Voice + Exit = . . . ?
Efficacy and solidarity in the Swiss health-care system∗

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Abstract
This paper discusses the nature and consequences of voice and exit options in the Swiss health care system. In the context of health insurance they failed to contain the increase of expenditures, while in the context of the implementation of subsidy policies by subnational units they led to a significant decrease of solidarity.

1 Introduction
Worldwide, changes in health-care policies have been both extensive and intensive since the 1970s, pushing public authorities to reconsider the nature of their intervention. Nevertheless, the health-care realm has remained a public affair—no retrenchment was brought about in fact—but the fiscal imperative and the growing costs imposed new political strategies. In particular, the introduction of managed competition among providers and regionalization have been two common features of the new health-policy environment across Europe (Freeman, 2000; Palier, 2004). While the former should contain costs at the macro-level, the latter should allow to implement locally and more efficiently the new policy setup.

Alongside those reforms, the role of the different involved actors has changed. Patients, doctors, and third-party payers, as well as politicians

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profit from new resources, options and *choices* to steer, correct and influence health policies.

This common framework allows us to grasp the pertinence of Hirschman’s (1970) concepts of exit and voice for the study of contemporary health-care systems. Indeed, current health policies are characterized by an increasing interaction between political and economic factors at many decisional levels, providing consequently concerned actors with an increased amount of opportunity of exit or voice in case of dissatisfaction. For instance, patients are allowed to exit and switch between public providers, jump into the private sector, or move to another country in the last resort. Moreover, voice options are possible to either influence the policy-making process or to redress decisions already made (Freeman, 2000).

Empirically, we focus on health policy in Switzerland. For the application of these concepts, this case can be considered “typical” (Gerring, 2007, 91–97). First, the Swiss health-system presents an unique public–private mix which, combined with the tools of the direct democracy, empower the use of exit and voice for individual and public actors. Second, the poor performances of the system in meeting their main objectives, the continual augmentation of premiums and costs, and the simultaneous erosion of solidarity make all the use of those analytical tools particularly attractive.

Our aim is thus to explain the effects of the system in the light of exit and voice. We seek to evaluate their impact on the outcomes, especially concerning the individual behavior of patients, doctors and insurers on the one hand, and the cantonal freedom on the other. The findings demonstrate that, on the individual side, the exit and voice options are, respectively, counterproductive and inefficient concerning the overall efficiency of the system. On the cantonal side, the large room of maneuver promoting exit and the federalist opportunity of voice can explain the erosion of the solidarity, particularly through a dynamic of “policy drift” (Hacker, 2004a).

The paper is structured as follows. Section 2 develops the theoretical arguments on exit and voice options, as well as the nature, causes and consequences of policy drift. Section 3 introduces the Swiss health care system and opportunities for exit and voice. Section 4 documents the effects of exit and voice strategies used by individual actors, while Section 5 presents the influence of both options at the public level, through a case study of a specific canton (Vaud). The conclusion sums finally up the main arguments and findings.

### 2 Theoretical framework

Our theoretical framework is twofold. On the one hand, the concepts of *voice* and *choice* developed by Hirschman (1970) permit us to conceptualize systematically health-care policies in Switzerland and explain part of the
intended and actual outcomes—namely, cost containment and the market mechanism—focusing on the individual level of action.

On the other hand, the theory of policy drift (Hacker, 2004a) help us highlight the erosion of the main solidarity tool—public subsidies for low income people—which take place at the cantonal (public) level.

In other words, we use the concepts of exit and voice as explanatory factors for the outcomes of the Swiss health system, both in terms of efficacy and solidarity. Especially for this second point, the dynamic of policy drift should be seen as an effect of the process which can be efficaciously investigated through Hirschman’s tools.

2.1 The concepts of exit and voice

The concepts of exit and voice, developed by Hirschman (1970), have the advantage to be highly generalizable, as well as “attractive for its combination of economic and political theory” (Freeman, 2000, 109). As a consequence, it has a large applicability and can be used to analyze and explain a wide range of political and economic issues.

The basic argument is simple. In a context of declining quality performances of firms or organizations, customers or members have two different options to demonstrate their disapproval. On the one hand, they can “exit” and stop buying firm’s products or leave the organization they belong. On the other hand, people can use their “voice” and express the dissatisfaction to the management, seeking to correct the causes of the quality deterioration. Whether the former is typical of economic actions, the latter is characteristic of political arrangements.

Exit and voice are not mutually exclusive: voice can complement or even substitute the former (Hirschman, 1970, 30). This depends in fact on the ability or willingness of actors to articulate their interests. In other words, how costly the use of voice is with respect to its possible benefits. Actually, the outputs of the voice option are uncertain, if compared to the certainty of exit.

The institutional context and political arrangements play here a great role in shaping the choice between the two options, especially reducing the costs of voice and promoting it. “[I]nstitutional rules establishes the background conditions for the actions of politicians, bureaucrats, interests groups, and voters who wish to enact or block policies” (Immergut, 1992, 27). As pointed out clearly by Immergut (1992), the institutional configuration (constitutional rules and partisan representation particularly) constitutes a fundamental background for actors willing to influence, block or redress the decision-making process. The creation of some veto points will influence the strategic power of particular interest groups or actors, redirecting decision through particular paths. Therefore, depending on the institutional arrangement, the power of voice over exit is intensified. This provides actors
with incentives, opportunities and constraint to manifest their disapproval and marshal important bargaining power.

2.2 Policy drift and welfare state reform

Are welfare state programs under continual pressures? Have social policies been scaled back during the last decades? These questions are at the core of the study of welfare state development and have given rise to a large debate. Perhaps the most famous work is Pierson’s (1994) book “Dismantling the Welfare State?”, which has had a long-lasting impact on the study of social policies. There, the main question was whether retrenchment, namely “[…] policy changes that either cut social expenditures, restructure welfare state programs to conform more closely to the residual welfare state model, or alter the political environment in ways that enhance the probability of such outcomes in the future” (Pierson, 1994, 17), occurred in Great-Britain and in the US during the Thatcher and Reagan administrations. Results were surprising because the study highlighted the continuity of social programs, despite strong pressures for retrenchment.

Pierson (1996) found that for welfare state reform, the role of political parties is not the same as for welfare state development, which led him to formulate his thesis on the existence of a “new politics of the welfare state.” Due to the concentrated and immediate political costs of reform, the diffused gains over the long term, the centrality of social programs in citizens’ everyday life, the strong vested interests and the relatively clear accountability for cuts, changing social policies is an inherently risky task. Policy feedbacks create high transition costs which make social policies path-dependent and therefore particularly resilient.

At the same time, against a backdrop of (apparent) legislative stability, a set of structural changes has taken place. Changes in labor relations, family structures and socioeconomic factors (Pierson, 2001; Bonoli, 2007) have made social policies less and less adapted to existing needs. Consequently, a growing mismatch between new risks and old benefits has emerged. But is this gap caused by the inattention of policy-makers, or is it due to explicit political strategies?

According to (Hacker, 2004a), the latter seems to be the case. Following Pierson, the conventional approach to welfare state reform has focused predominantly on explicit changes in formal rules, such as cuts in spendig, but has neglected more indirect strategies, such as preventing existing social program from being updated to take into account new needs. In this perspective, the gap between social risks and coverage is not only due to exogenous shocks, nor is it driven exclusively by an apolitical and unintentional overlook of the emergence of new social demands. Rather, it is a direct consequence of political struggles.

