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Continuing what the report of last year, the subjects are still the same. namely revision of the health insurance law, but with some apparently minor, but still very significant changes:

1. Medical practice – development of networks
2. Medical demography – the so called need clause
3. Hospital and health financing

Parliament and government are under heavy pressure because the premiums have increased of about 30% since the introduction of the new law in q1996 introducing compulsory basic social insurance, solidarity and equality: This new law was supposed to dam in some ways the steadily increases known before. Not only it has not been the case, but simultaneously the financial participation of the government, cantonal or federal, did not stop to decrease slowly so that nowadays, people, the citizen, pay about 65% of the costs from his pocket, and the public funding, i.e. the tax payers, pay the rest, about 35%. Last year, we lived a new increase reaching up to a mean of 9%, which of course raised a lot of anger and recriminations. This raises considerably the pressure on the federal government and parliament to revise the law, furthermore because we have federal elections this fall.

Health insurances and large parts of the political parties share the idea that competition should contribute to lower the prices as it is the case in the other market areas. This is of course not the case. The mechanisms in the case of health are much more complex and have been the subject of numerous studies on how to regulate offer and demand in this particular case. And we all know that no satisfactory solution is on hand. However the main fault for this steadily health cost increases have been designed to be the medical doctors, because of higher volumes of services, whatever the evolution of old age demography or medical technology. Reduction in the number of practitioners should achieve the goal of reducing costs. The first version of the revised law foresaw then to introduce free contracting between the insurers and medical doctors. It appeared rapidly that this move would endanger the free choice of the practitioners and give to much power to the insurances. For these reason the chances of the revised law would have been limited in case of referendum.

Simultaneously, i.e. on the 3rd of July 2002 the Department of Interior responsible for health introduced a need clause for three years, that is prohibition of any new practice opening during this lapse of time. Knowing this issue in advance, about 2000 young practitioners asked for their licence to practice beforehand, bringing the signification of this decision to nothing or even worsening the situation, because this overpasses largely the usual number of new licenses delivered each year (in the range of 500 a year usually).

The new minister of health Pascal Couchepin starting his job this year (her predecessor Ruth Dreifuss went into pension) had the smart idea to combine this clause of need and free market in the revision: the cantons have to define the

need, what overcomes the need belongs to free choice and free contracting conditions from the insurers. In other words a closed market is built up like in many other fields or similarly to the countries knowing a fully state guaranteed health system like Great Britain or Spain. It means concretely that there are free jobs or not, the possibility left to insurers to hire supplemental medical staff being highly theoretical in these circumstances. The present state is not put into question, so no one is going to loose his actually valid licence – the free choice of doctors isn't either. So politically this new version has very good chances to go through.

It has been however associated with all kinds of other measures as the incitation to build up networks offering the full range of services, not subject to the clause of need, but where the medical staff shares the financial responsibility with the insurers. In other words it means global budgeting through the health insurance of the organisations. We have always disputed this kind of model because it feels us unethical to put the responsibility of medical restrictions and rationing on the shoulders of the doctors dealing directly with the patient without democractic approval. The other measures concern all kinds of tricky administrative, financial obligations and checks as if medical doctors were all abusing of the system. This is going undoubtedly to worsen the working conditions. There is an obvious contradiction between the high demand in knowledge and professional achievement and financial pressure and restrictions on the other hand. On the long run this is going to lead to a shortage as is already known in other countries, because no one is ready to make such an effort and dedication to be poorly paid otherwise.

On the hospital financing system which I already developed last year, both cantonal governments and insurers should support half of the costs all included. Payment is based on DRG's still to be defined. In the future a so-called monistic system should cover also the outpatient medical care in order to suppress the actual financial distinction between inpatient and outpatient care: inpatient is subsidised by the cantonal government, outpatient care is fully charged to the insurers. However there are some difficulties to carry out these changes. Although promoted and consequently wished by the insurances, it would mean additional costs of about a billion CHF, i.e. 650 millions Euros what is not absolutely the purpose of the game. This should be encountered by increased participation of public funding to decrease the premiums of the lower and middle class income. And both cantons and federal government are meeting presently very difficult financial situations obliging to decreased budgeting leading to a lot of political unrest.

To sum up the project is a health system similar to the British one, but in a mixed financial environment, taxpayers and insured individuals, with the aim to introduce market mechanisms. The Senate will probably pass the law by the end of this month (September 2003). Pressures will be exerted to solve the differences with the national Council during the same session, but I doubt very much it will succeed. If so the Swiss Medical Association will think about launching a referendum together with other interested circles.

And to conclude a small remark concerning the working conditions of medical trainees. They managed to be put under the law on work limiting their weekly contribution to 50 hours. It appears to be extremely difficult to offer efficient

training in these conditions, particularly for operating specialties. The problems are unsolved so far and we do not dare to think about the 35 hours of our French colleagues! This is another reason to be afraid of future shortages.

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