ESPN Thematic Report on Inequalities in access to healthcare

Switzerland

2018

Philipp Trein
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European Social Policy Network (ESPN)

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

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Summary / Highlights

The Swiss healthcare system is based on three pillars: federalism (power-sharing between levels of government), liberalism (e.g. individual choice for patients and market elements for providers) and subsidiarity (delegation of competencies to private/non-state actors at the lowest level of government). This implies that there are de facto 26 cantonal health systems, which are coordinated by the national government mainly through the national health insurance legislation. Potential inequalities in access to healthcare result from the high non-progressive insurance premiums and/or co-payments for treatment because individuals cannot afford services or forgo examinations and visits to the doctor because they are too expensive. This is especially the case for poor, low-income earners and elderly individuals. Another dimension of inequality concerns regional differences: insurance premiums, the ratio of doctors to patients, types of healthcare provider networks, and eligibility for subsidies all vary considerably between cantons, which might result in inequality of access due to differences in prices and the availability of certain treatments. To remedy this, there are a number of policies in place. Most notably, all cantons offer subsidies on premiums, which alleviate the high premium costs for individuals on low income. However, the level of subsidies differs between cantons. Another policy that is in place concerns redistribution between cantons, because in some cantons citizens were paying insurance rates that were too high; therefore, between 2014 and 2017, individuals in 11 cantons needed to pay more, while in other cantons citizens enjoyed lower prices for health insurance. The biggest challenge in Swiss health policy remains the high cost and increasing health insurance premiums. Measures to reform this problem should ensure that inequality in access is tackled among poorer population groups, for example the elderly living along or those who are poor and already depend on public transfers. Furthermore, measures should make sure that regional inequalities in services and prices do not increase further, which could extend inequalities in access to healthcare.

1 Description of the functioning of the country's healthcare system for access[1]

The healthcare system in operation today in Switzerland is based on the health insurance law adopted in 1994 and valid since 1996 (LAMal; Loi fédérale sur l'assurance maladie), which replaced the earlier law of 1911. The 1994 reform signified a change from a voluntary health insurance system to a universal and mandatory health insurance system (OKP – *Obligatorische Krankenpflegeversicherung*) (Uhlmann and Braun, 2011).

The health insurance system consists of three pillars: mandatory basic health insurance, with its three parts (illness, accident and maternity), which covers most incidents; complementary health insurance, which is voluntary and covers costs like private or semi-private rooms in hospitals and specific treatments such as dental care; and voluntary insurance for daily cash benefits, making up loss of income in the case of longer stays in hospital (Indra et al., 2015).

These insurance schemes are offered by private health insurance agencies. In the case of basic health insurance, insurers are not allowed to make a profit (they are part of the social insurance system); in the case of the other two kinds of insurance, profit is permissible. This means different access criteria: in mandatory health insurance, insurers are required, despite competition for insurance contracts, to accept all applications, irrespective of gender, previous illness or age. Individuals, on the other hand, are free to choose their doctor and even specialists (unless they have specific contracts with lower premiums that limit this choice), and they can also choose their preferred insurance agency (though this choice is limited to the canton in which they live). Treatment outside the canton is possible, however, if a patient is prepared to pay the difference in price. Since January 2018, patients no longer have to pay for cantonal price differences in the case of outpatient treatment.[2]

Insurance premiums in Switzerland are individual based and are not related to income; this makes the health insurance system regressive and typical of a private insurance system (state-led and social insurance systems have progressive income systems for health premiums). Employers do not contribute to premium payments. Individuals pay the providers of health services direct and are reimbursed by their insurance companies. Since the introduction of national health insurance, insurance premiums and national health expenditure have increased steadily (FOS, 2018a).