Hacker crystallized these ideas in the concept of “policy drift,” which
refers to those “changes in the operation or effect of policies that occur without significant changes in those policies’ structure” (Hacker, 2004a, 246). If a given policy cannot be easily revised, policy makers can opt for “hidden” strategies instead of promoting formal policy changes that have little chances of success. In fact, as pointed out by Immergut (1992), the institutional context can determine the extent and feasibility of policy change, providing the concerned actors with specific strategical options to hinder policy adaptation. Hence, blocking proposals aiming to adapt social policies to new risks and to preserve a constant level of social protection can be an effective political strategy to change social policies without changing them, so to speak. A long-term consequence of such strategies can be that social programs are gradually transformed in a more residual direction, leading to a dynamic of “risk privatization” (Hacker, 2004a, 249) which leaves citizens with less public support to face the economic and social costs of the new risks.

To sum up, the concept of “policy drift” is useful to explain the paradoxical trend of “reform without change and change without reform” (Hacker, 2004b, 721), in which formal policies remain stable, while outcomes do not. This approach also emphasizes incremental and differentiated changes, in contrast to wide-sweeping claims of convergence, “race to the bottom,” or “Americanization” across national welfare state programs (Starke, Obering and Castles, 2008). Change occurs not through wide-ranging reforms but through more “subterranean” strategies, which are nevertheless highly politicized. Policy makers can drive the orientation of social programs through blocking activities, hostile agenda setting or partial policy adaptations, instead of pursuing formal revisions with little chance of success.

3 The Swiss health-care system

3.1 Overview

The Swiss health-care system is characterized by an interesting public-private mix, which was introduced in 1994 by the law on health-care insurance (LAMal). A basic insurance package is mandatory but provided by about 90 private insurers. The main features of social-insurance and liberal models coexist within the same system, with the expectation that the objectives of coverage, quality and cost containment can be simultaneously attained.

On the private side, insurers are the key actors and compete to attract clients. Insurance is compulsory but premiums are independent from revenue and are paid exclusively by individuals, with no contributions from employers like in social insurance systems.

On the public side, the federal government regulates the insurance market. Firstly, premiums are set by health-care insurers but must be approved by federal authorities. Moreover, because the risk structures of the different
insurers vary greatly, a risk-adjustment scheme helps limit the variations of premiums among insurers. In addition to equity concerns, this should also stimulate competition based on costs and quality rather than the selection of “good” risks. Finally, health-care insurers must accept all patients for the “basic package,” while for complementary coverage the market is relatively free and health-care insurances can select people also on the basis of their health status.

Social insurance systems are highly redistributive because they are financed by taxation and social contributions which depend on revenue and are paid also by employers. By contrast, the Swiss system is much less redistributive because it is financed mainly by insurance premiums that are independent from income. However, there is a public subsidy system whose aim is to reduce health insurance premiums for low-income people. This is the main social component of the Swiss health-care system. It is quite decentralized and cantons benefit from significant room for maneuver. Cantons set up their own systems, which vary on several important dimensions such as eligibility criteria, generosity, recipients identification, procedures and modalities of payment (Balthasar, 2003).

The system is financed with federal matching funds, which are fixed through decree every four years and are assigned to cantons following specific criteria, such as population, financial capacity, and number of insured people living abroad. Until 2001, cantonal mean premiums were also taken into account, but the abrogation of this criteria was decided in 1998 following a cantonal initiative in order to increase incentives for cantons to reduce costs. Cantons must match the federal contribution with their own funds. However, the cantonal contribution can be reduced up to 50%, in which case the federal contribution is also reduced by a corresponding percentage. Cantons have progressively increased their utilization of these resources, but all cantons do not exhaust them. In 1996, the median value was just over 60%, which means that half of the cantons used only less than two thirds of the federal budget. By contrast, in 2006 the median value was about 85%. This means that half of the cantons used almost all the federal contribution, but it also means that the other half renounced to a significant part of the federal budget.

Thus, health-insurance subsidies aim to reduce insurance charges for people who cannot afford to pay them. They are the main social component of an otherwise quite liberal system. Given the significant room for maneuver left to cantons, specific subsidy policies, as well as outcomes, vary considerably within Switzerland.

3.2 Voice and exit options

According to Hirschman (1970, 120), few organizations or arrangements can extensively combine both exit and voice options. However, this consideration
seems not to fit the Swiss health-care system, in which the public-private mix and the particular institutional setting allow patients, insurers, healthcare providers, and cantons to profit from a wide range of freedom and consequent strategic opportunities.

Therefore, all actors involved will use the instruments of regulation at their disposal to meet the basic objectives of the system, namely solidarity, cost containment and overall quality of care. The federal state will intervene with the public instrument highlighted in the previous section if the need arises (Conseil fédéral suisse, 1991). Table 1 and the next two paragraphs sum up exit and voice strategic options for each actor.

Exit  The liberal side of the system, based on market competition and self-regulation mechanisms, enhances the individual freedom of choice and, consequently, the use of the exit option. Choice and exit are intrinsically linked and mutually self-reinforcing. Hereafter, to simplify our argument, the term of exit will imply a great amount of choice as a logic precondition. In this paragraph, however, we maintain these distinction to better understand the characteristics of the system which promotes exit.

Patients have many possibilities of choice, because the overall system is built on the contractual liberty. First of all, people can (or must) pick out—within their canton of residence and between different insurance companies—their basic mandatory package. This is diversified into four main types of policy insurance, which vary in cost sharing amount and scope for choice. In addition, a complementary voluntary insurance can be bought. Finally, residents can also freely choose their health-care provider, except for insurance types which expressly limit the scope for selection.

The liberal character of the insurance system lets dissatisfied patient to exit and switch insurers relatively smoothly. Price and quality reasons should here play a great role, like for any consumables. Moreover, patients can switch, for various reasons, the type of insurance policy, their own care supplier, as well as the canton of residence. Although this last option may be remote, the large differences in premium levels and facilities across cantons make it appealing and realistic.

Insurers’ choice is more limited and companies offering a basic package can only fix every year the monthly premiums, which must then be approved by the federal authorities. The selection of good risks is formally forbidden

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1 First, insurance with a yearly basic deductible of 300 SFr. Second, a higher deductible between 500 and 2'500 SFr., which permits to pay a cheaper monthly premium increasing the cost sharing. Third, a bonus insurance, in which people who do not claim for reimbursement receive a bonus at the end of the year. Finally, limited choice insurance that promotes cost containment through the role of doctors as gatekeepers or HMOs arrangements.

2 It covers dental and ophthalmological care, medicaments without prescription and better hospitalization services.
Voice and exit strategies in the Swiss health-care system.

Table 1: Voice and exit strategies in the Swiss health-care system.

- **Patient**: Direct democracy
- **Insurer**: Lobby, Direct democracy
- **Doctor**: Lobby, Direct democracy
- **Canton**: CDS, cantonal referendum, Council of States

<table>
<thead>
<tr>
<th>Actor</th>
<th>Voice</th>
<th>Exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Direct democracy</td>
<td>Switching company, insurance type, doctor, canton</td>
</tr>
<tr>
<td>Insurer</td>
<td>Lobby, Direct dem.</td>
<td>Risk selection(^1), leave unprofitable canton</td>
</tr>
<tr>
<td>Doctor</td>
<td>Lobby, Direct dem.</td>
<td>Large professional freedom</td>
</tr>
<tr>
<td>Canton</td>
<td>CDS(^2), cantonal referendum, Council of States</td>
<td>Policy adaptation (fit particular needs or limit obligations)</td>
</tr>
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</table>

\(^1\) The risk selection is legally allowed only for complementary insurance policies.

