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Ideas and Power in Swiss Health Care Party Politics

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Résumé

La pression financière croissante sur les Etats-providence a abouti à des réformes dans presque tous les systèmes de santé entraînant des choix difficiles entre les objectifs principaux tels que liberté, qualité, équité et viabilité financière. En se basant sur la théorie des « acteurs veto » et la théorie spatiale, cet article démontre comment le choix pour une certaine combinaison d'objectifs de politique de la santé et des stratégies concomitantes ainsi que des instruments est décidé dans le système des partis en connectant les « idées », c'est-à-dire les idéologies des partis, et la répartition du pouvoir entre le gouvernement et le parlement. L'article se penche sur la réforme du système de santé suisse à partir de 1990.

Mots-clés : partis politiques suisses, réforme du système de santé, idées, théorie des « acteurs veto » et théorie spatiale.

Abstract

Increasing financial pressure on welfare states have led to reforms in almost all health care systems leading to difficult choices between the main objectives of liberty, quality, equity and financial viability. This article demonstrates how the choice for a certain mix of health objectives and concomitant strategies and instruments is decided in party systems by linking « ideas», i.e. party ideology, and power distribution in government and parliament and by using veto-player and spatial theory. The article focuses on Swiss health care reforms since the early 1990s.

Keywords: Swiss party politics, health care reform, ideas, veto-player and spatial theory.

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INTRODUCTION

Welfare states have been under serious financial strain during the last twenty years or so, which led to a curtailing of expenditures, new ideas on rights and obligations of citizens and attempts to increase the efficiency of structures and processes. Financial viability became the most important priority in welfare policy-making when stagnating economic growth diminished the revenues of most OECD countries. The health care sector, our topic in this article, has been no exception to this rule (Grabow 2006). The conquering of the political agenda by concerns for financial viability has, however, not been without political struggle. Financial viability is part of what one might consider being an "*uneasy rectangle of objectives*" in welfare policies: In all welfare sectors there have been concerns for liberty, quality, and equity next to financial viability.[1] The problem is that these four objectives can be in conflict with each other,[2] which causes difficulties in achieving all four objectives at the same time and to a similar degree. Political parties must make a choice which of these preferences they prefer most and which less. At the same time there are different ways *how* to achieve each objective as such. Financial viability, for example, can be realised by simply adding sufficient tax resources. Other ways would be to raise premiums substantially or to cut down services. Again, parties must decide which means they prefer as each way demands other resources or has other side effects on other variables. *We are interested in this article how the choice for a certain mix of health care objectives and concomitant strategies and instruments is decided in party systems*.

We believe that the choice depends on "ideas" and "power" (Heclo 1974): on the one hand on belief systems or ideologies of parties and on the other hand on the distribution of power in government and parliament and veto-positions of parties. Ideologies decide about the preference-order

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[1] "Liberty" means the right of welfare beneficiaries to choose their service of preference (e.g. schools in the education sector, employment in labour market policies, or doctors and hospitals in health care); "quality" refers to the services offered: in the case service givers are sufficiently qualified, advanced technologies are used, or a satisfying infrastructure is at the disposition of welfare beneficiaries (e.g. schools equipped with the newest information technology; employees in labour market offices who are well educated and instructed; or short waiting lists for an operation at an hospital) than we may consider the system as being of high quality. "Equity" is probably the objective that is the most politicised as it falls on the "left-right-cleavage" of party politics: it can be defined as a fair or equal distribution of revenues or services. "Financial viability", finally, can be defined as the capacity of a system to deliver cost-efficient services and generate sufficient resources in order to maintain the system.

[2] The pursuit of financial viability for example can create trade-offs in all other objectives: Curtailing expenditures can result in the exclusion of certain beneficiary groups jeopardising equity; it can also reduce the quality of services if money for more advanced technology is lacking; and it can have consequences for liberty, if it means a reduction of the choice of services.

and the kind of instruments parties choose in the policy space. Power distribution and veto-positions determine which ideologies prevail after a decision is taken in parliament. We expect that parties have different preference-orders with regard to the four objectives in question as well as to the choice of instruments depending on their ideologies and electoral strategies.

We will use the Swiss reform process in the regulation of health care since the 1990s as an empirical example and apply spatial theory, in particular veto-player theory, in order to understand the reform decisions taken. Our interest in "ideas", "belief systems" or "ideologies" needs, however, some refinement of the preference model usually applied in spatial theory and veto-player theory. Our concept allows speculating about future shifts in the status quo on health care policies in Switzerland.

ANALYTICAL FRAMEWORK

In order to explain health care choice in party systems, we apply "analytical politics" (Hinich and Munger 1997) and "spatial theory" (Laver and Shepsle 1996; Shepsle and Bonchek 1997) respectively, in particular "veto-player theory" (Tsebelis 2002). We think, however, that the theory needs some refinements before it can be fruitfully used in the context of party systems.

Most analyses in spatial theory are dealing with preferences of actors in a policy space based on "issues". Using a policy space with two issue dimensions this signifies that parties will choose for example a certain amount of social security spending on the one hand and military spending on the other. The intersection between the two points is the combined "ideal point" of the party in the policy space. Such a view is questionable when it comes to parties: preferences in a policy space express the choice of what in the literature on party systems is called "*policy-seeking*" parties only while "*vote-seeking*" and "*office-seeking*" as dominant strategies of parties are not taken into account (Kitschelt 1994; Müller and Strom 1999). A pure "policy-seeking" party, i.e. a party which is only interested in the realisation of its policy goals whatever this means for election outcomes and, from there, for office-holding, may exist but certainly only as an extreme case. We think that Strom and Müller are right in stating that party strategies are always a mix of all three objectives (Strom and Müller 1999) though we believe that vote-seeking and office-seeking will play most of the time a predominant role as no party can survive without the mobilisation of a significant group of the population. Spatial theory should therefore try to integrate conceptually these different strategies in order to understand the dynamics in party systems. Two considerations seem important in this respect:

