People's Voice Survey in Switzerland

2025-2026

Emma Clarke-Deelder
Anna Duchenko
Günther Fink

Funded by the Swiss National Science Foundation, co-funded under the Transforming Health and Care Systems (THCS) partnership of EU Horizon Europe (GA No. 101095654)

THCS transforming health and care systems

QuEST Quality Evidence for Health System Transformation

Swiss TPH

Contacts

Swiss TPH
Kreuzstrasse 2
4123 Allschwil
Switzerland
www.swisstph.ch

Prof. Dr. Günther Fink
Senior Scientific Group Leader
Health and Development Economics
E-mail: guenther.fink@swisstph.ch

Disclaimer

The project has received funding from the Swiss National Science Foundation under the co-funded partnership of Transforming Health and Care Systems, THCS, (GA N◦101095654 of the EU HORIZON Europe Research and Innovation Programme)

The views and ideas expressed herein are those of the author(s) and do not necessarily imply or reflect the opinion of Swiss TPH or the European Commission. The European Commission is not liable for any use that may be made of the information herein.

Abbreviations

AAPHS	Adolescent and Adult Perspectives on Health System Performance in Switzerland
CHF	Swiss Francs
EKNZ	Ethics Committee of Northwest and Central Switzerland (Ethikkommission Nordwest- und Zentralschweiz)
FOPH	Federal Office of Public Health (Bundesamt für Gesundheit)
GDP	Gross Domestic Product
HMO	Health Maintenance Organisation
HQSS	High-Quality Health Systems
KVG/LAMal	Krankenversicherungsgesetz / Loi sur l'assurance-maladie (Federal Health Insurance Act)
OECD	Organisation for Economic Co-operation and Development
PVS	People's Voice Survey
QuEST	Quality Evidence for Health System Transformation
SNSF	Swiss National Science Foundation
Swiss TPH	Swiss Tropical and Public Health Institute
THCS	Transforming Health and Care Systems
WHO	World Health Organisation

Executive Summary

The People's Voice Survey (PVS) measures health system performance from the perspective of the population, including health needs, healthcare use and experience, perceived quality, affordability and confidence in the health system. To date, the PVS has been implemented globally in more than 25 countries.[1,2] This report presents findings from the first PVS conducted in Switzerland, implemented in 2025/26 by the Swiss Tropical and Public Health Institute (Swiss TPH) as part of an EU-funded project titled *Adolescent and Adult Perspectives on Health System Performance in Switzerland* (AAPHS).

Switzerland has one of the best-resourced health systems in the world, but high and rising premiums place a substantial financial burden on households, and the increasing diversity of the population may require adaptation to ensure the health system serves all needs.

As part of the 2025/26 Swiss PVS survey, we interviewed a nationally representative sample of the Swiss population as well as representative samples of recent migrants from Afghanistan, Eritrea, and Ukraine. Data were collected via an online panel (1,749 responses) and a mail-based survey (1,049 responses). The sample included adolescents aged 15-19 as well as adults aged 20 and above.

Key findings include:

- **High confidence in receiving quality care:** Confidence in the health system's ability to provide quality care was high. Most Swiss respondents were confident that they would receive quality care if seriously ill, with confidence highest in the French-speaking region (87.1%), followed closely by the German-speaking region (86.3%), and lower in the Italian-speaking region (75.1%). Confidence was similarly high among migrant populations, ranging from 78.9% among Ukrainian respondents to 85.6% among Afghan respondents.

- **Affordability concerns:** Confidence in the ability to afford quality care if seriously ill was substantially lower than confidence in receiving quality care and varied considerably across language regions: 72.0% of respondents in German-speaking Switzerland were confident they could afford such care, compared with only 51.3% in the French-speaking region and 51.6% in the Italian-speaking region. Financial barriers were also evident in reported experiences: 5.4% of Swiss respondents had borrowed money to afford healthcare in the previous 12 months. Among migrant populations, healthcare-related borrowing was higher at 8.7% overall, reaching 14.9% among Afghan respondents.

- **Gaps in insurance literacy and navigation:** Knowledge of key insurance principles was generally high among Swiss respondents. Knowledge and awareness of personal insurance arrangements were substantially lower among migrant populations: more than half could not report their own deductible, and many were unable to identify their insurance access model, indicating important challenges in navigating the Swiss health insurance system.

- **Uneven preventive care coverage:** Uptake of preventive services varied substantially by type of service and across language regions. In the Swiss national sample, coverage was highest for dental examinations (68.6%) and blood-pressure checks (63.7%), while fewer than half reported a general health check-up (43.8%), blood sugar testing (33.4%), cholesterol testing (32.9%), or mammography (29.6%) in the past 12 months (among those

[1] Kruk ME, Lewis TP. Introduction to The Lancet Global Health's Series on the People's Voice Survey on Health System Performance. *Lancet Glob Health*. 2024;12(1):e14–e15. doi:10.1016/S2214-109X(23)00512-0.

[2] Lewis TP, Roder-DeWan S, Malata A, et al. Measuring people's views on health system performance: design and development of the People's Voice Survey. *PLoS Med*. 2023;20(10):e1004294. doi:10.1371/journal.pmed.1004294

eligible for each type of care). Particularly pronounced regional differences were observed for mammography: coverage among women 50 and older was 22.8% in German-speaking Switzerland, compared with 46.8% in French-speaking and 53.4% in Italian-speaking Switzerland, highlighting important variation in preventive care uptake across the country. Marked regional differences were also observed in general health check-up coverage, which was substantially lower in German-speaking Switzerland (35.3%) than in the French-speaking (66.9%) and Italian-speaking (54.6%) regions.

- **High mental health burden and gaps in mental healthcare**: In the Swiss population, 10.4% rated their mental health as "poor" or "not so good", with the burden particularly high among adults aged 20–39 (18.5%). At the same time, 5.8% reported an unmet need for mental healthcare in the previous 12 months. Mental health burden was even higher among Ukrainian respondents, 25.7% of whom rated their mental health as "poor" or "not so good", Only 32.2% of Swiss respondents rated the quality of mental health services highly ("very good" or "excellent"). Among all health services assessed, mental health services got by far the lowest ratings.

- **Gaps in adolescent health and responsive care for adolescents**: Although adolescents aged 15–19 generally reported good physical health, 22.6% reported a longstanding health condition, and 11.1% rated their mental health as "poor" or "not so good". Adolescent healthcare experiences were somewhat less positive than those of adults, particularly regarding involvement in decisions, sufficient provider time, and privacy. Discussions of adolescent-specific health issues with providers were limited: mental health was discussed with 35.6%, sexual health with 23.8%, bullying with 9.1% and physical violence with 5.3%. While 70.1% of adolescents reported having a provider with whom they could speak confidentially, only 54.9% had spoken with a provider without a parent or guardian in the previous year. When asked what services or changes they would like to see, adolescents highlighted better access to mental health services, including more age-appropriate psychological and psychiatric support, greater affordability and insurance coverage, and more timely and responsive healthcare.

- **Unmet healthcare needs:** Among Swiss respondents, 15.8% reported having needed care but not received it in the past 12 months, The same was true for 5.8% in mental health. Among migrant populations, the corresponding proportions were 12.7% for physical healthcare and 3.6% for mental healthcare, with the highest reported gap in physical healthcare among Ukrainian respondents (14.2%).

- **Views on reform and public responsiveness:** Views on the health system reform varied across population groups. Overall, 44.6% of Swiss respondents considered major changes necessary, while 5.4% favored more fundamental restructuring. Younger adults expressed a greater preference for change: among those aged 20–39, 48.2% supported major changes, while 69.7% of respondents aged 65-79 felt the system worked well and required only minor changes. Perceived need for reform was highest in the Italian-speaking region, where 60.8% of respondents favoured major changes, compared with 40.8% in German-speaking Switzerland. Confidence that the government considers public opinion in healthcare decision-making was low, ranging from 24.6% (Italian-speaking) to 39.9% (German speaking).

Table of Contents

Contacts 1

Disclaimer 1

Abbreviations 2

Executive Summary 3

1. Introduction and Background 3

1.1 Switzerland: country context 3

1.2 The Swiss healthcare system 3

1.3 Conceptual framework 4

2. Survey Objectives 4

3. Research Methods 6

3.1 Study design 6

3.2 Study population and sampling 6

3.3 Sample size and response 6

3.4 Survey instrument 7

3.5 Statistical analysis 7

4. Sample Characteristics 7

5. Survey Results 9

5.1 Self-assessed health 9

5.1.1 General health 9

5.1.2 Mental health 11

5.1.3 Reporting longstanding disease 14

5.2 Health insurance 15

5.2.1 Insurance knowledge 15

5.2.2 Primary care model choice 17

5.2.3 Monthly premiums 18

5.2.4 Deductible choices 19

5.2.5 Supplemental insurance 21

5.3 Patient activation 22

5.4 System competence: preventive care, quality of care, and adverse experiences 23

5.4.1 Preventive care coverage 23

5.4.2 Care utilisation and quality of usual care 26

5.4.3 Quality of most recent visit 30

5.4.4 Perceived quality of specific services 34

5.4.5 Adverse experiences, unmet need and affordability 35
5.5 Health system confidence 38
5.6 Overall health system assessment 40
6. Summary and Discussion 43
6.1 Health status and equity 43
6.2 Insurance system complexity and equity 44
6.3 Access and utilisation of care 44
6.4 Preventive care and system competence 45
6.5 Health system confidence and reform views 46
6.6 Migrant inclusion and health-system navigation 47
6.7 Adolescent health and adolescent-responsive care 48
6.8 Strengths and limitations 49
6.9 Conclusions and policy recommendations 49

1. Introduction and Background

1.1 Switzerland: country context

Switzerland holds one of the top positions globally both with respect to population health and health systems resources. Life expectancy is 84.3 years, more than three years above the OECD average, while preventable and treatable mortality are among the lowest in OECD countries. These outcomes, however, come with high resource use: Switzerland spends 11.8% of GDP on healthcare, compared with an OECD average of 9.3%, making the performance and sustainability of the system important policy concerns. [3]

Financial protection is a particular challenge. Only 68% of health expenditure is covered through mandatory prepayment, below the OECD average of 75%. Households have to cope with often substantial insurance premiums and face additional out-of-pocket expenditures due to deductibles, co-payments as well as services not covered by insurance.[3] Rising and unequally distributed healthcare expenditure and insurance premiums have become prominent policy concerns. The Federal Council's Health2030 strategy identifies affordability, health inequalities and the financial sustainability of high-quality healthcare among the major challenges facing the Swiss health system[4].

At the same time, Switzerland is an increasingly diverse society, with approximately 27% of the resident population holding foreign nationality.[5] In 2025, approximately 165,000 foreign nationals moved to Switzerland: 73% were from EU/EFTA countries, 7% were from European third countries, and 20% were from other third countries.[6] There were approximately 25,000 asylum applications, with the largest numbers from Afghanistan, Eritrea, and Turkey. In addition, following the outbreak of war in Ukraine in 2022, a large number of displaced Ukrainians have received Protection Status S in Switzerland.[7] Ensuring that a decentralised and complex healthcare system remains accessible and responsive to people with different socioeconomic circumstances, languages, healthcare needs and levels of familiarity with the system is therefore an important dimension of health-system performance.

1.2 The Swiss healthcare system

Switzerland has a decentralised health system in which responsibilities are shared between the federal government, cantons, municipalities and citizens. The Federal Health Insurance Act (KVG/LAMal) requires residents to obtain compulsory basic health insurance from an authorised

[3] OECD. *Health at a Glance 2025: OECD Indicators*. Paris: OECD Publishing; 2025. doi:10.1787/8f9e3f98-en. Available from: https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025_a894f72e.html

[4] Swiss Federal Council. Health2030: the Federal Council's health policy strategy for the period 2020–2030 [Internet]. Bern: Swiss Confederation; 2019 [cited 2026 Sep 10]. Available from: https://www.bag.admin.ch/en/the-federal-councils-health-policy-strategy-20202030

[5] Federal Statistical Office (FSO). Population and households statistics (STATPOP): permanent resident population by citizenship [Internet]. Neuchâtel: Federal Statistical Office; 2024 [cited 2026 Sep 10].Available from: https://www.bfs.admin.ch/bfs/en/home/statistics/population/surveys/statpop.html

[6] State Secretariat for Migration (SEM). Migration Report 2025. Bern-Wabern: State Secretariat for Migration [cited 2026 Sep 18]. Available from: http://www.migration.swiss.

[7] State Secretariat for Migration (SEM). Foreign population and asylum statistics 2023 [Internet]. Bern-Wabern: State Secretariat for Migration; 2024 [cited 2026 Sep 10]. Available from: https://www.sem.admin.ch/sem/de/home/publiservice/statistik/asylstatistik/archiv/2024.html

insurer.[8] The benefits covered by basic insurance are defined nationally and are the same across insurers, including outpatient and inpatient treatment, prescribed medicines and specified preventive services. Premiums vary by insurer, place of residence, age group, insurance model and deductible, while premium subsidies are available to reduce the financial burden for eligible households.

A distinctive feature of the Swiss system is the considerable choice available to insured individuals. In addition to the standard insurance model with free choice of provider, policyholders can choose alternative models such as family doctor, HMO or telemedicine models, which generally restrict the first point of contact in return for lower premiums. Adults can also choose an annual deductible ranging from CHF 300 to CHF 2,500, with higher deductibles associated with lower premiums. After the deductible is reached, patients generally pay 10% of additional costs up to an annual maximum of CHF 700, alongside a contribution for inpatient hospital stays. These arrangements give individuals substantial choice but also require them to understand and navigate different insurance and access options.

Primary care is predominantly provided by office-based general practitioners and group practices and plays an important role in coordinating access to other healthcare services, particularly under family doctor and HMO models. Specialist care is provided in both outpatient and hospital settings. Voluntary supplementary insurance is also available for services or amenities beyond compulsory insurance. Overall, the system combines universal compulsory coverage with decentralised governance, substantial consumer choice and relatively high levels of individual cost-sharing.

1.3 Conceptual framework

The PVS is inspired by the key principles of health systems proposed by the Lancet Commission on High-Quality Health Systems (HQSS Commission): (1) health systems are for people; (2) people should be able to receive good quality, respectful care within their country's resource capacity; and (3) high-quality care should be the raison d'être of health systems.[9] The HQSS framework motivates the research objectives, focusing on people (foundations), user experience (process of care), and the resulting confidence (outcome quality measure) in health systems among both users and non-users.

2. Survey Objectives

The overall aim of PVS Switzerland was to describe and compare the perceptions and experiences of the Swiss healthcare system among the general adult and adolescent population and among high-needs groups (recent migrants), and to measure inequities in health system perceptions and experiences.

More specifically, we aimed to:

1. Describe health system utilisation patterns, user satisfaction, user experience, and confidence in the Swiss healthcare system across the general adult population, adolescents, and recent migrants;

[8] Swiss Confederation. Federal Act of 18 March 1994 on Health Insurance (KVG/LAMal), SR 832.10 [Internet]. Bern: Swiss Confederation; 1994 [cited 2026 Sep 10]. Available from: https://www.fedlex.admin.ch/eli/cc/1995/1328_1328_1328/fr?version=20251231&utm_source=

[9] Kruk, Margaret E., Muhammad Pate, and Zoë Mullan. "Introducing the Lancet Global Health Commission on high-quality health systems in the SDG era." The Lancet Global Health 5.5 (2017): e480-e481.

2. Compare perspectives on healthcare services among different population groups, including by language region, age, gender, and educational attainment;
3. Document inequities in utilisation, satisfaction, experience, and health system confidence, with particular attention to adolescents and recent migrants from Afghanistan, Eritrea, and Ukraine; and
4. Identify key areas for intervention to improve health outcomes for all population groups.

3. Research Methods

3.1 Study design

We conducted a nationally representative cross-sectional survey of the Swiss population aged 15 and older and also interviewed representative samples of recent migrants from Afghanistan, Eritrea and Ukraine. The study protocol was reviewed by the Ethics Committee of Northwest and Central Switzerland (EKNZ). The survey was conducted in 2025 and 2026 and was part of the international QuEST (Quality Evidence for Health System Transformation) Network's People's Voice Survey programme, which enables cross-country comparisons of health system performance from the population perspective.

3.2 Study population and sampling

The survey targeted three distinct population groups:

- Adolescents (aged 15-19) and adult (aged 20+) residents in Switzerland, sampled through an online panel managed by YouGov Switzerland (formerly LINK online panel); a small subsample of the general population (aged 15+) was also recruited through the mail survey to allow assessment of potential survey modality effects.
- Recent migrants – arriving between 2015 and 2024 in Switzerland, aged 15+ from Afghanistan, Eritrea, and Ukraine, sampled through a mail-based survey using address lists obtained from the Federal Statistical Office.

The survey was conducted in eight languages: German, French, Italian, Ukrainian, Dari, Pashto, Tigrinya, and English, to ensure accessibility across all target groups.

3.3 Sample size and response

We collected 2,798 surveys: 1,749 through the online panel and 1,049 through the mail survey, including 810 respondents from the three migrant populations.

Table 1. Sample size and survey distribution (unweighted)

Group	Letters sent / Panel	Completed	Response rate
Swiss – Online panel	—	1,749	—
Swiss – Mail survey	1,000	239	23.9%
Afghanistan – Mail survey	1,317	286	21.7%
Eritrea – Mail survey	1,317	175	13.3%
Ukraine – Mail survey	1,297	349	26.9%
Total	—	2,798	—

Response rates for the mail survey were lower than anticipated (we had assumed 30% participation), particularly for the Eritrean sample (13.3%). We sent two reminder letters to all participants not responding to our first invitation, but uptake remained relatively low. For the Eritrean population, several factors contributed to the exceptionally low participation rates, including limited literacy, lack of familiarity with study languages and lack of trust in authorities.

3.4 Survey instrument

The PVS questionnaire covers the following domains: general and mental health status; healthcare utilisation patterns; usual source of care; user experience during the most recent health visit; coverage of preventive care services; health insurance choices; affordability of care; health system confidence; and overall assessment of the health system. The Swiss version included additional questions specific to the Swiss insurance system, including the respondent's chosen deductible level and supplemental insurance holdings. A validated translation and back-translation process was followed for all non-English language versions.

3.5 Statistical analysis

Descriptive statistics are presented as proportions and means with 95% confidence intervals. Post-stratification weights were applied to the Swiss national sample estimates to align the sample with national demographic characteristics (age, gender, language region). For the migrant sample, weights were applied to make the sample population representative of all migrants from Afghanistan, Eritrea and Ukraine arriving in Switzerland between 2015 and 2024. All following tables use these weights, which means that reported averages should reflect behaviors and attitudes of the targeted populations.