\(^2\) Conference of the cantonal health ministers.

for basic packages, while it is allowed for complementary ones. Insurers can thus accept or refuse the voluntary coverage depending on the individual health status. Another realistic option is “exiting” an unprofitable cantonal market and concentrate the activities in the more attractive ones. Finally, an insurance can also abandon the basic insurance market, concentrating its efforts into the private sector.

Doctors do not enjoy precise exit options, but they can benefit from a traditional professional freedom which allow them to act quite freely—especially in the realm of ambulatory care. Relative small pressure can be exerted on them by insurers, which are legally obliged to contract with all providers. Moreover, incitations to limit the supply of medical acts are also few, in particular because of the fee-for-service reimbursement system.

Finally, the decentralization of the health-care system allows cantons to implement their own policies, mainly concerning subsidies, hospital planning and financing. As we have seen in particularly for subsidies, cantons have a great room for maneuver and are able to act quite freely within the boundaries fixed by the law. They can, so to speak, exit and adapt some requirements to fit their needs or limit obligations at best. The example proposed in the Section 5 will describe this option and modalities of enactment in detail.

**Voice** In our theoretical framework, we have drawn exit as a typical strategy to challenge dissatisfaction in the economic realm, whereas voice is more present in political conflicts. Indeed, because the Swiss health-care system combines economic incentives with political challenges, it is not surprising
that the different actors—publics and privates—benefit from a huge amount of both exit and voice strategic resources, as a consequence of their also vast possibility of choice.

Hence, patient and insurers (doctors do not seem to need an exit option, holding already a strong power position) are motivated by strict economic considerations. Besides, the universality of the system makes a real and complete exit simply impossible. At this stage, the voice option comes into play, well supported by an institutional context which promotes strategic opportunities (through referendum and popular initiative) for individuals and interest groups. In the past, many reforms and policy propositions were challenged by interest groups and citizens (see Immergut, 1992). The tools of direct democracy—in particular the referendum, which has generally a negative turnout at the polls—gave enormous bargaining power to opposed interest groups, from the most influential to the smallest and weakest ones. As a consequence, they were capable to act strategically and rise their voice, threatening the use of the referendum to block the reform. The role of the popular initiative is also important and more propositional.

Political and institutional actors face a similar situation. Being the insurance provided by private insurances, the federal government has limited regulative competences. The (federalist) legislative design gives therefore a large amount of freedom to the cantons, which have a wide room for maneuver to set up their particular health policies. From this institutional point of view, cantons gain a considerable decisional power and they can adopt either a voice or an exit strategy—the former to best suit the federal law to their needs, the latter to legally “escape” the federal undesirable requirements. Another time, the institutional setting (e.g. the upper Chamber of the parliament, the cantonal referendum or the Conference of the cantonal health-care ministers) provides the public actors with some powerful strategic resources.

To sum up, we can sketch out a sort of double level of influence, namely brought to bear by individual and public actors. What are the consequences of both “exit” and “voice” at the aggregate level, especially for the viability and the social efficacy of the Swiss health-care system?

4 Patients, insurers and doctors: an inefficient combination of exit and voice

To start with, we want to analyze how the various actors use these exit and voice strategies, along with their concrete effects on the health-care system in Switzerland. In this section, we focus on patients, insurers and doctors, drawing a comprehensive picture of the interactions between those actors and their strategic options.

On the one hand, our purpose is to check whether the liberal side of
the health system, which promotes to a large extent opportunities for exit, assures the fulfillment of the expected objective of cost containment and solidarity through increasing choice and market competition. On the other hand, due to the particular institutional framework, we wish to assess the impact or limits of the voice option on the decision-making process and adaptation of the health-care system.

In the first paragraph, light is shed on exit and its outcomes. The second one aims at investigating voice and direct democracy tools. We collect information from statistical data (OFSP, 2009), evaluation studies (Colombo, 2001; OECD, 2006), and different official administrative documents.

4.1 Exit and its consequences

To better understand the consequences of exit on the health system, we summarize the use of this option by patients, doctors and insurers. The extent to which each actor uses their exit opportunities is a fundamental prerequisite for the efficiency of the entire system and the achievement of its goals, which will be both outlined at the end of each paragraph.

**Patients** The exit option for patients mainly relies on switching freedom, which represents the basis of the liberal conception of the health system. The main goal of cost containment should be achieved through the competition among insurance companies and the reinforcement of the individual choice (Colombo, 2001, 18). Indeed, to work properly, the mechanism has to be based on high available information and no opportunities for risk selection or premium adjustment by the insurers. People should therefore switch on an equal basis.

How is the switching mechanism working? Unfortunately, only limited data are available about this fundamental mechanism of the LAMal, coming from a survey of the Federal Office for Social Insurances (1997-2000) and the Federal Office for Public Health (OFSP, 2009; Colombo, 2001, 26). Although those data (see Table [2]) are impossible to compare, they point out a very limited switching behavior—between 1997 and 2000, concentrated among healthy and young people, despite high information availability (Colombo, 2001, 27). This appears to be driven prevalently by negative rather than positive issues—i.e. respectively, quality degradation versus price motivations. Data on Table [2] suggests also that people tend to switch more insurance types than companies, showing a decreasing trend for the standard deductibles and a parallel increment of limited choice options.

Therefore, we can conclude that people are often insensitive to their own insurer performances, and “loyalty” (Hirschman, 1970) to a company can limit the benefits and advantages of the exit option. This insensitiveness hinder the generation of adequate market signals. In addiction, company
<table>
<thead>
<tr>
<th>Year</th>
<th>% of sickness funds switching</th>
<th>% of insured per insurance type (total 100)</th>
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<tr>
<td></td>
<td>% of insured per deductible</td>
<td>Ordinary deductible</td>
</tr>
<tr>
<td>1996</td>
<td>—</td>
<td>65.9</td>
</tr>
<tr>
<td>1997</td>
<td>4.80</td>
<td>56.6</td>
</tr>
<tr>
<td>1998</td>
<td>5.40</td>
<td>55.4</td>
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<tr>
<td>1999</td>
<td>2.70</td>
<td>55.0</td>
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<tr>
<td>2000</td>
<td>2.10</td>
<td>54.0</td>
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<tr>
<td>2001</td>
<td>—</td>
<td>53.0</td>
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<tr>
<td>2002</td>
<td>—</td>
<td>51.8</td>
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<tr>
<td>2003</td>
<td>8.70</td>
<td>49.7</td>
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<tr>
<td>2004</td>
<td>9.52</td>
<td>49.0</td>
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<tr>
<td>2005</td>
<td>8.07</td>
<td>48.3</td>
</tr>
<tr>
<td>2006</td>
<td>9.38</td>
<td>44.7</td>
</tr>
<tr>
<td>2007</td>
<td>8.82</td>
<td>41.6</td>
</tr>
</tbody>
</table>

| Variation 1996-2007 | −24.3 | +2.0 | −0.3 | +22.6 |

Table 2: Share of insured switching their insurance company and insurance type distribution across the population, percentage, 1996-2007 (Sources: Colombo, 2001; OFSP, 2003-2007, Tables 1.49, 11.11 and 11.17; BFS, 2008, Table su-d-1.2.2.1.13).


