CHAPTER 19

Health Policy

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19.1 Introduction

Health policy entails the regulation, financing, and provision of a wide range of medical and non-medical services to prevent and cure diseases. This complex task makes it one of the most multifaceted and expensive fields of public policy. Strong professional interests and autonomies, expensive treatments, equity of access, quality concerns, and increasing costs render policymaking challenging. In Switzerland, health policymaking occurs against the background of direct democracy, decentralized federalism, liberalism, consensual policymaking, and subsidiarity. This system grants subnational policymakers, voters, as well as private actors considerable access, voice, and influence on decisions in health policy.

In terms of macro-indicators related to health, Switzerland can only partly be considered a success story. The majority of the Swiss population is satisfied with the country's health care system (FOPH 2016a). From a medical point of view, Switzerland has a high life expectancy rate at birth (83 as of 2015), median childhood mortality (3.9, 2015), low rates of preventable mortality (159 per 100,000 in 2013), and rather low cancer death rates (223.5 per 100,000 in 2013). However, it also has rather high

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suicide rates (12.2 per 100,000 as of 2013, with a historically even higher rate) compared to other Organization for Economic Co-operation and Development (OECD) countries (OECD 2016). The main challenge for Switzerland is rising costs for health and long-term care, as well as issues in the distribution of these costs. In 2015, Switzerland spent 11.5 percent of its gross domestic product (GDP) on health policy (the OECD average is 9 percent), and 3.7 percent of these expenditures were out-of-pocket contributions from patients, as compared to an average of 2.4 percent in the OECD (2016). Health insurance carriers pay for most health expenditures, whereas cantons and municipalities cover the largest share of the health expenditures by the state (FOPH 2017a). The biggest challenge is the rising health care burden for the population, since health insurance premiums continually increase (FOPH 2017b) and a considerable share of the population relies on cantonal subsidies to pay their health insurance fees (FOPH 2014a).

The next section discusses the institutional foundations of Swiss health policy. Then, I present the constellations of the politico-administrative and private actors in Swiss health policy and discuss the resulting political conflicts. This chapter then turns to current challenges for health policymakers in Switzerland.

19.2 Institutional Foundations

National health policy is based on a health insurance law adopted in 1994 and in force since 1996 (LAMal; 'Loi fédérale sur l'assurance maladie'), which replaced the earlier law of 1911. The reform in 1994 signaled a change from a voluntary health insurance system to a universal and mandatory health insurance system. This switch came late in comparison to other European countries (Uhlmann and Braun 2011). The main responsibility for health policy rests with the Federal Office of Public Health (FOPH), founded in 1893, and originally responsible mainly for public health, especially health promotion and illness prevention. Responsibility for health insurance would only be transferred to the FOPH in 2003 (Trein 2018).

A comparative assessment of health care systems suggests that Swiss health care policy follows a collective negotiation logic, in which subnational public actors (such as cantons) as well as private actors (such as health insurance bodies, professional organizations, private hospitals, or the pharmaceutical industry) possess considerable influence and lobbying power. Hierarchy and market logics are less important, although the Swiss

system shares important similarities with the US health care system, one which emphasizes market elements in the financing and provision of health care (Böhm et al. 2013).

Historically, three organizational principles have shaped actor constellations and the institutions of the Swiss health system: federalism, liberalism, and subsidiarity (Sager et al. 2010; Vatter and Rüefli 2014, 828).

- **Federalism:** Switzerland is a 'coming together' federation, in which the subnational governmental units (cantons) formed the national government. Originally, the cantons had the power to make policy over health issues, and only gradually and selectively transferred health policymaking to the national level. In principle, Switzerland has 26 different health systems and health policies, and policies adopted at the cantonal level often preceded national regulations. This was true for health insurance itself (Uhlmann and Braun 2011), for the implementation of alcohol policy (Sager 2003, 2004) and tobacco control policy (Trein 2017). Cooperation between cantons always played an important role for national health policy as well, with the Conference of Cantonal Public Health Directors (CPHD) that has existed since 1919 (Trein 2018). Thus, the decentralized federal structure impeded the creation of national health legislation longer than in other countries where subnational governments had less policy competencies.
- **Liberalism:** Health policy in Switzerland has a strong liberal element. This means that policies constraining the liberties of individuals and businesses are notoriously unpopular. Citizens and elites, particularly in the central and eastern part of the country, prefer a small but effective state instead of a large redistributive machinery. Support for a limited state also affected the creation of a national health insurance scheme. Since the early twentieth century, population and elites have repeatedly opposed, and more significantly, voted against policy proposals that aimed at creating a national health insurance law or that called for creating a public health insurance organization operated by the state (Alber and Bernardi-Schenkluhn 1992). In 2014, voters rejected a popular initiative demanding the establishment of a public health insurance organization[1] (Trein

[1] The title of the popular initiative was Eidgenössische Volksinitiative 'Für eine öffentliche Krankenkasse': https://www.admin.ch/ch/d/pore/vi/vis401.html, accessed October 26, 2017.

