

Civil Society Engagement Mechanism

Universal Health Coverage 2030 in Switzerland

Results from the survey respondents of 7 organizations

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Universal health coverage means that all people have **access** to the health services they need, when and where they need them, without **financial hardship**. It includes the **full range of essential health services**, from health promotion to prevention, treatment, rehabilitation, and palliative care ([WHO 2021](#)). To make health for all a reality, the UHC concept proposes that we need: individuals and communities who have access to high **quality health services** so that they **take care of their own health** and the health of their families; **skilled health workers** providing quality, **people-centred care**; and **policy-makers committed to investing in universal health coverage**.

In Switzerland the Federal Office of Public Health (FOPH) writes that UHC has been largely achieved in terms of service coverage, but the increase in health costs is a major challenge that needs to be met. Despite high investment in health (around 83 billion CHF/year), the respondents mentioned several gaps within the prevailing system to reach UHC.

In Switzerland health insurance is the gatekeeper to **access** to the health system. However, certain people groups, for example sans-papiers, have no access to the public health system at all, and get health care only through services, which NGOs offer. People with less education, low health literacy, and people with a migration background often have difficulties in knowing and understanding the regulations, responsibilities and entitlements in the health system. Language barriers, the lack of information in easy words and the lack of “case managers”, who accompany and support people in the complex system contribute to access problems.

Finding a health provider is difficult for people with multi-morbidities, chronically ill and disabled persons. Since they require more time and higher frequency of visits, it is not financially attractive for the service providers to enroll them in their practice. Besides this, other accessibility barriers to service providers because of physical barriers prevail, despite certain laws and construction regulations which foresee easy access for handicapped people. Since health service data are not disaggregated and analysed other than by educational and migration background, it is difficult to assess who else in the society has access problems.

The high insurance premiums, coupled with a dual co-payment system of franchise and cost-share is unique and makes health care hardly affordable. The different tariffs of co-contribution are an entry barrier, particularly for poorer segment of the society and chronically ill patients, who automatically fall into the highest category of insurance premiums. There is no policy under development to abolish co-payments and franchise and insurance premiums. In order to counteract **financial hardship**, there are state paid mechanisms in place, which subsidies people with low income, or if costs exceed a certain income threshold. The increasing costs of health subsidies also strain cantonal health budgets. Up-front payments, late reimbursement and reimbursement mechanisms where the insurer has no influence on, can bring particularly for people with low income, elderly and disabled people and large families to the verge of poverty.

At the federal level, different disease-centered health policies and the national health strategy 2030 exist. Health is regulated by the “health insurance law” which focusses around the insurance mechanisms of different disease-centered and curative health services. Since Switzerland does not have a “health law” at federal level, important **essential health services** such as prevention and health promotion, are only regulated at cantonal level, or outsourced to independent bodies or NGOs. Only 2.4 % of the health budget is invested in prevention. A federal health law, which emphasizes prevention and integrated care, and where responsibilities and financial contribution is clearly regulated, could enhance health outcomes and alleviate costs. “Health laws” exist at cantonal level only and each canton regulates the health service delivery and distribution of resources to health services on its own. The huge differences for some services among cantons and the widening of the inequity gap calls for a re-thinking of the distribution mechanism at cantonal and federal level. It was mentioned that particularly long-term care receives much less funds than acute medicine. Also the COVID-19 pandemic made the need for increased resources and access to psychological support, especially for the young people, evident.

The **quality** of health services is perceived as good, because of a high end infrastructure and well educated health professionals. However, because of information asymmetry, it is difficult to judge service quality as a patient. Patients tend to rate the quality of health services better, because they are afraid to have no access at all, particularly in rural areas, where service coverage is limited. Inequity in service quality for women was also mentioned in regards to diagnostics and medication. Since research is mostly performed on men, the male body is the “example”, which often leads to wrong diagnosis or wrong medication for women. Since health outcomes and quality of life is not included and measured as performance indicators in the health system, it is difficult to objectively analyse service quality.

The DRG and TARMED based reimbursement mechanisms incentivizes the service providers to perform technical tasks on the patient. Taking time to listen and understand a patient’s problem and needs, time for counselling and psycho-social support or merely time for getting undressed and dressed are not remunerated. Lack of respectful care and respect for **self-determination** are other factors which have been reported to negatively affect quality of care. Disabled women and girls find it difficult to exercise their reproductive health rights, so that service providers are taking their desire and needs into account. Mentally challenged persons were reported to not be included in decisions about their care plans and end of life care. Informing and building the capacity of the health personnel in areas of respectful behavior and self-determination, in particular around health issues of people with a handicap are areas for improvement. These examples of poor service quality coupled with contra productive financial incentives are not at all conducive to perform **patient-centered care**, where the person and holistic and integrated care and support is at the centre.

Sufficiently well educated and **skilled health workers** are the backbone of a good health system. However, human resources in health are increasingly scarce, because of poor working conditions and lack of acknowledgement and appreciation of the health workforce. Career paths are limited and task-shifting initiatives (e.g. nurse practitioners) not appreciated by the strong lobby of some health professions. Training and retention of skilled health workers, using attractive and innovative approaches need to be urgently addressed. In an ageing society like Switzerland local human resources are essential in order to meet the health needs of the population, to guarantee good access and coverage, to contain costs and to not drain the already scarce workforce globally.

Policy makers seem committed to invest in Universal Health Coverage. However, investments occur in a patchwork manner within the already existing laws and regulations of the health system and often result in an increase of administrative inefficiencies. Huge untapped potential was mentioned in the areas of digitalization and in the inclusion and

integration of representatives of specific people groups (for example migrants, disabled people) in the policy development, (emergency) planning taskforces or sounding boards. Furthermore, opportunities to work more inter-sectoral and tackle the SDGs through and with a health lens, not only looking at the service provision, should be better leveraged. Policy makers are encouraged to increase their risk-appetite to innovation and to develop a visionary think-tank, which would sketch an integrated health system from a new perspective, thinking newly about financing mechanisms and how patient-centered care can be lived and appropriately remunerated, taking learnings and good examples from other countries into account.