Though insurers may not adapt premiums to gender, age or past history of illness (an exception is made for children and young adults in education, who benefit from reduced premium levels), premiums may vary for other reasons: together with the USA and the Netherlands, Switzerland is the only country offering 'deductibles' on basic insurance. These can vary between 350 Swiss francs (CHF) (EUR 300) and CHF 2,500 (EUR 2,160). Deductibles are seen as a way to reduce cost pressure on the system. About 60% of individuals use such deductibles (FOPH, 2018a). Furthermore, there is the possibility to choose insurance with lower premiums, but with restricted access to providers (e.g. by general practitioners or health maintenance organisations). The use of these cheaper insurance forms has also increased over the years (18% of insured in 2006 to 67.2% in 2016; FOPH, 2018a). Insurers can also offer a 'bonus' for those who have not used any of the healthcare services during the year.

In 2015, 35% of the cost of health services and drugs was financed by health insurance premium payments. In addition, private households contributed about 29%, in the form of out-of-pocket payments and deductibles, and they also paid about 8% for private health insurance. Other social insurances pay 10% of the national health expenditure. Public

[1] This section is based on Bonoli and Trein (2018).

[2] Federal Office of Public Health (FOPH), https://www.admin.ch/gov/de/start/dokumentation/medienmitteilungen.msg-id-68789.html, accessed 13 January 2018.

bodies contribute only 18% to health spending, with cantons paying the lion's share (FOS, 2018a).

There is large variation in the premium levels between cantons. Being a federal country, in Switzerland premium levels are calculated on the basis of 'cantonal risk' (incidence of illness; average provider costs) and are fixed for a canton and for up to three administrative sub-regions within one canton. This procedure has led to differences between cantons when comparing the highest and the lowest median premium level. For example, in 2013 the average insurance premium for one adult with a standard deductible (CHF 350 (EUR 300)), including accident coverage, varied from CHF 269 (EUR 233) in Nidwalden to CHF 473 (EUR 409), in Basel-Stadt. Furthermore, the prices of pharmaceutical products vary from canton to canton: in 2013, average spending on pharmaceuticals under the obligatory health insurance was CHF 418 (EUR 362) in Appenzell Inner-Rhodes but CHF 833 (EUR 721) in Geneva (Nold, 2015: 212; Indra et al., 2015: 227).

Households bear substantial additional costs in the form of co-payments and out-of-pocket payments for drugs and medical services, respectively. These payments are set at 10% of the cost and at CHF 15 (EUR 13) per day for hospital stays. A maximum amount per year applies: CHF 700 (EUR 605) for adults and CHF 300 (EUR 260) for children. This amount needs to be paid in addition to the deductibles and the health insurance premiums. Thus, the Swiss healthcare system requires individuals to have enough cash to pay (or pre-pay) for treatment, in order to ensure access to health services. There are policies in place to assist individuals who cannot afford co-payments and insurance premiums (to be discussed below).

In the case of voluntary insurance, the governance structure is different. Insurers (both commercial ones and those working under the rules of the social insurance system) are not only free to make a profit, but are also free to define eligibility and even exclusion criteria according to risk assessments. These types of insurance contracts are mostly complementary to the standard health insurance package, and provide services (such as dental insurance) that are not covered by basic health insurance, travel insurance offering full coverage for healthcare costs abroad, a completely free choice of hospital, treatment in private hospitals, etc. (FOPH, 2018b). Insurers can select the patients and risks they are prepared to accept; thus, older individuals or those with pre-existing conditions might not be admitted to the complementary health insurance packages.

In Switzerland, the legal obligation to have health insurance means that everyone has basic health insurance, and therefore access to healthcare services. This includes vulnerable groups, such as asylum seekers, whose health insurance contributions are covered by municipal social assistance. Regarding asylum seekers, cantons are allowed to limit their freedom of choice of health insurance and healthcare providers.[3]

Due to the decentralised nature of the Swiss healthcare system (Trein, 2018a), there are regional differences not only in insurance contributions (which are also related to differences in the economic power of cantons), but also in terms of access to healthcare. This concerns, for example, the availability of integrated care providers, which link different sectors of the healthcare system, such as prevention, outpatient treatment, inpatient treatment and long-term care. In recent years, more and more Swiss citizens have chosen health insurance that offers cheaper premiums, but that limits choice to specific providers, such as so-called 'doctor networks' (*Ärztenetzwerk*), which may be health maintenance organisations or telemedicine centres. The choice among these providers can vary between regions. For example, in rural areas there might be less choice between integrated care networks than in urban regions or particularly in urban centres. Consequently, the geographical location of domicile has an impact on the degree of choice for integrated healthcare services in Switzerland (Berchthold and Kaspar, 2015). Furthermore, in Switzerland there are significant regional differences regarding various types of treatment.

