santésuisse

Meeting with representatives of the Ministry of Health and Wellness of the province of Alberta, Canada – June 14, 2006

Part 3: Public and private clinics and hospitals: the role of the private sector

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I. Introduction regarding the role of the private sector versus the public sector

There is no substantial difference between public and private hospitals what concerns their role in the Swiss health system and the medical services they offer and assume – except from the financing system. While public hospitals have the benefit of public subsidies or contributions which cover more than 50 % of their total operational costs and the totality of the investments, the financing of the private hospitals and clinics is provided mainly from sources other than public subsidies or contributions, as practically the whole costs of these hospitals are on charge of the compulsory medical and nursing care insurance (for hospitalizations in the general wards and aside from a small part going on charge of the separate accident insurance) and of the voluntary complementary insurances for hospitalizations in the semi-private and private wards. These complementary insurances are covering the additional hospital costs and private doctor's fees for semi-private and private hospitalizations in the public as well as in the private hospitals.

Depending on how many hospitals and hospital beds are needed in the cantons to secure the supply of hospital medical treatment and nursing care based on the hospital planning every cantonal government has to establish following the regulations in the Swiss law on health insurance – or Health Insurance Act (HIA) - the private hospitals have to be considered in a an adequate proportion (article 39, paragraph 1, letter d HIA).

In most of the rural regions and smaller cantons, only public hospitals are available. In the bigger cities – like Zurich, Berne, Lausanne, Geneva, etc. – there are also private hospitals established aside from the public ones and the University hospitals (totally 5 University hospitals, in Zurich, Basle, Berne, Lausanne and Geneva). For the cantons and especially for their budgets, it's very interesting to have hospitals operated on a private basis, as by the present health insurance law (HIA), they don't have to allow them subsidies or contributions. Therefore the cantons have not only a tendency, but also a very big interest to close public hospitals which they co-finance when they have to reduce over-capacities.

Example of the canton of Berne, which is the second largest canton of Switzerland:

Before the year 2000, there were 29 public hospitals (including the University hospital) plus 11 private clinics operational. Due to considerable over-capacities in the sector of hospitalizations, 8 public hospitals – all situated in rural regions - were closed within 3 years, while the number of private clinics stayed unchanged. Of the 11 private clinics, 8 are situated in the city and agglomeration of Berne, while aside from the public University hospital, 2 other public hospitals are established in this city. So far, there don't seem to be any intentions by the Ministry of public health and social welfare of the canton of Bern to close down public hospi-

tals in the city of Berne or to take off some private hospitals from the cantonal hospital list (which would force them to close down too).

This differential financing of the hospitals creates a very unfortunate imbalance between the two kinds of establishments and leaves a bitter taste for the insurers, but also for the insured population, as the insurers have to pay more than twice as much for a hospitalization in the general ward of a private clinic compared with a stay in a public hospital, while especially in cantons or regions with many private hospitals, the population gets charged with higher premiums for their medical and health care insurance. So far, the repeated claims of santésuisse that the cantons should be obliged to contribute to every hospitalization in a hospital which was admitted on their cantonal hospital lists without a differentiation whether the patient was hospitalized in a public or in a private hospital were not heard by our national politicians – this of course mainly due to the intense opposition of the cantons, especially those with many private hospitals.

II. Questions of the Canadian delegation

How do public and private provider organizations compare in terms of quality and safety?

1. *How are quality and safety of health services regulated and enforced, particularly when private delivery is prevalent?*

   To guarantee quality and safety and to apply a certified quality management is mainly the concern of the hospitals and clinics. There is no difference between public and private hospitals regarding the regulatory conditions stipulated in the Swiss law on health insurance - or Health Insurance Act (HIA) - as they are valid for all the hospitals allowed to bill their treatments and performances on charge of the health insurance.

   In the HIA, there are regulations under article 58 stipulating that the Swiss Federal Council can foresee a systematical scientific controlling regarding the securing of the quality or of the appropriate supply of the performances on charge of the compulsory medical and nursing care insurance. He can transmit this controlling to the professional organizations or other institutions and has to regulate with which measures the quality or the appropriate supply of the performances has to be secured or re-established.

   Practically all the contracts signed between santésuisse on behalf of the insurers and the public and private hospitals or their associations contain regulations about the obligation of the hospitals to secure and guarantee the quality of the treatments. Many hospitals, but mainly those situated in the German speaking part of the country, are securing their quality management by applying a quality-check system which is continuously developed by a society called “Outcome”. In this system, no difference is made between public and private performances. It’s the same for all the hospitals. This system is based on quality-checks of the treatment of various diagnoses and medical indications.

