La sanità in Svizzera e nel Canton Ticino

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CURRENT PROBLEMS AND FUTURE CHALLENGES IN THE SWISS HEALTHCARE SYSTEM

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INTRODUCTION

In 2004 the cost of health care in Switzerland broke the psychological barrier of SwF 50 billion in totalling SwF 51.7 billion, an amount which at the time represented 11.6% of Swiss GDP and was equal to an annual cost per person of PPP-$ 3,827 (Federal Statistical Office, 2006). This figure meant that Switzerland was not only the European country that invested most in the health sector, but that it also experienced one of the highest average growth rates for health spending in the OECD area since the second half of the 1990s.

In addition to this evident difficulty in managing and containing healthcare expenditure, there are at least four other supplementary problems concerning health policies and politics and which have been underlined in two recent evaluations of the performance of the Swiss healthcare system:*

1. In terms of effectiveness, the results obtained by the Swiss healthcare system are no better than those obtained by some other European countries where the costs are noticeably lower;

* See in particular OECD (2006) and Kommission für Konjunkturfragen (2006).

2. in a small country like Switzerland, the decentralised decision-making structure of a Federal State makes it impossible to implement economies of scale and to foster the necessary specialisation in the hospital sector, while at the same time erecting protectionist barriers that are highly advantageous to local inpatient facilities;
3. the continuous increase in health insurance premiums means that a significant, ever- increasing section of the population can no longer afford these compulsory payments;
4. in the ten years since the introduction of the Federal Health Insurance Law (FHIL), the impact of competition among private health insurers on cost-effectiveness of healthcare providers can be considered as very modest, while there is increasing evidence that insurance companies practice cream-skimming, selecting the risks to be insured with the result that good and bad risks are progressively segregated.

The chapter is organised as follows: The second section contains a more extensive explanation of the four problems currently facing the Swiss healthcare system, while the third section illustrates the difficulties encountered by health insurance reforms, with particular reference to the hospital environment since the changes that are expected in this sector will presumably lead to stronger motivation to plan and introduce codified patient pathways. The chapter closes with a look at possible medium-term changes, from which it can reasonably be supposed that in future the cantonal barriers that exist in Switzerland in the hospital market will be progressively broken down and competition between public and private inpatient institutions will be developed on a country-wide basis.

THE FOUR PROBLEMS CURRENTLY FACING THE SWISS HEALTH CARE SYSTEM

The Swiss health care system must quickly find a solution to at least four problems.

The problem of effectiveness

The high level of costs in the Swiss healthcare system does not appear to be accompanied by better results in terms of effectiveness (OECD, 2006). It should be pointed out that the Swiss healthcare system, where the "curative" aspect is more prevalent than the idea of disease prevention and

health promotion, is based on a liberal concept of medicine and that the majority of the population recognise the necessity for state intervention and the legitimacy of universal protection against the risk of illness (Achtermann, Berset, 2006). The Swiss healthcare system assigns a central role to patients-consumers and places great emphasis on their right to choose the type of medical care they want.* Because of universal health insurance, excess supply(in terms of doctors and other healthcare professionals, hospital beds, diagnostic equipment and state-of-the-art technology), the complete freedom for patients to choose their healthcare provider and reimbursement schemes that encourage consumerism (fee-for-service payment for outpatient treatment, per diem payment for inpatient hospital care), the health services in the Confederation are available to the entire population without waiting lists and with a fairly modest co-payment. Compulsory contracting, sanctioned by current Federal legislation, guarantees the right to sign a contract with any of the health insurance companies to doctors whose qualifications allow them to work free-lance and to hospitals that are included on the hospital planning of at least one canton. By the terms of this agreement, all services provided by any health provider that (in theory) respects the principles of quality and cost-effectiveness are entirely reimbursed by the health insurance companies on the basis of pre-established tariffs.** If on the one hand patients in Switzerland are free to choose their own doctor, to change doctor whenever they want and to visit a specialist without a doctor's referral,*** on the other hand patients have a lack of access to information about the clinical quality, effectiveness and appropriateness of the health treatment offered to them. They are told nothing about the performances of individual doctors and medical institutions, which are rarely measured or compared, with the result that patients are not provided with the information they need to make informed choices and therefore they do not have any real decision-making independence. In general Swiss people are satisfied with their health system (Bolgiani et al., 2003). However, given that there are no

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* According to authors such as Herzlinger and Parsa-Parsi (2004), the Swiss health sector is a clear example of consumer-driven healthcare.