(1) Vote- and office-seeking has been integrated by Ganghof and Bräuninger who propose to relax the policy-seeking assumption and to stronger value "positional" considerations of parties (Ganghof and Bräuninger 2003). If one does so, the authors claim, one can demonstrate that par-

ties value outcomes in the policy space differently depending on their status as "government", "neutral" or "opposition parties". Parties that are thinking in terms of votes need to claim credit for changes in law production and regulations. Voters judge parties on their visible contribution to such changes. Government parties need to prove that they were able to introduce the promises they have made at the beginning of the government period which may lead to concessions to other parties with a veto-position. Opposition parties, by contrast, need to demonstrate to their voters that they have had significant influence on the final choice made in the party system. Therefore, it is primordial for them to shift any outcomes as near as possible to their preferred point. Opposition parties are, as the authors write, particularly sensible to "*policy sacrifice*", i.e. to results that do not correspond to their preferred point in the policy space. This has direct implications for parties' "*level of accommodation*" (Ganghof and Bräuninger 2003: 12): government parties may have larger levels of accommodation than proposed by normal veto-player theory, while opposition parties may have smaller than expected levels of accommodation.

(2) We think that the reference to "positions", which depend strongly on votes for parties, needs the inclusion of another argument. In fact, if parties depend on votes, one can argue that it is less "policy issues", which are decisive for the judgment of voters than underlying "ideas" or "ideologies" of parties (Hinich and Munger 1994).[3] It is not the decision of parties to support or reject one or other issue that is relevant for the voter but arguments that try to embed this position within the broader framework of causal theories, basic principles and value judgments.

To give an example that will play a role below in our analysis of health care policy decisions in Switzerland: Parties have to decide on the generosity of health care benefits in the basic health insurance which each citizen can make use of. The alternatives are, first, to include almost all services within the basic insurance and, second, to include only a small number of benefits and let people conclude at their own will and costs complementary insurance schemes. Third, a middle position would be to apply a mix of services to be included into basic and complementary insurance schemes. Parties would not just choose one of the three alternatives and hope for a positive effect on voters and offices. They would reason why alternative one, two, or three is the better alternative and what further go-

[3] Ideologies are defined as "an internally consistent set of propositions that makes both proscriptive and prescriptive demands on human behaviour. All ideologies have implications for (a) what is ethically good, and bad; (b) how society's resources should be distributed; and (c) where power appropriately resides" (Hinich and Munger 1994: 11). The literature on "policy ideas" and "policy frames" distinguishes in addition between the more general level of "metaphysical principles" and the more "specific principles" applied in the context of policy sectors. Specific principles are "hypothetic-deductive statements, which allow the operationalization of values" in a policy sector (Surel 2000: 497) as well as "secondary aspects" (Sabatier and Jenkin-Smith 1993) defining the more concrete instrument choice. Ideology in the sense of Hinich and Munger corresponds above all to the level of "metaphysical principles" that determine the two other ideational levels.

ing purposes it serves. Party X may try to convince voters that an equal distribution of resources and equal chances need generous benefit schemes while party Y may use the argument that only own responsibility of citizens for the use of health care resources will lead to an efficient use of resources and hence, to financial viability. A small number of benefits in the basic insurance would serve this purpose. Such arguments, which refer directly to a choice how to use an instrument, with what quality and to what degree, are themselves embedded into general ideologies or "metaphysical principles" that are opposed within a party system (Surel 2000). The arguments for equity in the distribution of health care benefits and for "own responsibility" in the use of resources fit, for example, well into the well-known "left-right cleavage" in party systems. Parties on the left usually oppose the principle of individual responsibility while parties of the right will deny the responsibility of the state to advance equity. This is part of their general (and different) assessment of the role of the state and the market as well as of the responsibility of the individual in society and of the collective. The choice of one of the three alternatives is therefore a representation of underlying ideological principles of party that are competing for predominance of their ideology in the party system.

Ideologies are at the same time a "shortcut" for voters' decision that save energy and time in identifying the preferred party and a mechanism of political identification, which plays an important role in voters' choice.

The reference to party ideologies does not only play a role during election campaigns but is present in each parliamentary decision and therefore ubiquitous in party struggle. Each party is responsible to its voters during parliamentary discussions and when decisions are taken. This means that signals to voters on the base of "ideology" will play a permanent role when parties try to build majority coalitions. Each discussion on specific policy issues will necessarily be accompanied by more encompassing arguments that fit into the different ideologies parties defend. This is why we think that we should not, when assessing choices in party systems, measure coalition building on the base of issue positions of parties in the policy space but on the base of their positions within the "*ideological space*" that are justifying the choice in the policy space.

In sum, it is therefore "positions" and "ideology", which seem to be more adequate points of reference in order to understand dynamics and choices in party system than issue positions in the policy space.

IDEAS AND POWER IN THE SWISS PARTY SYSTEM

We will take a quick look at the Swiss party system in order to understand both power relations and general ideological positions of parties. These general ideological positions influence debates on health care issues, which we will discuss in the next sections. We need both information on power and ideas in order to understand "feasible win-sets" in the ideological space.

Ideology

We will briefly sketch the ideological space in the Swiss party system in terms of the "left-right dimension", which has been the most dominant ideological dimension according to our empirical research, by using the results of two comparative studies (see above all Hug and Schulz 2007). As we will deal above all with two periods – the beginning of the 1990s before the new health insurance law was adopted; and the more recent years – we can refer to two expert-based estimations of the "left-right space" in Switzerland: Huber and Inglehart (Huber and Inglehart 1997) classify *party policy positions* in 1993 on an ordinal scale (1= left-wing; 10= right-wing). At the beginning of the 1990s the distance between the most left-wing party (the SP) and the right-wing parties (FDP; SVP) was considerable (2.6 vs. 6 and 6.25 respectively), while the CVP was comparatively centre/left-wing with a score of 4.4, this above all because of its strong sense for "solidarity" in the distribution of resources.

