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ЕВРОПЕЙСКА АСОЦИАЦИЯ НА СТАРШИТЕ БОЛНИЧНИ ЛЕКАРИ
ASOCIAȚIA EUROPEANĂ A MEDICILOR DIN SPITALE

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For admissions, the sixth version of SwissDRG is in force: the tariff structure has matured with realistic cost weights but the base tariffs negotiated with the insurers are too low, making activities almost always in deficit. This has long been compensated by significant revenue from patients benefiting from private complementary health insurance, but this area, subject to more flexible legislation, is now also contested by the price watch authority, arguing that the capital gain offered is not substantial and does not justify the high charges.

Last year's focus was on outpatient care. There is a real political desire to favour the transfer of activity from admissions to outpatients, leading to the creation of lists of mandatory procedures to be performed without admission in 5 cantons. Justification for exceptions cause an increase in administrative work for hospital physicians and there is, for the moment, no national coordination for this matter. Furthermore, the state does not contribute to outpatient care, whereas it funds more than half of the expenses for admissions, which represents a poor incentive.

The tariff structure for outpatients, composed of a multitude of services remunerated separately as listed on the previous century's database, is completely outdated. The tariff partners could not agree on its review, to the extent that the Federal Council has again used its authority to intervene with a massive reduction in tariffs in all technical areas. This represents an important shortfall for hospitals, reaching up to 30% in relation to the previous year in certain fields such as radiology or gastroenterology.

Generally, the debate is dominated by the inevitable increasing rise of health costs, with all sorts of recommendations, often contradictory, to stop this vicious spiral.

The idea of a global budget has gained ground and we are witnessing growing nationalisation of the health system. The balance of healthy competition between hospitals and the necessary guarantee of adequate patient care is incessantly put back into question: difficult political compromises are swept away in referendums, each region wanting to maintain an excessive infrastructure while spreading costs over a larger community.

With regard to the media, the impossible task for increasing numbers of the middle class to pay for their insurance premiums is under debate, even though approximately one third of health costs are paid by the patients directly. Searching for "culprits" responsible for these high charges has unfortunately recently been focused on doctors, an easy target following disagreement between specialists and general practitioners concerning outpatient tariffs. The attitude of certain colleagues, boycotting

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several procedures and consequently taking patients hostage, did not attract any public sympathy for our cause. Initiatives looking to give more autonomy to other branches and to free them from medical control are very popular. Furthermore, the country's highest judicial body recently passed a troubling verdict, placing political considerations (the citizens' choice favouring primary health care) above the law (necessity for remuneration consistent with economic principles).

Generally, growing pressure on our hospitals has claimed its first victim: heads are rolling en masse in senior management, transfers are increasing for senior physicians, a large number preferring to devote time to their patients in a calmer, private setting. This tendency, however, is not inevitable: a healthy and respectful distribution of expertise between political authority, management and executive health care providers can re-establish and guarantee the confidence needed for efficient running of our establishments.

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