** It should be noted that doctors' income in Switzerland are decidedly higher than those of their colleagues in neighbouring countries (OECD, 2006).

*** The only exception to this is those people who voluntarily opt to either fully or partially waive their right to freely choose their doctor in exchange for a lower premium, as part of a special form of managed-care insurance cover.

indicators of the quality and appropriateness of the treatment on offer, this satisfaction is not so much due to clinical effectiveness as to the fact that people have immediate access to healthcare and that there are no restrictions on their freedom to choose in matters of health.

Since it is common knowledge even in Switzerland that financial resources are not unlimited, it would appear unthinkable that the Swiss will continue to accept further increases in health spending without being able to quantify the benefits in terms of outcomes.

The problem of efficiency: Why the saying "small is beautiful" is not always right

The efficient use of available health resources is further compromised by the decentralised organisation of the healthcare system, inspired by the principles of federalism. With the adoption of the FHIL in 1996 and the introduction on a national scale of compulsory health insurance, the Swiss population accepted the idea of establishing a form of universal public service that provided a standard benefit basket for every Swiss resident. The cost of this service (amounting to approximately 65% of total health spending), was largely collectively financed, by means of two sources: compulsory health insurance premiums and tax revenues of cantons and municipalities, that provide for financial support to particular facilities such aspublic-interest hospitals, nursing homes and homecare services.*

In accordance with the Federal Constitution, individual cantons and not the Confederation are responsible for organising and regulating the population's healthcare needs. Even though this small Federal State only has a population of 7.4 million, the 26 cantons are required to function independently, particularly as far as the hospital structure is concerned, and must ensure that the needs of the people who reside there are provided for by either a sufficient number of healthcare institutions in the canton or by officially recognised institutions situated in the immediate surrounding area. It is therefore not surprising that half the existing hospitals have less than 120 beds, which is well below the optimal size both from the economic and the clinical effectiveness points of view (Farsi, Filippini, 2006).

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* This includes direct financial help for health treatment and grants to low-income households, for example for the payment of compulsory health insurance. This item of public expenditure is jointly financed by the Confederation and the cantons, currently by means of an intergovernmental equalising transfer system (Crivelli, Filippini, 2006).

Federalism does not simply mean that the economies of scale are inadequately utilised, but it also makes it difficult to put competitive pressure on the different healthcare structures. Federal law states that health insurance must cover a patient's stay in any hospital situated within the canton where the patient resides, and that only in cases where there is a proven need (backed by authorisation from the cantonal doctor) must it cover cross-border hospitalisation. The principle of canton sovereignty is a formidable barrier to market entry and in effect protects hospitals in any canton from being compared with those in any other part of the country, thereby favouring the consolidation of regional monopolies* and hampering the necessary specialisation of healthcare institutions.

The problem of equity

The Swiss heathcare system financing is one of the most unfair among economically advanced countries (Wagstaff et al., 1999). According to the World Bank's definition of vertical equity, the more the costs of a health system are financed in a proportional (or even progressive) way compared with the income of the citizens, the more vertically equitable that system is considered to be. In Switzerland two thirds of healthcare costs are financed independently of income, with the result that a large part of the population has to bear an intolerable level of costs. In the last ten years compulsory health insurance premiums, which are calculated independently from income, have increased on a national level by 75%, a rate considerably higher than the increase in state funds available for earmarked subsidies for low-income households. It is not surprising that an increasing number of people is no longer able to afford the cost of health insurance and is therefore forced to personally take on an important part of the risk or even suspend payment of the premiums.**

Added to the problem of vertical inequity is the problem of horizontal inequity. As a consequence of both the autonomy conferred on the cantons by Federalism and various public expenditure policies, the costs that certain social groups have to pay for compulsory health insurance premiums differ

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* See, for example, Porter and Teisberg (2006) for an explanation of the importance of promoting a competitive spirit between hospitals that is cable of overcoming regional boundaries.