[3] Swiss Refugee Council, https://www.refugeecouncil.ch/asylum-law/legal-status/asylum-seekers.html, accessed 7 May 2018.

For example, there is large regional variance in specific operations, such as caesarean, prostate removal in cancer patients, or meniscus (knee) operations.[4] To take as an example the differences regarding caesareans, these can be explained by regional differences in childbearing ages. Other differences, such as meniscus operations, show a regional variance that is more puzzling; thus, there is a need for further research to find our whether there is regional over- and/or under-supply with specific treatments.[5]

Switzerland is one of the richest countries in the world (2016 GDP of USD 63,889 (EUR 55,000)); it has a relatively moderate level of income inequality (Gini 0.297 in 2014) and high life expectancy (83 years at birth in 2015). At the same time, it has one of the most expensive health systems in the world (USD 7,919 per capita (EUR 6,824) in 2016) (OECD, 2018). As mentioned above, healthcare governance rests on three pillars in the Swiss health system: federalism (power-sharing between levels of government), liberalism (e.g. individual choice for patients and market elements for providers) and subsidiarity (delegation of competencies to private/non-state actors at the lowest level of government) (Trein, 2018b). Furthermore, health spending has increased steadily since the introduction of national health insurance in 1996. For example, the standard premium for adults (over 26) was CHF 173.10 (EUR 150) in 1996, but had risen to CHF 465.30 (EUR 403) by 2018. In addition, the country has rather high out-of-pocket health expenses for individuals. In 2016, for example, 37.22% of national health expenditure entailed out-of-pocket expenses for patients. This figure includes amounts paid through private and supplementary health insurance. The share was higher in 1996, but the constant reduction in out-of-pocket expenditure has been accompanied by a steady increase in the share of health expenditure paid by health insurance providers (which, in turn, have increased insurance premiums) (Table 1).

Table 1: Selected health expenditure indicators

Year	Average standard premium for adults in CHF (EUR)	Difference over the previous year	Health expenditure as percentage of GDP	Health insurance provider expenses (percentage of national health expenditure)	Out-of-pocket expenses (percentage of national health expenditure)
1996	173.10 (150)	–	9.7%	28.3%	45.62%
2000	211.70 (183)	3.8%	9.8%	30.1%	44.39%
2005	290.20 (251)	3.7%	10.8%	33.2%	39.42%
2010	351.10 (304)	8.7%	10.7%	34.0%	38.23%
2015	411.80 (356)	4.0%	11.9%	35.4%	36.64%
2016	428.10 (370)	4.0%	12.2%	35.6%	37.22%
2017	447.30 (386)	4.5%	-	-	-
2018	465.30 (402)	4.0%	-	-	-

Sources: FOPH (2018b); FOS (2018a).

[4] For exact numbers, consult the following homepage, which presents the results of a research project to analyse regional differences in healthcare availability. The project is implemented by the Swiss Health System Observatory (OSAN) and the Institute for Social and Preventive Medicine at the University of Bern: www.versorgungsatlas.ch, accessed 6 May 2018.

[5] *Tages-Anzeiger*, https://www.tagesanzeiger.ch/wissen/medizin-und-psychologie/wo-aerzte-am-haeufigsten-operieren/story/30714084, accessed 6 May 2018.