2. *Do Swiss residents have the ability to “queue-jump”, or pay for faster service, using their own money?*

   It cannot be completely denied that mainly in private clinics, this probably happens, of course without the knowledge of the other patients or the insurers (!), but more likely in rare cases, especially if patients would have to invest their own money. Because article 44, paragraph 1 HIA forbids to doctors, hospitals and other performers in medical care to charge more than the official fees and prices for medical treatments and performances which fall under this law (the so called tariff protection).

But this regulation only applies on ambulatory treatments and hospitalizations in the general wards of all the hospitals, public and private, which have been admitted on the cantonal hospital list (article 39, paragraph 1, letters d HIA).

What happens probably more often is that patients with a complementary insurance for hospitalization in a semi-private or private ward get a certain preference and could queue-jump or are being queue-jumped if on a waiting list, as long as there is no emergency amongst the general ward patients who are on this list.

3. *How do private sector provider organizations set fees for their services? How are fees and profit margins regulated?*

Following the regulations of article 43, paragraph 3 HIA, the fees for hospitalizations in the general wards have to be negotiated with the health insurers, precisely with the regional branches of santésuisse, who is acting on behalf of all the insurers who are members of this association. This applies to all the public and private hospitals which have been admitted on the cantonal hospital list based on the hospital planning of every canton.

For ambulatory treatments and hospitalizations in the general wards, no profit margins are accepted in the calculations of the tariffs and fees. Only the imputable costs (see under following point 4) which are determined under article 49, paragraph 1 HIA can be included in the fees the hospitals can charge to the insurers.

For the calculation of the imputable costs and finally of the fees and tariffs, santésuisse has created its own hospital tax calculation system which usually is being served as the main basis for the negotiations. Aside from the calculation of the imputable costs, santésuisse also insists on a benchmark between hospitals practicing equal or similar treatments. Depending on the results of the benchmark, hospitals with too high costs per case can or will be penalized with a reduction of their fees.

Where especially the private hospitals can include profit margins in their fees, is in the tariffs for patients hospitalized in the semi-private and private wards. These fees do not fall under the law on health insurance and have to be negotiated with each insurer for the domain of the complementary insurances which are subject to the law on the insurance contract. The difference between the costs for a hospitalization in a semi-private or private ward and a stay in the general ward is on charge of the patient or of his complementary insurance if he/she has contracted such as insurance.

4. *How do public and private (for profit) provider organizations compare in terms of what they charge or are paid for their services?*

Following the regulations under article 49, paragraph 1 HIA, for hospitalizations in the general wards, fees on charge of the compulsory basic medical and nursing care insurance include:

For public hospitals	*For private hospitals*
Maximum 50 % of the imputable operational costs, excluding costs due to overcapacities, for instruction and research and for investments. Presently, the coverage degree of the determined imputable costs varies between 44 % to 49 %, with a nation wide average of about 47 %.	Maximum 100 % of the imputable operational costs, excluding costs due to overcapacities and for instruction and research, but including the costs for investments. Presently, the coverage degree of the imputable costs can only be estimated. It could be around 92 to 96 %.

While in the past, most of the hospital fees were fixed with prices per day, now more and more contracts with the hospitals foresee fees fixed with prices per case. The prices per case can either be fixed per department (e.g. internal medicine, surgery, gynaecology, ophthalmology etc.) or by diagnosis-related groups (DRG's). Presently, representatives of the hospitals, of the insurers (including santésuisse on behalf of all the insurers) and of the cantonal health departments as well as of the Conference of the Ministers of public health are working on a project for introducing so called "Swiss DRG's".

Figures from the data pool of santésuisse:

Costs for hospitalizations in <u>public</u> hospitals paid by the compulsory, basic insurance for medical and nursing care by the insurers members of santésuisse for their customers in the canton of Berne during the year 2004*		*Costs for hospitalizations in <u>private</u> hospitals* paid by the compulsory, basic insurance for medical and nursing care by the insurers members of santésuisse for their customers in the canton of Berne during the year 2004*	
Total amount	Sfr. 356,9 millions	Total amount	Sfr. 283,9 millions
Per day	Sfr. 277.80**	Per day	Sfr. 822.60***

* Not including psychiatric clinics and specialised clinics for rehabilitation
** Coverage degree of 46 % of the imputable operational costs, excl. investments
*** Coverage degree of 92 % of the imputable operational costs, plus investments

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