** In the Canton of Ticino alone, 5,000 people were declared insolvent at the end of 2005 as a result of not being able to pay their insurance premiums.

considerably from one canton to another. This produces an anomalous situation where a standardised benefit basket is guaranteed on a national level, but the funding and production of these services (for the part paid for from income taxes) is left to the discretion of the individual cantons. The result is a high level of heterogeneity in the organisational models and regulations adopted, the existing production capacity (density of doctor's surgeries and beds capacity in acute hospitals), the average level of expenditure and the results obtained in terms of outcome (for example mortality amenable to medical intervention).* It is important to note, however, that the diversity in the organisational models and in the cost of public services is widely recognised as being a typical benefit of Federalism (Oates, 1999). The structure of the federal State makes it possible to adapt the services the public sector offers to the preferences (which are sometimes very different) of the people resident in the various regions of the country and to compare the performances of the different, competing regulatory settings.

In 2004 the average annual cost of public services fluctuated between a minimum of around SwF 2,290 per capita in the Canton of Appenzell to a maximum of approximately SwF 5,900 in the Canton of Geneva (Fig. 1.1), while the Canton of Ticino spent SwF 4,310 and was the fourth highest spender.

It is not only the cost of public services that differs so much between the various cantons but also the way these costs are covered by general taxation, compulsory premiums and co-payments. Given the variability in total costs and the amount covered by taxes, together with the fact that local authorities in the cantons enjoy a great deal of freedom in choosing the way they distribute earmarked subsidies for paying premiums, it is not surprising that the incidence of the net health insurance premium on the disposable income of a household differs greatly from one canton to another. In the case of a family of four persons (father, mother and two children) with a total gross income of SwF 70,000 and assets of SwF 100,000, in 2004 the incidence of the premium, net of subsidies, for identical insurance cover varied between a minimum of 4.7% in the Canton of Obwalden to almost four times as much (16.2%) in Neuchâtel (Balthasar et al., 2005). Territorial disparity, which is implicit in a Federal State, is so pronounced in this case that it questions the very principle of social citizenship.

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* More detailed information about determining the regional differences in pro capita spending can be found in Crivelli et al. (2006).