If we take a look at a more recent study in 2003 (Benoit and Laver 2005) the absolute position of these four parties remains unchanged but one notices a move to the right in the case of the SVP and also a greater distance between SP and CVP with a clearer clustering of CVP, FDP, and SVP on the right hand side of the left-right continuum.

The analysis of left-right ideological positions suggests therefore in both periods stronger affinities between the SVP, FDP, and CVP while the SP remains somewhat isolated though there are links with the CVP on the equity dimension.

Power distribution

Switzerland has an over-sized cabinet with the same four parties that share seven government seats since 1959. The party composition has therefore never changed though the distribution of seats among parties has recently. The cabinet can, however, not be regarded as a normal coalition government as there is no common coalition programme. Government members are elected individually by the parliament as "federal councillors" and policies are negotiated ad-hoc within government.[4] The four main parties – the Socialist Party (SP), the Christian-Democratic Party (CVP), the Liberal-Radical Party (FDP) and the People's Party (SVP) – that have permanent "councillors" in government had a majority of votes between 72.5% (1991) and 86.5% (1999) in the National Council[5]

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[4] Even though there is a minimalist framework agreement on policy lines issued after the election of government members. This agreement is not subject to negotiations between parties and does not bind parties in parliament. Its contents are, in addition, generally so broad that actual policy-making necessitates future ad-hoc bargaining in the government.

[5] The National Council represents the people, whereas the Council of the States represents the cantons.

with an average of 82% since 1971. Majorities were even clearer in the Council of the States: the lowest percentage there was 89% in 1999 and the highest percentage 100% in 2003. As both chambers have completely equal rights in decision-making, this gives a particular strong veto-power to the four government parties. These figures demonstrate the oversized character of the Swiss government and it justifies that we will take only these four parties into account when discussing policy choices in the parliament.

The relative power of the four parties in terms of parliamentary seats has varied. In the National Council the SVP and the SP are the strongest parties at the moment[6] (62 and 43 seats of 200), with the FDP and the CVP following (each 31 seats). There is one remarkable trend in the development of relative powers that is of importance for our discussion and that is the growing strength of the SVP after Switzerland refused in a referendum to join the European Economic Region in 1992 (being the weakest party of the four at the beginning of the 1990s) and a corresponding downward trend for the FDP and Christian-democrats which had been the two strongest parties in the beginning of the 1990s.

This downward trend has not really had an effect for relative powers in the Council of the States where the CVP and the FDP – because of the particular electoral rules (overwhelmingly majority rule; each canton having 2 seats) – are the strongest parties (15 and 12 seats of 46) in 2007 (SP: 9; SVP: 7). The latter parties have gained some seats in relation to the centre parties since the beginning of the 1990s without changing the fundamental power relationships.

This distribution of power demonstrates that today all parties have considerable veto-power: the SVP and the SP above all in the National Council and the FDP and the CVP in the Council of the States.

If one looks at the number of parliamentary seats for parties and selects the period 1991-1995 (the period when the major new health insurance law was introduced) and 2003 until today, which are of interest in our article, one sees that in the first period majority coalitions were only possible with participation of both the FDP and the CVP.[7] In the second period 2003 until today, the formation of a winning coalition has become much more complicated. There are no more corresponding minimum winning coalitions in both Houses. In the Council of the States, even today no majority can be formed against the CVP (either FDP/CVP or CVP/SP) while

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[6] Elections November 2007

[7] We looked at both Chambers. Though in the National Council other winning coalitions were possible (between the FDP and the SP and the CVP and the SP) these coalitions would have faced the veto of the Chamber of the States where only a FDP and CVP coalition had a majority. This means that it needed at least the participation of the FDP and the CVP in solutions to be found. And this coalition could have imposed its solution in both Chambers. Of course, there was always the possibility to include one or both other parties in both chambers.

the CVP has become too small to play a pivot role in the National Council. In the National Council three minimum winning-coalitions are possible on the sheet: FDP/SP; FDP/SVP; and SVP/SP. Either the SP or the SVP must therefore be included in winning coalitions in the National Council. Given the pivot role of the CVP in the Chamber of the States it is very likely that the coalition, which is needed to overcome the status quo must include more than two parties. A coalition of either the FDP/CPV and SP or of the FDP/CVP and SVP seems to be needed to change the law in this period. A recent review of "parliamentary rating" (NZZ 12.10.2007) demonstrated that the right-wing/centre coalition wins about 40% of votes in parliament since 1999 while the left-wing/centre coalition succeeds with a percentage of about 27%. The "extreme coalitions" – SP/CVP against FDP/SVP – is on a constant decline since 1999 and wins only with a rate of 15% during the last parliamentary period.

A last point: Ganghof and Bräuninger raised the status of parties as government and opposition parties[8] in party systems. Switzerland is interesting in this respect. The participation of party representatives in the four-party government could lead to the conclusion that the four parties in office should be considered government parties. In fact, this is not true. As there is no coalition agreement between parties and the four parties do not need to think about office-seeking because of their guaranteed inclusion in the government, these parties can in fact behave like opposition parties potentially supporting the government (compare Ganghof and Bräuninger 2003: 5). There is, however, one exception to this rule: each office or each department in the government is trusted to one of the parties. As policies of departments are overwhelmingly formulated by the responsible "federal councillor", his or her party has all reason to defend the policy position of the councillor in parliament. Parties in Switzerland change therefore their status as government and supporting opposition parties depending on policy sectors. In health care for example, three different parties were government parties in the period under investigation (1991-2007): first the Christian-democratic party (CVP; between 1991 and 1996), then the socialist party (SP; 1996-2003), and finally the liberal-radical party (FDP; 2003-). This means that parties do not only vary their status between policy sectors but also in time. This has to be taken into account when we try to assess party levels of accommodation in Switzerland.

We will see in the next section how these ideological positions and the power distribution have influenced party politics in health care.

[8] We will not include "neutral" parties here.

