

# WENNBERG INTERNATIONAL COLLABORATIVE SPRING POLICY MEETING 2018

## Regional Health Care Data in the federated health care policy system of Switzerland – a bright or dooming future? Ulrich Wagner / Michael Lindner - FSO



**Smarter Health Care**  
National Research Programme



Schweizerische Eidgenossenschaft  
Confédération suisse  
Confederazione Svizzera  
Confederaziun svizra

Swiss Confederation

Federal Department of Home Affairs FDHA  
**Federal Statistical Office FSO**

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# Rising health care costs in a governance perspective – problems and chances

- Main Public and Policy attention on
  - sickness funds & rising premiums each year
  - the federal government (held as politically responsible)
  - Hospital data
- Limitations:
  - sickness funds finance only 35% (28 bn) of total health care costs (78 bn)→ neglecting big positions like 28% (22 bn) of Out-Of-Pocket-Payments
  - Cantons bear the primary responsibility for health services on the provider's perspective, federal government mainly for the financing perspective
  - Hospitals are responsible for 35% (27 bn) of health care costs
- → Public and Policy attention is lopsided, **but seem very much driven by the fact that only data about sickness funds & hospital data are available “on time”**

# Health Accounts – Switzerland int. embedded

- National Data: 77bn costs, presented in 4 dimensions:
  - Providers, e.g. hospitals, institutions, doctors, dentist.,
  - Functions, e.g. curative inpatient, curative outpatient, long term care
  - Schemes, e.g. state, sickness funds, accident insurance,...
  - Sources, e.g. state, corporations, households
- International comparability guaranteed through:
  - A common framework, laid out in the manual “Systems of Health Accounts” (Joint Collection by OECD, Eurostat and WHO → **including extensive validation efforts**)
  - Classification, Definitions, delimitations
  - Enough room for national solutions → Swiss National Health Accounts able to highlight information of national interest



# Health Accounts – System for Switzerland - the model

I) Klassifikation	II) Daten		III) Methodik	IV) Werte (Mio.)		V) Qualitätsbericht			
	Position	Quelle		Haupt-Variablen	Annahmen, Methodik, Periodizität	einzel	Summe	Punktschätzung	Fortschreibung
A Krankenhäuser	Nr. 1	Krankenhäuser	(1) KS-Statistik (2) MS-Statistik	Ertrag, Kosten, Defizitdeckung, Beiträge, Pflegetage	Ertrag+Defizitdeckung+unged. Defizit, plausibilisiert – Exporte, ökonomisch geschätzt über Pflegetage	27'148	27'148	5 Gut	
B SOMED	Nr. 2	SOMED	SOMED-Statistik	Aufwand	-	12'640	12'640	6 Sehr gut	
C Ärzte	Nr. 3	Ärzte	(1) Datensatz mediz. FMH (2) Gewerbestatistik (3) FMH-Ärztstatistik (4) Extrapolation KVG	(a) AHV-Einkommen Ärzte (b) Anteil "Mixed Income" (c) # Ärzte	nur 2009: Punktschätzung Ertrag=(a/b)*c ab 2010: Retropolation über Annahme: Wachstum Total = Wachstum KVG [aus (4)]	15'427	15'427	5 Gut	2 Schwach
D Zahnarztpraxen, Zahnkliniken	Nr. 4a	Zahnarztpraxen	Statistik SSO, Buchhaltung und # Praxen	(a) Ertrag pro Praxis (b) Anzahl Praxen	Ertrag= a*b	4'019	4'248	4 Genügend	
	Nr. 4b	Universitäre Zahnkliniken	Statistik Hochschulfinanzen (BFS)	Aufwand Dienstleistungen	-	49		6 Sehr Gut	
E Ambulante Leistungserbringer	Nr. 5a	Psychotherapeuten	(1) FSP-Daten, (2) nicht korrespondierende KVG-Zeitreihe (Ärzte)	Ertrag, Extrapolation	nur 2012: Studie FSP (1) ab 2013: Retropolation über Annahme: Wachstum Ertrag = Wachstum KVG Ärzte [sici (2)]	544	4'407	5 Gut	2 Schwach
	Nr. 5b	Physio., Ergo., Logo., Chiro.	(1) korrespondierende KVG-Zeitreihe (2)	Extrapolation, Fixfaktor	Ertrag = a*150%	1'558		2 Schwach	
	Nr. 5c	Hebammen	Fixfaktor			82		2 Schwach	
	Nr. 5d	Spitex (nur Pflege, ohne Haushalt)	Spitex-Statistik	(a) Ertrag Total, (b) Stunden Haushalt (c) Stunden Pflege (d) Anzahl Mahlzeiten (e) Umrechnungsfaktor	Ertrag Pflege = a*[b/(b+c+d)*e]	1'312		6 Sehr Gut	
	Nr. 5e	Pflege durch Angehörige	(1) AHV-Sonderauswertung (2) Anteil 25%	(a) AHV-Hilfflosenentschädigung zu Hause (b) Anteil 25%	Ertrag= a*b-a*25%	140		5 Gut	3 Ungenügend
	Nr. 5f	Pflege d. Angehörige	IV-Sonderauswertung	Hilfflosenent. zu Hause	-	991		5 Gut	
	Nr. 5g	Privatfinanz. Pflege	B,S,S-Studie	(a) Anzahl Klienten (b) Durchschnittspreis	Ertrag = a * b	414		5 Gut	
	Nr. 5h	Ernährungsberatung	(1) korrespondierende KVG-Zeitreihe (2) Fixfaktor	(a) Extrapolation (b) Fixfaktor	Ertrag= a*b-a*200%	34		2 Schwach	
F Unterstützende Dienstleistungen	Nr. 5i	Sonstige	Restkategorie KVG	Ausgaben	-	215		4 Genügend	
	Nr. 5j	Sonstige	Restkategorie UVG	Ausgaben	-	130		2 Schwach	
F Unterstützende Dienstleistungen	Nr. 6a	Labore	MwSt-Statistik	Umsatz ohne Exporte		1'025	1'460	5 Gut	
	Nr. 6b	Rettung, staatlich	Finanzstatistik	Ausgaben		105		6 Sehr Gut	