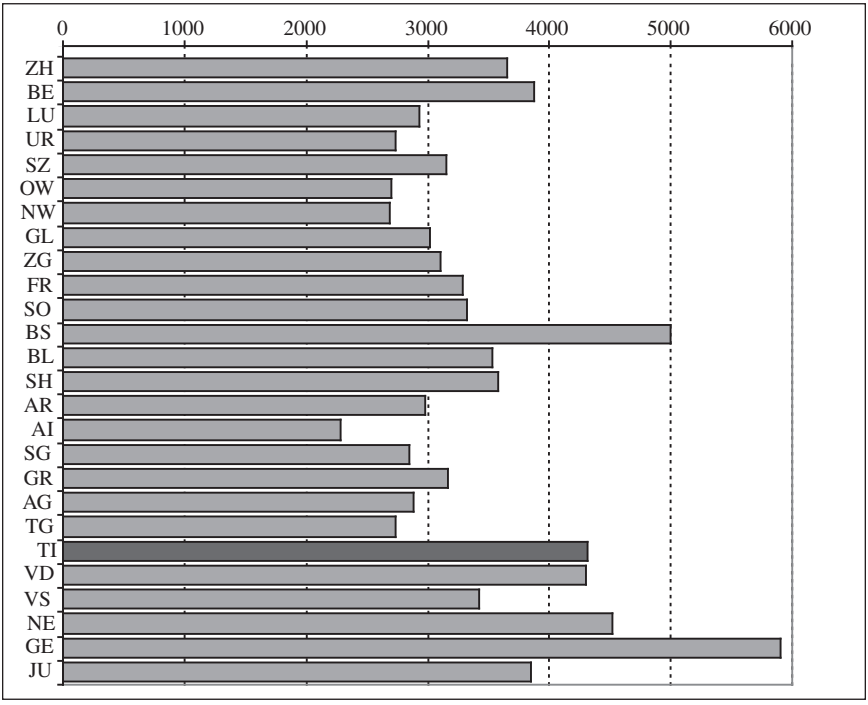

Figure 1.1 Per capita socialised health expenditures in the 26 cantons (2004) Federal Statistical Office (2006) and Federal Public Health Office (2006).

THE RUINOUS COMPETITION BETWEEN HEALTH INSURANCE COMPANIES

With the 1996 reform, the Swiss health system moved closer to the managed competition model drawn up by Enthoven at the end of the 1980s.* Recognising that free market rules did not function properly when applied to healthcare providers (because of the problems linked to the asymmetry of patient information), the Swiss legislator decided to shift competition from the healthcare providers to the health insurance sector. Consequently, every individual has the right to change their insurance company every year,

* Cf Enthoven (1993; 2003) and Enthoven and Tollen (2005).

choosing from a wide range of private non-profit companies.* Competition in the area of sickness funds is based on community flat-rated premiums and a standard insurance cover, with the result that insurance companies expected to put pressure on the healthcare providers by negotiating fees and checking performance standards. The companies also have the right to sell innovative insurance contracts that make it easier for them to control costs and access to health services by means of selective contracting (or gatekeeping), utilising guidelines and introducing no-claims bonuses. On their part, every individual has the right to decide whether they want to remain in the conventional system, thereby enjoying the freedom of unrestricted access, or if they would prefer to limit this freedom by signing one of the alternative contracts in exchange for a discount on the basic premium. Unfortunately in the first ten years since these new rules were introduced, the effects of the introduction of competition between insurers has been anything but encouraging (Bolgiani et al., 2006). The level of premiums offered by an insurance company does not just depend on its ability to control costs and check the appropriateness of treatment, limiting as much as possible the consequences of the so-called moral hazard, but also on the portfolio of risks it covers. As a result of an insufficient risk equalisation mechanism (Beck et al., 2003) and of the difficulty companies have in promoting managed-care contracts, competition between sickness funds has up to now concentrated more on the selection of risks rather than on "managing" healthcare service supply. Swiss law formally prohibits risk selection and, within the context of compulsory insurance cover, insurers are obliged to accept all types of client on the same conditions.

However, since old people and ill people continue to show little inclination to change their insurers and those who are more open to the idea of switching are generally "good risks", the absence of an effective risk equalisation mechanism has led to the division of the population into groups of mainly "bad risks" and groups of almost exclusively "good risks". In recent years sickness funds have refined the selection process by introducing specially targeted marketing campaigns, sponsoring sports events, selling insurance policies on the Internet, linking them to complementary insurance plans aimed at healthy people, running down the damage handling service and delaying the reimbursement of the cost of treatment.

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* It should be noted that these companies, which are restricted from making a profit from basic health insurance, benefit from less strict regulations when they operate, sometimes through twin companies, in the supplementary insurance sector.

THE DIFFICULT PATH OF THE REFORM OF THE FEDERAL LAW ON HEALTH INSURANCE

The change of strategy in the reform process

In the light of the problems outlined above, it is not surprising that in recent years healthcare and the reform of health insurance have been very high on the Swiss political agenda. All of the country's political parties recognise that the main objective of the health sector reform process is to contain social spending by means of health insurance, and naturally there are contrasting ideas about the best method of doing this. On the one hand there are those who favour reinforcing market dynamics (by means of increased privatisation of healthcare, the deregulation of contracts, the reorganisation of State intervention and increased individual responsibility), while on the other hand there are those who look favourably on stricter State control of healthcare supply and on linking spending more closely to a person's income. After years of heated debate, the first attempt to reform the current Federal healthcare laws failed in December 2003, and there are two possible explanations for this:

