Luzern. SRL Nr. 800a - Spitalgesetz - Systematische Rechtssammlung SRL - Kanton Luzern [Internet]. 2006 [cited 2026 Feb 18]. Available from: https://srl.lu.ch/app/de/texts_of_law/800a

32. Der Grosse Rat des Kantons Aargau. SAR 331.200 - Spitalgesetz - Kanton Aargau - Erlass-Sammlung [Internet]. 2003 [cited 2026 Feb 18]. Available from: https://gesetzessammlungen.ag.ch/app/de/texts_of_law/331.200

33. Der Kantonsrat Schaffhausen. SHR 813.100 - Spitalgesetz - Kanton Schaffhausen - Erlass-Sammlung [Internet]. 2004 [cited 2026 Feb 18]. Available from: https://rechtsbuch.sh.ch/app/de/texts_of_law/813.100

34. Homemonitoring und Hospital at Home [Internet]. Bern; 2024 [cited 2025 Aug 27]. Available from: https://www.parlament.ch/de/ratsbetrieb/suche-curia-vista/geschaeft?AffairId=20244339

35. Klinik Arlesheim. Medienmitteilung Kanton Basel-Landschaft unterstützt Pilotprojekt “Hospital at Home” [Internet]. 2023 [cited 2026 Jan 11]. Available from: https://www.klinik-arlesheim.ch/images/downloads/Medienmitteilung_HospitalatHome_21062023_V3.pdf

36. Klinik Arlesheim. Medienmitteilung Kanton Basel-Landschaft unterstützt Pilotprojekt “Hospital at Home” [Internet]. 2024 [cited 2024 Apr 19]. Available from: https://www.klinik-arlesheim.ch/images/downloads/Medienmitteilung_HospitalatHome_21062023_V3.pdf

37. Informationen – advantAGE [Internet]. [cited 2026 Jan 26]. Available from: https://advantage.nursing.unibas.ch/informationen-zu-advantage/

38. Schweizer Radio und Fernsehen (SRF) [Internet]. 2025 [cited 2026 Jan 8]. Baselland investiert Millionen in «Hospital at Home». Available from: https://www.srf.ch/news/schweiz/zu-hause-statt-im-spital-spitalbehandlung-zu-hause-baselbiet-baut-hospital-at-home-aus

39. Sitex. Contrat Sitex HAD Genève – Patient Lamal [Internet]. 2025 [cited 2026 Jan 17]. Available from: https://t7h8c5q5.delivery.rocketcdn.me/wp-content/uploads/2025/01/ilovepdf_merged-4.pdf

40. Kanton Bern. Gemeinsame Medienmitteilung des Spitalzentrums Biel (SZB), des Kantons Bern und der Einkaufsgemeinschaft HSK - Spitalzentrum Biel, Kanton Bern und Einkaufsgemeinschaft HSK spannen in der Ambulantisierung zusammen [Internet]. 2025 [cited 2026 Jan 20]. Available from: https://www.be.ch/de/start/dienstleistungen/medien/medienmitteilungen.html?8b1d0196-733d-442c-ba8b-c37b6f17fb1f

41. République et canton de Genève. Règlement fixant le tarif-cadre des prestations fournies par les pharmacies d’hospitalisation à domicile (RTCPHD) [Internet]. 1997 Sep 4. Available from: https://silgeneve.ch/legis/index.aspx

42. OECD. The Economic Benefit of Promoting Healthy Ageing and Community Care. OECD Health Policy Stud. 2025 Oct 7. doi:10.1787/0f7bc62b-en

43. Hat der Bundesrat die Risiken und Folgen des Konzepts “Hospital at Home” abgeschätzt? [Internet]. Bern; 2024 [cited 2025 Aug 29]. Available from: https://www.parlament.ch/de/ratsbetrieb/suche-curia-vista/geschaeft?AffairId=20243750

44. Scherler M, de Vocht A, Grampp M, Rohr D. Hospital at Home - A model with a future [white paper]. Deloitte; 2022.

45. Brecher AL, Urbanski-Rini D, Amelung V. Hospital@Home – Ein innovatives Versorgungskonzept für die Gesundheitsversorgung der Zukunft [Internet]. Röhn Stiftung; 2025 Nov [cited 2025 Nov 21]. Available from: https://www.rhoen-stiftung.de/wp-content/uploads/2025/11/RSt_Hospital@Home.pdf

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10. About this country profile

This country profile was developed as part of a research project on sustainable financing and reimbursement models for acute somatic care episodes that substitute hospitalization in Switzerland, funded by the second seed funding call of the Swiss Center for Care@home, Bern University of Applied Sciences. The project aims to inform the design of a Swiss-specific financing framework compatible with the upcoming EFAS reform (unified ambulatory-inpatient financing from 2028) by systematically mapping and comparatively analyzing international evidence on hospital-substituting acute somatic care at home implementation. Country selection was guided by criteria including: (i) high-income setting, (ii) documented hospital-substituting acute care at home implementation beyond isolated pilots where possible, (iii) sufficient publicly available information on governance and reimbursement arrangements, and (iv) relevance for Swiss policy (including relevance to a multi-payer system and decentralized governance). Information in this profile was developed via cross-country comparative policy mapping and documented in standardized tables with evidence notes. Evidence was compiled across (i) rapid scoping searches of PubMed/MEDLINE-indexed literature to identify country-specific descriptions of governance/regulation, financing and reimbursement, and implementation features; (ii) targeted country-specific grey literature (e.g., ministry/authority documents, tariff schedules, payer/provider materials, national reports) to verify and complete regulatory and reimbursement details; (iii) health-system context sources (e.g., OECD/WHO/World Bank/Commonwealth Fund) to interpret arrangements within each health-system setting, and (iv) expert input and validation. Extracted information was entered into a standardized country-profile template and synthesized within-country in (a) a narrative summary and (b) a regulatory–incentive framework with a derived traffic-light assessment for cross-country comparison. The overarching purpose was policy learning: to derive implications for the future development of Switzerland's hospital-substituting acute somatic care at home financing and reimbursement architecture. The profile reflects the status of financing and reimbursement as of January 2026 and focuses specifically on payment mechanisms, governance structures, and incentive alignment. For a review of clinical outcomes or cost-effectiveness, which fall outside the scope of this comparative analysis, consider the report by Brecher et al. (2025) (45).