THE SWISS HEALTH CARE SYSTEM IN THE BEGINNING OF THE 1990S: BUILDING A HEALTH CARE REFORM

The Swiss health insurance system was for a long time based on a federal law dating from 1911. Though most competences in health care are attributed to the cantons, the federal government has the right to regulate health insurance Swiss-wide. Except for one minor revision in the year 1964, the law on health insurance remained unchanged until 1994 when the so-called LAMaL ("Loi sur l'assurance maladie"), the new health insurance law, was adopted by the federal parliament. This law changed the existing "liberal" or "private insurance model" to a hybrid type (Bertozzi and Gilardi forthcoming) in between the private insurance and social insurance model (see for a discussion of classifications of health care systems Palier 2004; Blank and Burau 2007: 10-17). In this chapter we want to understand how, given the ideological struggle in the partisan system, this reform came about. What were the main ideological positions concerning the health care system and what role did power distribution play in the adoption of the LAMal?

Until 1994, the predominant liberal features of the Swiss health care system were obvious: the health insurance was not compulsory; there was little regulation concerning insurants' benefit packages; profit-oriented, private health companies were competing for wealthy and healthy clients; there existed premiums per capita which differed in reference to age, sex, risk and regions; and the liberty to choose among medical practitioners prevailed (Bundesrat 1991).

Basically, the health insurance agencies were autonomous to a large extent. The federal legislation prescribed some minimal standards, which could not prevent negative effects on equity in health care, like for example the obligation to accept any insurant within five years who fulfils the statutes of the health insurance company. Furthermore, each health fund was seen as a "risk community" of its own. No solidarity existed between people exposed to bad risk and those who were young and healthy. The federal government did pay some money to insurance agencies in order to balance the system and ensure quality (Bundesrat 1991: 102-03). However, these payments were clearly not sufficient with as a consequence that insurance agencies did practice risk selection and offered different premiums according to the risk of becoming sick or not.

The health insurance system in the beginning of the 1990s was primarily financed by per capita premiums of the insurants (78 %) which were not related to income; the second source of financing (7 %) were co-payments of the insurants, which included mandatory annual deductibles and a 10 per cent co-payment for costs exceeding the mentioned deductibles; the third source of payments were state subsidies (15 %) to which the federal government contributed about 10 per cent and the cantons about 5 per cent (Bundesrat 1991: 102). The contributions of the federal government were frozen at the level of 1976 and not adapted to the an-

nual prise rise. Consequently, with health costs constantly rising, this caused an important increase of premiums with a clear unequal distribution among insurants. Additionally, the quality of services (above all hospital care, home nursery, prevention measures) was not regarded as satisfactory to most parties and the federal government.

This accumulation of problematic outcomes of the existing health insurance system led to a questioning of the system in several respects supported by all four parties in the federal government. Partisan struggle how to solve the problems was mainly based on two dimensions:

- The *first dimension* tackled the question how the rising costs in health care could be dealt with. How could *financial viability* be reinstated These questions did raise general ideological questions about the regulation of the health care system: Should the solution be inspired by the private insurance, a social insurance or a national health service model? [9] Was it right to continue in organising the health care system in terms of competition amongst insurers and develop instruments that treat citizens as consumers and rational economic subjects or should the state take over the responsibility to organise the system and abolish market instruments?
- The *second dimension* had to answer the question to what extent a *fair or equal distribution of costs* had to be envisaged? One answer was to leave choices, as before, to the market and individual responsibility and accept an unequal distribution of the costs in the system and of access to health services. Another answer was to develop policy measures that would at least support the most precarious social groups and at a maximum guarantee an equal distribution of costs in the system and universal and equal access to health care.

It is on these two dimensions that the ideological struggle among the four parties in health care flared up. And, together, these two dimensions constructed the ideological space in which the four parties SP, FDP, SVP and CVP articulated their preferences. Let us briefly discuss the different health care beliefs of parties to understand their positioning and their relative distance to each other in the ideological health care space:

- The FDP emphasised financial viability and argued that if a turnaround in the rise of costs would not be achieved, the systems (financial) fairness between rich and poor would diminish. With increasing premiums lower income groups would fail to pay for even a minimal health insurance. In order to stabilise the overall costs, the

[9] Which is defined as a type "based on a concept of social solidarity and characterized in effect (though not always by design) by a universal coverage health insurance generally within a framework of social security" (Blank and Burau 2007: 12). The "private insurance model" is "characterized by the purchase of private health insurance financed by employers and/or individual contributions that are risk oriented" (ibid., 11). The "national health service" system "is characterized by universal coverage funded out of general taxation" (ibid., 12).

party propagated "demand-oriented instruments" focusing on self-responsibility and cost awareness, e.g. deductibles and co-payments. On the supply side it argued for more competition on the health market and a more efficient use of the scarce (financial) resources (Neue Zürcher Zeitung (NZZ), 29.08.1988: 15).[10] As a consequence, both coalitions to the left (social responsibility) and to the right (market mechanisms) were possible, though the centre of beliefs was clearly towards a private insurance health care system with individual responsibility and strong market mechanisms.

- The CVP positioned itself more in direction to the "social insurance model". It clearly refused the prevailing liberal outlook of the health care system with its sometimes striking disparities. In order to enhance the systems equity, the party argued for example for a moderate increase of federal subsidies to support specifically lower-income households and for the compulsory health insurance (NZZ 18.10.1988: 21, 21.11. 1988: 18). However, with regard to financial viability it was clear at the same time that the party did not want to abandon the liberal foundation of the whole health system, which meant e.g. support for premiums per capita payments on the demand-side and the maintenance of competing private insurance agencies on the supply-side.[11]
- For the SP, the private insurance system was responsible for the rising costs and unequal results of the health system. The main objective to be achieved was to enhance equity and the main instruments were a mandatory health insurance, better standard benefit-packages, income related premiums or, if the latter would be politically not feasible, more federal subsidies for poor and low income households in case of premiums per capita. In sum, the party wanted more collective responsibility within the health care system instead of individual responsibility (NZZ 15.04.85, 30.11.88: 25, 15.12.88: 24).[12]

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[10] This point of view corresponds to the ideological core beliefs of the party which propagate individual freedom that should help citizens to design their life in personal responsibility, preferably with as little state intervention as possible that, if at all should create though some regulation in order to forego negative effects of unbridled market dynamics is seen as necessary. The party does not demand solidarity or equal rights but believes above all in a policy of creating equal opportunities.

