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Swiss popular initiative for a single health insurer. . . once again! ☆

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ABSTRACT

The article describes a recent Swiss popular initiative, aiming to replace the current system of statutory health insurance run by 61 competing private insurers with a new system run by a single public insurer. Despite the rejection of the initiative by 62% of voters in late September 2014, the campaign and ballot results are interesting because they show the importance of (effective) public communication in shaping the outcome of a popular ballot. The relevance of the Swiss case goes beyond the peculiarities of its federalism and direct democracy and might be useful for other countries debating the pros and cons of national unitary health insurance systems versus models using multiple insurers.

After this electoral ballot, the project to establish a public sickness fund in Switzerland seems definitely stopped, at least for the next decade. Insurers, who opposed the initiative, have effectively fed the “fear of change” of the population and have stressed the good outcomes of the Swiss healthcare system.

However, the political pressure favoured by the popular initiative opened a “windows of opportunity” and led the federal Parliament to pass a stricter regulation of health insurers, improving in this way the current system.

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1. Purpose of health policy

On September 28th 2014, Swiss voters rejected the citizens' initiative “For a public health insurance fund”, which proposed replacing the 61 insurers that currently run the compulsory health insurance system with one single, public health insurance fund.

Promoters of the initiative criticised several aspects of the current system.

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Firstly, per capita health expenditure is high and in 2012 amounted to more than 6000 USD PPP, or over 11% of the GDP. Secondly, in-patient care funding has a significant level of public participation (55% of DRG-based payments to hospitals), but insurers and providers negotiate tariffs on their own, without involving public authorities. Thirdly, integration between healthcare providers is poor: the system seems fragmented, with weak incentives for cooperation or to develop prevention programmes [1].

Further criticisms raised against the current system refer more specifically to the lack of transparency in the insurance sector. A first area of debate is the fact that insurers simultaneously administer both the not-for-profit compulsory health insurance contracts, and the for-profit voluntary supplementary insurance policies, making it difficult for public authorities either to guarantee

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separation between the two areas of activity, or to avoid making cross-subsidies between them. Another major transparency-related problem arose in 2008, as citizens and politicians discovered that health insurers, which have to establish fully funded “community-rated” premiums in each Canton, had in fact set premiums higher than the actuarial levels in some Cantons, while in others the premiums were systematically lower. Since the actuarial reserves of each insurer are managed at the national level, the population of some Cantons ended up in paying over a decade a fraction of health expenditure related to citizens living in other Cantons. Although not explicitly illegal, this practice of cross-subsidisation, which had lasted for years, was strongly censured by the citizens and local politicians of those Cantons that were paying too much, and became a strong argument in favour of the initiative.

Finally, further criticisms highlighted the unhealthy competition between health insurers (driven by cream skimming), a major aspect of which is related to poor risk adjustment, which has been based on a formula (defined in 1993) that has not been improved over the last two decades [2]. Despite the reform of risk adjustment accepted in 2007, but implemented only in 2012 [3], the 61 insurers still compete in terms of selecting good risks instead of improving services, and making extensive use of the selective contracting tools available [4]. The gap between the lowest and the highest premiums offered by different insurers, for the same coverage, in the same region, can therefore exceed 100%.¹ Other efficiency arguments raised by the promoters of the initiative mentioned the estimated savings that would result from the following cost reductions: the abolition of marketing costs (190 million euro); the elimination of the administration costs incurred by people switching annually from one insurer to another (80 million euro); the potential economies of scale related to insurance system management; the major reduction in the paperwork of healthcare professionals; and the estimated 1.65 billion euro/year in savings arising from the improved integration of prevention and of health care delivery.