1. the failure of the project was caused by the heterogeneity of the subjects covered by the parliamentary bill, which ended up dissatisfying the majority of the political groups in parliament and resulted in the creation of a cross-party coalition to block the reform;
2. the failure was due to a shrewd political calculation that took into account the role in Switzerland of direct democracy and anticipated the risk that public reaction to the reforms could delay the entire reform process by a number of years.* The right to a referendum, which is the same as the right of veto, would result in any amendments to the law passed by parliament being suspended, and any such amendments would then only become law if they were approved by a referendum. Since at least one of the proposed reform measures was bitterly opposed,** there

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* Constitutional modifications, as well as adhesion to certain international organisations, are subject to a compulsory referendum and therefore must be voted on by the population, while modifications made to Federal laws that do not concern the Constitution or international agreements are subject to an optional referendum. In other words, such modifications must be voted on by the population when at least 50,000 registered voters request a referendum, and the signatures of these voters must be collected within 100 days of the publication of the parliamentary bill.

** This refers to the abolition of the right to contract.

existed the real possibility that the entire bill could be rejected, which would have meant that the decision to reject the reform would only have been reached at the end of 2004 and that the legislative procedure would have had to begin again from scratch, thereby also delaying by many years the less controversial changes.

After analysing this result, the Federal government reached the conclusion that the parliamentary rejection of the reform did not impinge on the strategic policies of the reform but merely made it necessary to change the approach and the method of making the decisions. The main change in the project presented in the spring of 2004* was that the different aspects of the reform had been unbundled. The principle elements of the second revision of the FHIL were presented with only minor modifications, but rather than being integrated into one single parliamentary bill they were divided into seven separate legislative packets. Each one of these had to be approved individually by parliament and each one could, if necessary, be the subject of a separate referendum. With the hindsight of two years, however, it can be seen that unfortunately this strategy did not produce the hoped for results, and up to the present time only two of the seven packets have been approved (the urgent measures and the packet dedicated to the reduction of premiums, which has been considerably downsized during the many parliamentary debates). Even reforms that initially were thought not to be "very controversial", such as the introduction of a prospective hospital financing model based on treatment, are still a long way away from being accepted. This is not the place for a detailed discussion of the highly controversial and far from definitive development of hospital funding reforms. Instead we will limit ourselves to outlining the reasons that have made it necessary to design a new funding system and to illustrating the bill approved by the Council of States in March 2006, which will soon (December 2006) be the subject of a debate in the Lower House (National Council), while briefly highlighting the main differences between these proposals and the government project presented in September 2004. While the probability that the key aspects of this law will be ratified by parliament is very high, we are not dealing with the finished article but rather with an intermediate step since in future years there should be a gradual breaking down of the cantonal barriers and the creation of a national hospital market that is also open to competition from

* Cf Federal Council (2004a).

neighbouring countries (cross-border care), and is capable of stimulating added value for the patient, based on incentives that increase both quality and cost efficiency.. With this in mind, it is essential to read the study made by two university professors in June 2006 (Leu and Polena, 2006), which in recent months has been carefully examined by the Health and Social Security Commission of the National Council (CSSS-CN), and the references to the introduction of a monist financial system contained in a message issued by the Federal Council in September 2004 and in the motion voted by the Council of States in March 2006, on the occasion of the approval of the parliamentary bill (CSSS-CS, 2006).

The reform of hospital funding and the parliamentary bill currently under discussion

The current law states that the way hospitals are funded depends on who owns the individual institutions. In the case of public hospitals or publicly-subsidised hospitals, compulsory health insurance can be used to cover a maximum of 50% of treatment costs for ordinary hospital stays while the remaining 50%, the total cost of investment and the cost of training and research must be paid from the general tax revenues generated by the cantons. Therefore treatment in public hospitals is partly paid for by the health insurance companies and partly by the State, while private clinics are exclusively paid for by the insurance companies (either from compulsory health insurance policies or from supplementary private cover policies). As a direct result of regulations that were far from clear, between 1997 and 2001 there was a series of legal cases only resolved by three sentences handed down by the Federal Insurance Tribunal (TFA).* The

