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ЕВРОПЕЙСКА АСОЦИАЦИЯ НА СТАРШИТЕ БОЛНИЧНИ ЛЕКАРИ
ASOCIATIA EUROPEANA A MEDICILOR DIN SPITALE

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In the inpatient sector, the main difficulties have been observed with acute somatic cases, this now being the sixth version of SwissDRG. Although complex and polymorbid patients generate their fair share of high costs, the infrastructures and multi-disciplinary teams needed to care for them are not covered by the base rates agreed. These patients are thus gradually being concentrated in specialist hospitals which are often far away from their loved ones. In contrast, a choice of good risks is increasingly being observed, with the emergence of certain niches without care obligations in more peripheral institutions, for example in orthopaedics. General services are not included in the DRG payments but are not sufficiently supported by government bodies either. Doctors' postgraduate training, which is also excluded from DRG financing, is not adequately subsidised by the cantons, encumbering the budgets of hospitals which provide it and giving the private hospitals, which do not, an edge in terms of productivity. The competitive market that the legislator so desired is starting to make its presence felt: only the very efficient hospitals are still managing to keep up their investments, which are no longer paid for out of the public purse.

In the outpatient sector, the fee reform has failed with the parties at the table failing to reach an agreement. The Federal Council has therefore used its subsidiary powers to intervene again, ordering a unilateral reduction in fees for the services which have become more routine and bringing an end to the valorisation of extensive specialist training. This decision is a reflection of the political pressure, with increasing insurance premiums no longer justifiable even though a reduction in doctors' earnings is not causing any public outcry. It is true that a per-service fee could encourage an increase in the number of operations, while a flat-rate fee, currently under discussion for outpatient services as well, could potentially put a stop to this trend.

In all their activities, therefore, hospitals are now under huge pressure. This change is prompting managers to seek innovative solutions. From this perspective, the kind of lean management being practised systematically by certain US hospitals seems promising. Simplifying and standardising the processes for the sole benefit of the patient certainly makes sense. The principle of a fast, proactive and tiered pathway, combined with an autonomy that empowers all those involved, is an encouraging path to take.

On a media level, the leeway in the system with its proliferation of unnecessary operations has been highlighted several times. Given the lack of quality checks for indications, it is hard for the hospitals to justify themselves. However, the payment of performance bonuses to certain senior doctors is, justifiably, being vehemently opposed. Doubts are now occasionally being expressed about another issue, the shortage of doctors, in view of the increasing number of specialist centres in major towns and cities. However, the problem is one of distribution, not just geographically but also between different

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specialisms. With over a third of doctors practising in Switzerland coming from abroad, the need to train more students in this profession remains essential in our country.

Generally speaking, the hospital environment remains attractive to doctors but the contingencies of the Swiss Employment Act are increasingly passing the burden onto senior doctors. This has made them less motivated, as a recent satisfaction survey reveals. One solution might be to develop the careers of doctors in executive roles, which would make life easier for clinical staff and enable them to devote their full attention to looking after patients and acting as teachers and mentors.

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