2018). Liberalism also guided the design of the national health insurance law in 1994, which made health insurance coverage mandatory but nevertheless had private providers offering the health insurance packages. Interestingly, insurers are not allowed to make profits with the basic insurance package, and, despite competition for insurance contracts, are required to accept all applications for basic health care coverage regardless of gender, age, or pre-existing medical conditions (Uhlmann and Braun 2011). The prevalence of liberal values also played a role in the failure of proposals aimed at introducing preventive health policies. In 1993, for example, voters and parliament rejected a popular initiative calling for a complete ban on alcohol and tobacco advertising (Cornuz et al. 1996), and more recently, a national framework law to create a preventive health care policy failed after several rounds in the national parliament (APS 2012; Fontana 2012).

- **Subsidiarity:** Subsidiarity means that social or political issues should be dealt with at the lowest possible level of government. This implies that local non-state actors should be brought in to deal with policy problems, and is a reason non-state actors play an important role in health policymaking and in local delivery of health or long-term care services. In Switzerland, for example, non-governmental organizations such as the Swiss Cancer League or the Swiss Lung League assist patients and create health promotion programs. Historically, health insurance was first provided, following the subsidiarity principle, by local health insurance providers, but their numbers have dwindled and national companies offer contracts in many cantons (Trein 2018). Politically, subsidiarity also implies that the providers of health services, whether these are doctors or pharmaceutical companies, also have an important role to play, and as a result they, too, are often consulted in the policymaking process.

19.3 Competencies of Actors

The main politico-administrative actors (Knoepfel et al. 2011) in the Swiss health care system include the national political executive and its associated administrative units, most notably the FOPH, the federal parliament, with its various political parties, the cantonal governments, and administrative units, particularly the departments of health and the cantonal public health officers (*Kantonsärzte*), the cantonal parliaments and

parties, and the municipalities. In addition, private actors regulate important areas in health policy and, thus, functionally occupy roles as politico-administrative actors.

19.3.1 Federal Government, Cantons, and Municipalities

The federal government is responsible for public health matters, in particular those related to infectious diseases and epidemics. It is thus responsible for health protection, prevention, and cure, and in addition, more general health care policy. This includes passing framework legislation, setting out the catalog of benefits covered by health insurances, admitting drugs to the country and setting the prices of health care services, ensuring health care quality, subsidizing health insurances, and providing oversight (Vatter and Rüefli 2014, 835).

The cantons are responsible for implementing federal health policies, including public health protection in cases of infectious diseases. Furthermore, they are in charge of implementing health insurance policies, providing health care infrastructure (e.g., the planning of hospitals, approving labor agreements in the health sector, and implementing health insurance subsidies). In addition, cantons also put their own health policy legislation into place, meaning they are responsible for the provision of health services, for planning and building public hospitals, and for regulating the providers of ambulant care (admitting into practice and controlling services provided). Furthermore, the cantons collaborate at the national and regional levels over health policy. At the national level, the cantons cooperate in the CPHD on a variety of topics, including health occupations or health insurance. There are also regional conferences (East, Central, Northwest, and West Switzerland) of cantonal health directors (Füglister 2012; Vatter and Rüefli 2014, 836).

The federal government and the cantons share a number of competencies in health policy, particularly in promoting health, preventing non-communicable diseases, and in health education. Furthermore, both levels of government share responsibility for the education of health personnel, and in regulating and recognizing the various health professions.

The municipalities also have competencies in health policymaking, mostly in providing complementary health care services in long-term care. Compared to the national and cantonal levels, the scope of these competencies is small. They may well become more important in the future, as expenditures for long-term care are very likely to increase (Trein 2016; Vatter and Rüefli 2014, 835–836).