* The sentence handed down on 16 December 1997 by the TFA established the obligation for an individual's original canton to contribute to the costs of staying in a hospital outside of the canton, even when the individual in question stayed in a private or semi-private room in a publicly-subsidised private hospital. On 19 December 1997 the TFA handed down another sentence establishing that the individual's canton of residency must contribute to the medical costs only when the treatment takes place outside the canton of residency in a publicly-subsidised private hospital (and therefore this sentence did not apply to treatment received in a private clinic outside the canton of residency). A sentence handed down by the TFA on 30 November 2001 clarified once and for all that a general hospital ward is held to be "insured", therefore article 49 of the FHIL must be interpreted as establishing the obligation for cantons to contribute to the cost of all hospital stays in publicly-subsidised private hospitals, independently of the type of ward or room the patient stays in.

Tribunal's decision established important obligations for the parties involved in the payment of hospital costs (compulsory insurance, private cover and cantons)* and the need for transitory legislation (an urgent federal decree from the Federal Council), as well as making a structural change to the system indispensable. The three sentences represented an anomalous situation for Switzerland, since a decision that probably would not have obtained the necessary parliamentary approval was "forced" into law by the courts. As can easily be imagined, however, a court ruling is not as balanced as a parliamentary bill and these sentences have produced some undesired effects, the most notable being an intolerable disparity in treatment between public hospitals and private clinics. The obligation for cantons to contribute to hospitalisation costs does not particularly influence the choice of where to go for treatment for those people who only have compulsory health insurance (the obligation to contract with all hospitals means that health insurance companies cannot influence the patient's choice of hospital), but it does have a strong influence on those people who have supplementary private cover). As long as supplementary health insurance policies are governed by private law, they can continue to offer a reduction in premiums in exchange for reduced freedom of choice. A widespread diffusion of limited-freedom private policies (for example, limited to publicly-subsidised hospitals) could seriously threaten the economic survival of private clinics and the Swiss hospital system, which is contingent on the presence of both public and private hospitals.

The main points contained in the bill approved by the Upper House (the Council of States) in March 2006 are the ones indicated by the Federal Council in its message of 15 September 2004.** More specifically the new law aims to:

- the introduction of a national (full-costing) prospective per-case-payment scheme (SwissDRG)***, which would make hospital performance comparable across the 26 cantons and across hospitals with different ownership status (public versus private);
- shifting the focus from object financing to subject financing;

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* In particular, an increase in the costs cantons are liable for.

** Federal Council (2004b). The bill cannot become law until the Lower House (the National Council) gives its approval. The bill is due to be discussed in the 2006 winter parliamentary session.

*** An ISO resources classification system, to be known as Swiss DRG, is currently being designed to take into account the specific situation in Switzerland.

- ensure that cantons and health insurance companies are in a symmetric position with regard to hospital financing. The current situation where insurance companies pay per day based on historical costs and cantons cover the residual costs (or, in the case of Ticino, pay a global budget), favours and compounds the strategy of cost-shifting between the two. In future, hospital services will be based on prospective fees that will be proportionally divided between cantons and insurers. In this way a proportion of every additional franc spent for a treatment (effectively every franc saved) will be paid by the cantons and the insurers, motivating them both in equal measure to keep strict control of hospital services and their respective costs.

It is important to stress how the bill approved by the Council of States differs in some important respects from the government's initial project. Since the fiscal contribution currently made to hospital funding differs from one canton to the other, the senators decided to introduce changes that from the financial point of view were as neutral as possible and therefore not to impose the same financial contribution on a national level. The result was that for those cantons where the level of health insurance premiums was higher than the average national premium the contribution was fixed at 60% of the prospective payment, while for those cantons where the premiums were lower than the average the part covered by the cantons could decrease (at the discretion of the cantons themselves) up to a threshold of 45%.

