The impact of consensual decision-making, corporatism and direct democracy on Swiss healthcare reforms

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So where does “Obamacare” fit into all this? Basically, it’s a plan to Swissify America, using regulation and subsidies to ensure universal coverage.

Paul Krugman, New York Times, 16 agosto 2009
Why are the US going Swiss?

Substantial reform of Swiss health insurance in 1996 based on Enthoven’s idea of managed competition (Enthoven, 1978):

- universal coverage of a compulsory benefit basket,
- mandatory community-rated health insurance with earmarked subsidies to low-income households,
- competition among health insurers within a regulated environment
- consumer-driven choice of MC-plans with selective contracting and/or gatekeeping
- no serious cost containment regulation
Why are the US going Swiss? (continued)

- **Result**: continuous increase in premiums over time (+65% in the last 10 years) and burden of health insurance becoming not affordable anymore, in particular for the middle class.
Features of the Swiss system of governance

● Three fundamental aspects impact on the governance of the Swiss health care sector:

➢ a strongly decentralized political system, based on subsidiarity, consensual decision-making and the institutions of direct democracy;

➢ a liberal economic culture, which emphasizes economic freedom and citizens’ preference for consumer-driven decisions, combined with the acceptance of a significant role played by the private sector;

➢ a unique historical path of social security, partially run by non-profit institutions (sickness funds, pension funds). The Swiss welfare system is less redistributive than that of most EU countries, but it offers generous coverage of social risks.
The Swiss “way of reform”: slow and full of conflicts of interest

- Direct democracy and federalism are at the origin of the exasperated slowness in the adoption of reforms in the Swiss health system.

- Unbalanced and radical revisions have a high likelihood of being rejected in popular ballots → **Status quo bias**

- Private stakeholders are systematically involved in decision-making, by institutionalized participation mechanisms at the political level (consultation procedure), as well as by the right to be represented in the different control and management agencies

- Strong lobbying activity within the Parliament and strenuous defence of corporative interest.
Popular ballots are a radical form of “voice”

- Between 1974 and 2008 the Swiss population was called to the ballot-box 12 times to deliberate on reforms in the health insurance sector.
- All proposals but the 1994 referendum on the FHIA and the vote on two federal decrees have been rejected in popular ballot.
## History of 35 years of popular ballots on health insurance reforms

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Participation Rate</th>
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<tbody>
<tr>
<td>1974</td>
<td>Failure of a popular initiative (rejected by 70% of voting people and all cantons) and rejection of the counter-proposal (by 61% of voting people and all cantons).</td>
<td>39.2%</td>
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<tr>
<td>1985</td>
<td>Urgent federal decree accepted in referendum (by 53% of voters).</td>
<td>34.7%</td>
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<td>1987</td>
<td>Law amendment rejected in referendum (by 71% of voters).</td>
<td>47.6%</td>
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<tr>
<td></td>
<td>Start of the preparatory work for the KVG</td>
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<tr>
<td>1992</td>
<td>Failure of a popular initiative (rejected by 60% of voting people and all but one of the cantons).</td>
<td>44.4%</td>
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<tr>
<td>1993</td>
<td>Urgent federal decree accepted in referendum (by 80% of voters).</td>
<td>39.8%</td>
</tr>
<tr>
<td>1994</td>
<td>Failure of a popular initiative (rejected by 76% of voting people and all cantons) + KVG accepted in referendum by 51.8% of voters.</td>
<td>43.8%</td>
</tr>
<tr>
<td>2000</td>
<td>Failure of a popular initiative (rejected by 82% of voting people and all cantons).</td>
<td>41.7%</td>
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<tr>
<td>2003</td>
<td>Failure of a popular initiative (rejected by 73% of voting people and all cantons).</td>
<td>49.7%</td>
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<td></td>
<td>Failure in the Parliament of the 2nd revision of the KVG</td>
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<td>2004</td>
<td>Start in the Parliament of a new approach to the 2nd revision of the KVG (unbundling strategy)</td>
<td></td>
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<tr>
<td>2007</td>
<td>Failure of a popular initiative (rejected by 72% of voting people and 21 cantons).</td>
<td>45.9%</td>
</tr>
<tr>
<td>2008</td>
<td>Failure of the referendum on the counter-project to the withdrawn popular initiative “for lower insurance premiums” (rejected by 69.5% of voting people and all cantons)</td>
<td>43.7%</td>
</tr>
</tbody>
</table>
The increasing impact of emotional campaigns
stopp
Ja zum Minarettverbot

Odense – 06.07.2010
More exit or more voice in the Swiss healthcare sector?

- The 2007 popular initiative of the left: single payer, income-dependent premiums, more voice and less exit (rejected by 72% of voters).
- The 2008 referendum favored by the right: more market and less voice in terms of hospital planning (rejected by 69.5% of voters).
Correlation between share of voters supporting the single payer issue and level of per capita health spending

\[ y = 0.4834x - 0.1975 \]

\[ R^2 = 0.7246 \]
Split opinions = “status quo bias”
Examples of recent reform paths (1)

- **Hospital financing reform** (introduction of DRG and of equivalent financing scheme for public and private hospitals).
  - **2000**: Start of the discussion in Parliament (broad revision of FHIA, rejected in 2003)
  - **2004**: Unbundling strategy → new draft bill on hospital financing
  - **2007**: Draft bill accepted by Parliament, after several amendments (5 HPM-reports!)
  - **2012**: Performance payment in force
  - **2017**: Dual financing scheme (55%-45%) in force.
  - Time needed: **16 years**!
Examples of recent reform paths (2)

- **Risk adjustment reform**
  - **1990**: First international health economics conference in Zuerich. Paper by Van de Ven showing that risk adjustment based only on gender and age will not be effective.
  - **1993**: Introduction of risk adjustment based only on sex and age groups
  - **1997**: Formal start of a political discussion to improve the formula. An insurer specialized in cream skimming was very effective in freezing the reform process (using legal and illegal means)
  - **2007**: Decision to include in the formula one additional factor (hospitalization in the previous year) accepted by the Parliament.
  - **2012**: new risk adjustment in force (but current discussion of further improvement of the formula)
  - Time needed: 15 years (22 years since a clear scientific evidence was available)
Examples of recent reform paths (3)

- Managed Care Reform
  - **1990**: first HMO started in Zuerich (considered as a pilot project under an experimental legislation)
  - **1996**: FHIA legally allowed MC contracts on a voluntary basis (reduction of freedom in exchange of a premium discount).
  - **1996-1999**: rapid increase in the number of MC contracts (positive selection effect), but most models without budget responsibility
  - **2004**: Unbundling strategy → new draft bill on managed care
  - **2010**: bill accepted by the lower house: only for insured enrolled in an integrated network of care with budget responsibility co-payment will continue to be at the level of 10%. All other insured will have to face a co-payment of 20% (3-years contracts and obligation to offer in all regions at least one MC-contract with budget responsibility)
  - Time needed: **more than 20 years**.

Odense – 06.07.2010
Cantonal heterogeneity in the popularity of MC: 1997

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<td>MC market share</td>
<td>4.7%</td>
<td>8.2%</td>
<td>8.3%</td>
<td>10.0%</td>
<td>16.9%</td>
<td>24.3%</td>
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</tbody>
</table>

Source: UISP (2009)
Cantonal heterogeneity in the popularity of MC: 2008

Source: UfSP (2008)
Population survey (April-May 2010)

- Insured who are not willing to give up totally free choice of GP and unrestricted access to specialists should be charged a higher co-payment.