4. Sample Characteristics

Table 2 presents the demographic characteristics of the weighted Swiss national sample (N=1,988) and migrant subsample (N=805). In the national sample, the largest age group was 40–64 years (44.0%), followed by those aged 20–39 years (31.7%) and 65–79 years (16.3%), while participants aged 15–19 years represented 7.3% and those aged 80 years or older 0.7%. The weighted sample was evenly distributed by gender, with 50.0% male and 50.0% female participants. Regarding educational attainment, 39.5% had secondary or vocational education, 29.8% had higher education, 16.3% had completed Grade 10 or less, and 14.3% were still in school. Among participants with available employment information, 38.8% worked full-time, 33.5% worked part-time, and 27.7% were not working for pay. The income distribution was relatively balanced, with 51.1% reporting an annual income of CHF 75,000 or less and 48.9% reporting an income above CHF 75,000. Across the national sample, 71.7% were from the German-speaking region, 24.2% from the French-speaking region, and 4.0% from the Italian-speaking region. The weighted migrant subsample included participants from Ukraine (N=526), Afghanistan (N=202), and Eritrea (N=77), with broadly similar distributions across linguistic regions.

Table 2a. Sample demographic characteristics

	German	French	Italian
Swiss national sample (N=1,988, weighted)[a] **%**			
	71.7%	24.2%	4.0%
Age group			
Age 15-19	71.9%	22.6%	5.5%
Age 20-39	72.2%	23.7%	4.2%
Age 40-64	70.9%	25.2%	3.9%

	German	French	Italian
Age 65-79	73.7%	22.9%	3.4%
Age 80+	56.2%	38.9%	4.9%
Gender			
Male	71.6%	24.3%	4.1%
Female	71.8%	24.2%	3.9%
Educational attainment			
Grade 10 or less	71.9%	26.1%	2.1%
Secondary/vocational	68.8%	26.5%	4.7%
Higher education	74.4%	21.5%	4.1%
Still in school	73.9%	21.7%	4.4%
Employment status			
Full-time (100%)	72.6%	23.2%	4.2%
Part-time (<100%)	76.8%	20.7%	2.6%
Not working for pay	65.1%	29.5%	5.3%
Income group[b]			
Income ≤ CHF 75,000	67.6%	27.3%	5.1%
Income > CHF 75,000	78.3%	19.7%	2.0%
Migrant subpopulations (N=805, weighted)[c]			
Subpopulation			
Afghanistan	67.7%	28.6%	3.7%
Eritrea	66.7%	29.6%	3.7%
Ukraine	66.5%	27.8%	5.7%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Income information was only provided by 1,162 Swiss respondents.

[c] Weights for the migrant subsample are based on the total migrant populations from Afghanistan, Eritrea and Ukraine living in Switzerland.

Table 2b. Migrant subpopulations demographic characteristics

	Afghanistan	Eritrea	Ukraine	Total migrant subsample
Migrant subpopulations (N=805, weighted)[a]				
%[b]				
	25.0%	9.6%	65.4%	100.0%
Age group				
Age 15-19	18.4%	29.1%	15.4%	17.5%
Age 20-39	47.2%	34.2%	28.3%	33.6%
Age 40-64	24.0%	28.9%	41.3%	35.8%
Age 65-79	10.3%	7.8%	13.3%	12.1%
Age 80+	0.0%	0.0%	1.7%	1.1%

	Afghanistan	Eritrea	Ukraine	Total migrant subsample
Gender				
Male	70.6%	40.0%	32.9%	43.0%
Female	29.4%	60.0%	67.1%	57.0%
Educational attainment				
Grade 10 or less	30.4%	22.6%	2.1%	11.2%
Secondary/vocational	12.3%	15.9%	4.3%	7.4%
Higher education	20.8%	24.9%	75.5%	57.0%
Still in school	36.4%	36.5%	18.0%	24.4%
Employment status				
Working for pay full time (100%)	30.2%	40.4%	17.7%	22.7%
Working for pay part-time (less than 100%)	15.3%	17.4%	19.6%	18.4%
Not working for pay	54.5%	42.2%	62.7%	58.9%
Income group [c]				
Income <= 75k	97.2%	93.8%	88.2%	90.1%
Income > 75k	2.8%	6.2%	11.8%	9.9%

[a] Weights for the migrant subsample are based on the total migrant populations from Afghanistan, Eritrea and Ukraine living in Switzerland.

[b] Percentages represent the distribution within each migrant subpopulation (column percentages).

[c] Income was reported by 335 migrant participants: 85 Afghans, 62 Eritreans, 188 Ukrainians

5. Survey Results

5.1 Self-assessed health

5.1.1 General health

Respondents were asked to rate their general health on a five-point scale from “poor” to “excellent.” Table 3 presents self-reported general health status by demographic group and subpopulation.

Table 3. General health status

	Poor	Not so good	Good	Very good	Excellent	Total
Swiss national sample (N=1,976)[a]						
%						
	1.0%	10.2%	44.9%	31.9%	12.0%	100.0%
Age group						
Age 15-19	0.4%	4.4%	27.0%	45.8%	22.4%	100.0%
Age 20-39	0.6%	8.2%	37.2%	33.8%	20.2%	100.0%
Age 40-64	1.1%	12.1%	47.5%	31.4%	7.8%	100.0%
Age 65-79	1.8%	10.8%	59.5%	24.6%	3.3%	100.0%

	Poor	Not so good	Good	Very good	Excellent	Total
Age 80+	0.0%	28.6%	71.4%	0 (0.0%)	0.0%	100.0%
Gender						
Male	0.9%	7.4%	43.5%	33.4%	14.9%	100.0%
Female	1.2%	13.0%	46.3%	30.4%	9.2%	100.0%
Educational attainment						
Grade 10 or less	1.8%	13.4%	50.2%	19.7%	14.9%	100.0%
Secondary/vocational	1.2%	13.6%	48.4%	28.4%	8.4%	100.0%
Higher education	0.8%	6.6%	42.3%	38.5%	11.9%	100.0%
Still in school	0.1%	4.4%	34.8%	41.6%	19.1%	100.0%
Income group						
Income ≤ CHF 75,000	1.2%	13.7%	53.6%	23.9%	7.6%	100.0%
Income > CHF 75,000	0.4%	7.6%	37.5%	38.0%	16.5%	100.0%
Language region						
German	0.5%	10.9%	43.7%	32.2%	12.7%	100.0%
French	2.2%	8.3%	47.3%	31.4%	10.7%	100.0%
Italian	3.0%	8.5%	50.9%	29.7%	7.9%	100.0%
Migrant subpopulations (N=788)[b]						
Subpopulation						
Afghanistan	4.2%	11.4%	40.3%	22.2%	22.0%	100.0%
Eritrea	1.9%	8.7%	41.3%	32.3%	15.8%	100.0%
Ukraine	2.5%	26.3%	50.2%	12.1%	8.8%	100.0%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

In the Swiss national sample, 44.9% rated their health as “good” and 43.9% as “very good” or “excellent”, while 11.2% reported “poor” or “not-so-good” health. Self-rated health generally declined with age, with “very good” or “excellent” health reported by 68.2% of participants aged 15–19 years, compared with 27.9% among those aged 65–79 years. Men reported “very good” or “excellent” health more frequently than women (48.3% vs. 39.6%) (*see Fig. 1*). More favourable health ratings were also observed among participants with higher educational attainment and those still in school, while differences between linguistic regions were relatively small.

Greater variation was observed across migrant subpopulations. “Very good” or “excellent” health was reported by 48.1% of Eritrean and 44.2% of Afghan participants, compared with 20.9% of Ukrainian participants. Conversely, 28.8% of Ukrainian participants rated their health as “poor” or “not so good”, compared with 15.6% of Afghan and 10.6% of Eritrean participants. Overall, Ukrainian participants reported less favourable general health than the Swiss national sample, whereas health ratings among Afghan and Eritrean participants were broadly comparable to those observed in the national sample.

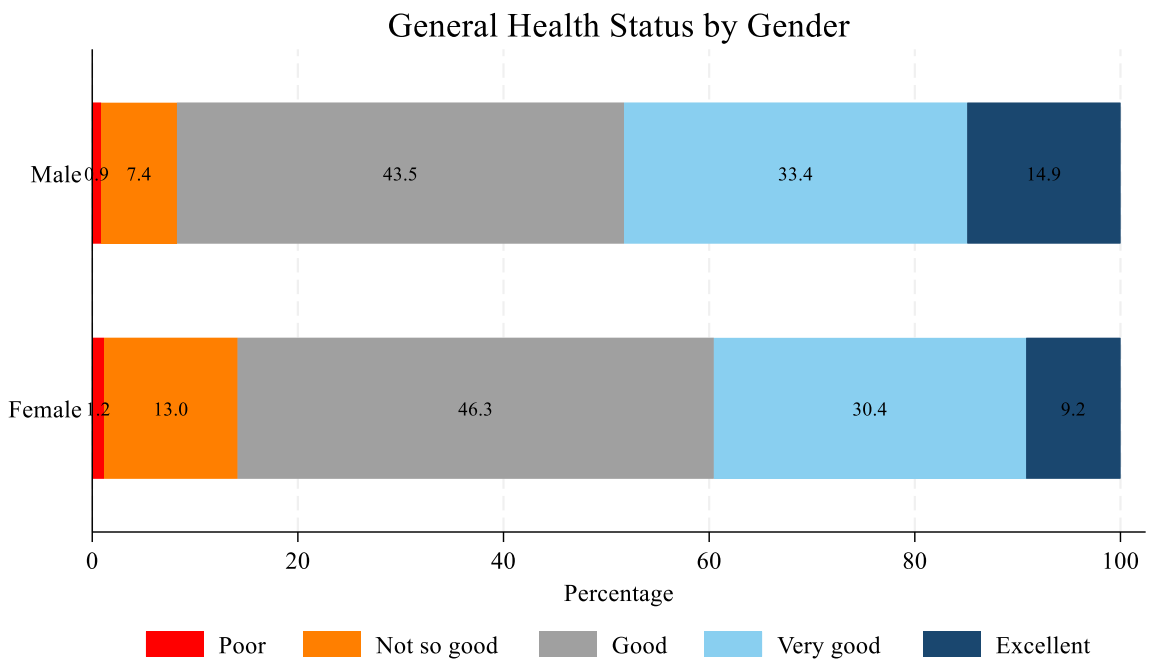


Figure 1. General health status by gender, Swiss national sample

5.1.2 Mental health

Table 4 summarises self-rated mental health status. Overall, mental health ratings in the Swiss national sample were positive, with 57.6% of participants reporting "very good" or "excellent" mental health and 32.0% reporting "good" mental health. Approximately one in ten participants (10.4%) rated their mental health as "poor" or "not so good" – this was most common in the 20-39 age group (18.5%) followed by the adolescents (11.1%) and least common among ages 80+, where no response below "good" was received (Figure 2). Differences were also observed by gender: women were less likely than men to report "very good" or "excellent" mental health (51.3% vs. 63.8%).

Table 4. Mental health status

	Poor	Not so good	Good	Very good	Excellent	Total
Swiss national sample (N=1,972)[a]						
%	1.3%	9.1%	32.0%	38.4%	19.2%	100.0%
Age group						
Age 15-19	1.4%	9.7%	29.5%	30.5%	28.9%	100.0%
Age 20-39	3.2%	15.3%	31.3%	31.1%	19.2%	100.0%
Age 40-64	0.3%	7.5%	31.5%	42.8%	18.0%	100.0%
Age 65-79	0.2%	2.1%	34.3%	44.8%	18.6%	100.0%
Age 80+	0.0%	0.0%	76.9%	23.1%	0.0%	100.0%

	Poor	Not so good	Good	Very good	Excellent	Total
Gender						
Male	0.4%	7.3%	28.5%	41.0%	22.8%	100.0%
Female	2.2%	10.9%	35.6%	35.8%	15.5%	100.0%
Educational attainment						
Grade 10 or less	1.9%	12.7%	32.1%	41.0%	12.3%	100.0%
Secondary/vocational	1.1%	8.7%	34.2%	36.7%	19.3%	100.0%
Higher education	0.4%	6.5%	28.1%	41.8%	23.1%	100.0%
Still in school	2.9%	11.8%	33.8%	33.1%	18.4%	100.0%
Income group						
Income ≤ CHF 75,000	1.3%	11.5%	40.8%	31.8%	14.6%	100.0%
Income > CHF 75,000	0.5%	6.3%	23.9%	43.7%	25.6%	100.0%
Language region						
German	1.1%	8.6%	30.9%	39.2%	20.2%	100.0%
French	1.5%	11.2%	34.0%	36.6%	16.7%	100.0%
Italian	2.8%	6.0%	40.0%	35.6%	15.5%	100.0%
Migrant sub-populations (N=785)[b)]						
Subpopulation						
Afghanistan	4.2%	11.0%	37.7%	24.9%	22.2%	100.0%
Eritrea	0.0%	4.0%	38.9%	32.5%	24.6%	100.0%
Ukraine	1.9%	23.8%	47.8%	15.3%	11.3%	100.0%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

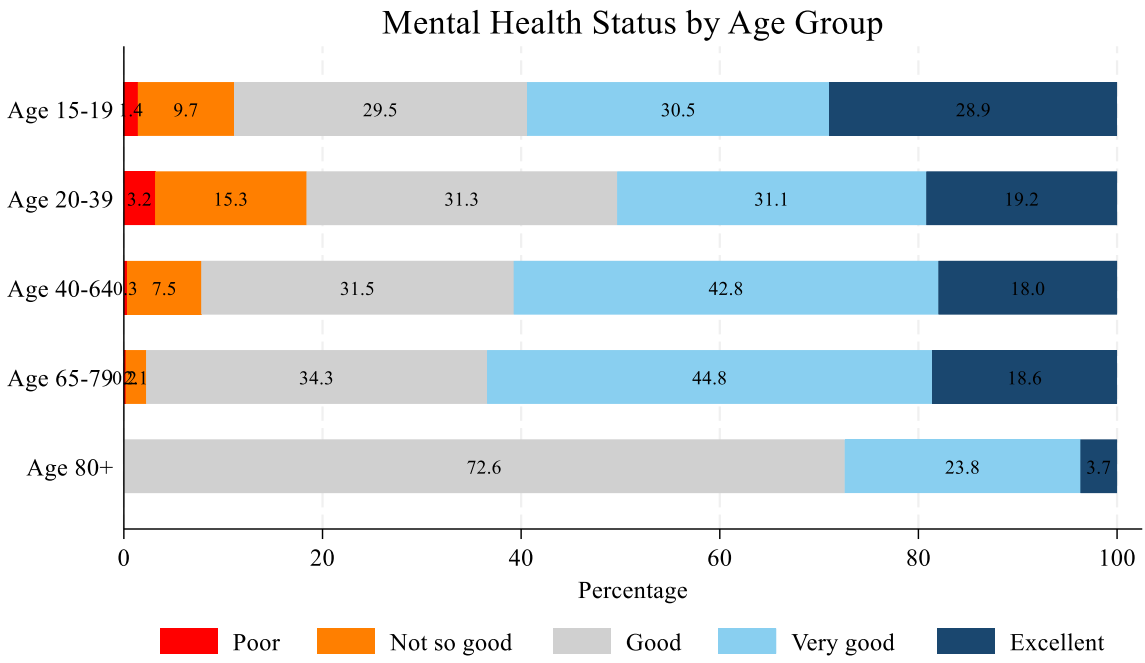


Figure 2. Mental health status by age group, Swiss national sample

Within Switzerland, the German-speaking region showed the most favourable ratings, with the highest proportion reporting "very good" (39.2%) or "excellent" mental health (20.2%). The French-speaking region had the highest share of respondents (12.7%) rating their own mental health as "not so good" or "poor" *(see Fig. 3)*.

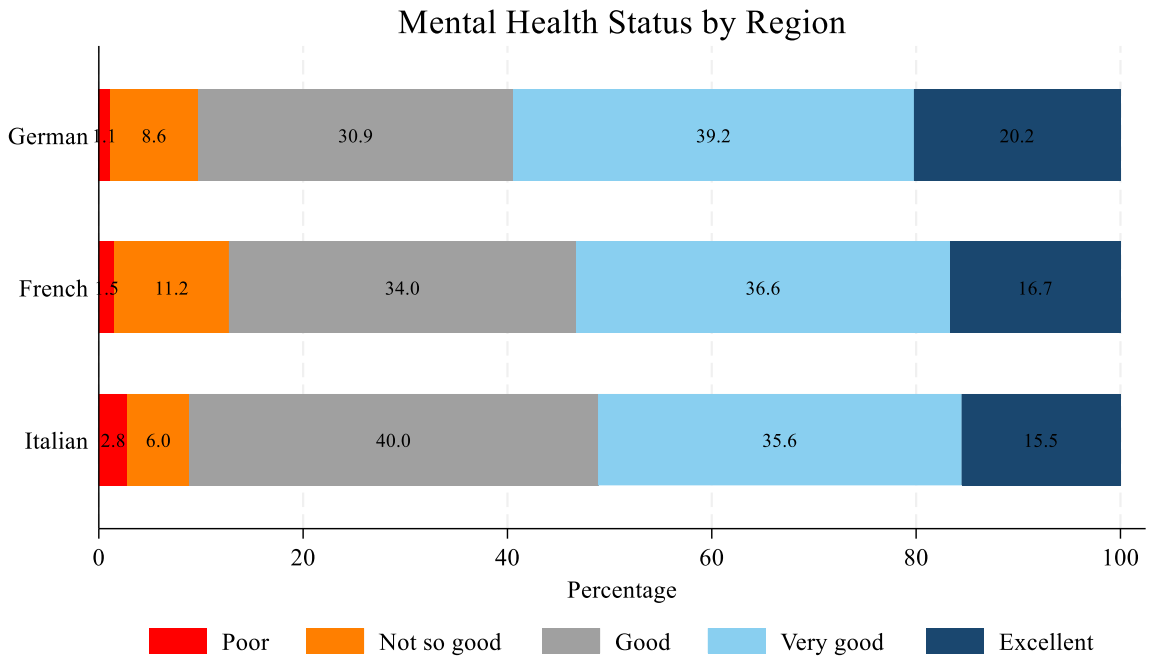


Figure 3. Mental health status by language region, Swiss national sample

There were striking differences in mental health status across migrant subpopulations *(see Fig. 4)*. Ukrainian migrants reported markedly poorer mental health than other groups, with nearly 26% rating their mental health as "not so good" or "poor" — more than double the rate in the Swiss general population (10.4%). Eritrean respondents reported the best mental health of the migrant groups, with 57.1% rating their mental health as "very good" or "excellent".