2 Analysis of the challenges in inequalities in access to healthcare in the country and policies to deal with them

Overall, there are no striking inequalities in access to healthcare in Switzerland (OECD, 2016: 155). The combinations of annually increasing insurance premiums, high deductibles and co-payments, as well as the limited access to complementary insurance services can, however, make access to healthcare difficult for the elderly and those on lower income generally. Nevertheless, patients report overall high satisfaction with the Swiss health system. According to the International Health Policy Survey of the Commonwealth Fund, 66% of respondents reported being very satisfied with the health system, which includes short waiting times for appointments and operations, quick results from labs, and good quality treatment (Merçay, 2016).

Nevertheless, against this background, there are potential inequalities in access to healthcare. Notably, individuals who are poor or on low income will have a problem in having enough ready cash for high health insurance premiums and co-payments, and are therefore less likely to seek medical assistance. Thus, those population groups with a high proportion of poor people are most likely to have limited access to healthcare, or else will forgo treatment and medical tests. These include, for example, the elderly (65 and over; poverty rate of 14.7%), especially those elderly people who live in a single-person household (poverty rate of 25.4%), single parents with young children (poverty rate of 19.7%), individuals who live in the Ticino canton (poverty rate of 16.5%) and individuals whose household income comes mainly from public transfer payments, such as the public retirement insurance (AHV – *Alters- und Hinterlassenenversicherung*) (poverty rate of 22.8%) or other types of transfer income, such as social assistance (poverty rate of 32.4%) (FOS, 2018b). Due to the high co-payments required, individuals who belong to these groups might have limited access to healthcare.

There are policies in place to deal with these problems. Notably, health insurance premiums are much lower for children, and there are lower co-payments and deductibles. More generally, taking into account the considerable costs that the Swiss system generates for individuals, policy makers have introduced subsidies for lower-income groups to deal with insurance premiums. In 2016, 27.3% of all premium payers profited from such subsidies. Eligibility criteria and amounts are defined by the cantons and can therefore differ. The highest rate of claimants for help with their premiums is in the canton of Zurich (32.8% of the insured population) and the lowest rate is in Basel-Landschaft (19.8% of the insured population). In terms of age cohorts, 27.5% of those over 65 receive help with premiums, which is well above the average; whereas in the 0-30 age group, 36.7% of individuals receive help with health insurance premiums; in the 19-25 age cohort, up to 42% receive subsidies. The federal government offers to pay 50% of these subsidies if cantons match those payments (Bonoli and Trein, 2018; FOPH, 2018).

The system of subsidies thus provides relief for some of the problems induced by a healthcare system that places a strong emphasis on individual out-of-pocket payments; in particular, young cohorts – which naturally have less disposable income – receive support from government. Nevertheless, these interventions target the premiums for standard health insurance. It is much less clear how those individuals who need special and more extensive treatment but who do not qualify for insurance premium subsidies deal with the high costs. In particular, elderly patients might face difficulties even if they receive a subsidy. To give a brief example: an elderly couple that has a standard insurance premium of CHF 465.70 (EUR 403) per month might easily face yearly expenditure for health above EUR 10,000.[6] This does not include the cost of medication (which is not covered by basic health insurance) or treatment that falls under complementary health insurance (such as dental implants). If the couple failed to take out complementary health insurance when they were younger, it may be difficult to do so later on, because insurers may refuse to admit patients with pre-existing conditions to complementary insurance schemes. This is

[6] CHF 13,276.80 (((12*465.70)*2)+(2*(1,050[co-payments]))).

particularly awkward for those who earn enough (or own enough property) not to qualify for cantonal subsidies. Others might find themselves in a situation whereby they need to mobilise a much larger share of their pension funds for healthcare than planned, due to the continuous increase in health insurance premiums (Table 1). More research is required into the extent to which this is a social and political problem and whether vulnerable groups receive enough support to ensure good access to healthcare.

The second dimension of the Swiss healthcare system that potentially produces inequality of access concerns regional variance in health policy outputs. Notably, there are differences in the premium rates between cantons, the share of those insured who benefit from premium subsidies, the ratio of doctors to patients in the outpatient sector, and the incidence of some typical surgical procedures, such as arthroscopic meniscectomy (knee operation) (Table 2).