[11] This point of view corresponds to the "metaphysical principles" of the Christian-democratic party, which strongly propagates both individual liberty and own responsibility on the one hand, and charity and solidarity for others on the other hand.

[12] These policy beliefs in health care are clearly anchored in the core beliefs of the party: equity is a very strong core principle of the party that has its source in the conviction that not individual liberty as such is a basic precondition for the welfare of human beings and the society but liberty in solidarity. The state should act as a guarantor of the social rights of the individuals and ensure the redistribution of wealth.

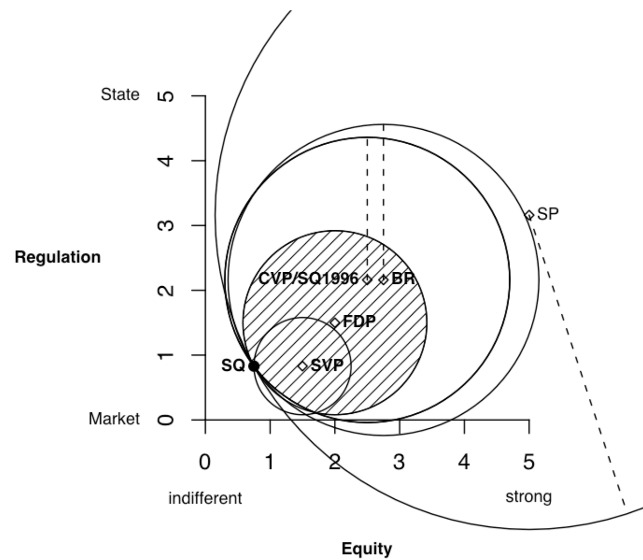
- The SVP was neither willing to raise federal subsidies nor to introduce premiums related to income. Furthermore the party was sceptical about the idea of a mandatory health insurance, although it didn't refuse it categorically. It acknowledged some systemic failures like the de facto limited liberty for the insurants or the decline of the health system's fairness (NZZ, 17./18.12.88, 18.12.90: 19). Nevertheless, the party primarily aimed to reduce costs and to re-install financial viability of the health care system. The health system itself was not regarded as failure and as a result the party argued vehemently against a systemic change towards a national health system.[13]

In the following figure we have endeavoured to represent this ideological space in health care politics. We used the two main dimensions defining the "left-right divide", i.e. "regulation" with its extremes "state" and "market as the vertical axis and "equity" with its extremes "strong" and "indifferent" and positioned each party within this space by measuring their ideological stance on a number of health care reform issues. Details about empirical measurement are given in the appendix at the end of the article.

The position of parties is classed on a five-point ordinal scale for each issue and averages were calculated on each issue. Also included is the policy position of the government ("BR" for "Bundesrat") as the "agenda-setter", which means under Swiss circumstances above all the policy position of the minister of the interior, who was responsible for health care. In the beginning of the 1990s, the minister was from the Christian-democratic party. The *status quo* (SQ) reflects the regulations in existence before the new law was adopted in 1994. The status quo ("SQ 1996") reflects the outcome after adoption of the LAMal.

[13] As for the other parties, this policy position concerning the health care reform corresponds to the core beliefs of the party. The protection of the individual against transgression of the state is the most important objective of the SVP. If support is needed, private help is to be preferred to the help of the state. However, the welfare state as such is not abandoned. It should be maintained but its expenditures should be lowered while insisting on the own responsibility of people.

Ideological Space in Health Care Reform in 1991



It can easily be seen that all parties contested the status quo though to different degrees. Except for the SVP, the move was clearly towards stronger equity and more regulation. The SVP favoured minor modifications in favour of more equity but remained reluctant when it came to more state regulation. In this it presented itself as the most "neo-liberal" of all four parties.

The distribution of ideal points of all four parties allowed for a new "win-set" in the ideological space and new winning coalitions respectively and, hence, the possibility of reforming the status quo. As no winning coalition was possible at this time without both the FDP and the CVP (see above), and the indifference circle of the FDP was contained in the indifference circle of the CVP, the indifference circle of the FDP became the area in which future solutions could be found. The indifference circle of the FDP, being part of the wider indifference circle of the SP and the SVP, also allowed compromises with those parties. Their support was, however, not needed. In terms of the logic of supporting opposition parties that both the SP and the SVP pursued, they would strive for a solution which would be as near as possible to their policy position. The will to compromise of the SVP was, however, quite limited as it positioned itself near the status quo while any substantial move in the direction of its policy position would be welcome for the SP. Under these conditions, it is likely that the position of the "agenda-setter", i.e. the position of the responsible federal minister, may be decisive for the finding of a compromise. As he did not need the consent of the SVP but was obliged to remain within the indifference curve of the FDP, it was likely that the new status quo would be very near his own

position, which was also very near the position of the CVP, his supporting government party. The SP could support such a solution, as it would be significantly nearer to its own policy position. As the figure demonstrates, the position of the new status quo does confirm our expectations based on the spatial model. It is almost identical to the position of the CVP and very near to the position of the minister.

Most regulatory measures introduced in the new law fell into the "win-set" defined above.[14] It was often the Christian-democratic party and its compromising propositions that paved the way for the adoption of such measures. It is, however, interesting to state that even if the SVP supported the new law on health insurance in some aspects during the debates in the two chambers of the federal parliament, the party withdrew its assistance when it came to a popular referendum in December 1994. According to our model it can clearly be seen that the new status quo fell too far away of the ideological position of the SVP and was even lying outside its indifference curve, which explains the resistance of the SVP to support the new bill. There were other non-conflict issues concerning quality and liberty that needed discussion but found quickly unanimity among parties.