Countering these arguments, opponents of the initiative specified several strengths of the Swiss health system. Firstly, the Swiss are generally very healthy (life expectancy is 83 years; 81% of people say that they are in good health), and access to healthcare services is easy and timely. Moreover, administrative costs amount to only 5% of total mandatory insurance costs, so the only ways by which to reduce health expenditure are: (1) reduce the prices and/or quality of the insured services; (2) reduce the delivery of unnecessary health care (improved control of moral hazard); and (3) shrink the mandatory benefit basket. Another argument was that many health systems with one single insurer, or with a national health service, are facing heavy debts and serious funding problems, while Swiss insurers do not have any debt. Finally, several pro-market arguments were used, arguing that: public services are less efficient than private ones, and tend to develop a

bureaucratic mentality; the current possibility of switching insurer represents a strong incentive to offer good services; and the initiative would lead to a system with less – or no – freedom to choose provider or to have direct access to this provider.

2. Political and economic background

The Swiss health system is greatly appreciated by patients and by the population as a whole. Moreover, direct democracy, and the features of the Swiss political process, make it very difficult to implement major political reforms in the healthcare sector [5]. This is confirmed both by the lengthy legislative processes inside Parliament, and by popular ballots.

Despite these difficulties the healthcare and the health insurance systems remain at the centre of political debate, and are a recurring topic of citizens' initiatives.

The main economic elements of the basic health insurance system are [4,6]:

- Mandatory insurance reimbursements amount to less than 40% of providers' revenues; other payers are the Federal and Cantonal government (35%), families out-of-pocket (20%), and complementary insurance (5%);
- Insured parties choose both their insurer and the deductible (ranging from 280 to 2337 euro/year²; no deductible is the default-option for children); above the deductible, there is a 10% co-payment, up to a maximum of 654 euro/year (327 for children);
- Cantonal premium allowances subsidise the purchase of mandatory health insurance by middle- and low-income families (approximately 30% of the population receives a full or partial subsidy).

3. Health policy process

Public regulation of health insurance in Switzerland dates back to the beginning of the 20th century (the first organic federal law was approved in 1911 and implemented in 1914). Insurance cover levels of the population developed over time, reaching almost 100% before the 1994 approval of the new federal health insurance law, which introduced mandatory insurance coverage at the federal level by 1996. Since then, two citizens' initiatives have already tried to replace the current system of multiple private insurers:

- In 2003, 73% of voters rejected the citizens' initiative “Health at accessible prices” (which proposed a system of public insurers, and a funding mechanism secured partly by additional specific funds from Value Added Tax, and partly by contributions paid by insured families on the basis of their income and net wealth) [7];
- In 2007, 71% of voters rejected the citizens' initiative “For a single and social health insurer” (which proposed replacing the private insurers with one public insurer, and linking premiums to family payment capacity) [8].

¹ Premiums are available at <http://www.priminfo.ch/praemien/index.php?sprache=d>.

² Exchange rate used: 1 euro = 1.07 CHF.

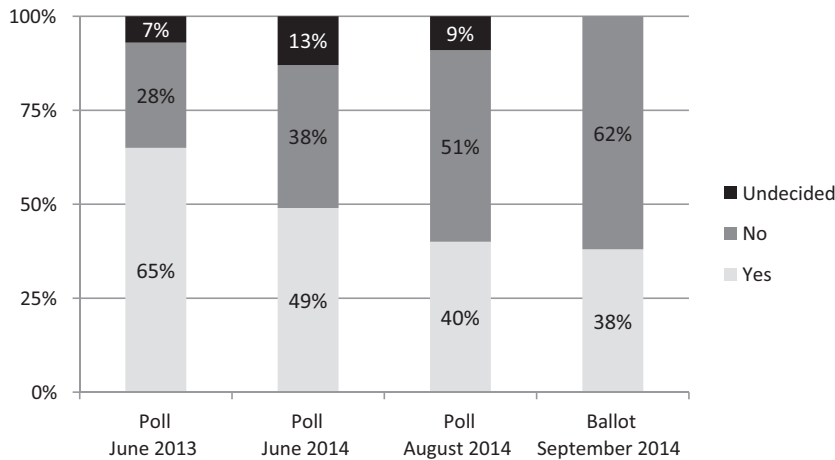


Fig. 1. Poll and ballot results, June 2013–September 2014.