2 Between 2003 and 2007, data on the overall share of insurance admission or switching are available from the Federal Office of Public Health (OFSP). To obtain a good proxy of the share of switcher, we have subtracted the share of childbirth and immigration.

managements are not affected by switching behaviors and consequently not stimulated to contain costs, encouraging both efficient and non-efficient insurers to survive, regardless of their economic performances (OECD, 2006, 135-136).

The reluctance to switch and the relative weak mobility, associated to the bad performance of the mechanism of risk equalization, limits the competition and the consolidation of the insurance cantonal markets. The more salient and direct outcomes of those weaken market signals are the limited price compensation and the lack of convergence in premiums, which increase also continuously and variously across cantons (OECD, 2006, 121).

In association with that, patients’ exit gives more others weak incentives for cost containment. First, the basic insurance package is broad and comprehensive, encouraging medical consumption. Second, the free choice of providers and the virtual absence of gatekeeping incite to consume more as

3Nevertheless, as pointed out by Table 2, people tend more to select types of insurance with a limited choice of the provider—either a gatekeeping doctor, or a HMO arrangement. In any case, both ordinary and higher deductibles cover three fourth of the population in 2007, meaning that the free choice of the provider still remains relevant (OECD, 2006, 123). HMOs do not spread widely also because of the independence of doctors and the limitation
well, for instance through “second consults” or turning direct to specialistic cares.

For reasons outlined in the following paragraph, insurers are not incited to introduce cost reducing measures, weakening the most important tool of cost containment of the Swiss health system. In conclusion, insufficient market and demand inputs are generated by the actual free switching system. As we will see in a while, the switching mechanism should improve the performances of sickness funds through quality-price ratios. However, other strategies are more appealing, undermining the switching efficacy and the fulfillment of its goals (Colombo, 2001, 49).

**Insurers** Competition among insurers should promote cost containment and cheaper premiums for all citizens. To reach this objective, it is extremely important to compete on quality–price ratios. Insurers should thus achieve the best benefit-cost ratio through market pressures and try to reduce their medical and administrative costs.

Because premiums are independent from health-status and risk selection for the basic package is not allowed, a risk compensation system supports the free and equal choice mechanism. Sickness funds with a better structure of risks pay contributions to a common pool which will then redistribute money to insurers with more expensive risk structures. Theoretically, this setup should eliminate all incentives for cream-skimming and assure a fair competition. In practice, the system suffers from many distortions.

Although legally forbidden, risk-selection assures a more profitable form of competition which has also perverse effect on the entire system. We can illustrate it as an exit option, which allows insurers to discard bad risks to maximize their profits. Two main motivations induce insurers to prefer this strategy to the envisaged fair competition.

First, the risk compensation system is based on gender and age as indicators for redistribution. In fact, these demographic measure are poor predictors of costs which are generated by bad risk structures. As a consequence, insurers are incited to carry on a distorted competition based on an indirect risk-selection.

Second, the legal obligation to contract with all providers makes it difficult to contain medical costs and thus promote a quality-price based competition. Insurers have a small room for maneuver to negotiate cheaper price for medical treatments—they are in fact set up by the TARMED, a standard tariff scheme based on medical acts—and choose the cheaper providers. This has a great impact on the overall costs of each sickness fund and a profitable

of the payment per capitation system. Insurers will finally occur in higher administrative costs for HMOs arrangements, thus their promotion has been limited. The benefits of a wide utilization of those arrangements would surely improve the care coordination, but the impact on costs is mixed (OECD, 2006, 138).
risk structure can limit expenditure and the reimbursement of medical acts.

As a consequence, the insurance market does not function properly. Sickness funds with bad risk structures will exit the market, even if they may have good level of cost efficiency. Insurers prefer to indirectly select good risks, limiting the medical consumption to contain costs. Indeed, they can easily access data on health status from complementary insurance questionnaires, because risk selection is legally allowed for voluntary insurance contracts. Insurers can then adopt indirect strategies of selection also for the basic insurance. For instance, they can downgrade the quality of service or delay reimbursements, seeking to encourage bad risks to exit the insurance. They can also adapt premiums indirectly, tying basic-complementary packages and promoting better prices if they are bought together. Finally, insurers can also target their advertisements and promotions on better risks (Colombo, 2001, 36).

Another possibility to limit insurance costs is to exit an unprofitable market. A good example of this opportunity is provided by Visana, one of the largest sickness funds in Switzerland, which in 1998 left eight cantonal markets with very bad risk structures (Schweizer Nationalrat, 1998b; Schweizer Nationalrat, 1998a). This unique event highlights another (indirect) exit strategy to select good risks and escape markets where costs are high. As outlined in the parliamentary discussions, the efficacy of the risk compensation scheme is questionable and the solidarity is dangerously called into question.

In conclusion, this risk-selection competition does not allow to achieve the goals of the system. No quality-prices ratios signals are promoted and there is a high incitation for cream-skimming—also dictated by a combination of historical fund structures, the low switching rate, and the partial risk adjustment scheme. This distorted competition does not incite sickness funds to ameliorate their overall performances and, consequently, reduce premiums.

**Doctors** In the Swiss health-care system, doctors benefit from a large professional freedom which permits them to exert a great influence. Especially because of the voice option (see the next section) empowered by the particular institutional configuration, the medical profession could always challenge every reform successfully and influence it at their will (Immergut, 1992). The actual leading position of doctors and their extensive freedom is therefore rooted in this past evolution.

In the LAMal system, doctors do not have any specific exit option. Nevertheless, owing to their professional independence, they are the linchpin of

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4 An abolition of the contract obligation is currently under discussion at the parliamentary level. The Council of States—the upper Chamber—has refused to discuss it and the National Council will deliberate on this issue during the summer session 2009.
the system and their behaviors can determine the main outcomes.

Actually, the regulation of ambulatory cares is left to the market and competitive mechanisms. There is no control or limitation on the supplier side, meaning that doctors are responsible for the amount of medical acts. In combination with the virtual absence of gatekeeping, the comprehensive basic package which reimburses a wide range of medical treatments, and the fee-for-service reimbursement system, this large discretionary power does not limit the supply and consumption of medical acts. Therefore, there is a high correlation between concentration of doctors and spending, meaning that the large freedom might promote supplier-induced demand (OECD, 2006, 118).

Care coordination is also weak and conditioned by fee-for-service, freedom of choice, and lack of gatekeepers. Hence, multiple agents in the in- and out-patient sector often interact in a discontinue sequence, which does not assure an efficient care chain.

To sum up the impact of this great amount of exit and the achievement of cost containment through competition and free choice, it may be useful to look more closely at Switzerland’s health spending as a share of GDP. Figure 1 shows the evolution of absolute total costs between 1996 and 2007, pointing out an increase for each component of the total health spending. All private contributions—cost-sharing, out-of-pocket payments and insurance premiums—have grown in absolute terms, and especially the part concerning insurance premiums. Besides, also the public and social contributions have gone up. Finally and interestingly, the financing balance—i.e. the difference between insurance effective contributions to the system and the premiums paid by citizens—shows mainly a negative value, meaning that the reserves of the insurance companies rises like premiums (OFSP, 2009, Table 9.08).

Although other factors—such as the technological evolution and the population aging—should be also taken into account to explain this cost evolution, we can conclude that the huge amount of exit which can be used by

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5 The methods of payments do not improve clinical and cost efficiency, both at the ambulatory and hospital level. In the former, fee-for-service reimbursement is an incentive for oversupply of unnecessary cares, both clinically and financially. However, the introduction of TARMED, a generalized tariff scheme, goes in the right direction and discard the use of some kind of exams which are financially undesirable.