Table 2: Regional variance in selected health policy outputs

Canton	Average premium. adult, 2018 in CHF (EUR)	Premium change compared to previous year	Share of insured receiving cantonal subsidies	Doctors in outpatient sector per 100,000 inhabitants, in 2016	Arthroscopic meniscectomy , cases per 1,000 inhabitants
Zürich	458.60 (397)	3.7%	**32.8%**	257	2.43
Bern	482.00 (417)	3.4%	29.2%	220	3.67
Luzern	413.20 (358)	2.7%	24.6%	166	2.19
Uri	375.90 (325)	1.8%	31.3%	**94**	3.34
Schwyz	400.90 (347)	1.6%	21.0%	146	**6.10**
Obwalden	384.60 (333)	2.2%	27.9%	120	2.62
Nidwalden	**367.80 (318)**	1.9%	20.7%	129	1.39
Glarus	405.30 (351)	1.9%	20.3%	152	1.57
Zug	384.40 (333)	2.2%	22.2%	206	4.37
Fribourg	438.00 (379)	3.8%	24.3%	138	4.65
Solothurn	458.40 (397)	3.9%	25.6%	164	3.38
Basel-Stadt	591.80 (512)	4.3%	28.8%	**425**	4.12
Basel-Land.	511.70 (443)	4.9%	**19.8%**	234	4.52
Schaffhausen	447.00 (387)	3.9%	32.1%	188	1.99
App. AR	403.20 (349)	4.4%	23.1%	171	4.63
App. IR	354.00 (306)	1.9%	30.9%	137	5.76
St. Gallen	423.60 (366)	2.9%	24.1%	191	4.93
Graubünden	392.00 (339)	3.0%	31.0%	175	3.48
Aargau	430.20 (372)	3.1%	25.4%	167	3.70
Thurgau	413.60 (358)	3.4%	26.8%	161	1.84
Ticino	495.10 (428)	4.5%	30.7%	219	3.07
Vaud	526.40 (455)	6.4%	27.6%	244	1.76
Valais	417.50 (361)	5.9%	20.7%	156	**1.43**
Neuchatel	510.70 (441)	5.4%	24.9%	220	3.14
Genève	**583.30 (504)**	5.4%	27.5%	376	1.62
Jura	511.60 (442)	4.8%	31.2%	144	2.17
CH	**465.30 (403)**	**4.0%**	**27.3%**	**219**	**3.06**

The variance in the cantonal indicators on health insurance could point to some inequalities in access, or to over- (or under-) coverage by healthcare services. Notably, in some cantons individuals pay higher health insurance premiums (for example urban cantons, such as Basel-Stadt and Geneva, but also larger cantons, such as Vaud) than in others (Nidwalden, Obwalden). At the same time, this does not necessarily mean that there is a higher probability of people receiving cantonal subsidies, since the cantonal standards

according to which policy makers set the premium subsidies vary. This can be illustrated by pointing out that the correlation between the level of the cantonal insurance premium and the level of subsidies is only at 0.2. On the other hand, the cantonal insurance premium is highly correlated with the number of doctors in the outpatient sector (0.8). The calculations are based on the data presented above (Table 2).

Furthermore, there are considerable differences between cantons in terms of the incidence of a specific type of knee surgery (Table 2), as well as of other surgical procedures.[7] The unequal distribution of standard surgery cases between cantons could be due to a regional over- or under-supply of such treatments. One health policy sector where this is the case is psychoanalysis and psychological treatment; a study published in 2016 shows that there are considerable regional inequalities in the availability of personnel for psychological care services. Especially in some rural areas, there are not enough qualified personnel to deal with adults who have complex psychological symptoms and need coordinated support (Stocker et al., 2016).