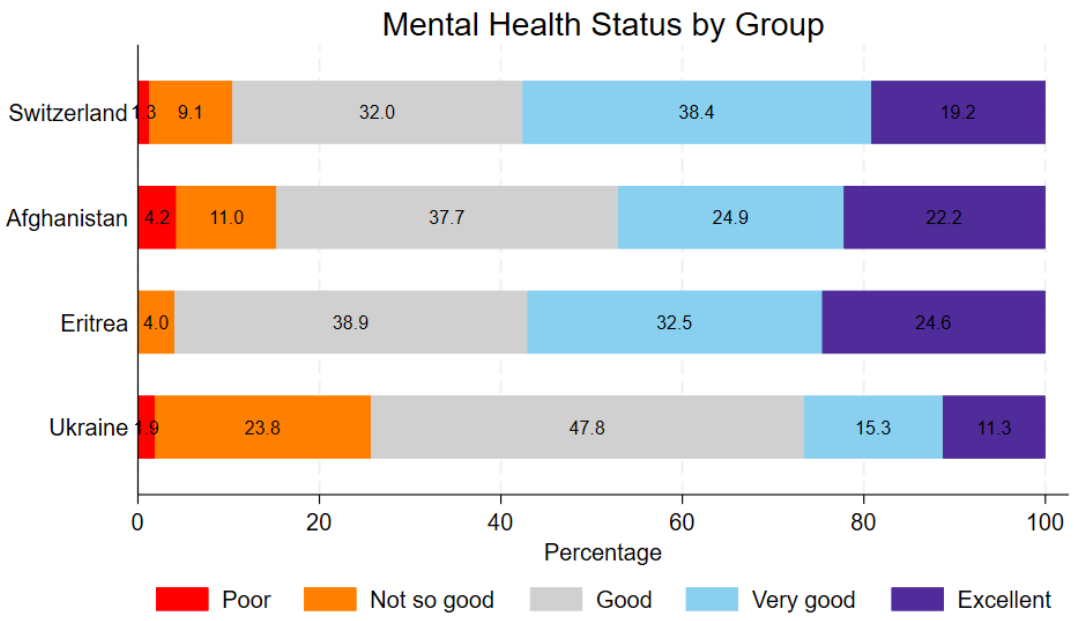


Figure 4. Mental health status by subpopulation

Self-rated mental health was highest among respondents with completed higher education, and lowest among respondents still in school *(see Fig. 5)*.

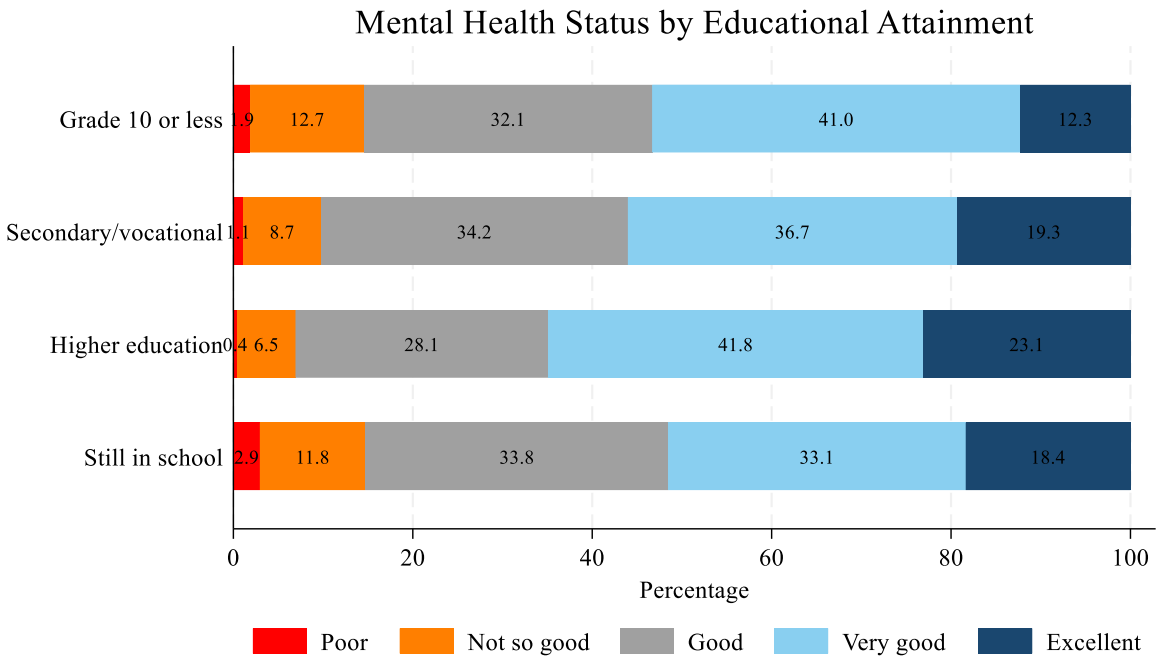


Figure 5. Mental health status by educational attainment, Swiss national sample

5.1.3 Reporting longstanding disease

We also asked respondents to report having longstanding disease, defining later as "llness, health problem, or mental health problem which has lasted or is expected to last for six months or more" (*see Fig. 6*). Overall, the proportion reporting a longstanding condition varied across age groups, from 22.6% among adolescents aged 15–19 to 53.8% among those aged 80 years and older. Around one-third of respondents aged 20–79 reported a longstanding condition (31.0–35.1%). Notably, more

than one in five adolescents reported a longstanding condition. While this was the lowest proportion across the age groups, it is nevertheless relatively high for adolescents, who are generally considered a population with good physical health.

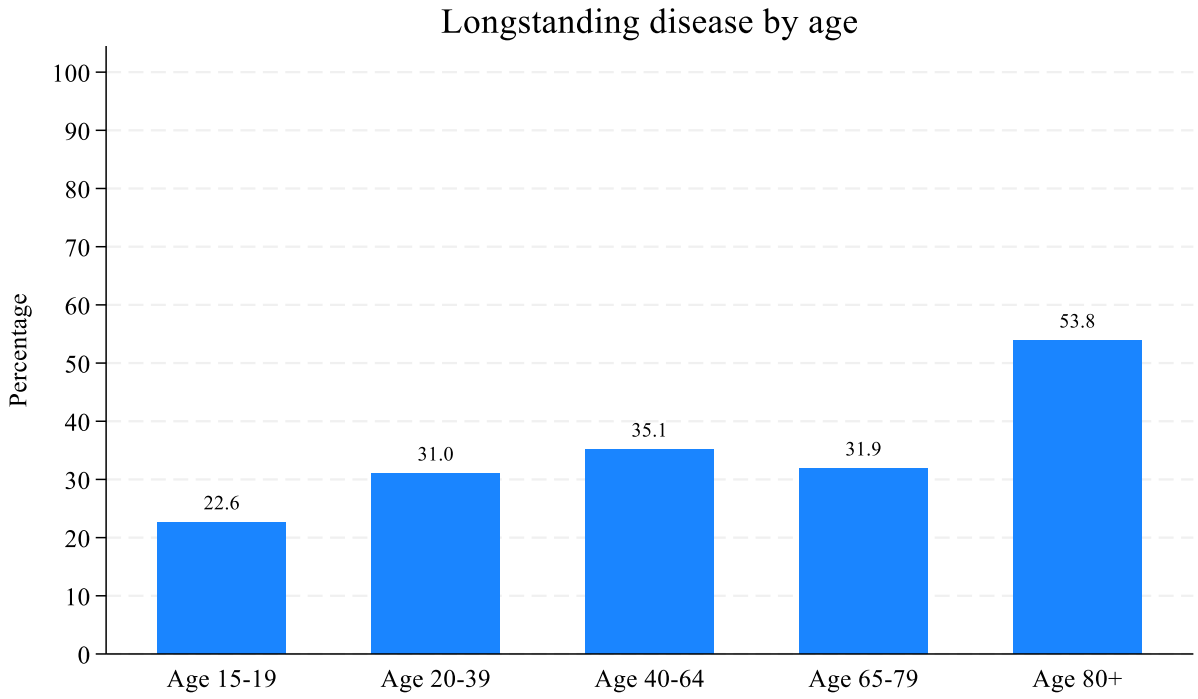


Figure 6. Having longstanding disease by age, Swiss national sample

5.2 Health insurance

Given that Switzerland's health insurance system is among the most complex in the world — and that insurance choices directly affect both access to care and financial exposure — the PVS included a dedicated module on insurance knowledge, primary care model choice, premium levels, deductible choices, and supplemental insurance holdings.

5.2.1 Insurance knowledge

Respondents aged 20 years and older were asked four *true/false* questions to assess their understanding of key features of the Swiss insurance system. Table 5 shows the proportion answering each question correctly (respondents who said "not sure" were coded as incorrect). These questions were not posed to adolescents because they rarely have to choose their own insurance plans.

The four questions tested knowledge of: (1) whether choosing a higher deductible leads to lower monthly premiums (true); (2) whether the standard "free choice" model has lower premiums than the family doctor model (false —models with family doctors as first access point are cheaper); (3) whether one saves money by choosing the highest deductible if one stays healthy for the full year (true); and (4) whether the HMO model prohibits use of emergency services without first contacting the HMO (false — emergency care is always accessible).

Table 5. Proportion of respondents answering insurance knowledge questions correctly

	1. Higher deductible = lower premium	2. Standard model NOT cheapest	3. Save with max deductible if healthy	4. Emergency always accessible
Swiss national sample (N=1,419)[a]				
% of correct responses	89.8%	74.8%	89.8%	52.5%
Age group				
Age 20-39	76.8%	47.3%	68.9%	53.3%
Age 40-64	85.9%	68.9%	89.6%	46.2%
Age 65-79	93.0%	80.6%	91.1%	60.2%
Age 80+	89.6%	73.2%	87.9%	45.2%
Gender				
Male	89.8%	73.9%	91.7%	52.8%
Female	89.7%	75.7%	87.9%	52.2%
Educational attainment				
Grade 10 or less	83.1%	62.8%	89.0%	37.5%
Secondary/vocational	92.3%	78.6%	89.1%	53.1%
Higher education	92.3%	80.0%	93.8%	60.3%
Still in school	82.5%	62.2%	81.5%	48.9%
Income group				
Income ≤ CHF 75,000	88.8%	72.9%	87.9%	49.2%
Income > CHF 75,000	93.2%	81.8%	95.0%	59.9%
Language region				
German	91.6%	76.7%	91.3%	59.7%
French	85.7%	69.3%	85.8%	33.3%
Italian	81.5%	74.2%	87.0%	40.3%
Migrant subpopulation (N = 810)[b]				
Subpopulations				
Afghanistan	29.1%	15.2%	35.6%	21.1%
Eritrea	45.6%	15.5%	46.3%	19.3%
Ukraine	31.0%	17.2%	31.7%	11.7%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

Insurance knowledge varied considerably by topic. In the Swiss national sample, knowledge was high regarding deductibles, with 89.8% correctly identifying both the relationship between higher deductibles and lower premiums and the potential savings from a maximum deductible, while 74.8% correctly understood the relative cost of the standard insurance model. In contrast, knowledge of emergency care access was low even among Swiss participants, with only 52.5% answering correctly. Higher education and income were generally associated with better insurance knowledge, although notable differences were also observed across age and language regions. Knowledge was substantially lower across all migrant subpopulations, particularly regarding the standard insurance model and emergency care access. Notably, only 11.7-52.5% of respondents

across all groups correctly identified that emergency care is always accessible under HMO models (4), suggesting a widespread misconception that could act as a barrier to appropriate care-seeking.

5.2.2 Primary care model choice

Table 6 presents the distribution of primary care plan choices across demographic groups and subpopulations. Among the Swiss national sample, the family doctor model was the most common choice (45.2%), followed by the HMO model (18.5%), standard model (17.9%), and telemedicine (16.7%). Among migrants, the family doctor model was even more predominant (62.6-80.5%), likely reflecting guidance from social workers, pre-defined insurance packages, and the value of a stable primary care relationship when navigating a new system.

Table 6. Primary care plan choices[a]

	Standard model	HMO model	Telemedicine model	Family Doctor model	Other	Total
Swiss national sample (N=1,926)[b]						
%	17.9%	18.5%	16.7%	45.2%	1.7%	100.0%
Age group						
Age 15-19	24.5%	16.3%	13.8%	43.8%	1.7%	100.0%
Age 20-39	20.8%	18.3%	21.5%	37.5%	1.9%	100.0%
Age 40-64	15.3%	18.4%	18.3%	46.3%	1.8%	100.0%
Age 65-79	16.8%	20.6%	5.5%	56.1%	1.0%	100.0%
Age 80+	26.4%	2.0%	0.0%	71.6%	0.0%	100.0%
Gender						
Male	20.2%	19.2%	19.1%	40.0%	1.6%	100.0%
Female	15.6%	17.8%	14.3%	50.5%	1.7%	100.0%
Educational attainment						
Grade 10 or less	15.3%	22.8%	11.2%	50.7%	0.0%	100.0%
Secondary/vocational	19.3%	19.0%	14.6%	44.7%	2.3%	100.0%
Higher education	15.8%	18.2%	22.3%	42.4%	1.3%	100.0%
Still in school	21.5%	12.6%	16.9%	46.7%	2.3%	100.0%
Income group						
Income ≤ CHF 75,000	16.0%	16.9%	15.0%	51.1%	1.0%	100.0%
Income > CHF 75,000	20.2%	21.4%	19.7%	36.3%	2.4%	100.0%
Language region						
German	16.9%	21.8%	17.9%	41.7%	1.7%	100.0%
French	22.2%	9.6%	13.7%	52.8%	1.7%	100.0%
Italian	11.7%	11.0%	13.8%	63.3%	0.2%	100.0%
Migrant subpopulations (N=665)[c]						
Subpopulation						

	Standard model	HMO model	Telemedicine model	Family Doctor model	Other	Total
Afghanistan	8.7%	9.6%	0.0%	80.5%	1.1%	100.0%
Eritrea	17.0%	15.2%	5.2%	62.6%	0.0%	100.0%
Ukraine	19.5%	7.0%	5.4%	67.4%	0.7%	100.0%

[a] 3.1% of Swiss, 10.2% of Ukrainian, 18.6% of Afghan, and 33.2% of Eritrean participants did not know the primary care plan of their insurance model

[b] Weights for Swiss national sample, excluding migrants subpopulation

[c] Weights for the migrant subsample

5.2.3 Monthly premiums

Table 7 shows the distribution of monthly premium payments reported by respondents, including premiums for basic insurance as well as any complementary health insurance. Among the Swiss national sample, the most common premium bands were CHF 300-399 (26.9%) and CHF 400-499 (27.6%), with 12.3% paying CHF 600 or more. As expected, premium levels were strongly associated with age: respondents aged 65-79 were concentrated in the higher premium bands (CHF 500+), while younger respondents and adolescents reported lower premiums, consistent with the age-graduated premium structure in Switzerland. Higher-income respondents also reported higher premiums, likely reflecting greater willingness to pay for lower deductibles, more expensive insurance models (e.g., the standard model vs. the family doctor model), and more complementary insurances. Italian-speaking respondents were more likely to report paying CHF 500 or more (64.6%), reflecting the higher premium levels in the canton of Ticino. Among migrants, Ukrainian respondents reported notably higher premiums than Afghan and Eritrean respondents, suggesting they may have selected more comprehensive coverage.

Table 7. Monthly health insurance premium distribution

	<CHF 200	CHF 200-299	CHF 300-399	CHF 400-499	CHF 500-599	CHF 600+	Total
Swiss national sample (N=1,757)[a]							
%							
	2.7%	8.0%	26.9%	27.6%	22.6%	12.3%	100.0%
Age group[b]							
Age 20-39	4.7%	10.5%	35.0%	26.7%	18.3%	4.7%	100.0%
Age 40-64	2.2%	7.4%	28.9%	29.0%	22.8%	9.7%	100.0%
Age 65-79	0.5%	1.8%	8.8%	24.6%	32.2%	32.1%	100.0%
Age 80+	0.0%	0.0%	0.0%	50.0%	0.0%	50.0%	100.0%
Gender							
Male	3.3%	9.0%	31.8%	26.2%	17.9%	11.8%	100.0%
Female	2.0%	6.9%	21.8%	29.0%	27.4%	12.8%	100.0%
Educational attainment							
Grade 10 or less	3.5%	13.5%	25.6%	25.9%	21.2%	10.3%	100.0%
Secondary/vocational	2.4%	4.9%	26.8%	26.4%	26.1%	13.4%	100.0%
Higher education	1.8%	4.8%	28.5%	30.4%	20.1%	14.5%	100.0%
Still in school	5.6%	24.6%	23.3%	26.0%	17.6%	3.0%	100.0%

	<CHF 200	CHF 200-299	CHF 300-399	CHF 400-499	CHF 500-599	CHF 600+	Total
Income group							
Income ≤ CHF 75,000	3.8%	10.4%	21.8%	28.6%	23.1%	12.4%	100.0%
Income > CHF 75,000	1.1%	5.3%	33.2%	26.2%	22.1%	12.2%	100.0%
Language region							
German	2.1%	8.8%	30.9%	26.8%	21.2%	10.1%	100.0%
French	4.4%	5.8%	18.1%	31.4%	24.5%	15.8%	100.0%
Italian	1.8%	6.3%	9.0%	18.3%	34.8%	29.8%	100.0%
Migrant subpopulations (N=420)[c]							
Subpopulation							
Afghanistan	5.6%	28.1%	24.0%	24.9%	12.7%	4.6%	100.0%
Eritrea	9.8%	12.4%	24.2%	34.4%	17.9%	1.3%	100.0%
Ukraine	4.7%	9.1%	22.2%	29.5%	22.2%	12.4%	100.0%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] The question was asked to respondents 20+ years

[c] Weights for the migrant subsample

5.2.4 Deductible choices

Table 8 shows the distribution of annual deductible choices. Among the Swiss general national sample, choices were broadly split between the minimum deductible (CHF 300, 40.5%) and the maximum (CHF 2,500, 43.6%), with relatively few choosing intermediate levels. . Individuals expecting little healthcare use may benefit from selecting a high deductible in exchange for lower premiums, whereas those anticipating substantial healthcare use may prefer a low deductible to limit out-of-pocket costs. Men were substantially more likely than women to choose the maximum deductible (51.6% vs. 35.8%), as were higher-income respondents (52.7% vs. 36.0%). Among migrants from Eritrea and Ukraine, the minimum deductible was more popular (48.9% - 50.9%), consistent with greater financial uncertainty and risk aversion among recently arrived populations; migrants from Afghanistan chose the minimum deductible at a similar rate to the general Swiss population.