6 Premiums include both mandatory and complementary insurance. Cost sharing consist of deductibles, 10% co-insurance over the deductible up to 700 SFr. and co-payments for hospitalization. Out-of-pocket outlays are in particular benefits not included in the basic package of the sickness funds (for instance, dental cares or medicaments without prescription) (OFSP, 2009).

7 Public outlays consist of subventions or direct payments to the health-care system (e.g. hospitals, home nursing, etc.) and public health, as well as administrative and prevention costs. Social insurance spending includes the social insurances, public subsidies to reduce premiums and other social contributions (OFSP, 2009)
Figure 1: Total costs of the Swiss health-care system, in million SFr, 1996-2007 (Source: OFSP 2009, Table 9.06)

the various actors has some perverse effects on costs and efficiency at the aggregate level. Generally speaking, the system is unconstrained both on the demand and supply side, the volume of medical acts and their prices determine both the high level of spending (OECD, 2006, 115).

Cost containment and efficiency relies mainly on cantonal government planning (especially concerning the hospital sector) and competition in the insurance market (for the ambulatory sector), but none of those mechanisms seem to assure the control of providers and moderate the demand. Overall, actors’ incentives for seeking cost-efficiency are thus weak (OECD, 2006, 112). The absence of a global binding budget, the presence of multiple financing agents or third-party payers encourage cost-shifting rather than cost controlling. The scope is thus ample to improve cost-efficiency: all providers, insurers, and patients have scarce incentives to enhance the overall efficiency, thanks also to their wide opportunities to exit.

4.2 Voice

As previous analyses of the Swiss health system have demonstrated, the referendum politics can limit the scope of possible reforms. During the last century, the referendum vote blocked a series of proposals for a compulsory
health insurance scheme—i.e. in 1899, after the Second World War, in 1974 and 1987—empowering even very narrow interest groups and actors, such as the chiropractors in the partial revision of 1964 (Immergut, 1992, 141).

For Immergut (1992) evidence from those attempted reforms emphasizes the referendum as the decisional linchpin in the Swiss policy-making process. Although it promotes voice for citizens at the polls, the referendum generates problems of collective action—especially, negative voting behavior, articulation and fragmentation of different interests—which hamper reforms and promote the status-quo (Immergut, 1992, 175-176). Hence, the use of the referendum as threat constitutes a powerful strategic weapon. Before discussing a new legislative proposal, negotiations must include all concerned interest groups, which can menace to use the referendum and its unintended outcomes to gain concessions and adapt the new law to their needs. Because of that, the consultation procedure at the parliamentary level (see the next Section for empirical evidence) is one of the most important steps through the decision-making process.

However, the referendum is not the only tool empowering voice. Indeed, all citizens or organization can use the popular initiative to express their needs or preferences. They only need to collect a certain amount of signatures to put a legislative proposal through the decisional process.

Have people used these voice opportunities extensively after the introduction of the LAMal? And what are the results? Before answering the questions, we should premise that—from Immergut’s perspective—the acceptance of the LAMal in 1994 was the exception to the rule. Nevertheless, we can consider it as a continuum in the Swiss health-care environment. People approved the referendum for the new health-care law with a majority of 51.8%. The consensus was indeed weak, and the adoption of this law did not constitute a real turnout for the health system. Indeed, the principal actors have remained the same, while the big change has been the introduction of a mandatory basic insurance for the entire population.

On the one side, after the introduction of the new law in 1996, no referendum was launched at the federal level to challenge the introduction of new part of the legislation or reforms. We can conclude that changes decided at the federal level, if approved by the Parliament, met all the expectations of the concerned actors—in fact consulted at the preliminary stage.

On the other side, citizens and interest groups have used three times the popular initiative. In 2000 and 2005, two similar proposals—respectively, the “Health-initiative” and the initiative “For a single and social sickness fund” (Parlement Suisse, 2000; Parlement Suisse, 2005a)—were launched to totally redraw the health system. Both initiatives, which were promoted

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8At the cantonal level, there is also the opportunity to call referenda. However, because of time and space limitation, we cannot list here all cantonal referenda and vote results. It is in any case important to note that citizens are allowed to use this voice option at the regional level.
by the Socialist party and other left-wing organizations, aimed at introducing premiums dependent on the revenue. In addiction, the initiative about the single insurer would have abolished the competitive market, substituted then by a centralized and public sickness fund providing the basic package. The other initiative “For cheaper health insurance premiums” (Parlement Suisse, 2005b), proposed in 2005, was put forward by the right-wing Swiss People’s Party (UDC). The main argument intended to limit the medical acts reimbursed by the basic insurance package, consequently reinforcing the importance of complementary insurances.

All three projects were not accepted by the Federal Council and the Parliament, which both encouraged the population to reject the initiatives at the polls. Moreover, for the third one, the Parliament elaborated a counter-project, which aimed at regulating the competition, that forced the UDC party to withdraw its initiative. Indeed, for center-right parties, the socialist initiatives would have reversed completely the LAMal system, without solving the problem of the growing costs. For the left, the UDC’s initiative and the softened counter-project would have promoted a “two speed” medicine without promoting the solidarity of the system.

At the polls, all those initiatives were rejected by a large majority of Swiss citizens—respectively 72.9%, 71.2% and 69.5%. Although the solution proposed came from two opposite parties and ideologies, they could not gather the necessary agreement to be accepted. Citizens might have had fear for a radical change, preferring the high quality of an expensive system. In addiction, the campaigns for vote highlighted the uncertain outcomes of the proposed system, dissuading thus their acceptance.

We can conclude that the voice option promoted new ideas and solutions for an improvement of the Swiss health system, coming from both sides of the political spectrum in the bargain. However, citizens were not ready to completely change the actual policy and discarded the proposals. As outlined by the Health Minister Pascal Couchepin (Parlement Suisse, 2005b) during a parliamentary discussion, Swiss people do not generally accept new and big change without knowing the possible outcomes. Perhaps the fear of new unintended outcomes made the voice option ineffectual to correct the problem of efficacy and solidarity of the system, confirming the negative trend of the direct democracy tools.

5 Exit and voice for cantons: erosion of the solidarity

In the Swiss health-care system, the federal conception gives to the cantons a wide room for maneuver—especially concerning the hospital planning and the subsidies for low income people. Cantons are in fact responsible to organize and supply health services in the in-patient sector and set up policy
rules regulating the distribution and amount of subsidies.

In this section, we focus on the subsidy policy (see Section 3 for a detailed overview), but we are also aware of the importance of a good hospital planning for an efficient global health system. This choice allows us to evaluate the second main goal of the Swiss health system, namely its solidarity. We will shed light on the evolution of premiums and subsidies, emphasizing the importance of voice and exit at the cantonal level as well. Moreover, the importance of politics will not be neglected, providing an explication of the mechanisms which undermine the efficiency of the only social corrective to the individual premiums.

5.1 The erosion of subsidies

Health-insurance subsidy policies are cantonal, but as Section 3 has shown, a decisive impulsion comes from the federal level. Cantons are free to spend as much as they want for subsidies, but the amount is largely defined by the matching funds set by the federal government. And here is where the problem begins. Between 1996 and 2007, health-insurance premiums increased by almost 90% on average in Switzerland, while the federal budget for subsidies increased by only slightly more than 60%. Thus, during the past decade cantons have had fewer and fewer federal resources to fund their subsidy systems. Cantons can decide to allocate additional money to subsidies beyond matching federal funds, but of course an insufficient adaptation of the latter to the increase of premiums constitutes a serious obstacle even for cantons determined to limit the erosion of their subsidies.