Sources for polls: GFS.Bern (June 2013 and June 2014: Health Monitor; August 2014: for SRF).

The 2003 and 2007 ballots highlighted the fact that the Swiss fear greater public intervention in health insurance, and that many voters oppose any further expansion of income redistribution.

For this reason, the new initiative confirmed the community rating premiums and the sizeable (and expensive) system of public subsidies to families, but it abandoned the idea – proposed in 2003 and 2007 – of premiums based on family income and wealth.

In the September 28th ballot campaign the initiative was opposed by most political parties, and by most people operating in the health system.

Supporters of the initiative included the Social Democratic Party (23% of lower house members in the Federal Parliament), some other minor parties (8%), most trade unions and the Swiss Association of Nurses.

Those opposing the initiative included the Federal Government, the centre and conservative political parties (69% of the lower house of Parliament), the health insurers, the representative bodies of businesses, the Swiss Farmers' Association, and the Association of Swiss Hospitals.

The Swiss Federation of Medical Doctors and the Association of Family Doctors were divided, and they did not give their members any recommendations in terms of vote.

The campaign was powerfully dominated by the opponents, who used simple messages in newspapers, periodicals, television, radio, and in the company magazines that insurers send to their clients. There were two main messages: opposition to increased State intervention in the healthcare sector (“public systems cost more than private ones, and reduce the freedom of choice”), and the risks associated with changing the system (“we know what we lose, but we cannot even imagine what we would find”).

According to Hirschman's rhetoric of reaction [9], the opponents' campaign made substantial use of ideological slogans and images, threatening the “socialisation” or “nationalisation” of the health system, evoking “red traps” and an “enormous State administration system” that would decide about the peoples' health. They also campaigned

for “less State, more market!” by emphasising the general virtues of free market competition, and also the “risk” of becoming like France, Italy, or the United Kingdom, with deficits in health system funding, long waiting lists, and alarming episodes of malpractice or poor organisation (an example of this attitude was the slogan: “I oppose the initiative because I do not want to find myself in the same condition as French, Italian or UK citizens. So I say no”). Moreover, opponents stressed the prospect of a lengthy transition period (described as a “no-man's-land”), which would introduce a great deal of uncertainty, continue for many years, and be very expensive. The worry associated with the idea of a non-reversible change was a major argument against the initiative.

The opponents' campaign kicked off in 2013 and strengthened in June 2014. Despite the absence of information regarding the real costs of this campaign, its strong and systematic presence in the media was observed by all. As a result, the percentage of those supporting the initiative fell constantly over time (Fig. 1). This decline in supporters, observed in the polls, shows that even the Swiss population was strongly influenced by cognitive biases, political beliefs and the action of media [10], since a majority in favour of the initiative (until June 2014) was transformed into a majority against it.

Conversely, promoters of the initiative were almost invisible in the main media. With a meagre budget, they began campaigning very late (mid-September 2014), and with a rather low level of visibility. In addition to this, promoters of the initiative failed to effectively counter the most ideological criticisms made by the opponents.

The main message of the proponents was about cost control, although cost savings estimates were almost impossible to define, particularly in the long term. Due to the conflicts of interest involved, the proponents also criticised the financial support given by health insurers to the campaign, arguing that insurers should not use money resulting from premium payments for purposes other than to reimburse providers and administer insurance coverage.