Table 8. Annual deductible (franchise) distribution

	CHF 300	CHF 500	CHF 1,000	CHF 1,500	CHF 2,000	CHF 2,500	Total
Swiss national sample (N=1,804)[a]							
N (%)							
	40.5%	7.2%	3.1%	3.4%	2.2%	43.6%	100.0%
Age group[b]							
Age 20-39	32.9%	6.0%	3.9%	2.6%	1.0%	53.7%	100.0%
Age 40-64	36.7%	5.0%	2.4%	4.7%	3.2%	48.0%	100.0%
Age 65-79	64.0%	12.8%	3.8%	1.5%	1.8%	16.2%	100.0%
Age 80+	84.1%	15.9%	0.0%	0.0%	0.0%	0.0%	100.0%
Gender							

	CHF 300	CHF 500	CHF 1,000	CHF 1,500	CHF 2,000	CHF 2,500	Total
Male	31.7%	6.1%	4.3%	3.7%	2.6%	51.6%	100.0%
Female	49.1%	8.3%	1.9%	3.1%	1.9%	35.8%	100.0%
Educational attainment							
Grade 10 or less	48.2%	13.6%	4.4%	1.8%	0.0%	32.0%	100.0%
Secondary/vocational	45.3%	7.6%	3.2%	4.3%	3.0%	36.6%	100.0%
Higher education	30.5%	4.5%	2.6%	2.2%	2.2%	58.0%	100.0%
Still in school	40.8%	4.0%	1.7%	5.7%	2.3%	45.4%	100.0%
Income group							
Income ≤ CHF 75,000	50.7%	7.6%	2.1%	2.4%	1.2%	36.0%	100.0%
Income > CHF 75,000	29.5%	6.0%	4.4%	4.0%	3.4%	52.7%	100.0%
Language region							
German	38.0%	6.6%	3.3%	3.5%	2.4%	46.1%	100.0%
French	47.1%	8.3%	2.5%	3.0%	1.8%	37.2%	100.0%
Italian	43.8%	9.6%	1.4%	4.1%	2.7%	38.4%	100.0%
Migrant subpopulations (N=313[c])							
Subpopulation							
Afghanistan	40.7%	9.2%	4.7%	0.7%	1.2%	43.5%	100.0%
Eritrea	48.9%	4.0%	1.0%	2.5%	5.5%	38.1%	100.0%
Ukraine	50.9%	11.9%	1.5%	1.6%	3.0%	31.1%	100.0%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] The question was asked to respondents 20+ years

[c] Weights for the migrant subsample

Figure 7 illustrates deductible choices by subpopulation. The distribution of chosen deductibles varied across population groups, although the lowest (CHF 300) and highest (CHF 2,500) deductibles were the most common choices in all groups. The CHF 300 deductible was more frequently selected among participants from Eritrea (49%) and Ukraine (51%) than in the Swiss national sample (40%) or among participants from Afghanistan (41%), while CHF 2,500 was less common in Eritrea (38%) and particularly Ukraine (31%) than in Switzerland and Afghanistan (both 44%).

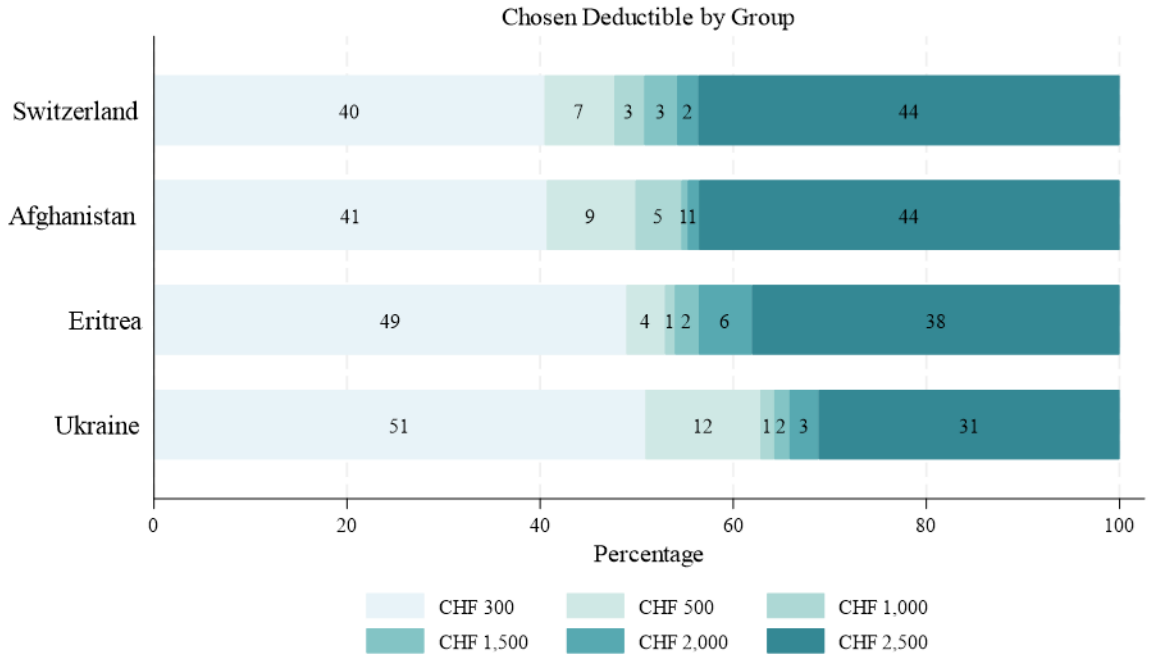


Figure 7. Chosen deductible level by subpopulation

5.2.5 Supplemental insurance

Table 9 shows supplemental insurance coverage across demographic groups and subpopulations. Swiss respondents showed substantially higher uptake than migrant groups across all categories. Alternative medicine coverage was highest overall (45.1% among Swiss respondents), followed by hospital (31.4%) and insurance for glasses (30.2%). Coverage was strongly associated with income: 50.4% of higher-income respondents held alternative medicine coverage compared to 39.1% of lower-income respondents, and 40.4% of higher-income respondents held hospital coverage compared to 25.8%. Among migrants, supplemental coverage was very low across all categories — only 5.2% of Ukrainian respondents held dental coverage, 3.7% hospital coverage, and 1.4% alternative medicine coverage — likely reflecting both lower awareness of supplemental insurance options and the financial constraints of recently arrived populations. Adolescents were more likely than older adults to have dental insurance (52.8% of adolescents compared to the overall average of 23.2% in the Swiss population) and less likely to have hospital insurance (23.1% vs. 31.4%) or alternative medicine insurance (33.8% vs. 45.1%); levels of pharmacy, glasses, and fitness insurance were generally similar between adolescents and adults.

Table 9. Supplemental insurance coverage (proportion holding each type, not exclusive)

	Dental	Hospital	Pharmacy	Alt. Medicine	Glasses	Fitness
Swiss national sample (N=1,926)[a] **%**						
	23.2%	31.4%	19.8%	45.1%	30.2%	16.0%
Age group						
Age 15-19	52.8%	23.1%	18.1%	33.8%	30.4%	12.8%
Age 20-39	30.1%	31.8%	19.9%	35.0%	29.2%	20.0%
Age 40-64	17.9%	30.6%	20.3%	53.7%	31.3%	15.4%

	Dental	Hospital	Pharmacy	Alt. Medicine	Glasses	Fitness
Age 65-79	11.7%	36.6%	19.0%	46.0%	27.8%	12.1%
Age 80+	0.0%	23.9%	13.9%	51.4%	56.9%	0.0%
Gender						
Male	25.9%	31.4%	21.3%	40.3%	30.0%	15.1%
Female	20.5%	31.4%	18.3%	49.8%	30.4%	17.0%
Educational attainment						
Grade 10 or less	23.3%	11.7%	9.3%	33.1%	23.6%	5.6%
Secondary/vocational	19.7%	31.7%	21.8%	51.4%	32.9%	16.6%
Higher education	24.5%	43.5%	21.9%	51.0%	30.9%	19.3%
Still in school	30.3%	27.7%	21.8%	28.8%	28.7%	19.5%
Income group						
Income ≤ CHF 75,000	18.0%	25.8%	17.3%	39.1%	28.5%	13.4%
Income > CHF 75,000	26.1%	40.4%	22.5%	50.4%	33.1%	19.6%
Language region						
German	25.7%	32.8%	17.3%	45.3%	32.8%	17.6%
French	15.6%	27.4%	26.0%	45.6%	21.3%	9.5%
Italian	24.4%	29.6%	26.9%	37.7%	36.9%	28.3%
Migrant subpopulations (N=810)[b]						
Subpopulation						
Afghanistan	5.4%	9.1%	7.8%	3.1%	6.5%	3.3%
Eritrea	13.8%	8.1%	9.7%	3.9%	7.4%	4.9%
Ukraine	5.3%	3.8%	2.3%	1.5%	2.8%	1.7%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

5.3 Patient activation

In the PVS, patient activation refers to a person's willingness and ability to take an active, independent role in managing their own health and healthcare. It is intended to capture autonomy, confidence, and decision-making power in interactions with health providers. Figure 8 presents two patient activation indicators: confidence in being the person responsible for one's own health and confidence in expressing concerns to health provider even without being asked. Overall, respondents reported high levels of patient activation. The majority of Swiss respondents (60.0%) were very confident in taking responsibility for their own health, while 34.8% were somewhat confident. Confidence in raising concerns with healthcare providers was somewhat lower: 34.1% reported being very confident and 50.5% somewhat confident. Low confidence was more common for raising concerns (15.3% not too or not at all confident) than for taking responsibility for one's own health (5.2%).

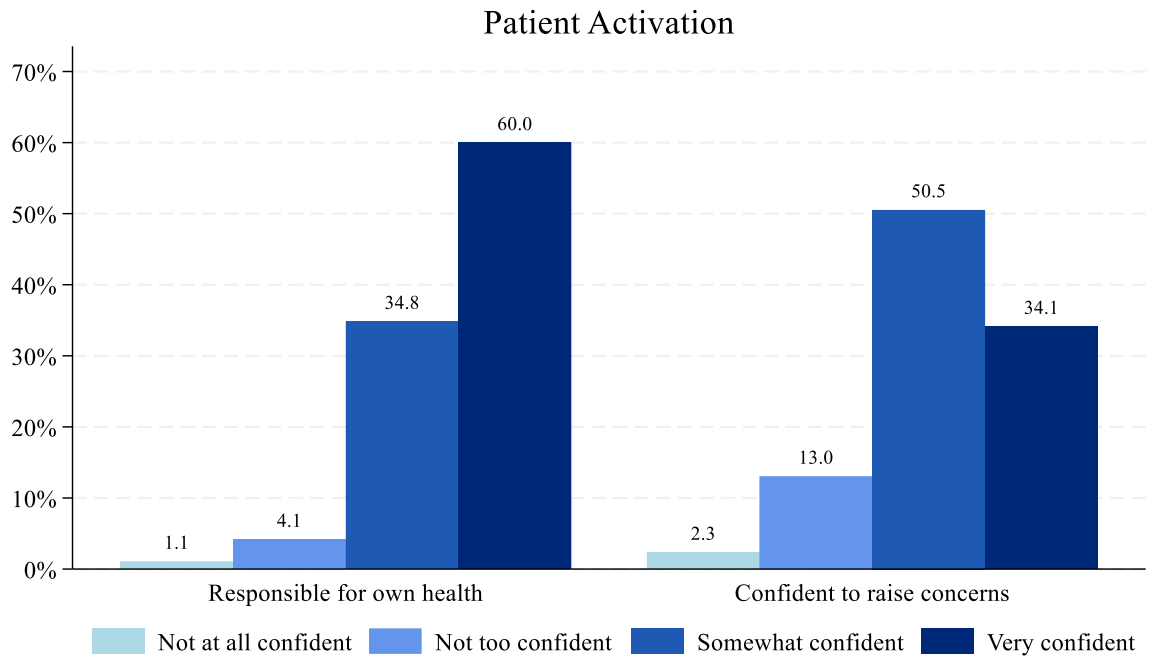


Figure 8. Patient activation indicators, Swiss national sample

5.4 System competence: preventive care, quality of care, and adverse experiences

5.4.1 Preventive care coverage

Table 10 shows the proportion of respondents who reported receiving each of nine preventive services (within the past 10 years for colon cancer screening and within the last year for all other services). In the Swiss national sample, dental examinations (68.6%) and blood pressure checks (63.7%) were the most commonly reported, followed by colon cancer screening among eligible participants aged 50 years and older (60.4%). Mammography among eligible women aged 50 years and older (29.6%), cholesterol testing (32.9%), and blood sugar testing (33.4%) were reported less frequently. Utilisation generally increased with age for blood pressure, eye examinations, blood sugar and cholesterol testing, and general check-ups, while mammography, cervical cancer screening, and colon cancer screening were less common in the oldest age group. Women reported higher use than men for blood pressure checks (68.5% vs 58.8%), dental examinations (71.3% vs 65.9%), and general check-ups (48.1% vs 39.4%). Differences by income were relatively small (less than 5 percentage points) for blood pressure screening, eye exams, blood sugar testing, and colon cancer screening, but larger for mammograms, cervical cancer screening, dental exams, cholesterol testing, and general check-ups. Regional differences were more pronounced: respondents from the French- and Italian-speaking regions generally reported higher coverage for several services than those from the German-speaking region, particularly for mammography, blood sugar and cholesterol testing, and general check-ups (*Fig. 9*).

In all three migrant subpopulations, preventive care coverage was generally lower than in the Swiss national sample, particularly for dental examinations and colon cancer screening. Ukrainian respondents reported relatively high coverage of blood pressure (66.9%), blood sugar (55.7%), and cholesterol checks (53.8%), with the latter two exceeding the corresponding proportions in the Swiss national sample. Eritrean respondents reported comparatively low coverage for several services, including cholesterol testing (19.0%), cervical cancer screening (22.2%), and colon cancer screening (23.1%). Afghan respondents had the highest mammography coverage among the three

migrant subpopulations (40.7%), but lower coverage of cervical (24.0%) and colon cancer screening (25.7%) than the Swiss national sample.

Table 10. Preventive care coverage (proportion receiving each service, not exclusive)

	Blood pressure	Mammo gram[b]	Cervical cancer	Eye exam	Teeth	Blood sugar	Choles terol	Checkup	Colon cancer[c]
Swiss national sample[a]									
%									
	63.7%	29.6%	43.1%	42.5%	68.6%	33.4%	32.9%	43.8%	60.4%
Age group									
Age 15-19	57.0%	—	9.7%	41.0%	72.6%	10.6%	12.0%	46.9%	—
Age 20-39	57.6%	—	48.3%	29.3%	59.6%	24.5%	16.4%	38.5%	—
Age 40-64	62.7%	29.9%	48.5%	41.4%	70.5%	34.4%	37.5%	43.0%	56.3%
Age 65-79	80.0%	30.3%	35.9%	70.8%	77.6%	55.6%	59.2%	53.6%	68.4%
Age 80+	76.4%	6.8%	10.3%	61.9%	95.9%	81.6%	81.6%	69.2%	26.3%
Gender									
Male	58.8%	—	—	42.6%	65.9%	32.8%	35.2%	39.4%	62.6%
Female	68.5%	29.6%	43.1%	42.5%	71.3%	34.0%	30.6%	48.1%	58.3%
Educational attainment									
Grade 10 or less	65.3%	26.1%	32.0%	48.1%	73.8%	32.6%	33.2%	46.9%	66.8%
Secondary/vocational	66.5%	30.6%	42.9%	47.5%	67.4%	38.1%	38.3%	47.5%	59.6%
Higher education	64.8%	31.0%	51.2%	37.7%	70.5%	34.1%	32.1%	39.1%	57.4%
Still in school	51.7%	16.7%	41.3%	32.7%	61.9%	19.7%	19.0%	39.7%	75.1%
Income group									
Income ≤ CHF 75,000	66.6%	28.8%	42.7%	40.9%	62.9%	36.9%	38.6%	46.1%	61.6%
Income > CHF 75,000	61.8%	35.6%	51.9%	41.6%	71.6%	33.7%	31.0%	38.3%	66.1%
Language region									
German	63.0%	22.8%	42.1%	41.2%	69.7%	30.1%	28.2%	35.3%	58.0%
French	63.7%	46.8%	45.3%	46.2%	63.9%	41.8%	43.9%	66.9%	67.2%
Italian	75.5%	53.4%	48.9%	44.0%	76.8%	42.7%	47.2%	54.6%	61.3%
Migrant subpopulations[d]									
Subpopulation									
Afghanistan	58.3%	40.7%	24.0%	44.5%	53.4%	32.9%	26.3%	41.2%	25.7%
Eritrea	51.2%	25.0%	22.2%	37.2%	40.5%	26.3%	19.0%	46.6%	23.1%
Ukraine	66.9%	25.4%	33.8%	38.6%	47.7%	55.7%	53.8%	36.2%	20.9%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] In women 50+ years

[c] In participants 50+, within last 10 years

[d] Weights for the migrant subsample

Figure 9 shows preventive screening coverage by language region. There were substantial regional differences. Coverage for mammograms among women aged 50+ was notably lower in German-speaking Switzerland (22.8%) compared to French- (46.8%) and Italian-speaking (53.4%) regions. General checkup coverage was considerably lower in the German-speaking region (35.3%) than in the French- (66.9%) and Italian-speaking regions (54.6%). Cervical cancer and colon cancer screening coverage was also lower in German-speaking Switzerland. These differences may reflect both variation in screening programme recommendations by canton and differences in clinical practice.

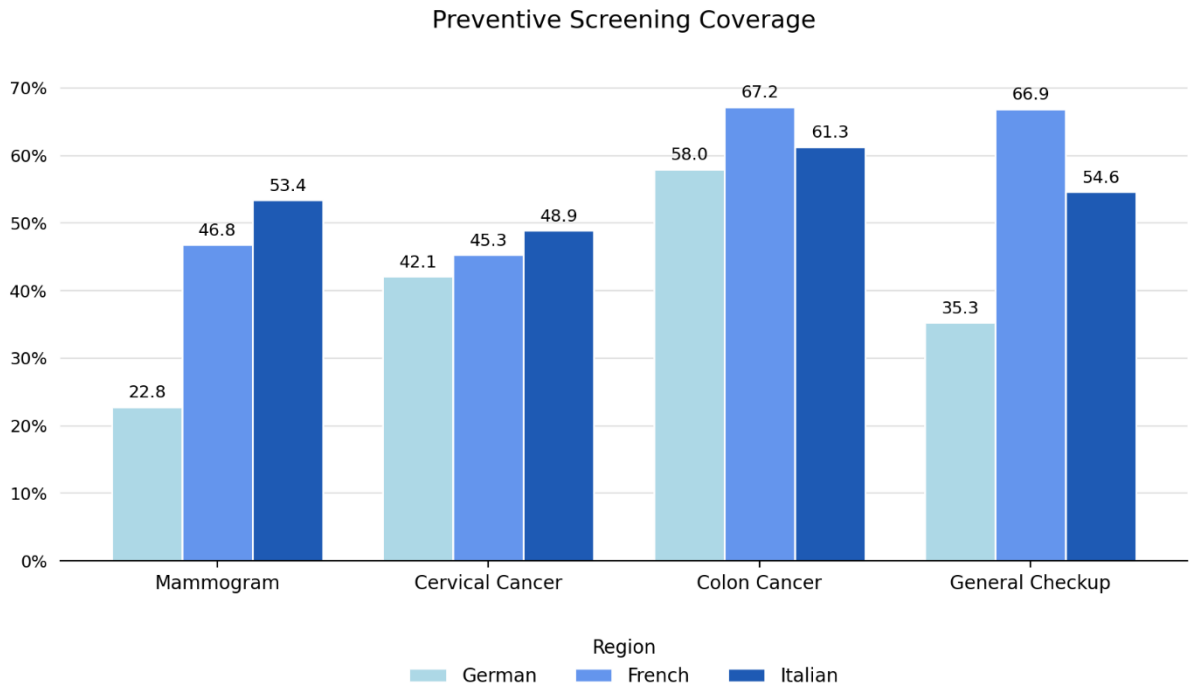


Figure 9. Preventive screening coverage by language region, Swiss national sample

We asked the adolescent subpopulation whether primary healthcare providers had discussed a range of preventive, behavioural, and psychosocial health topics during the past 12 months with them . As Figure 10 shows, the frequency of these discussions varied considerably across topics. Mental health was addressed most often (35.6%), followed by sleep (31.1%) and eating habits (28.5%). Around one-quarter of adolescents reported being asked about substance use (24.6%) or sexual health (23.8%), and 21.0% about social media use. Bullying (9.1%) and experiences of physical violence (5.3%) were addressed least frequently, suggesting that these more sensitive aspects of adolescent wellbeing were seldom discussed during primary healthcare contacts.