One can speak therefore of a new regulatory model that shifted the existing private insurance model into the direction of the social insurance model with its stronger emphasis on a fair redistribution within the health system while at the same time pursuing the objective of improved financial viability. The two disputed objectives of the liberal model, equity and financialiability, were, therefore attacked and settled. But one should be aware that this outcome was still a compromise between conflicting visions on how to set up a regulatory model in the health care system and it needed only sufficient "stress" on this system to come back to the compromise found.

BACK TO THE PRIVATE INSURANCE MODEL? REFORM ATTEMPTS SINCE THE NEW MILLENNIUM

And "stress" entered quickly. In fact, it never disappeared, which demonstrates that the regulatory model agreed upon in 1994 was not effective enough to solve the various problems at hand.

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[14] The five most important agreements which were made were: (1) the maintenance of the premiums per capita to co-finance the health system, (2) the systemic change from a optional to a mandatory health insurance, (3) the change from subsidies with a leaking-bucket effect to individual subsidies, (4) the extension of the benefits covered by the health insurance and (5) the suppression of different premiums per capita between men and women of the same age and with the same insurance policy. The five points fell into the win-set of the parties because they aimed at the same time to extend benefits, to enhance solidarity and to reduce costs. Furthermore, they were core-issues for the agenda-setting centrist CVP health minister and were consequently supported by the party itself, which bridged the compromise between the SP on the left and the FDP on the right-wing of the centre. To adopt the new bill the particular support of the SVP was not needed for this coalition.

Costs, already high, continued to rise steeply: from CHF 36.16 billion in 1995 (9.7 % of GDP) to CHF 51.7 billion in 2004 (11.6% of the GDP) (Bundesamt 2007: 166). They are estimated to rise to CHF 58 billion in 2007 (NZZ 19.12.2006: 21). This has led to soaring insurance premiums, which increased over the last decade much stronger than the price rise of the consumer basket of goods. Therefore the objective of financial viability was and still is clearly not attained and becomes the predominant concern of all parties but it are the centre and right-wing parties that underline in particular that the system might have reached its financial feasibility and that everything needs to be done to prevent the system from collapsing. It is said that new and stronger instruments of cutting down costs and expenditures are necessary. At the same time, equity remains on the political agenda: the enormous rise of insurance premiums begins to weight not only on lower but also on middle-income groups. It seems that the existing compensating mechanisms, the subsidies, which only paid to lower income groups, were not sufficient to compensate the rise in premiums.

In the following part we first demonstrate how the SP and the SVP intend(ed) to transform the health system in favour of their ideal positions in the ideological space. In a second step we point out how the CVP and the FDP argue on the foundations of the existing health system to move the future status quo towards more market economy and more personal responsibility. The third step will reveal where we could find the future status quo in health care reform policy.

The radicalisation of the SP

The longer the new regulatory model was effective, the less the SP was satisfied with the model chosen and decided to launch a "transformative discourse" (Bhatia and Coleman 2003) in order to strengthen equity. It attacked the existing regulatory model by underlining that it did not prevent market failures such as the chase for good risk groups nor did it really lead to more efficiency to attain the system financial viability. As a result, the number of people who do not pay their premiums is growing steadily, today about 120'000 people (NZZ 11.07.07: 13) and the burden for lower and middle income groups is increasing exponentially. To improve equity and, though less prominently, to enhance the health system's efficiency, the SP sought for support by way of popular referendums as it could not reckon on any majority coalition in parliament. A first referendum was held in 2003 and a second in 2007. Both aimed in one way or another for centralising and harmonising regulative power on the federal level. In fact, the propositions the party made – the financing of the health insurance by income-related premiums and the abolishment of the competitive system of insurance agencies by creating one single national health fund in the mandatory basic insurance – were in sharp contrast with the belief systems of the other three parties and consequently found no majority, neither in the party system nor among the population or the cantons.

The SVP's counter-attack

Diametrically opposed to the SP's policy position, not only on health but also on many other political questions, is the position of the SVP. To enhance efficiency and financial viability in the health system, the party argues strongly in favour of transforming the prevailing social insurance system into a pure liberal one. Not satisfied with the incremental reforms proposed by the liberal-radical minister responsible for health affairs, the SVP launched a referendum in 2004, which will be decided next year. In principle, the party wants to abolish the compulsory health insurance system and to replace it by an optional one, which would go back before the status quo of 1994. The party is, however, realistic enough to know that its policy position cannot win before the people. Therefore, it has moderated its claims suggesting less radical financial cuts by leaving the mandatory insurance untouched but focusing on an attack on the "abundant" individual benefit packages in the basic insurance instead which should be reduced considerably. A large number of benefits should be transferred to the complementary insurance. This proposition of curtailing benefits in order to reduce the costs of the system does find some sympathy among the FDP and the Christian-democrats. Both parties, which are at the centre in the discursive space, do rely, however, much more on incentive instruments instead on restrictive regulations.

The parties of the centre – searching for incremental reforms

When it comes to the two centre parties, the FDP and the CVP, one notices their efforts to find reform solutions that are somewhat between these two extreme policy positions. It is obvious, however, that the FDP with its minister of health (since 2003) is bowing its head more into the direction of liberal solutions while the CVP still bows into the direction of equitable solutions of financial viability. In contrast to the SVP and the SP, both parties are opting for a more incremental and gradual change of the health care system towards more market mechanisms and systemic fairness.

An important aspect in this sense has been the discussion about deductibles.[15] In order to control costs on the demand-side of the health system and to overcome the moral hazard problem (Lehmann 2003: 23), deductibles were used as an instrument before and after the introduction of

[15] This instrument was and still is designed in a twofold way: firstly, there is an obligatory amount that has to be paid by any insurants in the case of sickness; in 1994 this was CHF 150.- a year with a 10 per cent co-payment in case of additional costs with an annual limit of CHF 600.-. Secondly, there was and is the possibility for insurants to choose a higher optional deductible. In 1994, this optional deductible was cut into three different levels with a maximal amount of CHF 1200.-, in 2007 there are five different levels with a maximal amount of 2500.--.

