HEALTH AND HEALTH CARE INEQUALITIES IN SWITZERLAND: A BRIEF REVIEW OF THE LITERATURE

Alberto Holly

and Mohamed Benkassmi

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The authors are at the Institut d'économie et management de la santé (IEMS), University of Lausanne, Champ de l'Air, Bugnon 21, 1005 Lausanne, Switzerland.

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1211 Geneva 10, Switzerland

Tel: (41 22) 9173020
Fax: (41 22) 9170650
E-mail: info@unrisd.org
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1 INTRODUCTION

The purpose of this survey is to present an overview of the published literature on inequalities in health and health care in Switzerland. The intent is to cover the major issues of inequality in health status, health care delivery, health care financing, and relationships between social inequality and inequality in health. In relation to "globalisation", the analysis will examine the impact of Swiss migration policy on health inequality.

In relation to the topic of this survey, it is important to bear in mind that health care spending in Switzerland is particularly high. A comparison with health care spending in other countries puts Switzerland in second place, behind the USA both in absolute per capita terms and as a share of gross domestic product (GDP). In 2001, health care spending in Switzerland amounted in absolute per capita terms to 3248 dollars (4887 dollars in the USA), and to 10.9% of GDP (13,9% in the USA)[a]. These expenditure levels reflect, in part, the high level of per capita income in these countries. However, they may also mean high average level of services, high resource costs of services or inefficient provision of services.

Beside these considerations, equity questions need to be raised, since global reasoning (or in terms of averages) does not address distributional issues such as: are people getting the care that they need? Who face barriers in obtaining health care? In this survey, we will be interested not only in the resident population, but also in the situation of migrants, asylum seekers and refugees in Switzerland. A large part of this paper is devoted to this issue as it is one of the important aspects in Switzerland, as well as in other countries, of so-called "globalisation" in relation to health.

At the outset, it should be mentioned that the nature of the Swiss indicators are quite peculiar as we usually find good health status indicators and low inequality indicators relative to the other comparable countries. This is a striking finding given the private nature of the health insurance system.

It is also important to bear in mind that Switzerland experienced in 1996 an important change in the regulation of health insurance. Before 1996, when the Health Insurance Law (LAMa) was in force, health insurance was not compulsory, and this introduced inequalities in the health care system despite the fact that approximately 99 per cent of the population was insured in the early 1990s. For example, the optional nature of the health insurance system resulted in higher premiums for those who joined at a later age, and women's premiums were higher than men's at the same age. In addition the LAMa authorized private firms or public administrations to conclude collective supplemental insurance for all the personnel, and this particular feature of the health law was an important source of inequity.

One of the main purposes of the New Health Insurance Law (LAMal) in force since 1996 was not only to make health insurance compulsory, but also to correct for these inequalities under the LAMa as we explain in detail in this paper. However, some aspects of the LAMal itself may be at the origin of new sources of inequity in the health care distribution. To take only one example, within a given sickness fund, premiums contributions are community-rated (i.e. the same) to all their adults over the age of 25 living in the same canton. This means that premium contributions charged by a sickness fund are the same for all members and cannot be graded according to age and gender nor according to the income of the insured person. Given the compulsory nature of the health insurance, health insurance premiums are similar to taxes which

[a] *Source:* Organization for Economic Cooperation and Development (OECD), Health Data 2003.

do not depend on income. This naturally raises the question of the regressive financing of health care and puts a question mark over equity of access to care in relation to need under the LAMal.

In Switzerland, health care use inequality is rather a recent issue of research and concern. Most of the studies we present have been published after the mid-eighties. In one of the earliest publications on this issue, Lehmann, Martin and Gutzwiller (1986) argue that the political class in Switzerland did not recognize inequality in health as a problem, because of supply abundance, and the fact that the individual is seen to be responsible for his or her health (life style, health insurance, and her or his way to have health care). As this survey will show, Switzerland is not as safe from health and health care inequalities as it is often stated. Note, however, that a serious difficulty, specific to Switzerland, has to be taken into account. Most of the work presented in this survey corresponds to a period where the LAMal was not in force. It is fair to say that, despite the research work that has been undertaken on the impact of LAMal on the health care system, there is still a lot to be known about its effect on health and health care inequalities in Switzerland.

Before presenting this overview, we would like to bring to the readers' attention several points which require a cautious interpretation of studies, in general, about health and health care inequalities.