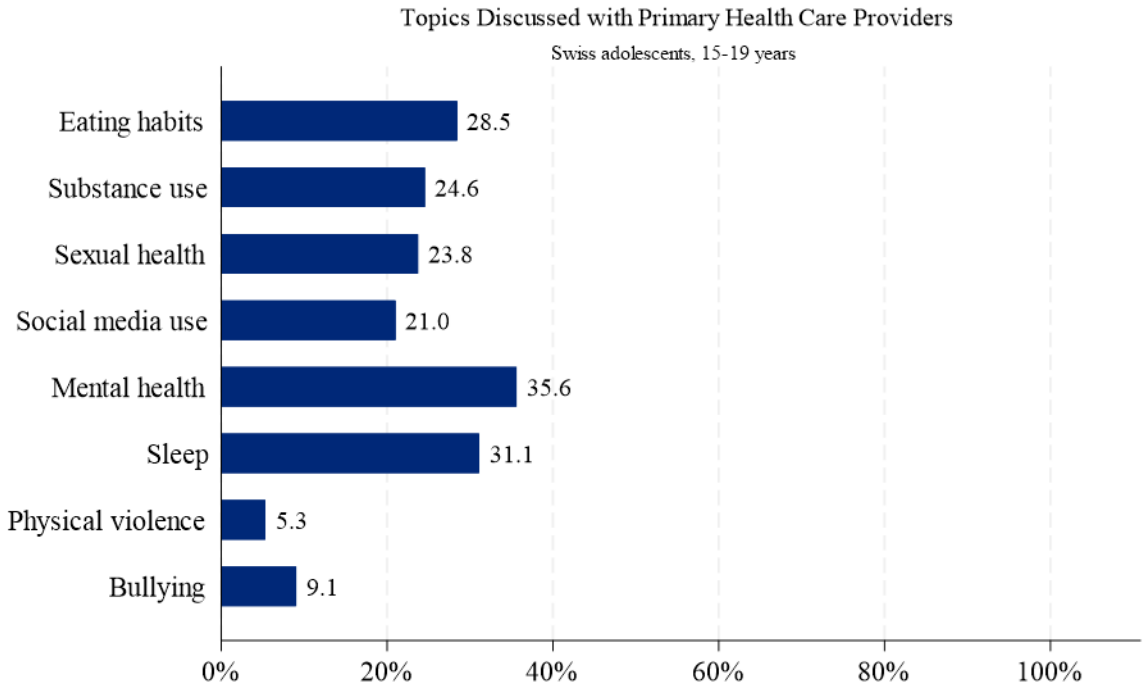


Figure 10. Preventive health topics discussed in primary care with Swiss adolescents in the last 12 months

5.4.2 Care utilisation and quality of usual care

Table 11 presents mean healthcare utilisation within last 12 months. In the Swiss national sample, the mean number of visits was 4.69, increasing from 3.40 among those aged 15–19 to 6.60 among those aged 80+, and was higher among women (5.34) than men (4.06). Among migrants, Ukrainians had the highest mean number of visits (5.90), while Eritreans had the lowest (2.96). The proportion of respondents with overnight stays ranged from 8.2% among Eritreans to 15.6% among Afghans. Telemedicine use was low overall (0.34 consultations on average) but was higher among younger adults aged 20–39 (0.68) and participants in the French-speaking region (0.54).

Table 11. Healthcare utilisation in the past 12 months (means)

	Healthcare visits (mean)	Facilities used (mean)	Telemedicine consultations (mean)	Any overnight stay (%)
Swiss national sample[a]				
N (mean)				
	4.69	2.19	0.34	11.0%
Age group				
Age 15-19	3.40	1.75	0.13	7.6%
Age 20-39	4.60	2.18	0.68	14.1%
Age 40-64	4.83	2.25	0.22	9.1%
Age 65-79	4.96	2.26	0.14	12.0%
Age 80+	6.60	2.21	0.13	4.2%
Gender				
Male	4.06	2.03	0.37	11.2%
Female	5.34	2.33	0.31	10.8%

	Healthcare visits (mean)	Facilities used (mean)	Telemedicine consultations (mean)	Any overnight stay (%)
Educational attainment				
Grade 10 or less	5.21	1.91	0.56	10.6%
Secondary/vocational	4.77	2.35	0.20	11.7%
Higher education	4.43	2.24	0.29	10.3%
Still in school	4.46	1.96	0.60	11.0%
Income group				
Income ≤ CHF 75,000	5.24	2.19	0.33	8.2%
Income > CHF 75,000	4.36	2.34	0.29	14.0%
Language region				
German	4.70	2.18	0.28	11.0%
French	4.77	2.20	0.54	10.6%
Italian	3.99	2.30	0.14	14.2%
Migrant subpopulations[b]				
Subpopulation				
Afghanistan	4.67	1.95	0.25	15.6%
Eritrea	2.96	1.57	0.49	8.2%
Ukraine	5.90	2.50	0.36	13.8%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

Table 12 shows the usual place of care. Most of the Swiss nationals (77.0%) reported having a family doctor as their usual source of care, while 16.5% reported having no usual place of care. Younger adults were most likely to report having no usual source of care, with 25.9% of respondents aged 20–39 reporting none. Among migrants, Eritrean respondents were most likely to lack a usual place of care (55.2%).

Table 12. Place of usual care

	No usual place of care	Family doctor	Other	Total
Swiss national sample (N=1,944)[a]				
%				
	16.5%	77.0%	6.5%	100.0%
Age group				
Age 15-19	12.6%	78.8%	8.5%	100.0%
Age 20-39	25.9%	67.7%	6.3%	100.0%
Age 40-64	15.0%	77.9%	7.1%	100.0%
Age 65-79	5.2%	90.7%	4.1%	100.0%
Age 80+	0.0%	92.3%	7.7%	100.0%
Gender				

	No usual place of care	Family doctor	Other	Total
Male	18.4%	75.3%	6.3%	100.0%
Female	14.6%	78.7%	6.7%	100.0%
Educational attainment				
Grade 10 or less	16.8%	78.2%	4.9%	100.0%
Secondary/vocational	14.3%	79.9%	5.8%	100.0%
Higher education	17.1%	75.9%	7.0%	100.0%
Still in school	21.4%	69.5%	9.1%	100.0%
Income group				
Income ≤ CHF 75,000	16.3%	77.8%	6.0%	100.0%
Income > CHF 75,000	19.0%	75.0%	6.0%	100.0%
Language region				
German	17.4%	76.6%	6.0%	100.0%
French	15.2%	76.8%	8.0%	100.0%
Italian	9.5%	84.2%	6.3%	100.0%
Migrant subpopulations (N=805[b])				
Subpopulation				
Afghanistan	17.1%	74.8%	8.1%	100.0%
Eritrea	55.2%	35.4%	9.5%	100.0%
Ukraine	17.2%	75.1%	7.7%	100.0%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

The proportion reporting no usual source of care was substantially higher among Eritrean respondents (55.2%) than among Ukrainian (17.2%), Afghan (17.1%), and Swiss (16.5%) respondents *(see Fig.11)*.

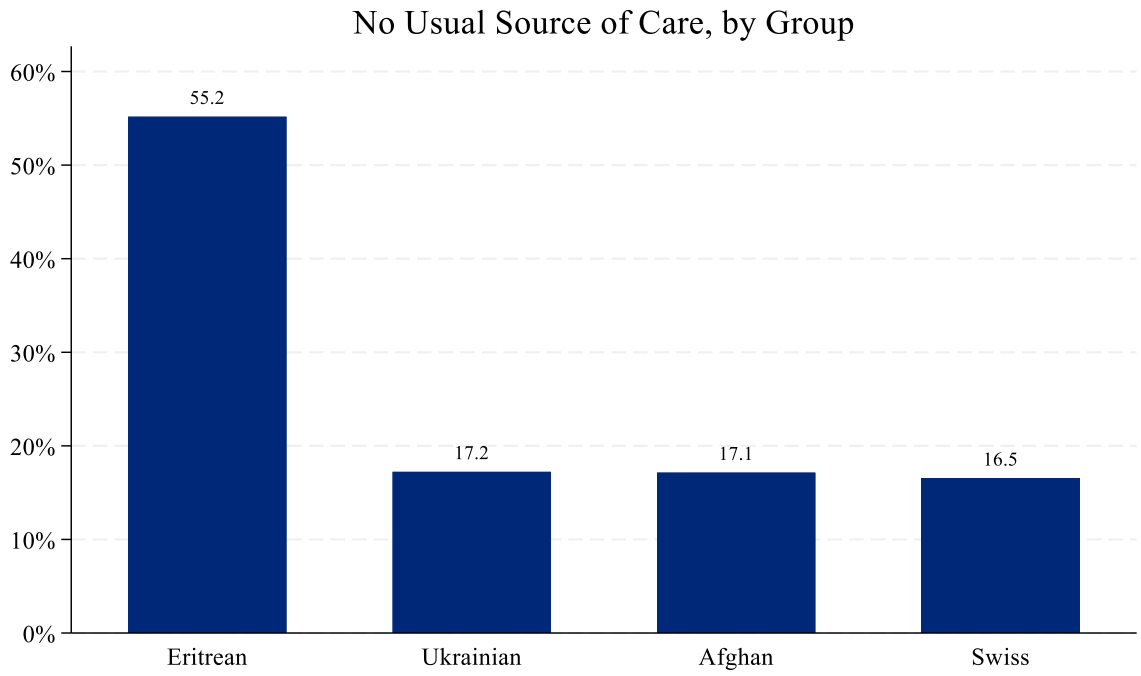


Figure 11. Proportion of participants reporting no usual source of care

Table 13 presents ratings of the overall quality of care received in the past 12 months among patients receiving any healthcare within the last 12 months. Among the Swiss national sample, 73.1% rated their care as "very good" or "excellent", with only 2.3% rating it "poor" or "not so good". "Excellent" ratings were slightly more common among French-speaking, higher-income, male respondents, and those in the 20-39 and 65+ age groups, compared to their counterparts. Afghan respondents reported both the highest share of "excellent" ratings and the highest share of negative ratings and Eritrean respondents showed the lowest "excellent" share. Given the small number of observations in these groups, these differences should be interpreted carefully.

Table 13. Overall quality of care received in the past 12 months

	Poor	Not so good	Good	Very good	Excellent	Total
Swiss national sample (N=1,536)[a]						
%						
	0.2%	2.1%	24.7%	47.2%	25.9%	100.0%
Age group						
Age 15-19	0.2%	1.6%	23.0%	54.1%	21.2%	100.0%
Age 20-39	0.4%	1.4%	29.8%	41.1%	27.3%	100.0%
Age 40-64	0.1%	3.0%	24.3%	47.2%	25.4%	100.0%
Age 65-79	0.0%	0.3%	18.4%	55.0%	26.2%	100.0%
Age 80+	0.0%	18.7%	31.9%	16.0%	33.4%	100.0%
Gender						
Male	0.1%	1.6%	20.5%	49.6%	28.3%	100.0%
Female	0.2%	2.6%	28.6%	45.1%	23.6%	100.0%
Educational attainment						

	Poor	Not so good	Good	Very good	Excellent	Total
Grade 10 or less	0.0%	1.9%	19.3%	52.1%	26.6%	100.0%
Secondary/vocational	0.0%	2.7%	21.6%	49.7%	26.0%	100.0%
Higher education	0.1%	1.9%	28.7%	42.5%	26.7%	100.0%
Still in school	0.8%	0.7%	31.9%	44.0%	22.6%	100.0%
Income group						
Income ≤ CHF 75,000	2 (0.3%)	2.1%	26.2%	48.6%	22.8%	100.0%
Income > CHF 75,000	0 (0.1%)	0.8%	21.5%	48.1%	29.6%	100.0%
Language region						
German	0.0%	1.7%	25.0%	48.5%	24.7%	100.0%
French	0.6%	2.4%	24.5%	42.5%	30.0%	100.0%
Italian	0.2%	6.3%	19.8%	53.2%	20.5%	100.0%
Migrant subpopulations (N=552[b])						
Subpopulation						
Afghanistan	3.9%	5.5%	27.4%	27.2%	36.0%	100.0%
Eritrea	2.0%	4.8%	33.3%	41.5%	18.4%	100.0%
Ukraine	1.1%	6.2%	39.3%	31.2%	22.1%	100.0%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

5.4.3 Quality of most recent visit

Tables 14 and 15 present detailed quality ratings for the most recent health facility visit across 12 dimensions, grouped into two tables. Table 14 covers interpersonal dimensions: provider knowledge of prior history, privacy, respectful treatment, explanation of care, involvement in decisions, and time with provider. Table 15 covers structural dimensions: waiting time, adequacy of equipment, ease of getting an appointment, privacy, case knowledge, staff courtesy, and the likelihood to recommend the facility (on a 0-10 scale). Positive rating includes those rating “very good” and “excellent”.

Across both interpersonal and structural dimensions, respondents in the Swiss national sample generally reported positive experiences with their most recent healthcare visit. Respectful treatment (86.1%), courteous staff (82.2%), knowledge of medical history (79.5%), adequate equipment (79.6%), and respect for privacy (79.6%) received particularly high ratings, while sufficient provider time (67.3%) and short waiting times (57.5%) were rated less positively. Experiences were generally more favourable among older adults and, for several dimensions, among men and respondents with higher education or income. Compared with adults, adolescents were somewhat less satisfied across all categories, particularly for treatment with respect (79.5% “very good or excellent” among adolescents compared with 86.1% overall), involvement in decisions (66.6% among adolescents, 74.0% overall), the amount of time with their provider (62.4% among adolescents, 67.3% overall), and the amount of privacy they had (70.9% among adolescents, 79.6% overall).

Ratings were consistently lower across migrant subpopulations, particularly among Eritrean respondents, although respectful treatment and courteous staff remained among the more positively assessed aspects of care. Overall willingness to recommend the facility was high in the Swiss national sample (mean 8.4/10) and somewhat lower among respondents from Afghanistan (7.6), Eritrea (7.8), and Ukraine (8.3).

Table 14. Quality of most recent health visit — interpersonal dimensions (proportion rating very good or excellent)

	Knowledge of history	Privacy respected	Treated with respect	Care explained	Involved in decisions	Sufficient time	Courteous staff
Swiss national sample[a]							
%							
	79.5%	79.6%	86.1%	77.4%	74.0%	67.3%	82.2%
Age group							
Age 15-19	76.4%	70.9%	79.5%	73.2%	66.6%	62.4%	78.7%
Age 20-39	77.6%	77.9%	84.8%	75.6%	70.7%	64.7%	80.1%
Age 40-64	80.9%	80.9%	85.7%	78.9%	74.5%	68.7%	83.0%
Age 65-79	82.3%	83.4%	91.3%	79.9%	82.7%	70.9%	85.6%
Age 80+	46.3%	71.5%	100.0%	53.2%	51.4%	53.2%	74.5%
Gender							
Male	83.3%	82.3%	88.3%	80.9%	75.1%	67.3%	84.1%
Female	76.1%	77.2%	84.1%	74.3%	73.1%	67.3%	80.4%
Educational attainment							
Grade 10 or less	79.5%	80.2%	89.2%	70.8%	69.7%	55.3%	79.6%
Secondary/vocational	79.2%	78.7%	84.9%	78.9%	75.4%	69.3%	82.3%
Higher education	83.0%	84.1%	86.5%	80.9%	76.9%	70.6%	86.2%
Still in school	73.5%	72.4%	85.3%	73.2%	68.6%	67.8%	76.8%
Income group							
Income ≤ CHF 75,000	78.3%	81.3%	87.2%	77.3%	75.0%	65.7%	81.0%
Income > CHF 75,000	82.9%	80.7%	86.9%	81.5%	76.5%	72.4%	84.8%
Language region							
German	80.1%	80.4%	86.3%	76.6%	73.6%	66.7%	83.9%
French	77.6%	76.5%	85.7%	79.9%	75.9%	69.0%	78.7%
Italian	81.2%	85.8%	83.6%	77.1%	70.5%	66.3%	74.4%
Migrant subpopulations[b]							
Subpopulation							
Afghanistan	63.0%	75.2%	76.5%	69.4%	65.6%	64.8%	79.0%
Eritrea	56.6%	60.0%	72.2%	58.3%	56.9%	53.6%	56.5%
Ukraine	68.4%	80.1%	81.8%	65.0%	60.8%	61.2%	83.4%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

Table 15. Quality of most recent health visit — structural dimensions (proportion rating very good or excellent; mean recommendation rating on 0-10 scale)

	Short wait time	Adequate equipment	Easy to get appt	Case knowledge	Recommend (0-10)
Swiss national sample[a]					
%					
	57.5%	79.6%	70.7%	74.7%	8.4
Age group					
Age 15-19	54.3%	72.7%	67.9%	72.5%	8.2
Age 20-39	52.8%	77.5%	75.8%	70.0%	7.9
Age 40-64	59.5%	80.7%	66.5%	76.7%	8.6
Age 65-79	62.7%	83.8%	74.1%	79.3%	9.0
Age 80+	42.1%	67.6%	60.8%	62.5%	8.9
Gender					
Male	62.5%	80.9%	73.8%	79.0%	8.4
Female	53.0%	78.4%	68.0%	71.0%	8.5
Educational attainment					
Grade 10 or less	54.1%	84.2%	75.4%	72.8%	8.5
Secondary/vocational	59.9%	81.4%	69.9%	73.9%	8.5
Higher education	61.1%	79.5%	69.0%	77.5%	8.5
Still in school	47.2%	69.5%	71.0%	73.7%	8.0
Income group					
Income ≤ CHF 75,000	54.4%	76.4%	69.0%	75.1%	8.4
Income > CHF 75,000	63.6%	84.0%	71.9%	75.6%	8.5
Language region					
German	56.6%	79.4%	70.3%	73.5%	8.4
French	59.9%	80.6%	72.2%	78.5%	8.5
Italian	58.1%	77.7%	68.9%	74.0%	8.4
Migrant subpopulations[b]					
Subpopulation					
Afghanistan	52.2%	69.0%	60.9%	67.7%	7.6
Eritrea	46.3%	62.3%	51.3%	51.7%	7.8
Ukraine	53.3%	76.9%	60.5%	68.3%	8.3

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

Table 16 shows waiting times for the most recent healthcare appointment. Among Swiss respondents, 23.9% waited one week or less, while 19.1% waited more than four weeks. Longer

waits (>4 weeks) were more common among adolescents (25.7%) and women (21.8%), while respondents aged 65–79 more frequently reported waits of ≤1 week (29.0%). Regional differences were also observed: short waits were most common in the German-speaking region (26.1%), whereas two-week waits predominated in the Italian-speaking region (36.5%). Among migrant subpopulations, waiting times were generally shorter, with most respondents reporting an appointment within two weeks: 59.3% among respondents from Afghanistan, 55.0% from Eritrea, and 57.7% from Ukraine. Longer waits of more than four weeks were comparatively uncommon, reported by 15.4%, 12.5%, and 13.3%, respectively.