Figures 2–5 document the erosion of health-insurance subsidies in Swiss cantons. They distinguish two groups of cantons: on the one hand those that use the federal budget in its entirety (which we will call “compliant” cantons as a shortcut), and on the other those who voluntary give up some part of it (“non-compliant” cantons). The figures also show non-parametric regression lines, along with 90% confidence intervals, for the two groups, which help us identify and compare trends over time.

We distinguish between compliant and non-compliant cantons because the former find themselves under greater pressure than the latter. If, despite using the federal budget in full and matching it appropriately, premi-

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9 Evidence suggest that the use of hospital planning as instrument to better allocate resources has been underutilized. Hospitals are not included and organized following a performance appreciation (OECD, 2006, 134). Financial and political pressures may have slowed down the use of hospital planning as instrument promoting cost-containment and efficiency. For instance, cantonal ownership of hospitals made difficult to choose the best arrangement and political dynamics play a competitive and leading role.

10 Concretely, the latter group includes those cantons than in 2007 used less than 100% of the federal budget. All these cantons never used all the federal budget in previous years.

11 Specifically, the conditional expectation function given year approximated using a locally weighted polynomial regression.
ums increase faster than subsidies, compliant cantons must find additional resources if they want to avoid a real erosion of benefits. By contrast, non-compliant cantons could, if need be, increase their use of the federal budget if benefits decline. It is of course possible that these cantons do not exhaust federal resources because they do not need them. In this case, we should observe that coverage has remained unchanged in non-compliant cantons. We can already anticipate that it is not the case.

Figure 2 simply shows the evolution of health-insurance premiums. They have increased sharply over time in all cantons, but with a significant difference in levels between compliant and non-compliant cantons. Premiums are higher in the former. At the same time, we see a significant overlap between the two groups, meaning that some cantons with higher premiums renounce some part of the federal budget, while others with lower premiums use it in its entirety.

Figure 3 shows what share of these premiums is covered by subsidies, on average, for people receiving a subsidy. These figures take into account not only the federal budget matched by the corresponding cantonal contribution, but also any additional money that cantons decide to devote to subsidies. Generosity decreased in both groups, but especially in compliant cantons. In fact, while until 2002 the subsidies of compliant cantons covered a greater share of premiums than those of non-compliant cantons, since then this dif-

Figure 2: *Health-insurance premiums. Dark circles refer to cantons that use all the federal budget; light triangles refer to cantons that renounce some part of the federal budget. Solid lines are nonparametric regression lines; dotted lines delimit 90% pointwise confidence intervals.*
Figure 3: Subsidy per beneficiary as a share of premiums. Dark circles refer to cantons that use all the federal budget; light triangles refer to cantons that renounce some part of the federal budget. Solid lines are nonparametric regression lines; dotted lines delimit 90% pointwise confidence intervals.

Figure 4: Difference between premiums and subsidies. Dark circles refer to cantons that use all the federal budget; light triangles refer to cantons that renounce some part of the federal budget. Solid lines are nonparametric regression lines; dotted lines delimit 90% pointwise confidence intervals.
Figure 5: Beneficiaries. Dark circles refer to cantons that use all the federal budget; light triangles refer to cantons that renounce some part of the federal budget. Solid lines are nonparametric regression lines; dotted lines delimit 90% pointwise confidence intervals.

ference became insignificant. In 2007, on average cantonal subsidies covered about 40% of premiums, with only minor differences between compliant and non-compliant cantons.

However, this percentage has very different consequences depending on the level of premiums, which, as we have seen, vary a lot and, on average, are higher in compliant cantons. Thus, Figure 4 shows the difference between premiums and subsidies, or, in other words, how much people receiving a subsidy must pay directly from their own pocket for health insurance. The trend is dramatic. In 1996, after taking subsidies into account, the average beneficiary had to pay about Sfr. 80 per month. In 2007, this amount was about Sfr. 170, that is, it had more than doubled. The trend is stronger in compliant cantons, in which, since about 2002, the average difference between premiums and subsidies has been higher (and increasingly so) than in non-compliant cantons. This is understandable: since compliant cantons exhaust the federal contribution, the only way for them to avoid shifting the increase in premiums onto beneficiaries is to throw in additional money not matched by federal funding. However, the trend in non-compliant cantons is not much better. For these cantons, the evolution means that subsidies have become much more ineffective while at the same time some part of the federal budget (between about 4 and 45 percent) remains unused. Thus, while the level of coverage varies significantly between compliant and non-
compliant cantons, the trend does not.

Finally, one explanation for these patterns, could simply be that some cantons give more money to fewer people, while others give less money to more people. This is indeed true: an increase of 1% in the share of beneficiaries is associated with a decrease of about 0.5% in the share of premiums covered by the subsidy. However, Figure 5 shows that the coverage of subsidies is virtually identical in compliant and non-compliant cantons, and that it has remained essentially stable at around 30% on average between 1996 and 2007. This means that the erosion of subsidies documented here is not an illusion due to the choice of diluting them by creating more beneficiaries.

These data show unambiguously that there has been considerable erosion in health insurance subsidies. During the past decade, the hefty burden of health insurance has been increasingly shifted onto individuals. The number of beneficiaries has remained relatively stable at around 30% of the population on average, and the share of premiums covered by subsidies has fallen, but not dramatically. However, in combination with an explosive increase in premiums, the result is that the amount that has to be paid directly by beneficiaries has, on average, doubled.

To sum up, this section has demonstrated that health-insurance subsidies have been significantly eroded since their introduction in 1996. Hence, also at the cantonal level, have the exit and voice options played an important role in determining those outcomes? In other words, have the cantonal actors used the options at their disposal? We turn to this question in the next sections.

5.2 Voice through the preliminary consultation procedure

Before drawing a legislative draft, the Federal Council sets up a consultation procedure to gather feedback from concerned actors, such as cantons, political parties, and many interests groups. This preliminary step constitutes the first blockage in the policy change process, in which cantons, in our case, play a great role promoting their voice (Conseil fédéral suisse, 1999; Schweizer Ständerat, 1999; Conseil des Etats Suisse, 2001; Conseil fédéral suisse, 2004). Because cantonal authorities want to maintain a large decisional autonomy concerning subsidy policies, every attempt to limit their room for maneuver and impose a new common rule is largely rejected. In all three revisions, the Federal Council wants to increase the homogeneity of the subsidy system by introducing some common minimal norms at the cantonal level. However, cantons are always skeptical and reject strongly every compulsory solution, stressing the federal conception of the system and the insufficient funds provided to achieve the reforms. Moreover, at every revision, the introduction

\[\text{Percent of premiums covered by subsidies} = 59.85(1.96) - 0.52(0.06) \times \text{percent of beneficiaries}, \ N = 312 = 26 \text{ cantons} \times 12 \text{ years}, \text{standard errors in parentheses.}\]
of a “social goal”\textsuperscript{13} and the definition of a specific number of beneficiaries were particularly criticized and, finally, discarded.