There some policies in place to deal with regional inequalities in health policy. For example, policy makers realised that the inhabitants of some cantons had been paying too much in health insurance premiums in the period 1996-2013. Therefore, in the years 2014-2017, the insured population in 11 cantons had to pay more, while those insured in other cantons paid less.[8]

In summary, the Swiss healthcare system works well and results in high satisfaction among the population with the healthcare services; survey respondents consider only a few changes to be necessary (Merçay, 2016: 35). As a consequence, there are no striking inequalities in terms of access to healthcare that the government has not already tackled. There are, however, some problems that could hint at inequality of access to healthcare. First, there are clear regional differences in the cost of health insurance, access to health insurance subsidies, the number of doctors in the outpatient sector and the incidence of certain types of treatment. It is not clear to what extent these differences can be explained statistically; but given the importance of federalism and subsidiarity, the opportunities for the federal government to intervene directly and regulate to get rid of these differences are limited. Furthermore, the emphasis that is placed on individual responsibility for healthcare through non-progressive health insurance premiums and high co-payments gives an advantage to those groups that are financially solvent, educated and healthy. Individuals with health and financial issues, such as the elderly or the poor, particularly those who live alone, might de facto have limited access to healthcare, as they are also anxious about the high cost. An international study has revealed that compared to other countries, a large number of individuals in Switzerland avoid visiting the doctor, having medical tests and taking medication because these things are too expensive (Merçay, 2016: 31).

Thus, there are three policy recommendations that emerge from this report:

1. Ensure that vulnerable groups, such as the young, the elderly and single parents, have access to health services and medication and do not avoid seeking medical assistance and tests due to high insurance contributions or co-payments.
2. More generally, the lack of coverage for dental health services is a problem. Since the basic health insurance package does not cover the services of dentists, high costs of dental care can become a burden on financially weak households and can result in individuals not going to the dentist. To deal with this problem, several French-speaking cantons have ballot initiatives in the pipeline for mandatory insurance for dental care (Trein, 2018c).

[7] *Tages-Anzeiger*, https://www.tagesanzeiger.ch/wissen/medizin-und-psychologie/wo-aerzte-am-haeufigsten-operieren/story/30714084, accessed 6 May 2018.

[8] FOPH, https://www.admin.ch/gov/de/start/dokumentation/medienmitteilungen.msg-id-65651.html, accessed 9 May 2018.

3. Ensure that regional inequalities do not get out of control. Therefore, more national control of regional price and supply inequalities may be necessary. Achieving this goal is admittedly difficult in the context of Switzerland, with its 26 cantonal health systems; nevertheless, in its proposed measures to reduce healthcare costs, the federal government has suggested measures to better control pricing nationally – for example, a national regulator to control the price of health services (Trein, 2018c).

3 Measurement of inequalities in access to healthcare in Switzerland

In Switzerland, assessing inequalities in access to healthcare should be done by calculating the net healthcare cost for age cohorts and income groups, by looking at the specific health insurance models that these groups have. For example, to what extent have they chosen deductibles and what supplementary health insurance do they have? This strategy will give an idea of who has access to comprehensive services and who cannot afford services or is likely to forgo medical consultations for fear of the costs. Coverage is in principle universal, and services are available to all income groups, including the self-employed and vulnerable groups with no income, such as asylum seekers or the long-term unemployed, who receive health insurance subsidies from social assistance contributions. However, prices and service density vary regionally – e.g. the distribution of doctors over a region or the freedom to choose from different provider networks. Therefore, it is possible that some regions (cantons) have better and cheaper healthcare coverage than others. These differences are potentially problematic for those who need coordinated interventions from different health professionals. It is possible to receive urgent care – even in another canton – at no extra cost, if the provider is registered with the basic health insurance scheme (OKP).

In Switzerland, country-specific problems regarding indicators for unmet need in healthcare or over-coverage with specific services may be related to the regional differences in health practices and reporting. To complicate the situation even further, there are hospital regions that are different from the cantons. In order to get an overview of regional differences concerning over- or under-coverage with healthcare services, a research project is currently under way with the aim of uncovering regional differences and similarities regarding healthcare access and coverage.[9]

[9] http://www.versorgungsatlas.ch/index.php/de/, accessed 14 June 2018.

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