19.3.2 Coordination Between Different Levels of Government

The mixture of shared and separated competencies in health policies creates coordination problems between levels of government. On the one hand, the national government has an incentive to shift policy competencies and costs to the lower levels of government. On the other hand, cantons may implement national policies and use funds related to health care in ways other than those intended by the national government, for example, when implementing policies in ways that fit the interests of a given cantonal government. Thus, federalism limits the ability of the national government to steer Swiss health policymaking (Vatter and Rüefli 2014, 845–846). Consequently, the federal government needs to incentivize cantons to cooperate and to negotiate, if or when necessary. This happens indirectly through the CPHD, in which the national government participates, but also via regional health ministers' conferences. The national coordination platform *Dialog Nationale Gesundheitspolitik* serves, amongst other things, as a forum for exchanging information and creating common national strategies (Füglister 2012; FOPH 2017c).

19.3.3 Private Actors

Private actors play an important role in Swiss policymaking and implementation, owing to the principles of liberalism and subsidiarity noted previously. In principle, health service providers (e.g., doctors, health insurance bodies, or pharmacies) compete for patients. Compared to countries like the Netherlands or Germany, Switzerland has more competition in its health care market (Hammer et al. 2008; Blenk et al. 2016).

Private actors are collectively organized in several areas of health care policy. Health care providers have the right to organize into peak interest organizations, which in turn are entitled to negotiate collective agreements about prices. Thus, sovereignty in wage bargaining is a key element of the Swiss health care system (Sager et al. 2010; Böhm et al. 2012, 64), though public authorities do control, and approve, the collective wage agreements reached.

Private providers of health care services include doctors, private hospitals, and pharmaceutical companies, which all are well-connected in the national parliament. Together with public hospitals, they form a block of

interests often opposed to health insurance bodies when it comes to the pricing of health services (Vatter and Rüefli 2014, 839–840). On the other hand, other coalitions may form, such as when private providers and health insurance bodies make common cause in opposition to patients and their interest representatives, for example, with respect to introducing a national unified health insurance. In addition, private actors play an important role in public health and prevention (Achtermann and Berset 2006). Interestingly, preventive health policies promulgated by the state are quite unpopular among citizens and elites alike.

19.3.4 Relationship Between Public and Private Actors

Private actors play a dual role both as rule-makers and as rule-takers in some parts of health policy, and one of the most important cleavages in Swiss health policy lies in the conflict between providers and financing agents. Private actors are important on both sides, whereas public actors take on the role of an arbitrator in the conflicts between health insurance bodies and health care providers. These disputes, for example, about changes to hospital financing or changes in the rules concerning the admissibility of drugs or adjustments in reimbursement stipulations in the national health insurance laws, turn into strong conflicts between private actors—rather than conflicts between private and public actors (Vatter and Rüefli 2014, 839–840).

The reclusive role of the state, especially of the federal government, in health care policy affects public action regarding preventive health issues. The Federal Office for Public Health pushes for encompassing preventive health policies, but these measures are unpopular among center-right and right-wing parties and lack substantial political support from powerful private health care actors, such as the medical profession or health insurance organizations. These private actors have especially a professional interest in preventative health policies but politically preventative health policy is less important for the medical profession and other private actors of the health care sector. Since they enjoy a strongly institutionalized position in Swiss health policy, they do not need an additional clout and have no incentive to make encompassing non-medical preventive health policies, for example, tobacco control, a high political priority (Trein 2018).

19.4 Current Policy Challenges and Related Political Conflicts

19.4.1 Health Care

In the health care literature, authors distinguish four different policy goals: cost containment, equity, liberty, and the quality of health care services. These four policy goals exist in every health system (Uhlmann and Braun 2011, 23) and policymakers need to balance them, as they may be in conflict with one another. Establishing a national health insurance law created (relatively) equal access to health care services, and these have been supported by public subsidies for health insurance premiums for low-income individuals (Beck et al. 2003). Nevertheless, the Swiss system remains highly regressive; low-income and middle-class households need to dedicate a considerably larger share of their income to health care than rich ones do (De Pietro et al. 2015, 232, 237). Therefore, if health expenditures continue to rise, this may disproportionately affect vulnerable groups such as the poor or low-income retirees.

In Switzerland, health insurance premiums have increased by a yearly average of 4.2 percent from 1996 to 2014. This is 40 percent every ten years, more than the average household income increase in this period (Vatter and Rüefli 2014, 846). General health expenditures increased from 5.3 to 7.5 percent of GDP from 1995 to 2015, according to the Swiss government (Fig. 19.1). These figures differ slightly from the numbers reported by the OECD, which uses a different basis for calculation, but they show the same trend. Thus, like elsewhere, cost control and financial sustainability are central problems for health policy in Switzerland.