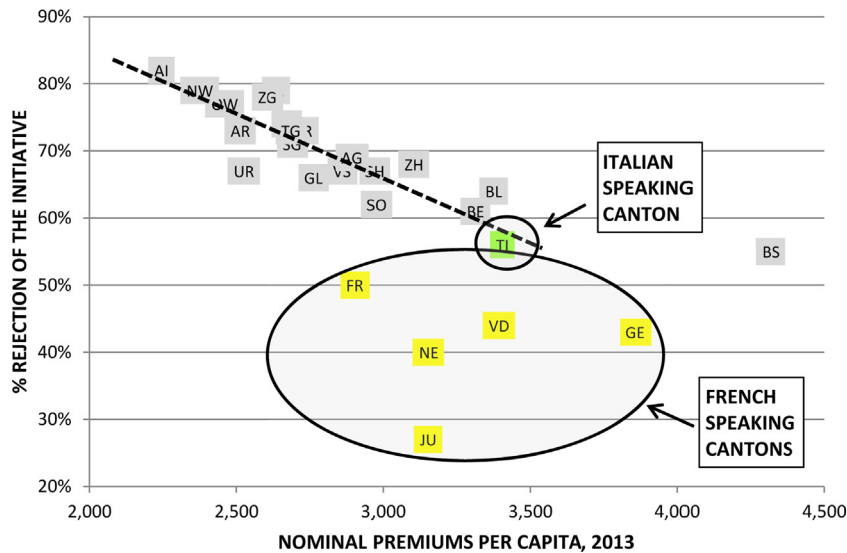


Fig. 2. Cantonal ballot results (rejection rates) related to nominal premiums per capita.

4. Outcomes

1. The initiative was rejected by 62% of voters, with “yes” voters amounting to 38%. The participation rate was 47%, which is fair for similar citizens’ initiatives. If we consider the three ballots of 2003, 2007 and 2014, the percentage of voters supporting greater regulation and the establishment of a public health insurance fund increased from 27% to 29% to 38%. Although not high enough to win, this final score is a remarkable result, if we consider: (i) the excellent health of the Swiss population; (ii) the liberal values of the Country’s political tradition; (iii) the good access to healthcare services, with the entire population entitled to a broad benefit basket; (iv) the solidarity features of the mandatory health insurance, such as community rating, open enrolment, and a widespread system of premium allowances subsidising middle- and low-income families; (v) the high average income and wealth levels of Swiss citizens, making it easier to accept high health insurance premiums.
2. The affordability of per capita premiums was strongly related to the ballot results in German-speaking Cantons (Fig. 2; dotted line). In these Cantons, the lower-than-average health insurance premiums were related to higher rejection rates of the single health insurer citizens’ initiative.
3. Fig. 2 also shows a clear “Röstigraben”, i.e. the divide between the French-speaking Cantons (Genève, Jura, Neuchâtel, Vaud and, to a lesser extent, Fribourg), and the German-speaking ones, with Ticino (TI; Italian-speaking) lying in an intermediate position.
This “Röstigraben” was already seen in the 2007 initiative, which gained the majority of votes in Jura (JU; 58%) and Neuchâtel (NE; 51%), followed by Genève and Ticino (GE and TI; 46%), Vaud (VD; 45%), Fribourg (FR; 37%).

4. For the first time this third initiative caused a split in the medical profession: the FMH (Swiss Medical Association) left its members free to support the initiative or to oppose it. Several prominent doctors, and also a sizeable committee of doctors, actively campaigned in favour of the initiative. In the past ballots the FMH had always advocated maintaining the existing system of competitive health insurance, and had consistently opposed a higher degree of government intervention. This new position can be partially explained by the abrasive confrontation between insurers and doctors in a 2012 ballot about managed care, subsequently rejected by 76% of voters, which was supported by the insurers but opposed by a large majority of medical doctors [11].
5. A major consequence of the citizens’ initiative was the sharp acceleration in the parliamentary process to pass a new federal “law on the supervision of mandatory health insurance”, which addresses several criticised aspects of the current legislation. This reform started in 2011, and in 2012 the Federal Government submitted a report to Parliament, but subsequent debate was very slow and insurers lobbied strongly against it (most insurance companies have Members of Parliament on their Boards). The “menace” represented by the initiative pushed Parliament to pass the new law on health insurance supervision as a way of dismantling the arguments of those promoting the initiative. The law was finally accepted on September 26th 2014, only 2 days before the voting day for the citizens’ initiative, and includes:
 - New measures regarding the governance of insurers (organisation, internal auditing systems, skills required for the management, etc.);
 - Clearer division between the basic coverage and the voluntary supplementary coverage offered by the same insurer (financial investments, attribution of administrative costs, etc.);