Table 16. Waiting time for the most recent appointment

	≤1 week	2 weeks	3 weeks	4 weeks	>4 weeks	Total
Swiss national sample (N=1,494)[a]						
%						
	23.9%	23.0%	21.6%	12.3%	19.1%	100.0%
Age group						
Age 15-19	24.2%	18.8%	19.2%	12.1%	25.7%	100.0%
Age 20-39	21.7%	22.6%	21.0%	12.3%	22.5%	100.0%
Age 40-64	22.8%	21.8%	22.6%	13.8%	19.1%	100.0%
Age 65-79	29.0%	28.2%	21.6%	9.2%	12.0%	100.0%
Age 80+	47.2%	30.4%	11.1%	11.3%	0.0%	100.0%
Gender						
Male	23.8%	24.9%	23.2%	12.3%	15.8%	100.0%
Female	24.1%	21.5%	20.3%	12.4%	21.8%	100.0%
Educational attainment						
Grade 10 or less	29.0%	12.3%	19.3%	11.8%	27.6%	100.0%
Secondary/vocational	24.8%	26.7%	20.2%	11.6%	16.7%	100.0%
Higher education	21.9%	24.7%	22.4%	14.1%	17.0%	100.0%
Still in school	20.0%	21.3%	26.7%	11.4%	20.6%	100.0%
Income group						
Income ≤ CHF 75,000	30.5%	19.9%	19.6%	12.3%	17.8%	100.0%
Income > CHF 75,000	18.3%	22.6%	25.1%	12.1%	22.0%	100.0%
Language region						
German	26.1%	20.6%	21.9%	11.1%	20.3%	100.0%
French	18.0%	28.1%	21.4%	16.0%	16.5%	100.0%
Italian	20.7%	36.5%	17.9%	13.3%	11.5%	100.0%
Migrant subpopulations (N=576[b])						
Subpopulation						
Afghanistan	32.5%	26.8%	17.1%	8.1%	15.4%	100%
Eritrea	27.5%	27.5%	25.0%	7.5%	12.5%	100%
Ukraine	27.4%	30.3%	17.2%	11.9%	13.3%	100%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

5.4.4 Perceived quality of specific services

Table 17 shows the proportion of respondents rating specific service areas as “very good”, or “excellent”. In the Swiss national sample, paediatric (64.5%) and maternity care (63.1%) received the highest positive ratings, followed by chronic disease care (58.0%) and rehabilitation (56.1%), while reproductive healthcare was rated highly by 45.3%. Mental healthcare stood out as the lowest-rated area, with only 32.2% assessing the quality of care as “very good” or “excellent”. Women generally rated services less positively than men across all areas, while respondents with higher incomes tended to report more favourable assessments than those with lower incomes, particularly for maternity, paediatric, chronic disease, reproductive and rehabilitation care. Respondents still in school reported comparatively low ratings for both mental health (28.1%) and reproductive healthcare (38.3%). Differences between language regions were generally modest, although overall quality was rated less positively in the Italian-speaking region (43.0%). Among migrant subpopulations, ratings also varied by service and population: Afghan respondents reported particularly high positive ratings for maternity (79.4%) and paediatric care (80.1%), while ratings among Eritrean and Ukrainian respondents were generally lower across several service areas.

Table 17. Perceived quality of specific service areas: proportion rating quality of services “very good” or “excellent”

	Overall	Maternity	Paediatric	Chronic disease	Mental health	Reproductive	Rehab
Swiss national sample[a]							
%							
	54.1%	63.1%	64.5%	58.0%	32.2%	45.3%	56.1%
Age group							
Age 15-19	54.2%	51.9%	67.9%	55.7%	32.3%	48.4%	61.6%
Age 20-39	50.7%	56.8%	65.6%	54.6%	34.1%	41.3%	52.8%
Age 40-64	54.3%	67.5%	62.5%	57.2%	28.5%	45.3%	56.7%
Age 65-79	61.0%	69.8%	66.2%	65.8%	40.5%	58.6%	57.9%
Age 80+	23.0%	100.0%	100.0%	88.4%	100.0%	100.0%	67.2%
Gender							
Male	63.1%	68.4%	69.9%	67.6%	41.7%	48.5%	61.7%
Female	45.0%	58.3%	58.5%	48.0%	23.0%	42.3%	50.3%
Educational attainment							
Grade 10 or less	54.7%	63.4%	69.0%	62.5%	36.3%	45.3%	52.8%
Secondary/vocational	53.4%	62.2%	61.4%	54.6%	31.9%	47.8%	54.5%
Higher education	54.9%	69.2%	68.2%	66.6%	32.8%	46.0%	60.8%
Still in school	53.4%	53.2%	60.4%	45.7%	28.1%	38.3%	53.7%
Income group							
Income ≤ CHF 75,000	48.3%	50.1%	56.9%	51.7%	33.7%	38.7%	51.5%
Income > CHF 75,000	57.7%	74.0%	71.0%	67.6%	33.5%	51.6%	64.3%
Language region							

	Overall	Maternity	Paediatric	Chronic disease	Mental health	Reproductive	Rehab
German	54.8%	64.4%	63.9%	58.5%	32.3%	45.9%	56.5%
French	53.7%	59.1%	67.5%	56.9%	31.0%	42.8%	55.1%
Italian	43.0%	62.5%	57.9%	55.7%	37.1%	48.9%	54.9%
Migrant subpopulations[b]							
Subpopulation							
Afghanistan	59.2%	79.4%	80.1%	66.3%	54.0%	60.9%	53.3%
Eritrea	47.6%	65.2%	57.2%	47.6%	40.7%	48.0%	46.8%
Ukraine	49.0%	72.9%	52.4%	49.1%	43.2%	51.7%	50.3%

[a] Weights for Swiss national sample, excluding migrants subpopulation

[b] Weights for the migrant subsample

5.4.5 Adverse experiences, unmet need and affordability

Despite the overall positive assessment of health services, some adverse experiences were reported by respondents. Medical mistakes were self-reported by perception of patients, who believed in their treatment within last year was a medical mistake, such as incorrect diagnosis or medication dosage prescribed. Unmet need was defined as having a health issue within last year but not receiving care for it. We also asked respondents if they had to borrow money or sell items to afford health services within last year.

For Swiss respondents, adverse experiences and unmet healthcare needs varied across language regions (*see Fig. 12*). Unmet physical healthcare need was the most commonly reported issue, affecting 15.8% overall and reaching 17.5% in the German-speaking region, while it was substantially lower in the Italian-speaking region (4.3%). Perceived medical mistakes were also relatively common (12.4% overall), particularly among Italian-speaking respondents (17.3%) and French-speaking respondents (15.0%). Financial difficulties, including having to sell items or borrow money, were more frequently reported in the French- and Italian-speaking regions. Mental healthcare unmet need and discrimination were reported by around 6% overall, with discrimination

highest in the Italian-speaking region (8.5%).

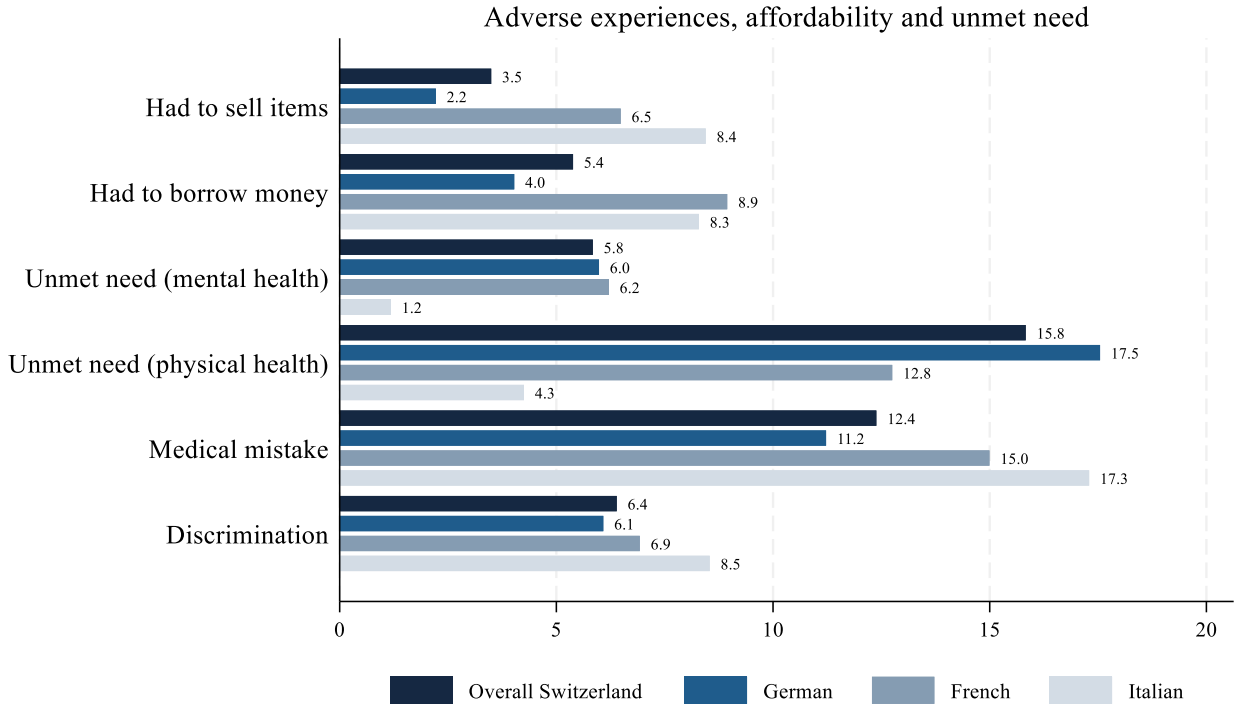


Figure 12. Adverse experiences, affordability and unmet needs within last 12 months, Swiss national sample

Among migrant subpopulations (*see Fig. 13*), medical mistakes (17.6%) and unmet physical healthcare needs (12.7%) were the most commonly reported adverse experiences, followed by having to borrow money to afford medical services (8.7%). Substantial differences were observed by nationality: Ukrainians reported particularly high levels of medical mistakes (21.7%) and unmet physical healthcare needs (14.2%), while Afghans most frequently reported having to borrow money (14.9%). Compared with the Swiss national sample, migrants reported lower unmet physical healthcare need (12.7% vs. 15.8%) and mental healthcare need (3.6% vs. 5.8%), but somewhat higher rates of perceived medical mistakes (17.6% vs. 12.4%) and borrowing money (8.7% vs. 5.4%). Reported discrimination levels were similar (5.1% vs. 6.4%).

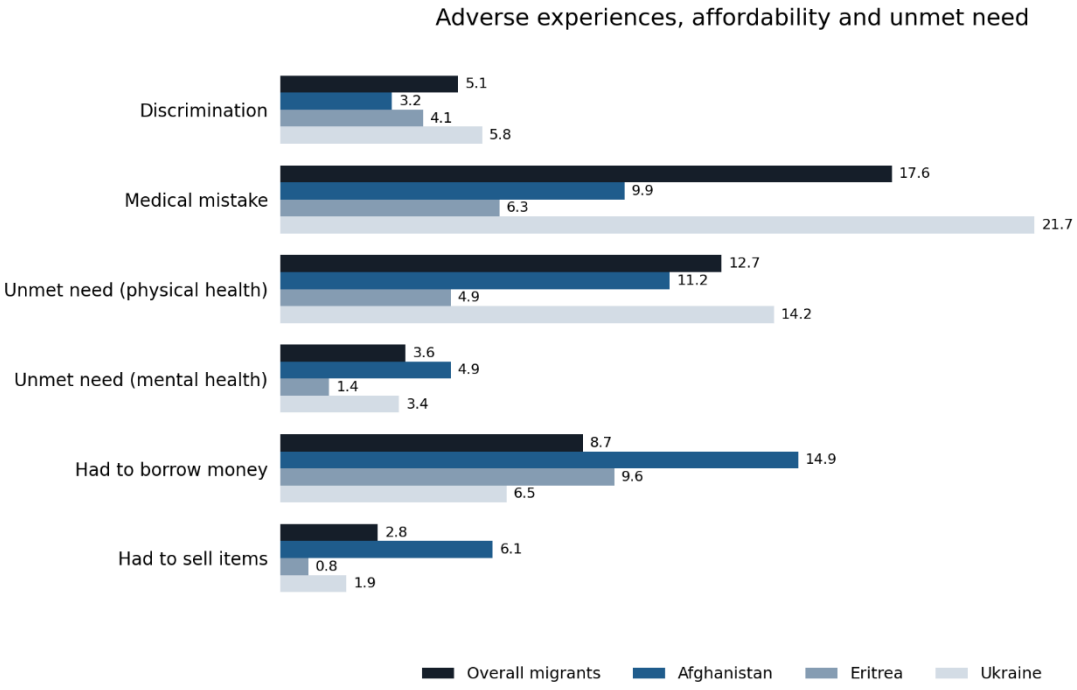


Figure 13. Adverse experiences, affordability and unmet needs within last 12 months, migrant subgroups

5.4.6. Adolescents' access to confidential care

Confidentiality is a core component of adolescent-responsive healthcare, particularly for sensitive issues such as mental health, sexual health, substance use and violence. The WHO recommends that adolescents can speak with healthcare providers privately and understand both confidentiality and its limits. WHO guidance emphasizes adolescents' evolving capacities, age-appropriate autonomy and removal of unnecessary parental-consent barriers to accessing care.[10]

In Switzerland, there is also no fixed age for independent healthcare consultations. The key criterion is the minor's capacity for judgement (*Urteilsfähigkeit*), assessed according to the individual and the decision involved. Swiss guidance indicates that minors capable of judgement can consent to treatment and are entitled to confidentiality; depending on the circumstances, capacity may be present from approximately 10–15 years of age.[11]

We asked adolescents aged 15–19 whether they had a doctor, nurse or other healthcare provider with whom they could speak confidentially, and whether they had spoken with a healthcare provider in private without their parents or guardians during the previous 12 months.

Overall, 70.1% reported having a healthcare provider with whom they could speak confidentially, while 54.9% had spoken with a provider without their parents or guardians in the previous year (*Fig. 14*). This suggests that confidential care was available to a majority of adolescents, but private healthcare interactions were less common. However, not having spoken privately does not necessarily indicate lack of access, as some adolescents may not have needed or had an opportunity for a private consultation.

[10] World Health Organization. Global standards for quality health care services for adolescents. Geneva: World Health Organization; 2025. [cited 2026 Sep 22]. Available from: https://www.who.int/publications/i/item/9789240114012

[11] Federal Office of Public Health. Professional or medical secrecy. Bern: Federal Office of Public Health. [cited 2026 Sep 22]. Available from: https://www.bag.admin.ch/en/professional-or-medical-secrecy

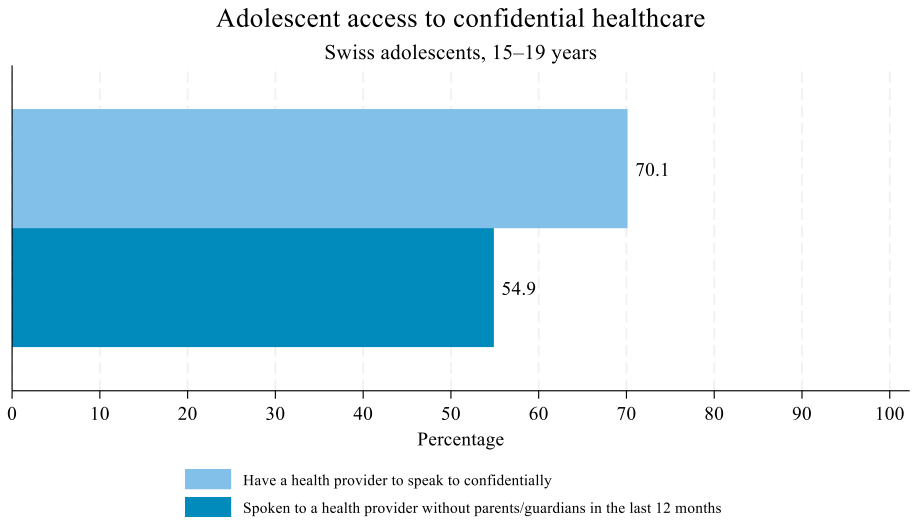


Figure 14. Access to confidential healthcare, Swiss adolescent subsample

We also asked adolescent participants whether there were any mental or physical health services they wished they had access to, and whether there were any other aspects of the healthcare system they would like to see improved. Open-text responses highlighted three recurring areas for improvement: access to mental health services, affordability and insurance coverage, and timely access to responsive healthcare. Mental healthcare was particularly prominent, with adolescents frequently describing shortages, waiting times and difficulties accessing age-appropriate psychological and psychiatric support.

5.5 Health system confidence

We assessed three dimensions of health system confidence: confidence that one would receive quality care if seriously ill; confidence that one could afford care if seriously ill; and confidence that the government considers public opinion in healthcare decisions.

Confidence in receiving quality care was high across all language regions with most respondents “very confident” or “somewhat confident” to receive quality care if needed, but lower in the Italian-speaking region (75.1%) than in the German- (86.3%) and French-speaking regions (87.1%).

Confidence in being able to afford quality care and that the government considers public opinion was much higher in the German-speaking region (72.0% and 39.9%, respectively) than in the French- (51.3%, 28.5%) and Italian-speaking regions (51.6%, 24.6%).