To deal with increasing health care costs, left-leaning political actors have proposed a single public health insurance agency (*Einheitskasse*) with regional sub-agencies. Proponents argue that such a system would create a simpler, cost-effective, and more transparent health system (Forster 2013). The national parliament (Sda 2013) objected to the proposal, and in September 2014, voters rejected a popular initiative on the subject. Nevertheless, the topic of public health insurance re-appeared on the political agenda in 2017, since politicians from the French-speaking cantons submitted a popular initiative proposing to give cantons the option to increase public control over health insurance premiums. They argued that the cantonal governments should have the competencies to set health insurance premiums and that this would help to keep cost under control (Kucera 2017).

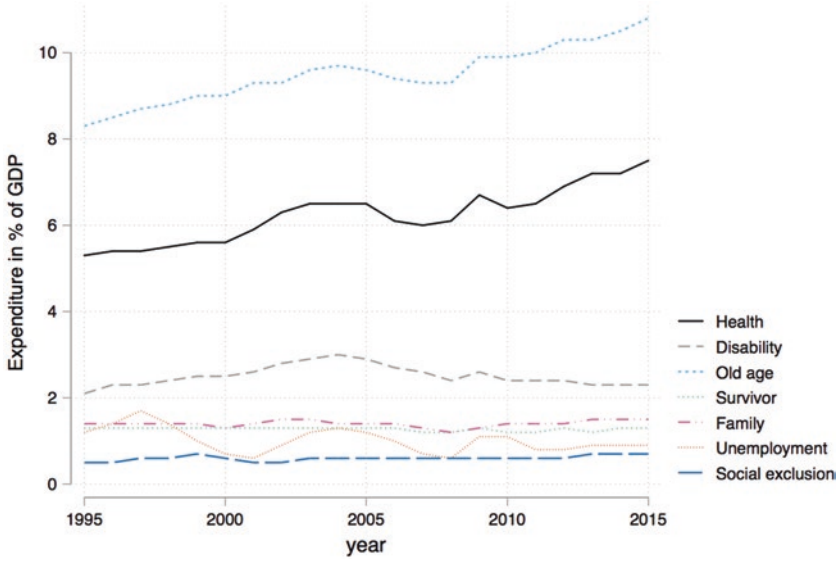

Fig. 19.1 Swiss health expenditure in comparison with other policy sectors. (Source: Social Expenditure Statistics, Swiss Confederation)

Cost containment also played an important role in other proposed reforms to health care, most notably in a proposal to change hospital funding and practices. The idea was to make prices more transparent across Switzerland and to reduce the overall length of treatment. This proposal resulted in tough conflicts between providers and health insurers, at the expense of the interests of patients and overall cost containment (FOPH 2014a, b; Kessler 2014; Weber 2015; Strupler 2018). Other initiatives, such as the proposal to increase the regulation of the managed care market,[2] argued that they too would improve cost containment in the Swiss health system (Vatter and Rüefli 2014, 846). Furthermore, a 2012 legislative proposal regarding managed care failed in a popular referendum (Schoch 2012).

[2] Switzerland has a rather liberal market for managed care models. These have cheaper rates than the standard health insurance model but patients are limited to specific networks of doctors, Health Maintenance Organizations, and telemedicine. The share of patients using the (cheaper) non-standard model of health insurance has increased over the years (Forum Managed Care 2010).

Against this background, (at least) four potentially overlapping reform strategies are possible, if not even probable. First, one could limit the increase of health expenditure by creating a (public) single payer system and by regulating prices. Due to the institutional path dependency in health policy, this is very unlikely to happen. Second, due to the aging population, health expenditures will naturally reduce. This, too, is very unlikely to happen any time soon. Third, health care coverage will progressively be reduced, and out-of-pocket co-payments will increase. This is likely to happen and is already taking place through rising health insurance premiums. Fourth, one could increase tax-financed subsidies for patients, resulting in an incremental transformation—by stealth—into a largely tax-financed health insurance system. This is very likely to happen and is already the case in the existing cantonal subsidies for insurance premiums.

19.4.2 Prevention and Public Health

The second major policy challenge in the field of health policy concerns preventive health policies, in particular, preventing complicated illnesses brought about through non-communicable diseases. The lack of coherent national preventive health policies and the lack of framework legislation at the national level are key problems in the Swiss health system.