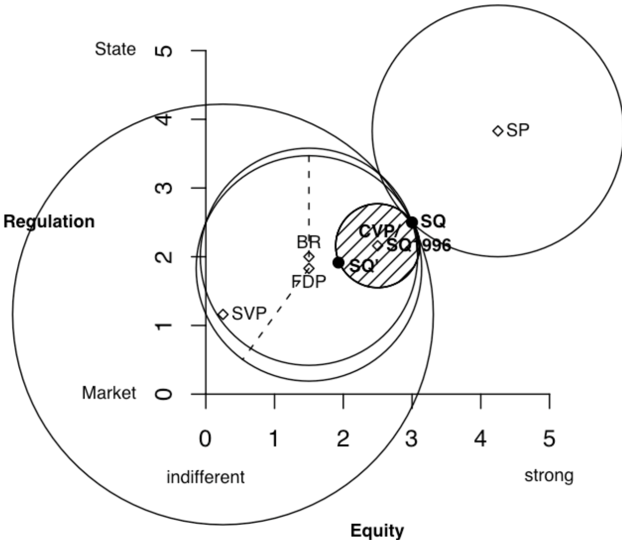
the new health insurance law in 1994. Nevertheless the SP always remained reluctant in accepting them and insisted on low rates of deductibles and to apply at least the subsidy system for lower incomes. The FDP, its minister of health, and the CVP attempted since 2003 to strengthen this instrument in order to ensure the system's financial viability. In 2003, the health minister, who can in some cases govern by decree, decided to increase the obligatory deductible and the annual co-payment.[16] He had to face massive resistance though by both the SP and the CVP, which indicates that the compromise built in 1994 is still alive: in one way or the other such reforms aiming to improve the financial viability have to take equity considerations into account. Furthermore, the government increased the possible levels of the optional annual deductibles for adults and adolescents in order to enhance the health systems financial viability and the personal responsibility. At the same time it reduced the discount on premiums an insurant could get with the intention to strengthen solidarity. Interestingly enough, the Christian-democratic party refused both the increase of the mandatory deductibles and the reduction of the discount on the premiums. On the one hand, it shared the socialist party's critical remarks that the increase would cause an additional pressure on persons and families with low and middle incomes and would have unacceptable consequences for equity. On the other hand, the CVP argued against a reduction of the discount because this would be a wrong incentive punishing those who take over personal responsibility though this would strengthen solidarity. This demonstrates very nicely the dilemma the centre position of the party faces in many reform discussions. The minister's own party, the FDP, welcomed the rise of the mandatory deductible. It criticised, however, as the CVP did, the reduction of the discount on premiums. It proposed to think about optional deductibles related to income with a maximum limit defined by law.

FUTURE WIN-SETS AND POLICY OUTCOMES

If one takes this discussion as an indicator of the distribution of party positions in the ideological space in the health care policy system, one notices that the "win-sets" shift gradually towards a private insurance model. Extremist positions are without a chance to win: The SP had to learn this twice during referendums; the SVP reacted proactively and reduced its radical propositions to a minimum. On the other side, it is also clear that all measures that try to enhance the financial viability still have to take the equity dimension into account, though to a lesser degree than in the 1990s. However, the question remains where the new win-sets will come to lie within the ideological space and where future reforms of the

[16] He aimed to enhance the mandatory deductible from 230.-- to 300.-- Swiss francs and the maximal annual co-payments per person from 600.-- to 800.--. Due to the resistance of the SP and the CVP he had to reduce the annual amount of co-payments to 700.--. Note that this figures only hold for the compulsory payments insurants have to face. In combination with optional deductibles there result other variations.

health insurance system might be located – towards more market, state, weak or strong equity? Our model helps to dare a prediction based on the same variables we have used for the estimation of the model in 1991 and taking into account the actual power distribution in parliament, which means, as explained above (see section 3) that a coalition of either the FDP/CPV and SP or of the FDP/CVP and SVP is needed to change the health insurance:



As the figure demonstrates, both the SVP and the FDP moved towards solutions with less equity in comparison to the LAMal adopted in 1994. It is interesting to state that both support at the same time more regulation than they did in 1991 during the parliamentarian debates about the new health bill, which indicates that in the meanwhile they acknowledged some systemic failures that need to be corrected. As expected, we see that the FDP reacts like a government party should: its ideal point lies very near to the health minister's preferences. The CVP didn't change its favoured position at all and sticks to its core values of "social capitalism" conveyed into the health care system, which means in fact – given that the CVP position influenced the compromise and the new status quo in 1994 to a great extent – that their indifference curve stays quite small, whereas the SP accentuated as described above their political demands for more regulation and more equity measures.

Given the need for either a CVP/FDP/SVP or a CVP/FDP/SP minimum winning coalition, we can state that a new status quo can only be found within the circle of the CVP, which is integrated into the FDP and the SVP indifference curve. A coalition with the SP has, given the lack of overlapping preferences no chance to be created at the moment. One can go even further in determining where more precisely we can expect future reform outcomes. Two considerations are of importance here: First, given the fact that the SVP remains a quite radical opposition party with in addition a high party discipline, it can be expected that its willingness to "sacrifice" will be low. This means that only a solution at the outer edge of the CVP indifference curve in direction to the SVP will be a feasible option for compromise because it is the nearest possible position (see the expected status quo "SQ" in the figure). Second, such an outcome is the more likely as this point is very near to the position of the minister who has agenda-setting powers and also very near to the policy position of the FDP.

If these expectations based on our model are right, this means that the health care system will move to a certain degree towards more liberalism and less equity. The CVP is still the main actor that prevents a more radical drifting of the system towards a clearly more private insurance system.