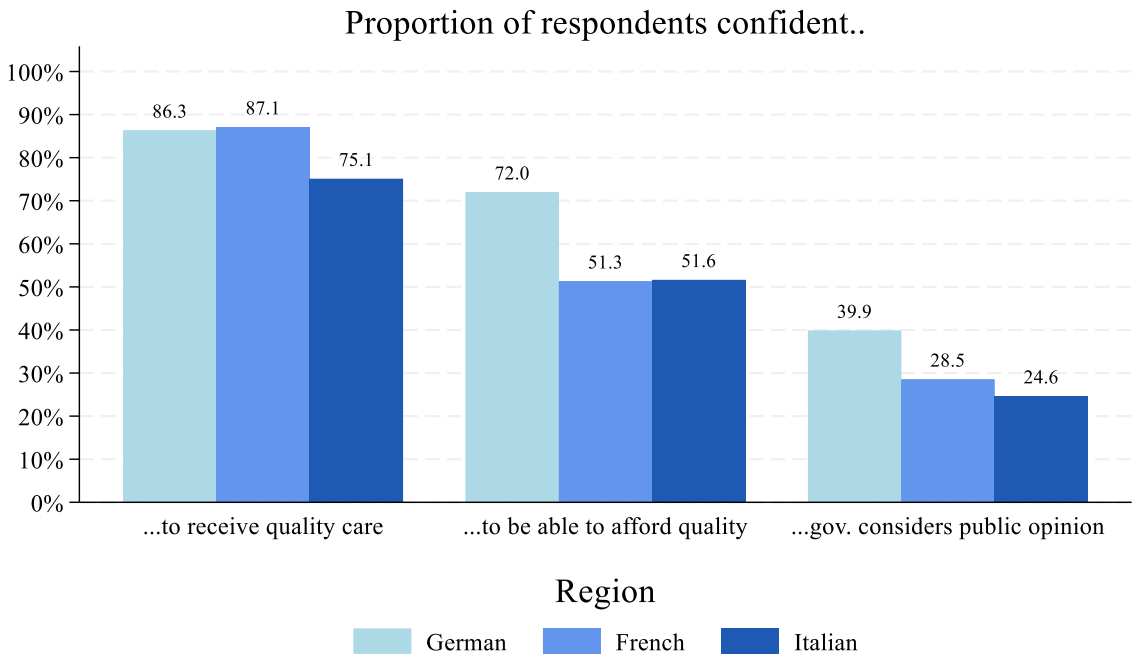


Figure 15. Confidence in health system and government responsiveness, Swiss national sample

The migrant subpopulations showed similarly high confidence that they would receive quality care if seriously ill, ranging from 78.9% among Ukrainians to 85.6% among Afghans (*see Fig. 16*). However, the pattern differed for the other dimensions: confidence in being able to afford quality care was lowest among Afghans (44.7%) but around 60% among Eritreans and Ukrainians, while confidence in government responsiveness was substantially higher across all three migrant groups (71.9–76.6%) than across the national sample.

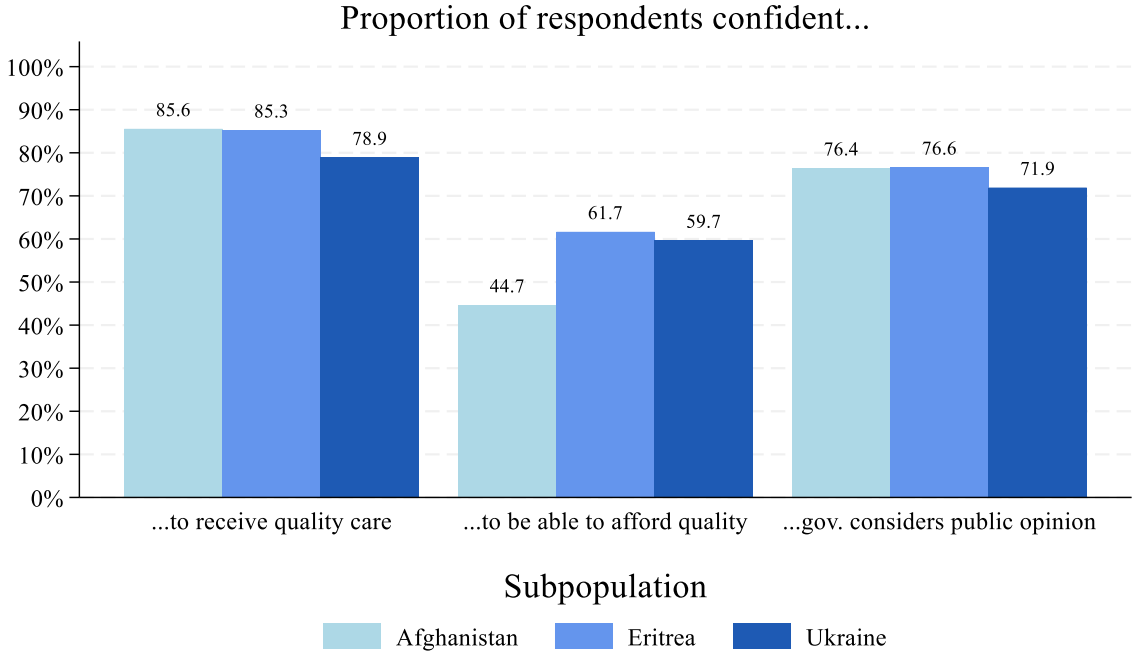


Figure 16. Confidence in health system and government responsiveness, migrant subgroups

5.6 Overall health system assessment

Respondents were asked to assess the Swiss healthcare system overall choosing between three statements: (1) the system needs to be completely rebuilt; (2) there are "good" things but major changes are needed; or (3) the system works pretty well and only minor changes are necessary.

Younger adults expressed a greater preference for change: among those aged 20–39, 48.2% supported major changes, while 69.7% of respondents ages 65-79 felt the system worked well and required only minor changes. (Figure 17). Younger adults (20-39) also had the largest endorsement of radical change, with 10.3% calling for a full restructure. Interestingly, individuals over age 80 were much more critical than individuals in the 65-79 age bracket.

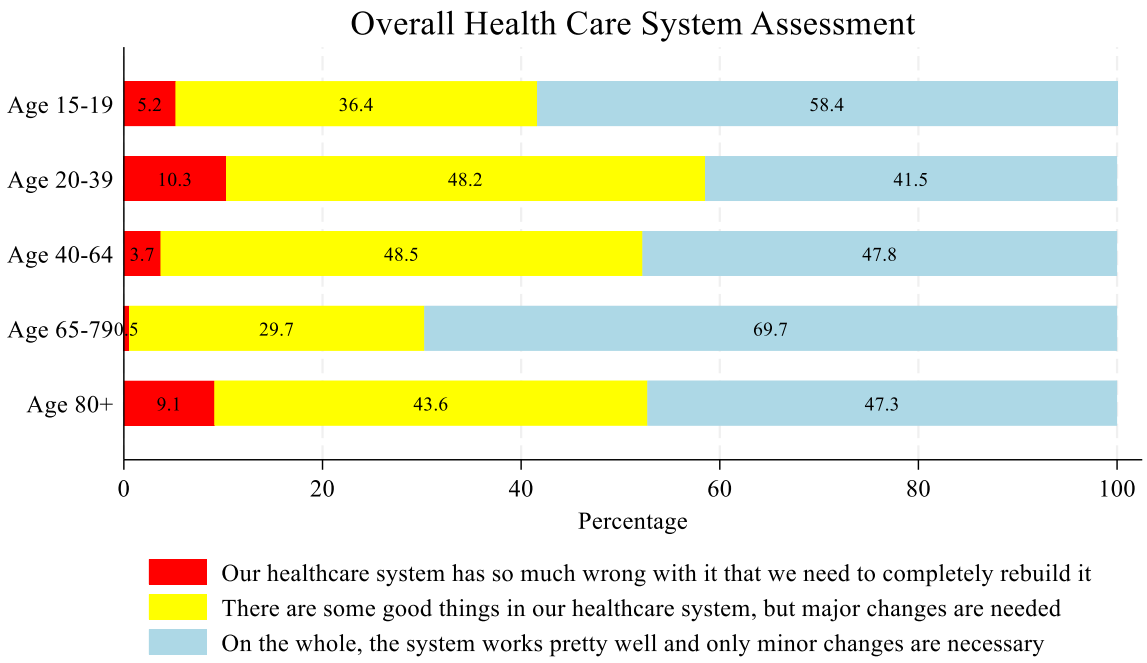


Figure 17. Overall health system assessment by age group, Swiss national sample

Regional variation was also notable (Figure 18). German-speaking respondents were most likely to say the system works well (53.4%), while Italian-speaking respondents were most critical (60.8% saying major changes needed, and 5.3% calling for the system restructure).

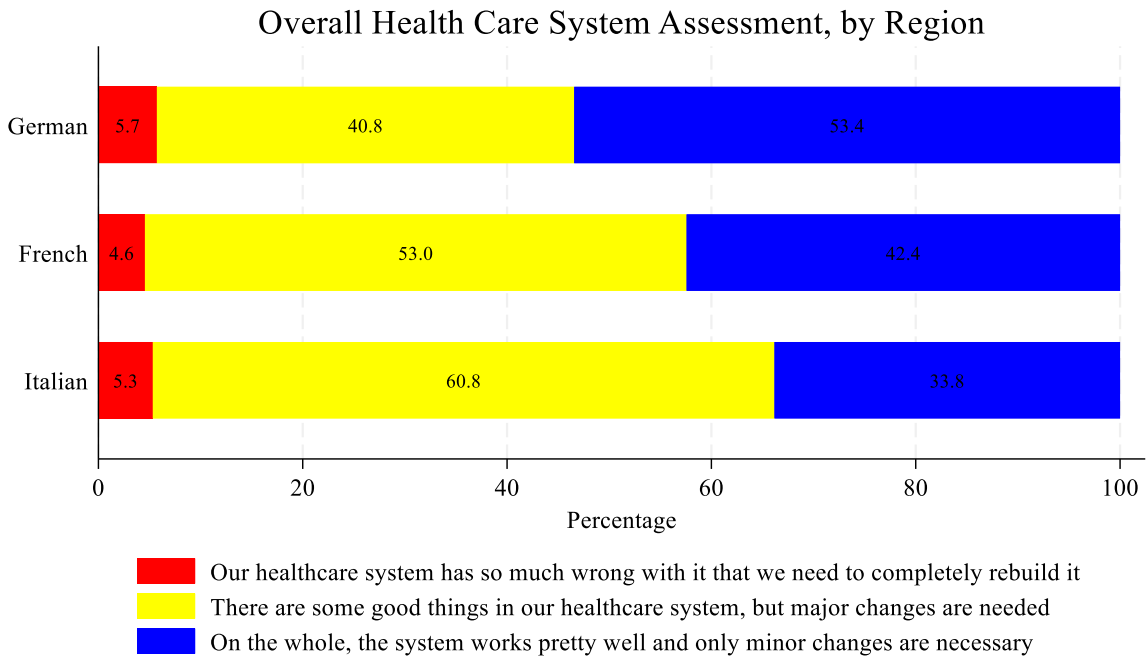


Figure 18. Overall health system assessment by language region, Swiss national sample

The Swiss general population appears to be more critical of the health system than migrants, with 44.6% calling for major changes and 5.4% for a full restructure. IIn comparison, 72.8% of Afghan respondents, 65.1% of Eritrean respondents, and 78.3% of Ukrainian respondents said the system works pretty well, which could reflect comparisons to health systems in their countries of origin.

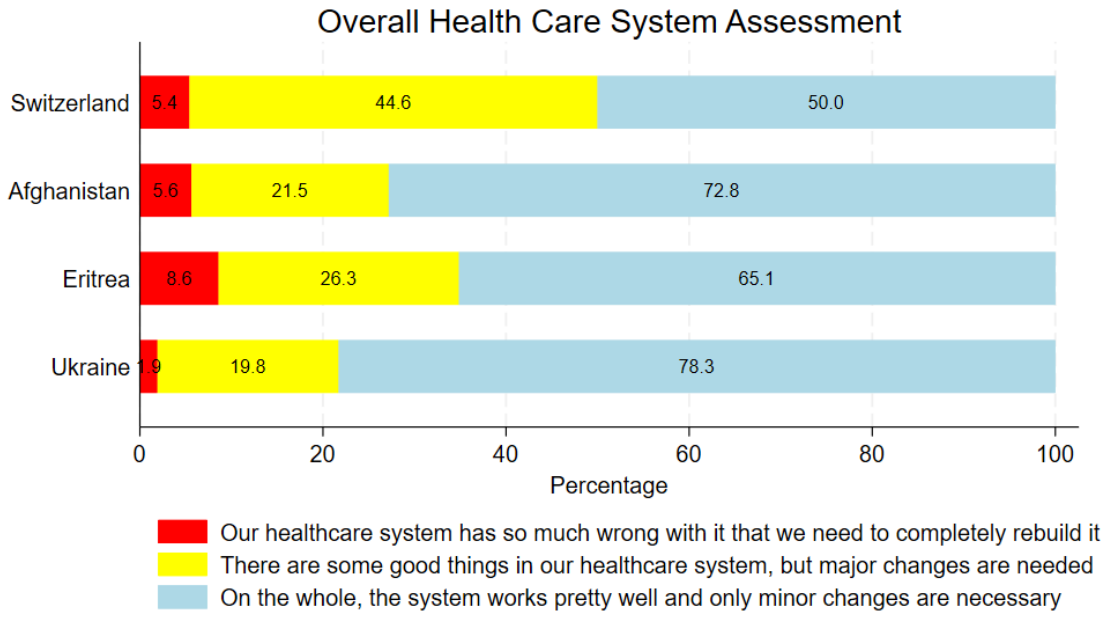


Figure 19. Overall health system assessment by subpopulation

Table 18 presents perceived trends in the Swiss health system over the past two years among the migrant subsample (N=805). We focused on migrant populations because changes over time may be more difficult for long-term residents to identify in a health system with which they are highly familiar. Overall, 72.9% of migrant respondents felt the system was staying the same, while 21.0% perceived improvement and 6.1% deterioration. Perceived improvement was more common among

Eritrean (39.2%) and Afghan (31.9%) respondents than among Ukrainians (14.7%), who were most likely to report that the system was staying the same (80.8%).

Table 18. Perceived trends in the Swiss health system over the past two years (migrant subpopulations only)

	Getting better	Staying the same	Getting worse	Total
% **Subpopulation**				
Afghanistan	31.9%	60.3%	7.8%	100.0%
Eritrea	39.2%	47.8%	12.9%	100.0%
Ukraine	14.7%	80.8%	4.6%	100.0%
Total	21.0%	72.9%	6.1%	100.0%

6. Summary and Discussion

This report presents findings from the first People's Voice Survey conducted in Switzerland, covering 2,798 respondents across the Swiss general population and three migrant communities. The survey was designed to fill a gap in existing evidence on how different population groups experience and assess the Swiss health system, with particular attention to adolescents and recently arrived migrants from Afghanistan, Eritrea, and Ukraine.

6.1 Health status and equity

Self-reported health was generally good in the Swiss national sample, but important differences emerged across age, gender, and socioeconomic groups. Overall, 11.2% of Swiss national respondents rated their general health as “poor” or “not so good”, while 43.9% rated it as “very good” or “excellent. General health declined with age and showed a clear socioeconomic gradient: respondents with higher education and higher income reported more favourable health than their counterparts. Women also reported less favourable general health than men, with 39.6% rating their health as “very good” or “excellent”, compared with 48.3% of men. These patterns are consistent with broader evidence showing that, despite Switzerland's generally favourable population health, health inequalities persist across socioeconomic groups[12].

General health differed substantially across migrant subpopulations, with Ukrainian respondents reporting poorer health than Afghan and Eritrean respondents and the Swiss national sample. This may partly reflect demographic differences, as Ukrainian respondents were older and predominantly female. The geographical proximity and greater accessibility of displacement routes from Ukraine may have made migration to Switzerland more feasible for older people and those with existing health limitations than the longer and more hazardous migration routes experienced by many refugees from Afghanistan and Eritrea. This interpretation remains tentative, however, as differences in health between the groups may also reflect conflict exposure, pre-migration health, socioeconomic circumstances and post-migration conditions.

Mental health showed a somewhat different age pattern. Overall, 10.4% of the Swiss national sample rated their mental health as “poor” or “not so good”, but this proportion reached 18.5% among adults aged 20–39, the highest of any age group. Women also reported less favourable mental health than men: 13.1% of women versus 7.7% of men rated their mental health as “poor” or “not so good”, while 51.3% of women compared with 63.8% of men rated it as “very good” or “excellent”. These findings broadly align with the Swiss Health Survey, which found higher psychological distress and moderate-to-severe depression among women than men and identified younger people as particularly affected by mental health problems.[13] The PVS findings therefore reinforce concerns about mental health among younger adults while also showing that poorer self-rated mental health is not confined to adolescents. Overall, the findings demonstrate why health equity assessments should examine both socioeconomic inequalities within the general population and heterogeneity between migrant populations rather than relying only on national averages.

[12] Federal Statistical Office (FSO). *Health Pocket Statistics 2024*. Neuchâtel: Federal Statistical Office; 2025 [cited 2026 Sep 10] Available from: https://www.bfs.admin.ch/asset/en/34027816

[13] Federal Statistical Office (FSO). (2023). *Swiss Health Survey 2022: First results*. Neuchâtel: Federal Statistical Office [cited 2026 Sep 10] Available from: https://www.bfs.admin.ch/asset/en/28885497

6.2 Insurance system complexity and equity

The insurance section of the survey highlights both the range of choices available within the Swiss health insurance system and the challenges these choices may pose for people who are less familiar with it. Deductible choices were strongly concentrated at the two extremes, CHF 300 and CHF 2,500, with lower-income and migrant respondents more likely to select the minimum deductible. Previous research shows deductible choice is shaped by multiple factors, including expected healthcare needs, financial circumstances, risk preferences and insurance literacy, making it difficult to interpret these patterns as reflecting financial optimisation alone[14][15].

This is particularly relevant for Ukrainian respondents, who were more likely to select the minimum deductible than the Swiss national sample and the other migrant groups. Their preference for a lower deductible may partly reflect their less favourable health profile and consequently greater anticipated healthcare needs, although this relationship cannot be established from the descriptive analyses.

Insurance literacy showed much clearer inequalities. Knowledge was substantially lower across migrant groups, while important gaps were also evident in the Swiss national sample. Most notably, nearly half of Swiss respondents and an even larger proportion of migrant respondents did not know that emergency care remains accessible under HMO models. Such misconceptions may have practical consequences if uncertainty about insurance rules discourages or delays appropriate care-seeking. These findings are consistent with previous Swiss research showing that navigating health insurance information and financial choices remains challenging for a substantial share of the population, with lower health-insurance literacy among non-Swiss residents[16].

Supplemental insurance coverage showed a similarly pronounced divide, with substantially lower coverage among migrant respondents, particularly Ukrainians. Differences in supplemental coverage may reflect financial resources, knowledge of available options, healthcare needs and length or security of residence in Switzerland. Overall, the findings suggest that equity within a choice-based insurance system depends not only on formal insurance coverage, but also on people's ability to understand, navigate and financially manage the available options.

6.3 Access and utilisation of care

Overall, the findings indicate substantial use of healthcare services in Switzerland, alongside some reported gaps in continuity, timeliness and ability to obtain needed care. Swiss respondents reported an average of 4.7 healthcare visits and used 2.2 different types of facilities during the previous 12 months. Utilisation generally increased with age, while telemedicine use remained relatively limited and was concentrated among younger adults.

Continuity of care was generally high in the Swiss national sample, with 77.0% identifying a family doctor as their usual source of care. Nevertheless, 16.5% reported having no usual place of care, compared with 20.5% among migrants, with particularly low continuity among Eritrean respondents (55.2% without a usual source). This finding is consistent with previous Swiss research highlighting the importance of family physicians as stable points of contact for refugees and asylum seekers, while identifying language barriers, mobility and fragmented information exchange as challenges to

[14] Boes S, Gerfin M. Health insurance subsidies and deductible choice: Evidence from regional variation in subsidy schemes. *Journal of Health Economics*. 2017;55:262–273. doi:10.1016/j.jhealeco.2017.08.002

[15] Boes S, Liu Y. Do individuals with better health insurance system knowledge make better decisions about their health plans? *Applied Economics*. 2024;56:8867–8883

[16] Bardy TLC, Boes S, et al. Assessing health insurance literacy in Switzerland: first results from a measurement tool. *European Journal of Public Health*. 2024;34(2):237–243. doi:10.1093/eurpub/ckad190.

continuity of care[17]. This suggests that universal insurance coverage does not necessarily translate into an established relationship with primary care, which may be particularly relevant for populations less familiar with the organisation of the Swiss healthcare system.