- New accounting criteria and rules for managing any insolvency situation;
 - A new process for setting basic insurance premiums: insurers will propose premiums to a Federal supervision authority, which has the power to accept or reject them, based on the alignment between the premium revenues and costs for each year and in each Canton. The Federal authority can also ask insurers to reimburse any parts of premiums that are set too high.
6. Moreover, on March 21st 2014 Parliament accepted a further risk adjustment improvement, adding new information about the morbidity of the insured population to the equalisation formula. This should partially improve risk adjustment and further deter cream skimming.
7. As a final piece of legislation, on September 12th, just 16 days before the citizen's initiative ballot, the Federal Government adopted a law regulating the partial reimbursement (approximately 40% of the entire imbalance) of insured communities who overpaid in the 1996–2013 period. As said above, in previous years the insured communities of some Cantons paid premiums that were higher than the actuarial levels, subsidising the insured of other Cantons. Politicians and the general public found out about these imbalances in 2008, arousing criticism about the poor level of transparency in basic insurance accounting systems. After much resistance on the part of the beneficiary Cantons and the insurers, Parliamentary debate on the issue began in 2011 and led to the decision taken in September 2014.

5. Conclusions

Following this new electoral ballot, the project to establish a public health insurance fund in Switzerland seems to have come to a halt, for the next decade at least. Insurers have effectively fuelled people's "fear of change", emphasising the good results achieved by the Swiss healthcare system, the freedom to choose almost any medical facility or provider, the lack of waiting lists, etc. So the social health insurance system established in 1996 is still in place, despite the substantial differences between premiums, the fact that competition between insurers is still driven by risk-selection, and the poor transparency of insurers.

The ballot defeat has also emboldened insurers: 11 days after the ballot, the main association of health insurers (Santésuisse) asked for the already-generous, tax-based funding to be increased by extending the current 55% public funding of DRG-based in-patient care payments also to the fee-for-service based reimbursement of out-patient care. Such a request would have been unimaginable prior to the ballot, when insurers were demanding more intervention from the markets and less from the State.

However, despite years of resistance to these reform measures, the pressure exerted by the citizens' initiative has forced Parliament to implement much-needed changes to the regulatory framework of the existing health insurance system. Although the reform of the health insurance regulation law can be considered as an attempt, by government and parliament, to block the much more radical reform proposed by the citizens' initiative, it is still a positive result for the promoters of the initiative.

Our analysis of the citizens' initiative, and of the final ballot's outcome, shows clearly that direct democracy has once again favoured the status quo, confirming the institutional rigidity of the Swiss politics with respect to the necessary health system reforms. However, the overall status quo of the current health insurance system could become a major obstacle to maintaining the financial sustainability of health care in Switzerland. In effect, rising healthcare costs could imply a further increase to the already substantial and expensive public allowances earmarked for low- and middle-income families, because the current financing model places a heavy burden on the middle class [12], and also because a large part of the population has rather limited capacity in terms of affording further premium increases. Moreover, the improved risk adjustment and regulation may be insufficient to discourage risk selection and to motivate the insurers to develop integrated care programs for the sick population and in particular for those with chronic conditions. Although more people are switching between health insurers (from 2.0% in 2008 to 8.1% in 2014), and despite the diffusion of information technologies that make it easy to compare premiums and other relevant information, the elderly and the sick continue to be locked to their original health plans. Ultimately, this might discourage health insurers from developing innovative care options for their clients.

Conflict of interest

The authors have no relevant interests to declare.

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