As a result, to make revisions more widely acceptable, only simplified versions of the original reform projects were put forward at the parliamentary level, and parliamentary commissions were forced to lighten the proposals. For instance, the first partial revision added only marginal and technical modifications to the law\textsuperscript{14} despite the need for stricter norms. On the other hand, the parliamentary commission revised the initial project for the third revision by targeting subsidies for a specific share of the population, namely children and young in education from middle-class and low-income families\textsuperscript{15} abandoning attempts to introduce a common minimal norm, as recommended by the Federal Council (Schweizer Ständerat, 2004; Conseil fédéral suisse, 2004). This solution pleased cantons and political parties, which could reach a compromise improving—even if only slightly and insufficiently—the overall system.

Although the preliminary consultation represents a first powerful filter in the decision-making process, discarding at the outset several options or influencing and redrawing projects, more blocking activities can be identified during the parliamentary phase. Here, political parties are the key actors. Many propositions aiming to improve the subsidy system were put forward at the parliamentary level during the past decade. Generally advanced by left parties, these proposals concerned the funding of the system—adapting means to needs—but also more technical and political aspects, such as the fixation of a common income threshold or the suppression of the possibility for cantons to give up a share of the federal contribution. Why were these propositions systematically rejected? There are several reason, depending on the situation and the object under review.

5.3 The Canton of Vaud: exit and drift?

For our cantonal case study, we focus on the canton of Vaud. Figure \ref{fig:vaud} shows the same information as Figure \ref{fig:all} (that is, the difference between premiums and subsidies), but highlights the canton of Vaud in comparison with all

\textsuperscript{13} Already in the original project of law, in 1991, a common “social goal” should have been introduced but was rejected. The charge for the health insurance should not have exceeded 8\% of income, and the difference should have been covered by subsidies. In 2001, for the second partial revision, a “graduated” system was put forward to better take into account all particular situations. Premiums should not have exceeded between 4\% and 12\% income a single and between 2\% and 10\% for a family, according to their means (Conseil fédéral suisse, 2004).

\textsuperscript{14} For example, consider the most recent situation to calculate subsidies, speed up all payments, and provide citizens with regular and complete informations about the eligibility right (Conseil fédéral suisse, 1999)

\textsuperscript{15} Cantons are now required to reduce by at least 50\% the premiums of children and every young in education up to 25 years of age. To do this, the federal budget was increased by SFr. 100 millions both in 2006 and 2007.
other cantons. We see that Vaud is quite representative of the rest of the country, both for the trend and for levels. In 1998 and 1999 the difference between premiums and subsidies was lower than the average, and between 2003 and 2005 it was higher, but overall Vaud followed the general trend and was very close to the mean level. Thus, it can be characterized as a “typical” case well suited for hypothesis testing (Gerring, 2007, 91–97).

According to the main characteristics of cantonal subsidy systems identified by (Balthasar, 2003), Vaud combines an income eligibility limit, personal information of beneficiaries through a yearly letter, requests for subsidies possible at all moments, and payment of the subsidy directly to insurers. In addition, the policy adopted by Vaud presents some specific features. In 1997, the LAVAMal—the application law on health insurance of the Canton of Vaud—addressed three main concerns, namely the high level of social protection of the system, the limitation of threshold effect among different income classes, and the promotion of cheaper forms of health insurance (Conseil d’Etat du Canton de Vaud, 1999). To reach these objectives, the law created two groups, namely “completely subsidized” and “partially subsidized” recipients. For the former, premiums are free, that is, completely paid by the state. For the latter, subsidies are calculated through a formula

\footnote{All people already receiving some social benefit are included in this category.}

\footnote{Partial subsidies are targeted on low income singles, couples and families with children.}
whose parameters are fixed yearly by the cantonal government. Therefore, these beneficiaries still have to pay a monthly charge, independent from the premium, which varies across approximately 300 different income categories. Lower incomes receive a proportionally more generous subsidy than higher ones.

In 2001, a reform was introduced to counteract a sizable reduction of the federal budget, estimated at around Sfr. 15–18 millions. Since then, subsidies have been fixed with reference to average premiums across insurers, which means that beneficiaries must pay any difference between the subsidy and their actual premiums. This gives beneficiaries incentives to choose cheaper insurers; at the same time, the state does not have to pay more for people affiliated with an expensive health insurance. The government was not to worsen coverage, which remains unchanged for beneficiaries whose premiums correspond to the reference threshold (Conseil d’Etat du Canton de Vaud, 2001).

However, the goal to maintain a constant premium charge over time has been impossible to achieve, as Figure 6 clearly points out. After a first phase of stability in 1996–1999, and an evident amelioration after 2005, there was a dramatic decline of the generosity, which caused an increased charge for every beneficiary. Concretely, the difference between premiums and subsidies nearly doubled during the period 1999–2005. In other words, the burden of health insurance shifted significantly from the state to citizens. What caused this trend? Two dimensions need to be taken into account, namely the technical and structural problems of the system on the one hand, and political decisions on the other.

Technically, the system of Vaud is quite complicated owing to the formula used to calculate subsidies. Its parameters are fixed by the government every year through complex simulations. Two parameters are especially hard to estimate, namely the evolution of premiums—if they increase by 1%, then an additional SFr. 3.5 millions are needed (Conseil d’Etat du Canton de Vaud, 2001, 172)—and the share of recipients, which can vary greatly from one year to the other according to income thresholds and the economic evolution.

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18 The reduction was due to the federal decision to no longer take into account the level of cantonal premiums in the calculation of cantonal budgets, with the goal of increasing incentives for canton to achieve cost containment. Because premiums in Vaud were higher than average, the diminution of the federal contribution had significant consequences in this canton.

19 Obviously, optimistic simulations and possible large previous bonuses determine an amelioration of the parameters and, consequently, of subsidies. This was the case between 1996–1998 and in at the end of the period of study. But the federal budget also matters. It grew abundantly especially during the first three years but also after 2005, due to the introduction of the third LAMal revision, which involved a yearly budget increase of SFr. 100 millions (Commission des Finances du Grand Conseil, 1999; Commission des Finances du Grand Conseil, 2000; Commission des Finances du Grand Conseil, 2002; Commission des Finances du Grand Conseil, 2003).
The budget is thus difficult to estimate and miscalculations have been very frequent, due in particular to misestimates of the number of beneficiaries. Underestimating it can imply a large budget deficit, as was the case in 1998, 1999, 2002, 2003, and 2004 (Commission des Finances du Grand Conseil, 2004, 2139). These deficits also affect decisions for the following years.

Therefore, this factor can partly explain the worsening of subsidy generosity between 1999 and 2005, when large deficits due to bad estimations forced the government to adjust the parameters in a conservative way. Additionally, after bad experiences between 2002 and 2004 (Commission des Finances du Grand Conseil, 2003), the government took into account a margin of error in the simulations, assuring at least a surplus that can be used, by law, in the following years.

In addition to the technical problems of the definition of the budget, other structural factors matter. On the one hand, the canton of Vaud has a huge public deficit, which restricts the room for maneuver for additional spending (Grand Conseil du Canton de Vaud, 1999). On the other hand, there has been a fast and continuous growth of the number of beneficiaries, premiums, and the “disputed amount”. Besides, also the distinction between “partially” and “totally” subsidized matters. In fact, the number of beneficiaries has grown differently in these two categories, which has had heavy consequences on the budget utilization. The “integral” subsidies absorb nearly half of the budget, independently from the specific parameters and the share of beneficiaries (SCRIS, 2006, 191-192). The “partial” subsidies suffer from this trend because of the smaller amount of money available for them.