However, this decision to make the amount of public funding flexible runs the short-term risk of making it more difficult for patients to move from one canton to another for treatment. It should be remembered that if a patient needs to be hospitalised in a structure outside their canton, the way things stand at the moment (and also in the future) the patient needs to have authorisation from his canton of residency and this canton is required to contribute to the cost of the hospitalisation. In future, the hospitalisation of a patient outside his canton of residency (for example, in a university hospital*) who lives in a canton with a premium lower than the national average will entail the patient's canton of residency having to pay 60% of the flat rate, while if the patient is hospitalised inside his canton

* The 5 existing university hospitals (where the majority of patients who seek hospital treatment outside their canton of residency go) are all to be found among the 9 cantons where the premiums are higher than the national average.

of residency the cost to the canton will be limited to 45%. Although many people have expressed a desire for the current structure of 26 separated cantonal hospital markets to be replaced by a project based on 5 coordinated macro-regions, and even though the new law contains a provision requiring cantons to coordinate their hospital planning, in its present form the funding regulations decided by the Council of States could, unfortunately, reinforce the barriers between the cantonal hospital systems and hinder patients from being free to choose the best hospital for their treatment. This is the main reason why many experts tend to believe that the parliamentary bill is merely an intermediate step and that since a number of structural problems will not be solved by the bill it will shortly be necessary to make new amendments to it.

The second important difference compared with the message from the Federal Council concerns the consequences of a healthcare institution being excluded from the hospital lists. Currently, if an institute is excluded from the hospital lists, compulsory health insurance patients cannot be referred to that institute. The law approved by the senators offers (at least in appearance) a stopgap solution to those excluded institutions. Sickness funds can, if they desire, sign contracts with and consequently pay for the services of institutions or individual departments of institutions that have been excluded from the hospital lists (structures which the cantons do not have a contract with), although precise legal limits apply. Hospitalisation in institutions included on the hospital list is funded in accordance with the method explained earlier, while in the case of hospitalisation in institutions excluded from the list the prospective reibursement will obviously be paid exclusively by the health insurance companies and by law cannot be higher than the amount normally paid by the same health insurance companies to institutions included on the hospital list.* In theory this regulation should make it less critical for an institution to be excluded from the hospital list, and respectively easier for the cantons to only include on their list those structures they consider necessary for covering the medical needs of their residents. However, in practice the difference in the amount of reimbursement paid to hospitals included on the list and hospitals excluded from the list appears to be so great as to make it almost impossible for hospitals not included on the list to survive. Although these

* In other words, the amount paid to those hospitals not included on the list by insurance companies for medical treatment must not exceed 55% (or 40% if the canton pays 60% of the flat rate) of the cost paid to an institution co-financed by the cantons.

institutions could decide to select the cases they accept (concentrating on the easier, more lucrative ones), reduce the level of quality or concentrate more on offering treatment to private patients (companies offering supplementary health insurance could benefit from being able to offer their clients a wider range of hospitals), it does nevertheless seem impossible that they could reduce their costs by between 45% and 60% compared with hospitals included on the list.

Unfortunately this parliamentary bill does leave at least two fundamental questions unresolved:

- The contribution made by cantons to funding hospitals has the merit of smoothing the social gradient of the community rating premium by introducing money derived from taxation into the system. Of the two main components of public spending in the health sector, hospital funding is much higher (SwF 5.3 billion in 2003) than the amount cantons spend on reducing premiums (around SwF 1 billion in 2003). Both the current system and the finance model drawn up by the Council of States propose to subordinate public participation to the supply of residential hospital services. Thanks to technological progress and the diffusion of techniques that allow many surgical operations to be performed in day hospitals, it is possible that in future demand for hospitalisation may decrease and consequently the proportion of "tax dependent" funding out of the total spending on health may also progressively decrease.
- The distortion between outpatient treatment and inpatient hospitalisation will be maintained. In other words, there is an incentive to practice cost shifting between inpatient and outpatient treatment, since transferring a patient from inpatient status to outpatient status (apart from the total cost) produces a reduction in costs for the cantons and a corresponding increase for the health insurance companies, while transferring a patient from outpatient to inpatient status produces an increase in costs for the cantons and an equivalent decrease for the health insurance companies. Obviously the possibility of transferring patients only applies to those cases where a patient's surgery or diagnosis can be performed in both day and residential hospitals. The choice of treatment is undeniably influenced by financial aspects linked, first and foremost, to the generosity of the reimbursement plan and only then to the identity of the third-party payer. Between 2001 and 2003 the cost of outpatient hospital treatment increased more quickly (+13.3%) than the cost of inpatient treatment (+10.4%), indicating the extent to which patients