A recent effort to create a national framework law for preventive health failed due to resistance from conservative and market-oriented parties. Certain economic groups also brought strong influence to bear on parliament, resulting in the upper chamber failing to approve the funding that would have been needed (APS 2012). This failure was all the more far-reaching, as the proposed law would have permitted a comprehensive preventive health policy to be created, which would have included other areas such as mental health. Such an action would be important since more than 40 percent of the recipients of disability insurance suffer from psychological illnesses (FOPH 2017d).

A better integration of preventive aspects into health policy formulation is now part of the federal government's comprehensive national health strategy (Gesundheit 2020), which defines 12 priorities and 36 specific policy measures to be put into place after 2016 (FOPH 2016b). In addition, the cantons have engaged in their own public health measures, for example concerning tobacco prevention (Trein 2017).

19.4.3 Long-Term Care[3]

A third important challenge for Swiss health policy concerns long-term care. The main problem is that the number of individuals in need of such care is likely to increase sharply. Long-term care is a cantonal responsibility, and they can delegate these competencies to the municipalities or to private organizations—an option they use frequently (OECD 2016).

Health insurances, cantons, and municipalities share the costs for long-term care. The health insurances have to cover a ceiling amount for ambulatory and stationary long-term care, which is fixed by the federal government. Patients have to pay a maximum of 20 percent of the ceiling fixed by the federal government. The cantons (and municipalities) have to cover the rest (FOPH 2016c). Furthermore, measures to compensate individuals caring for their dependent relatives are limited, and so are policies to (re)integrate those who have cared for a dependent relative back into the labor market. Those who take care of dependent relatives—often women—typically reduce their working hours in order to provide this care, but do so without adequate financial compensation or guarantees that they will be reintegrated into the labor market after the period of caregiving is over. Currently, the federal government is developing policies to deal with this problem.

Against this background, long-term care poses a major policy challenge for Swiss health policy. Policymakers will need to deal with the demand for more long-term care in the Swiss context of decentralized federalism, subsidiarity, and liberalism. These principles will make it difficult to formulate a national policy for long-term care, not least because private actors will certainly play an important role, and redistributive elements will need to be kept to a necessary minimum.

19.4.4 Actor Constellations in the Response to These Policy Challenges

In dealing with these policy challenges, the actor constellations and political traditions of Switzerland are likely to result in the following pattern of health policymaking.

The federal government will continue to provide framework legislation and overall strategies. Due to cost pressures and rising health care costs, the national government might need to use decrees to reform health policy, as they did in the 1980s. Changes to paradigms, such as creating a

[3] This section is based on a report written by the author about support for people of working age who have dependent relatives (Trein 2016).

national law for preventive health, are unlikely to occur due to resistance from the conservative/liberal majority in the national parliament. They are often unwilling to support large reforms that grant funds to the statist provision of health services, regardless of what kind they are. How national policymakers will address long-term care—whether through a new national law, cantonal solutions, or co-financing between health care funds and disability insurance—remains to be seen.

The cantons are likely to implement innovative health policies on their own, whether in preventive care or in terms of health insurance. A stronger role for the state in health insurance matters is more popular in the French-speaking than in the German-speaking cantons, leading to divergence between the different cantonal health systems. This also applies to the role that the state takes vis-à-vis private providers of health care financing and to what extent the state regulates potentially unhealthy individual behavior. On the other hand, if the cantons shared common interests, they are likely to work together and learn from one another in the various intercantonal conferences and, if necessary, to coordinate their opposition against the federal government.

Private actors, notably the providers of health and long-term care services as well as health insurance bodies, are likely to retain a strong role in health policy and will try to pursue their interests. These might be regarding cost containment measures or be in efforts to shift the costs for risks to the public sector. The self-organizing principle gives private actors and interest groups considerable influence, and their strong position in the national parliament ensures that these actors will continue to have significant veto power in future proposed reforms of the health care system.

19.5 Conclusion

Historically, federalism, subsidiarity, liberalism, and direct democracy have shaped Swiss health policy, and are important organizational and institutional pillars even now. This context means that policymakers, and voters, are suspicious about having a strong state determine health policy: various levels of government share policy competencies, and private actors, especially health insurance and health service providers but not patients, enjoy considerable influence.

This leads to coordination problems between different levels of government. It also means strong lobbying by interest groups in the health sector, opposition against restricting individual liberties (however this notion

is interpreted), and an overall limited steering capacity on the part of the state in health policy. The main policy challenge for Swiss health policy-makers concerns financial stability and rising costs. In the Swiss context, decision-makers need to pay particular attention to trying to contain increases in health care expenditures and to ensure that higher costs do not shift disproportionately and burden vulnerable groups such as the poor and the elderly.

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