First, from many point of views, including inequalities and health policy, an important distinction has to be made between health itself and health care. The nature of the relationship between health care and health is quite complex. In fact, the final output of health care is not "health", but rather intermediary goods which are inputs for the production of health, namely health care services. In addition, as is well known, the health of individuals depends not only on health care, but also on many other biological, cultural and social factors.

Second, in terms of equity, there is also a debate about the role of health care systems: should they guarantee equal access to health treatments to all social categories, or rather do they need to correct for biological and socio-economic inequalities by providing more care to the underprivileged population?

Third, there is a related issue which is only recently highlighted in the emerging body of literature, which is the multidimensional feature of inequalities. For example, one can compare health status, or income, separately, between two people. But, when more "health" is transferred from the rich to the poor, does the overall inequality (the multidimensional inequality) decrease? How to measure the multidimensional inequality variation? In general, researchers use only one-dimensional inequality measures, distributed by socio-economic classes.[a]

With all these precautions in the background, we review in this survey research and publications at the national level, as well as about international comparisons including Switzerland.

The plan of this paper is the following. In Section 2, we describe relevant aspects of the health insurance system in Switzerland. The policy followed up to now by Switzerland in the field of "Migration and Health" is summarized in Section 3. Section 4 presents work that has been undertaken around the inequality in health status, whereas Section 5 presents work on population behaviour with direct effect on health. Issues related to the health insurance system are presented in Section 6, whereas Section 7 addresses the specific issues of inequality in health care financing and the redistributive effects of health insurance. In Section 8, works which deal with inequality in the use of and access to health care are presented. Papers dealing with the importance of social environment on health and heath care inequalities are discussed in Section 9. We offer an intermediary conclusion regarding the migrant population in Section 10. Some concluding remarks and suggestions for future research are

[a] See, however, the work of Christian List (1999).

contained in Section 11.

Within each section, we attempted to present published articles dealing with health inequality at the national level of Switzerland as well as some international comparisons including Switzerland.[a]

2 ASPECTS OF THE SWISS HEALTH CARE SYSTEM

In this section we review some of the aspects of the Swiss health system which are relevant to this study[b]. We focus mainly on the aspects specific to the Swiss system, and on the changes introduced by the 1996 law on health insurance (LAMal). Before 1996, health insurance was not compulsory and introduced inequalities in the health care system. The purpose of the LAMal was precisely not only to make health insurance compulsory, but also to reduce inequalities in the previous system while maintaining the freedom of the patients and trying to control the increase in costs.

The health system in Switzerland is very complex. Health insurance is a federal responsibility while public health is essentially the competence of the cantons. The cantons are responsible for health services, preventive care and public health regulations. Each canton has in fact its own health legislation. Municipalities intervene mainly in the services to senior citizen, social assistance and home-care.

In general terms, health insurance plans are separated in Switzerland into: the "basic insurance" providing the so-called "compulsory benefit"- or "social benefits"- and supplementary insurance.

Until 1996, health insurance was not compulsory, but the Confederation encouraged it by granting subsidies to non for-profit sickness funds. Specifically, the Health Insurance Law (LAMa) fixed minimum requirements for this category of sickness funds, and defined very precisely what it is convenient to call "compulsory benefits" or "social insurance" benefits. It also required not-for--profit sickness funds to fulfill some obligations. For example, the imposition of exceptions to insurance for more than five years was prohibited, and in the event of disability, unlimited hospitalisation had to be offered. However, insurers could also establish rules regarding an age limit for admission, an initial waiting period during which the insured did not receive benefits, or a denial of benefits for five years for a pre-existing condition which recurs after admission.

As mentioned earlier, health insurance was not compulsory under the LAMa. Nevertheless, approximately 99 per cent of the population was insured. In addition, four cantons had made health insurance compulsory for the totality of the population. Some cantons had made it compulsory for some categories of the population, such as the elderly, children in age of schooling, apprentices, or people with low income. Some municipalities had also made health insurance compulsory for the totality of their residents.

For-profit sickness funds were excluded, and still are, from the "social" health insurance. Both not-for--profit sickness funds and for-profit sickness funds could provide supplementary voluntary insurance. Supplementary insurance plans vary along several dimensions: coverage of supplemental inpatient and outpatient services, coverage of allied health personnel and the payment system to care providers for each procedure or service. Note that the LAMa authorized private firms or public administrations to conclude collective supplemental insurance for all the personnel.

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[a] We have tried as much as possible to state with precision the data used and the methodology in the papers mentioned in this survey.