were transferred to day hospitals. In 2004 this tendency was reversed following the introduction of more expensive tariffs for day hospital treatment (TARMED), with the result that there was a moderate increase in the expenditures for outpatient treatment (+2.4%) and a notable increase in costs for inpatient treatment (+11.1%). During the first six months of 2005, following the introduction of prospective payment (AP-DRG) for inpatient treatment in a number of cantons, the cost of outpatient treatment began to rise again. This type of strategy is undoubtedly favoured by the fact that hospitals can always find an ally among the authorities that provide them with funding (either the cantons or the health insurance companies).

The long-term prospects of hospital funding reforms

We are fully aware that in this concluding section we are dealing with hypotheses. It is always difficult to foresee what the results of a legislative process will be and this is even more difficult in a democratic system like the one that exists in Switzerland, where the population has the power of veto contained in the democratic instruments of referendums and initiatives. Despite this, some indications of what may happen can be gleaned from official documents* that give an indication of the path the reforms in the hospital sector may take in the medium term. In particular, there are two paths open, one extreme and one moderate.

The radical scenario (currently strongly opposed by the cantons) involves the introduction of a monist financial system, with the following characteristics:

- a clearer separation between the purchasers of treatment for patients and the suppliers of treatment (the hospitals). With the aim of changing from a dual system (with two funding authorities) to a system with only one final interlocutor for the hospitals to deal with (at this point the most natural purchaser would appear to be the health insurance companies), the public money that is currently paid to the hospital sector could in future be retroactively distributed to either the health insurance companies** or directly to the patients (for example, in the form of vouchers);

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* This refers in particular to the Federal Council message of September 2004, motion 04.061 of the CSS-CS and the study conducted by Leu (2004). See also Kommission fur Konjunkturfragen (2006).

** Other methods of distributing the public funds could emerge.

- the abolition of cantonal hospital planning (with just a supervisory role for the health police), together with the abolition of the obligation for health insurance companies to contract. The sickness funds would then be in a position to freely choose the hospitals they want to sign a collaboration contract with, while at the same time they would still have to comply with regulations guaranteeing access to healthcare for the population (by having to sign contracts with a minimum number of hospitals);
- in this scenario some hospitals could still be state owned. According to the documents previously referred to, in this context public and private health institutions would compete on an equal footing, distortion between outpatient and inpatient treatment would be eliminated and the principle of canton territoriality would be abolished;
- analysts agree that this liberalisation of the hospital sector should be accompanied by an improvement in the current system of risk compensation.

The scenario suggested by Leu and Poledna (2006) is, on the other hand, more moderate since it proposes to transfer the task of hospital planning to the Confederation by setting up a national agency for regulating the hospital sector. Such an agency would be responsible for organising the benchmarking of hospitals, assessing both costs and quality and establishing the production capacity necessary for guaranteeing access to healthcare throughout the various regions in the country. In the model drafted by the two authors of the study, the obligation to contract would only be partially maintained and would only apply to those institutions that jointly satisfy the criteria of efficiency and quality, while there would be no obligation of any kind to sign contracts with the other hospitals. This model also envisages the abolition of the principle of canton territoriality, thereby allowing the Swiss population to choose the best-performing medical institutions.

In both scenarios the hospital system seems destined to become more competitive compared with the present situation. If, thanks to the introduction of regulations, it will be possible to break down the current information asymmetry concerning outcome indicators, thereby promoting competition between medical institutions on the basis of both cost and quality, then the introduction of clinical governance aimed at creating value for patients could become a successful strategic factor in Switzerland as well.