CONCLUSIONS

We have started our analysis with the assumption that all health care policy makers are confronted with the "uneasy rectangle of objectives", liberty, quality, equity, and financial viability. As these objectives are partly in conflict with each other and parties defend different priorities according to different ideologies, decision-making on the "rectangle" is subject to intense political struggle. In order to understand which choices are taken in health care policies, we have made reference to both "ideas" and "power", i.e. to the position of parties in the ideological space as well as to power distribution in government and parliament. Spatial theory in general and veto-player theory, enlightened by considerations about "vote- and office seeking" in terms of "positioning" (Ganghof and Bräuning 2003) and "ideologies" (Hinich and Munger 1994), helped to demonstrate how the four main parties in the Swiss party system arrived at a compromise in health care reform in 1994 and which reform compromise we can expect in the near future. In order to understand alternative "win-sets" to the status quo, it was useful to delineate the indifference curves of parties as well as their status as a government and supportive opposition party, which made it comprehensible why some parties insist to a stronger extent on a shift of the status quo to their preferred policy position than others. The position of the minister of health as the "agenda-setter" is underlined for the explanation of the positioning of the new status quo.

It was demonstrated that the party struggle in Switzerland about health care reforms focused above all on questions of how to achieve more financial viability while maintaining equity. The other two objectives, liberty

and quality, were less contested and agreements on measures and instruments could be more easily found.

The Swiss health care system changed in the 1990s from an overtly private insurance system to a "hybrid" system in between private and social insurance. Our analysis demonstrated more in detail what "hybrid" meant: the compromise between different policy positions that led to the acceptance of a compulsory health insurance, an individual premium per capita system, a competitive insurance system and equity-enhancing or compensating measures.

On the base of our model we were able to demonstrate how this compromise became possible: It needed a general shift of ideological positions of all parties in the beginning of the 1990s in direction of more regulation and stronger equity. Differences were only found to the extent that parties moved away from the status quo: the SVP remained relatively close to the existing status quo, while the SP positioned itself far away. Given the power relationships in the 1990s, it was clear that only compromises that integrated the two centre parties were feasible. In fact it was the "level of accommodation" of the FDP and the advantage of the CVP minister to be the agenda-setter, which was decisive for the outcome of the party struggle. The CVP, as the "government party" at this point of time, positioned itself near the minister.

The power distribution and the distribution of ideological positions demonstrate clearly the pivot position of centre parties in Switzerland that cannot, until today, be discarded in compromises: Their ideological preferences determine to what extent a more radical shift into the direction of the private insurance model (represented more and more by the SVP) or into the direction of the national health service model (represented by the SP) becomes possible.

This is also demonstrated with regard to reform options today. The major difference with regard to the situation in 1994 is that a new win-set needs – in addition to the centre parties – the inclusion of either the SVP or the SP, which represent polar positions in priority setting in health care. A winning coalition with the SP is highly unlikely because there are – due to the continuing radicalisation of health care reform positions of the SP – not sufficient ideological overlaps with the centre parties. A coalition with the SVP on the other hand suffers from the radical opposition stance this party is taking in and which might reduce its "level of accommodation" in such a way that it can be questioned if it is prepared to "sacrifice" its policy position to the only possible new status quo position on the indifference curve of the CVP and near to the liberal-radical minister of health and its party. This means that either the status quo will persist for quite some time or the SVP agrees nevertheless to accept this new status quo. The recent mitigation of the extreme proposals of the SVP of reform points into the direction of the latter solution. If this is the case, we can expect that the future regulatory system will demonstrate a moderate

shift to less equity and a very moderate shift to less state regulation. Other reform solutions are not to be expected for the near future.

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APPENDIX

We selected for both periods (1991-1996; 2003-2007) a number of health care reform issues that could reveal the ideological struggle between parties. We used qualitative document analysis to pinpoint stances of parties.

In order to measure the ideological position of parties on the "regulation" dimension in health care, we used three variables. All variables were rank-ordered with 5 as the maximum score and 0 as the minimum score:

The first variable, *taxes*, refers to position of parties concerning the financing of the health care system. Parties that opted for the financing completely out of taxes, are considered as parties favouring a very strong role of the state in health care (score 5), while the willingness to see health care financing as a collective responsibility diminishes with each score up to the demand that taxes should play no role at all (score 0).

The second variable, *premiums*, measures if parties defend that individuals must bear all risks (like illness, age, sex, etc.) which comes down to a defence of individual responsibility and market mechanisms (score 0), or if parties demand that premiums should be independent of such risks which implicitly accepts a more collective responsibility and the sharing of risks (score 5).

The third variable, *insurance*, discusses the position of parties concerning the role of health insurance funds: parties demanding a national public health fund, no private health insurance companies and compulsory health insurance clearly opt for "state-regulation" (score 5). Those arguing for free competition amongst private health insurers and no compulsory health insurance, are market-oriented (score 0).

For the measurement of party preferences on the horizontal axis with regard to *equity* (varying from "indifferent" (0) to "strong" (5)) we used the variable "risk compensation" and "benefit package".

The variable *risk compensation* refers to the obligation of insurers to balance out differences in the composition of insurant groups of insurance agencies. The obligation to compensate for age, sex, wealth, education, health and the degree of urbanity can be seen as a strong intention to foster equity in the system (score 5) while no compensation payments would indicate a strong indifference to equity (score 0).

The *benefit package* is taken as the second measure for an indifferent or strong sense of equity: the demand for a very generous benefit package in the compulsory basic insurance is an indicator for a party that does not want large differences between insurants groups (score 5) while the demand for a very reduced benefit package demonstrates an indifference towards equity (score 0).

To position each party in the discursive space on the vertical axis of the regulation dimension we took the specific arithmetic mean of the three

subvariables taxes, premiums and insurances as the “y” point in the coordinate plane and for the horizontal axis equity (strong vs. indifferent) the arithmetic mean of risk compensation and benefit package as the “x” point.

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