[b] This review makes use of the expositions of the Swiss health system contained in OECD (1994) and Swiss Federal Social Insurance Office (1997) and reproduces in part these expositions.

The optional nature of the health insurance system resulted in higher premiums for those who joined at a later age. Also, women's premiums were higher than men's at the same age, but could not be more than 10 per cent higher. As long as s/he was affiliated to the same sickness fund, the insured used to pay therefore the premium corresponding to the age at which s/he joined and their sex, this premium increasing nevertheless with the increase of the health costs. Note that if a person was insured by a collective insurance, then the premium could be much lower than for an individual insurance. In some extreme cases, premium could differ by a factor of twelve. For example, a young person could pay a low premium per month for a collective supplemental insurance whereas a person purchasing at the age of 60 only a “basic insurance” could pay a premium twelve times higher per month.

One of the main purposes of the New Health Insurance Law (LAMal) in force since 1996 was to correct for these inequalities under the LAMa. The “basic insurance” for medical and pharmaceutical care has been made compulsory for all persons resident in Switzerland. Under the LAMal, all applicants must be accepted without any reservations. The insured can choose freely their insurer. The sickness funds can be changed every half year as far as the “basic insurance” is concerned.

Also, under the LAMal, collective health insurance has been prohibited. Health insurance is based on the principle of the individual insurance, that is to say that each family member must be individually insured. Under the “basic insurance”, all sickness funds pay for the same benefit. The basic insurance covers, without limit of time, all benefits provided in the canton of residence by doctors or hospitals (hospital wards) including maternity costs, as well as periods spent in the hospital ward of a recognized hospital. The LAMal basic insurance was designed to cover inpatient expenses only in public hospitals. However, when a private hospital or clinic contracts to abide by the LAMal, then the LAMal basic insurance covers its expenses. Otherwise private hospital treatment could be covered only by supplementary insurance[a].

The costs of the most important medicines, in accordance with a comprehensive list, are also met. The medical costs of long-term care at home or in a nursing home are also mostly reimbursed (but not the costs of board and accommodation).

The “basic insurance” is essentially financed by premium contributions by the insured. All sickness funds have to charge a community-rated (i.e. the same) premium contribution to all their adults over the age of 25 living in the same canton. This means that premiums contributions are identical for each adult over 25 in a given fund and cannot be graded according to selected parameters (e.g. age, gender, etc.) nor according to the income of the insured person. However, this premium can vary from sickness fund to sickness fund. In addition, sickness funds must fix a premium for insured persons under the age of 18 which is lower than for older insured persons. They are permitted to do the same for insured persons under the age of 25 if they are attending school or pursuing studies or an apprenticeship.

It is important to note, however, that persons whose financial circumstances are modest are entitled to state assistance with premiums. The conditions depend, however, on the canton of residence.

Under the LAMal, insured persons must also contribute to costs by sharing in the costs of care they receive. For the basic insurance, the co-payment consists of an annual deductible and a coinsurance rate of 10 per cent on the expenses that exceed the deductible. Nevertheless, the co-payment cannot exceed SFr 600 per annum. The LAMal has introduced an insurance system with an expanded choice of deductibles. In exchange for a choice of a higher deductible by the insured person, the insurer reduces its premiums by a given percentage. The choice of deductibles and the

[a] Note, however, that the health law has recently changed in this respect; Cantons must also cover part of the expenses of treatments in private hospitals or clinics. This would have the effect of reducing the premiums for supplementary insurance.

associated premium reductions are laid down annually by the Federal Council. The different amounts of deductible are determined by the LAMal.

The insured is free to choose their doctor and the hospital. Note, however, that free choice of physician does not exist for patients in hospital wards, for those who only purchased a basic insurance. Also, doctors can practice where they wish and prescribe treatment as they see fit.

Resident persons can also purchase supplementary voluntary insurance in order to cover supplemental inpatient and outpatient services or allied health personnel. However, since most of the outpatient benefits are covered by the "basic insurance", the most popular supplemental insurances are those which meet the cost of treatment in private hospitals. In this case, patients are free to choose their physician.

In the context of the present survey, the situation of asylum seekers and refugees in Switzerland is worth presenting. While Switzerland has counted for centuries as one of the European states recognized as asylum countries, it took until January 1981 for the first Asylum Act to come into force, thus providing asylum with a legal basis. There are nearly 50 000 applications being filed in a single year. Persons staying in Switzerland and falling within the sphere of asylum are recognized refugees, provisionally admitted persons, refugees undergoing proceedings or rejected persons whose return it has not yet been possible to execute. There are approximately 180 000 at present.