These technical and structural problems are important, but they are only a part of the story. The political choices made by the government and by the parliament have had a big impact on the generosity of subsidies. On the governmental side, both parameters and the budget choice play an important role, while on the parliamentary side, the financial amendments put forward by various parties can change the proposals made by the government. Thus, at this stage, politics matter.

The government has a firm control on the evolution of subsidies. As we have seen, it can set the parameters which determine generosity as well as the global budget for subsidies. Concerning the latter, the decision has always been to take 100% of the federal funds and to complete them with the cantonal charge defined by the Federal Council. The goals of the government has been to have a generous system targeted especially on the lowest incomes, thus giving more to fewer people. The explicit goal of the government has also been to maintain a constant generosity over time.

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20 The “disputed amount” is the money that the state must pay to health insurance companies on behalf of people who fail to pay premiums. This amount increased during the period 1996-2007 and is included in the global budget (Commission des Finances du Grand Conseil, 2002).

However, the sharp increases in premiums, the number of beneficiaries, and the “disputed amounts” have created clear tradeoffs between the two objectives. The government cannot provide all recipients with a constant subsidy without adding money at its own charge, distributing more than the federal funds (and the corresponding cantonal contribution). Adding new money not matched by federal funds is the only solution to keep the generosity constant over time. The government has consistently rejected this option, but the parliament can amend budget proposals and can decide to spend more for subsidies. Indeed, such amendments have been regularly put forward by left parties, but have been systematically rejected. The balance of power between left and right has led the parliament to consistently support the status quo. In other words, the subsidy policy has been deliberately not adapted to the evolution of needs.

Table 3 gives an overview of all proposed amendments and the related decisions about their adoption. It appears clearly that only one amendment, moreover in a unique situation, was approved, while the others were rejected by the right majority that characterized both parliament and government except for the period 1996–1998, when the left hold a majority in government.

What has been the influence of the various actor in the decision making process? On the one hand, left parties have put forward many amendments to the budget to increase expenditures for subsidies beyond the limits set by the federal contribution, so as to keep the generosity of the system relatively constant. Left parties have repeatedly stressed that without more money, the social objectives set by the government itself could not be achieved. On the other hand, the right majority has consistently upheld governmental proposals. It argued that the financial situation of the canton was worrisome and that there was therefore no possibility to spend more money, which would aggravate the huge public deficit and debts (Grand Conseil du Canton de Vaud, 1999).

To sum up, then, there have been many attempts to increase the budget for subsidies, all of them coming from the left. The overwhelming majority of these proposals, however, have been rejected by the right majority, which

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21 For the 1999 budget, the government wanted to make an exception and take only 91.7% of the federal funds, which would have meant an economy of SFr. 5.6 millions for the canton (Conseil d’Etat du Canton de Vaud, 1998). This decision was motivated mainly by the huge deficit, which was a high priority for the government. At the parliamentary level, the right majority accepted the proposition, coming from the left, to go back to 100%, because of the heavy consequences for a big share of the population (Grand Conseil du Canton de Vaud, 1998).
<table>
<thead>
<tr>
<th>Year</th>
<th>SC Proposition</th>
<th>GC Amendment</th>
<th>Origin</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>100% Federal Budget</td>
<td>+ SFr. 2.1 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
<tr>
<td>1997</td>
<td>100% Federal Budget</td>
<td>No Amendment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1998</td>
<td>100% Federal Budget</td>
<td>No Amendment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1999</td>
<td>91.7% Federal Budget</td>
<td>+ SFr. 40 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ <strong>SFr. 26 Mio.</strong></td>
<td>SP, ECO</td>
<td>Accepted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ SFr. 16 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
<tr>
<td>2000</td>
<td>100% Federal Budget</td>
<td>+ SFr. 52 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ SFr. 28.5 Mio.</td>
<td>SP, ECO</td>
<td>Rejected</td>
</tr>
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<td></td>
<td></td>
<td>+ SFr. 15 Mio.</td>
<td>POP</td>
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</tr>
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<td></td>
<td></td>
<td>+ SFr. 10 Mio.</td>
<td>ECO</td>
<td>Rejected</td>
</tr>
<tr>
<td>2001</td>
<td>100% Federal Budget</td>
<td>+ SFr. 28.5 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ SFr. 21 Mio.</td>
<td>SP, ECO</td>
<td>Rejected</td>
</tr>
<tr>
<td>2002</td>
<td>100% Federal Budget</td>
<td>+ SFr. 12 Mio.</td>
<td>POP</td>
<td>Rejected</td>
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<tr>
<td>2003</td>
<td>100% Federal Budget</td>
<td>+ SFr. 15 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
<tr>
<td>2004</td>
<td>100% Federal Budget</td>
<td>+ SFr. 26 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ SFr. 11 Mio.</td>
<td>SP</td>
<td>Rejected</td>
</tr>
<tr>
<td>2005</td>
<td>100% Federal Budget</td>
<td>+ SFr. 65 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ SFr. 13 Mio.</td>
<td>SP</td>
<td>Rejected</td>
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<tr>
<td>2006</td>
<td>100% Federal Budget</td>
<td>+ SFr. 15 Mio.</td>
<td>POP</td>
<td>Rejected</td>
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<td>2007</td>
<td>100% Federal Budget</td>
<td>+ SFr. 20.5 Mio.</td>
<td>POP</td>
<td>Rejected</td>
</tr>
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</table>


*Keep the same amount of money as in 1998; *amount needed to go back to 100% of the federal budget; *surplus of 2000; *disputed amount.

prioritized financial stability over the stability of generosity. The increased “risk privatization” showed in Figure 6, then, has been the consequence of explicit political choices *not* to adapt the system the evolution of health insurance premiums. As a result, the burden of health insurance has been significantly shifted from the state onto individuals.

6 Conclusion

Because of its public–private mix, its high decentralization and its particular institutional configuration, the Swiss health system promotes simultaneously the use of both exit and voice options. Not only individual actors, such as patients, doctors and insurers, can benefit from these strategic options, but also public actors at the cantonal level. What are thus the consequences of
this great amount of voice and exit at the aggregate level?

Our analysis suggests that this combination of exit and voice has perverse effects on the efficacy and solidarity of the Swiss health-care system. On the one hand, individual actors have made a counterproductive use of exit, which stimulated unexpected and suboptimal outcomes. As a result, the objectives of cost containment, increased competition and enhancement of individual freedom could not be achieved and still represent paramount issues in the Swiss political debate. Moreover, the voice option has also proved its inefficacy to correct the default of the system.

On the other hand, at the cantonal level, public actors have extensively used the two options as well. First of all, they have influenced the evolution of the law at the federal level thanks to the voice option, trying to enhance or preserve their large room of manoeuvre. Second and consequently, cantons could “exit” their obligations and fit the law at their will, conditioning the erosion of public subsidies and the overall solidarity of the system. The dynamic of policy drift can be finally explained through this analytical lens, combining the strategic opportunities given by the federalist conception of the law and the particular institutional setup.

References


Parlement Suisse. 2000. Note de synthèse. "La santé à un prix abordable”. Initiative populaire (00.046).


174.

sion. Prämienverbilligung (04.033).” Amtliches Bulletin der Bundesversamm-


Starke, Peter, Herbert Obinger and Castles. 2008. “Convegence towards where:
in what ways, if any, are welfare states becoming more similar?” Journal of
European Public Policy 15(7):975–1000.