Patterns of healthcare utilisation also differed across migrant populations. Ukrainian respondents reported relatively high utilisation, averaging around 5.9 visits, whereas Eritrean respondents reported approximately three. These differences should not be interpreted straightforwardly as differences in access: higher utilisation among Ukrainian respondents may partly reflect their less favourable health profile, while lower utilisation among Eritrean respondents could reflect lower healthcare needs, their younger demographic profile, barriers to accessing care, or a combination of these factors. The cross-sectional data cannot distinguish between these explanations.

Timeliness of access presents a more mixed picture. Among Swiss respondents reporting a recent appointment, 46.9% obtained it within two weeks, while 19.1% waited more than four weeks. Waiting times therefore suggest that timely access cannot be assumed even within a well-resourced health system and should be considered alongside measures of unmet need. Indeed, unmet need provides more direct evidence of access barriers. 15.8% of Swiss respondents reported an unmet physical healthcare need during the previous year and 5.8% an unmet mental healthcare need, despite mandatory health insurance coverage. Financial barriers were also evident, with 5.4% reporting that they had borrowed money to afford healthcare. Among migrants, unmet physical and mental healthcare needs were somewhat lower (12.7% and 3.6%, respectively), but borrowing money was more common (8.7%), reaching 14.9% among Afghan respondents. Despite universal mandatory health insurance, financial barriers to healthcare remain relevant in Switzerland. Previous Swiss studies have documented cost-related forgone care, particularly among people with fewer financial resources, and have identified cost-sharing, deductibles and rising insurance costs as potential contributors to financial barriers to care[18][19].

6.4 Preventive care and system competence

Preventive care coverage varied substantially across services, suggesting that opportunities for prevention are not being realised uniformly. In the Swiss national sample, dental examinations (68.6%) and blood pressure checks (63.7%) were the most commonly reported preventive services, while substantially lower proportions reported blood sugar (33.4%) or cholesterol testing (32.9%), mammography (29.6%), cervical cancer screening (43.1%) or a general health check-up (43.8%). These differences should be interpreted cautiously, as eligibility and recommended frequency vary considerably by preventive service, particularly for cancer screening. Nevertheless, the findings indicate that engagement with preventive care is uneven across the population.

This is relevant in the broader context of the Swiss health system, which combines high overall healthcare expenditure with comparatively limited spending on prevention. According to OECD assessment, in 2023, prevention accounted for 1.9% of current health expenditure in Switzerland, compared with an OECD average of 3.4%. At the same time, performance varies considerably across preventive interventions: OECD data indicate relatively high cervical cancer screening coverage in Switzerland (75%), while breast cancer screening coverage (50%) remains below the OECD average

[17] Oehri J, Chernet A, Merten S, Sydow V, Paris DH. Improving primary healthcare access for asylum seekers and refugees: a qualitative study from a Swiss family physician perspective. *J Prim Care Community Health*. 2023;14:21501319231181878. doi:10.1177/21501319231181878

[18] Guessous I, Gaspoz JM, Theler JM, Wolff H. High prevalence of forgoing healthcare for economic reasons in Switzerland: a population-based study in a region with universal health insurance coverage. *Prev Med.* 2012;55(5):521–527. doi:10.1016/j.ypmed.2012.08.005

[19] Pletscher M, et al. How important is income in explaining individuals having forgone healthcare due to cost-sharing payments? Results from a mixed methods sequential explanatory study. *BMC Health Serv Res. 2022*. doi:10.1186/s12913-022-07527-z.

(55%). This variation is consistent with the PVS finding that engagement with preventive care is uneven across services[20].

Regional differences were particularly evident in preventive screening, with noticeable variation across the German-, French- and Italian-speaking regions. These findings are consistent with Switzerland's decentralised healthcare system, where the organisation and availability of organised screening programmes differ between cantons, contributing to unequal uptake of preventive services. The substantial regional variation observed in preventive screening is consistent with previous Swiss research showing differences in cancer screening utilisation across language regions and cantons. Mammography utilisation in particular has been higher in French- and Italian-speaking regions than in German-speaking Switzerland, with part of this variation associated with the uneven cantonal implementation of organised screening programmes[21][22].

Respondents' assessments of the quality of specific areas of healthcare similarly revealed considerable variation. Paediatric (64.5%) and maternity care (63.1%) received the most favourable ratings, followed by chronic disease care (58.0%) and rehabilitation (56.1%). In contrast, only 32.2% rated mental healthcare highly, the lowest rating of all service areas assessed, while respondents were also somewhat critical of reproductive healthcare (only 45.3% rated highly). Particularly low assessments of mental and reproductive healthcare among respondents still in education warrant attention.

The low perceived quality of mental healthcare is especially notable given the mental health patterns identified elsewhere in the survey, including the comparatively high proportion of younger adults reporting poorer mental health. Perceived quality should not be interpreted as an objective measure of clinical quality: respondents' assessments may reflect personal experience, accessibility, expectations, awareness of available services and broader perceptions of the healthcare system. Nevertheless, the Swiss population clearly sees gaps in access to high quality mental health care.

Overall, Switzerland performs strongly on many conventional health-system indicators—including low preventable and treatable mortality—yet the PVS identifies areas in which population experience and perceptions are substantially less favourable. Strengthening prevention and addressing areas perceived as less responsive, particularly mental and reproductive healthcare, may therefore complement Switzerland's strong overall health-system performance.

6.5 Health system confidence and reform views

Confidence in the Swiss health system was generally high with respect to the expected quality of care, but substantially lower for affordability and government responsiveness. Across language regions, 75.1–87.1% of respondents were confident that they would receive quality care if seriously ill, whereas confidence in being able to afford such care ranged from 51.3% to 72.0%. Confidence that the government considers public opinion in healthcare decisions was considerably lower, ranging from 24.6% to 39.9%. These findings suggest that trust in the clinical capacity of the health system does not necessarily translate into confidence in its affordability or responsiveness to citizens.

[20] OECD. Health at a Glance 2025: OECD Indicators. Paris: OECD Publishing; 2025. doi:10.1787/8f9e3f98-en [cited 2026 Sep 10] Available from: https://www.oecd.org/en/publications/2025/11/health-at-a-glance-2025-country-notes_2f94481e/switzerland_366ce195.html

[21] Muheim LLS, Senn O, Früh M, Reich O, Rosemann T, Neuner-Jehle S. Temporal trends and regional disparities in cancer screening utilisation: an observational Swiss claims-based study. *BMC Public Health*. 2021;21:23. doi:10.1186/s12889-020-10020-9.

[22] Jolidon V, De Prez V, Bracke P, Cullati S, Burton-Jeangros C. Revisiting the effects of organized mammography programs on inequalities in breast screening uptake: a multilevel analysis of nationwide data from 1997 to 2017. *Front Public Health*. 2022;10:812776. doi:10.3389/fpubh.2022.812776.

Regional differences were marked. Respondents in the Italian-speaking region expressed the lowest confidence in the health system, and 60.8% of Italian-speaking respondents called for major changes compared with 40.8% in German-speaking Switzerland.

Views on reform also differed substantially by age. Respondents aged 65–79 were the most positive, with 69.7% stating that the system works well and requires only minor changes. In contrast, adults aged 20–39 were the most critical: 48.2% called for major changes and 10.3% for a complete restructuring. This generational contrast may reflect differences in healthcare needs, financial exposure, expectations or experiences with the system, although the descriptive data cannot determine the mechanisms underlying these differences.

Migrant respondents presented a different pattern. Confidence in receiving quality care was similarly high, ranging from 78.9% to 85.6%, while confidence in affordability was notably lower among Afghan respondents (44.7%). At the same time, confidence that government considers public opinion was considerably higher among all three migrant groups (71.9–76.6%) than in the Swiss national sample. Migrant respondents were also more likely to report that the Swiss health system works well and requires only minor changes: 72.8% of Afghan, 65.1% of Eritrean and 78.3% of Ukrainian respondents selected this response, compared with a more critical assessment among the Swiss national population. These differences may reflect distinct expectations, previous healthcare experiences and reference points, but should not be attributed to any single mechanism without further analysis.

Among migrant respondents asked about changes over time, 72.9% perceived the health system as staying the same, while 21.0% thought it was improving and 6.1% thought it was worsening. Perceived improvement was more common among Eritrean and Afghan respondents than among Ukrainian respondents.

Overall, the findings suggest that confidence in the Swiss health system is multidimensional: respondents may simultaneously trust the quality of care while expressing concerns about affordability, political responsiveness and the need for reform. The more positive assessment among older respondents and the comparatively critical views in Italian-speaking Switzerland are consistent with previous Swiss survey evidence showing higher health-system satisfaction among older adults and meaningful regional differences in perceptions of healthcare[23]. The relatively low confidence that government considers public opinion should not necessarily be interpreted as low general institutional trust[24]. Previous OECD data show comparatively high trust in the Swiss federal government and high satisfaction with healthcare services, but these measures capture broader institutional trust and service satisfaction. The PVS item instead assesses a more specific dimension of responsiveness—whether people feel that public opinion is considered in healthcare decision-making. The findings therefore suggest that positive overall evaluations of institutions and healthcare can coexist with more critical perceptions of citizen influence over policy decisions

6.6 Migrant inclusion and health-system navigation

The inclusion of recently arrived populations from Afghanistan, Eritrea and Ukraine provides an opportunity to examine how migrants interact with a complex health system during different migration and settlement trajectories. Taken together, the findings suggest that formal entitlement to healthcare does not necessarily ensure an equal capacity to navigate the system. Rather than

[23] Federal Office of Public Health (FOPH). The majority of the Swiss population is satisfied with healthcare: results of the 2023 Commonwealth Fund International Health Policy Survey. Bern: FOPH; 2023 Available from https://www.admin.ch/en/nsb?id=99203

[24] OECD. *OECD Survey on Drivers of Trust in Public Institutions 2024 Results*: Country Notes – Switzerland. Paris: OECD Publishing; 2024 Available from: https://www.oecd.org/en/publications/2024/06/oecd-survey-on-drivers-of-trust-in-public-institutions-2024-results-country-notes_33192204/switzerland_133eef64.html

pointing to a single access barrier, the results indicate that effective navigation depends on understanding insurance arrangements, identifying appropriate entry points to care, establishing continuity with providers, and managing the financial and administrative requirements associated with healthcare.

Previous Swiss research supports this interpretation. Limited familiarity with the organisation of the Swiss healthcare system, language and communication barriers, and difficulties understanding insurance arrangements have all been identified as potential obstacles to appropriate healthcare use among migrant and refugee populations. More broadly, navigational health literacy is increasingly recognized in Switzerland as an important component of effective access to healthcare, particularly for disadvantaged population groups[252627].

Importantly, the PVS findings demonstrate that migrant populations should not be considered a homogeneous group. The contrasting patterns observed among Ukrainian, Afghan and Eritrean respondents suggest different combinations of healthcare needs, financial vulnerability, system knowledge and patterns of service use. These differences are likely shaped by multiple factors—including demographic composition, health needs, migration trajectories, language, duration and circumstances of residence, and previous experience with healthcare systems—and cannot be attributed to migration status alone.

From a health-system perspective, these findings support approaches that facilitate navigation rather than relying exclusively on individuals to acquire knowledge of a complex system independently. Evidence from Switzerland suggests that structured models providing an initial point of contact and support can facilitate asylum seekers' transition into regular healthcare, while language barriers remain an important challenge to effective primary care. Improving accessible information, language support and linkage to primary care may therefore help translate formal healthcare coverage into more effective access for newly arrived populations.

6.7 Adolescent health and adolescent-responsive care

Adolescents generally reported favourable physical health, with 68.2% rating their health as “very good” or “excellent”. Nevertheless, 22.6% reported a longstanding health condition**,** a notable proportion for this young age group, and 11.1% rated their mental health as “poor” or “not so good”. These findings are consistent with previous evidence from Switzerland showing that, despite generally favourable health among young people, mental health and longer-term health needs remain important concerns, with recent national monitoring also identifying mental health as an area requiring particular attention.[2829] The PVS extends this evidence into later adolescence by examining not only health status but also adolescents’ experiences with the healthcare system. Adolescents rated several aspects of their most recent healthcare visit less positively than the overall population, particularly involvement in decisions (66.6% vs. 74.0%), sufficient provider time (62.4% vs. 67.3%), and privacy (70.9% vs. 79.6%). Preventive and psychosocial topics were also not

[25] Federal Office of Public Health (FOPH). Health literacy [Internet]. Bern: Federal Office of Public Health; [cited 2026 Sep 10]. Available from: https://www.bag.admin.ch/en/health-literacy

[26] Jaeger FN, Pellaud N, Laville B, Klauser P. The migration-related language barrier and professional interpreter use in primary healthcare in Switzerland. *BMC Health Serv Res*. 2019;19:429. doi:10.1186/s12913-019-4164-4

[27] Mantwill S, Schulz PJ. Low health literacy and healthcare utilisation among immigrants and non-immigrants in Switzerland. *Patient Educ Couns*. 2017;100(11):2020–2027. doi:10.1016/j.pec.2017.05.023

[28] Delgrande Jordan M, Schmidhauser V, Balsiger N. Santé et bien-être des 11 à 15 ans en Suisse – Situation en 2022, évolution dans le temps et corrélats: Résultats de l’étude Health Behaviour in School-aged Children (HBSC). Lausanne: *Addiction Suisse*; 2023.

[29] Balsiger N, Delgrande Jordan M. Gesundheit und Gesundheitsverhalten von 11-, 13- und 15-jährigen Jugendlichen im Jahr 2022 und Entwicklung über die Zeit: Die Schweiz im internationalen Vergleich – Ergebnisse der Studie Health Behaviour in School-aged Children (HBSC). Lausanne: Sucht Schweiz; 2025.

routinely addressed in primary care: mental health was discussed with 35.6% of adolescents, sexual health with 23.8%, bullying with 9.1%, and physical violence with 5.3%. While 70.1% reported having a healthcare provider with whom they could speak confidentially, only 54.9% had spoken with a provider without a parent or guardian during the previous year. Adolescents' own suggestions for improvement reinforced these findings, highlighting better access to mental health services and age-appropriate psychological and psychiatric support, improved affordability and insurance coverage, and more timely and responsive healthcare.

6.8 Strengths and limitations

This survey has several important strengths. The multilingual design — with translations into Ukrainian, Dari, Pashto, Tigrinya, and English alongside the three national languages — is a methodological innovation that substantially improves the quality of data from migrant groups compared to surveys relying solely on national languages. The inclusion of adolescents (aged 15-19) fills an important gap in existing Swiss health survey data. Finally, weighting of both the national and migrant samples improves the population relevance of the descriptive estimates and enables comparisons across demographic, regional and population groups.

Key limitations should also be noted. Response rates for the mail-based migrant surveys, while comparable to similar studies, were moderate (13.3-26.9%), and non-response bias cannot be excluded. Migrants who are harder to reach — those with very limited language skills, irregular housing, or shorter stays in Switzerland — are likely underrepresented. The cross-sectional design prevents causal inference. Self-reported data on health status, care quality, and insurance choices may be subject to recall and social desirability bias. Finally, the adolescent subsample was recruited primarily through the online panel, which may over-represent adolescents with better digital access.

6.9 Conclusions and policy recommendations

The People's Voice Survey provides a population-centred perspective on the performance of the Swiss health system. Overall, the findings portray a system in which confidence in the quality of healthcare remains high in most areas, but important gaps exist in affordability, prevention, mental healthcare, health-system navigation and perceptions of government responsiveness. These findings suggest that strong health outcomes and extensive resources do not necessarily translate into equally positive experiences across all dimensions of care.

We highlight seven priority areas for policy action:

- **Strengthen financial protection and affordability of care**. The combination of unmet healthcare need, healthcare-related borrowing and relatively low confidence in being able to afford care suggests that mandatory insurance as well as cantonal premium waivers and subsidies do not fully eliminate financial barriers. Policies addressing out-of-pocket costs and perceived financial burden should therefore remain central. This is consistent with the broader policy challenge identified in Switzerland's Health2030 strategy, which recognizes rising premiums and patient cost-sharing as important pressures on households[30].
- **Increase the emphasis on prevention and reduce regional variation**. The substantial variation in preventive service uptake, particularly cancer screening, supports stronger and more consistent preventive-care pathways across cantons and language regions. A rigorous evaluation of current cantonal policies as well as clear policy guidelines are needed to fine-tune and optimize preventive health care services.

[30]Swiss Federal Council. Health2030: the Federal Council's health policy strategy for the period 2020–2030 [Internet]. Bern: Swiss Confederation; 2019 [cited 2026 Sep 10]. Available from: https://www.bag.admin.ch/en/the-federal-councils-health-policy-strategy-20202030

- **Strengthen mental healthcare responsiveness, particularly for younger populations.** Mental healthcare received the least favourable assessment among the service areas examined, while poorer self-reported mental health was particularly evident among younger adults. Even though the coverage of mental health services through health insurance has been expanded substantially, the perceived quality of care received by patients remains low. Strengthening mental healthcare should therefore be a health-system priority, with a focus on improving timely access, responsiveness and continuity of care.
- **Make the health and insurance system easier to navigate.** Knowledge gaps were not restricted to recently arrived populations, suggesting a broader need for clearer and more accessible information on insurance choices, access models and pathways through the healthcare system. Navigation support should be designed around differing levels of health and insurance literacy and should be accessible across languages and population groups. Strengthening people-centred and coordinated primary care is also consistent with current international recommendations for improving health-system performance.
- **Strengthen population voice in health-system decision-making.** The contrast between high confidence in receiving quality care and much lower confidence that government considers public opinion suggests an opportunity to strengthen meaningful public involvement in health policy. Mechanisms for consultation and participation should not only collect population views but also demonstrate how these perspectives inform policy decisions.
- **Integrate migrant populations into mainstream healthcare**. Migrants generally expressed high confidence in Swiss healthcare, while lower insurance literacy, gaps in having a usual source of care and financial barriers indicate difficulties navigating it. Policy should therefore focus on facilitating integration through early linkage to primary care, multilingual information and interpretation, and navigation support within existing services. Such an approach can promote continuity and equity while avoiding fragmentation or the creation of parallel pathways that may inadvertently separate migrant populations from the wider healthcare system.
- **Strengthen adolescent-responsive care.** Healthcare services should better respond to adolescents' physical, mental and psychosocial needs by ensuring timely access to age-appropriate care, particularly mental health services, and by providing routine opportunities for confidential consultations and meaningful involvement in healthcare decisions. Primary care contacts could be used more systematically to address relevant preventive and psychosocial topics, including mental health, sexual health, substance use, bullying and violence.