As a general rule, the law places on an equal footing all people requesting asylum or benefiting from collective protection and does not tolerate any a priori discrimination or exclusion. Asylum seekers and refugees are entitled to at least the same benefits as the resident population, as additional specific health care expenses may be covered by the Confederation. To this end, the Confederation grants subsidies to the Cantons. However, the new Order 2 on asylum relative to funding[a] stipulates that the Cantons have to impose a limited choice of sickness funds and of health care providers while preserving quality of care. Cantons have taken up their responsibilities in a number of different ways, most of them in the form of a managed care system.

3 THE POLICY FOLLOWED UP TO NOW BY SWITZERLAND IN THE FIELD "MIGRATION AND HEALTH"

This section is devoted the migration issue. This is one of the important aspects in Switzerland, as well as in other countries, of so-called "globalisation" in its relation to health[b].

At this stage, it is worth emphasising once again that asylum seekers have rights to a full package of health care benefits. However, the way they can exercise their rights over health care services varies among Swiss cantons. Also, policies in the field of "migration and health", beyond the benefits covered by LAMal, vary greatly among Swiss cantons, where different measures of prevention and of promotion of health were developed. Some measures also have been undertaken at the Federal level, for example the AIDS protection campaign.

The need for action in this field acted from the very start of the Nineties as pressure to promote measures targeted to certain groups of migrants. The question of the cost of asylum has also been the subject of several debates, which have lead *inter alia* to several initiatives at national and cantonal levels. In addition, since until 1996 health

[a] Ordonance 2 sur l'asile relative au financement, August 11th, 1999.

[b] The material in this section is drawn in part on the document "Migration et santé. Stratégie de la Confédération pour les années 2002 à 2006" published by the Swiss Federal Office for the Refugees. It brings out the policy differences between cantons in this field, and mentions some actions taken on the federal level.

insurance was not compulsory, legal migrants as well as asylum seekers lacked rights as far as health care services were concerned. The situation varied among the cantons; in some cantons asylum seekers received a voucher for a limited amount of cash, which implied the existence of some form of rationing.

Since 1996, the situation has changed, as migrants and asylum seekers obtained the right to a full package of health care benefits. However, they often experience difficulties in accessing the health care system, in part because of their lack of knowledge of the health care system. For this reason, methods were developed in general in the cantons in order to reduce these difficulties (points of contact, interpreting services or projects for setting-up networks for health care services for asylum seekers). Special measures were developed *inter alia* for the people who come under the asylum jurisdiction. In addition, measures of prevention and of promotion of health were developed for the migrant population. In this area, the majority of the cantons leave this activity to private and self-financed organisms. Ten cantons have developed an autonomous cantonal policy in this field. Two different approaches seem to prevail, even if important differences exist in the way in which each one of them uses resources. On one side, one finds the cantons which intervene primarily in the area of prevention (minimal structures in Zurich and Glaris, more developed in Neuchâtel and in Thurgovie). This approach gives primary importance to the behaviour and responsibility of migrants and asylum seekers as regards to health, and secondary importance to the reduction of difficulties in order to access to the health care system.

In contrast with this, one finds on the other hand cantons which, in addition to supporting prevention, endeavour to further the access to the health care system. There too, regarding prevention, it is necessary to distinguish between minimal interventions (Vaud, Schwytz and Soleure) and the recourse to systematic measures (Basle and Geneva). Note that in the majority of the cantons, it is private organizations, sometimes supported by the public authorities, which take part in the majority of the interventions in the field of the migrants' health. It is only in the cantons of Geneva, of Neuchâtel, of Basle-City and Basle-Countryside that the authorities are at the origin of the implemented measures.

Regarding access to health care, some cantons have set-up networks for asylum seekers, in the form of "managed care", involving agreements between one sickness fund and specific health care providers. In this case, health care services to asylum seekers are only provided through these networks.

At the federal level, *inter alia*, the "Project Migration and Health" has been developed. Vis-à-vis the HIV and AIDS, the aim is to adopt appropriate measures to ensure that the prevention programs also reach the migrant population. Based on the AIDS prevention programme, the initial pilot scheme had seen its targets extended little by little into prevention in the field of drug abuse and other aspects of health promotion.

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