# Health Accounts – Switzerland int. embedded in the SHA System of OECD/WHO/Eurostat

## Results:

- System of Health Accounts (SHA) 2011 generates consistent and comprehensive data on health spending, and answers the following three basic questions:
  - What kinds of health care goods and services are consumed?
  - Which health care providers deliver these goods and services?
  - Which financing scheme pays for these goods and services?
- The answers can be used as a monitoring and evaluation tool to track changes in policy priorities and so to contribute to evidence-based policy-making through
  - transparency, comprehensiveness and comparability by standardized methodologies

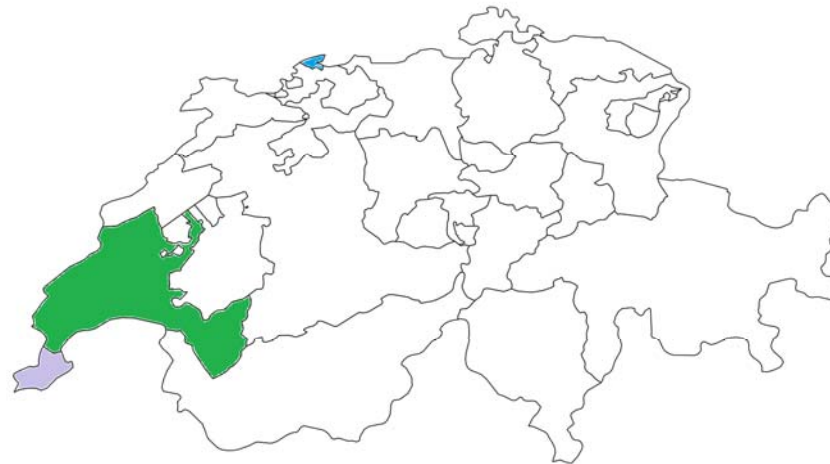
# Health Accounts – Switzerland int. embedded in the SHA System of OECD/WHO/Eurostat

- Results:
  - The case of Switzerland: Results in the OECD Data Base, publications like “Health at a Glance” or the 2011 OECD/WHO Review of the Swiss Health System
  - Used in most discussions concerning the Swiss Health System (right now: i.e. care density or the “report of the expert group for cost reduction in the social health insurance”)
  - But no systematic benchmarking, no systematic uncovering of weak spots and their (root-) causes, no ambitious goal setting (although high goals could be reached, which is demonstrated by other countries) on the level which is responsible for “structure”
- Hypothesis:
  - This is because the data on the relevant (cantonal) level as in means of cantonal health accounts are not yet available and comparable

# Cantonal Health Accounts

## – current state of affairs (1)

- Cantonal Health Accounts up to now only in the **Canton of Vaud** (3<sup>rd</sup> largest canton, 9 % of Swiss population, Capital Lausanne)
- Slowly increasing interest, e.g. in the Cantons of **Geneva** and **Basle-City**

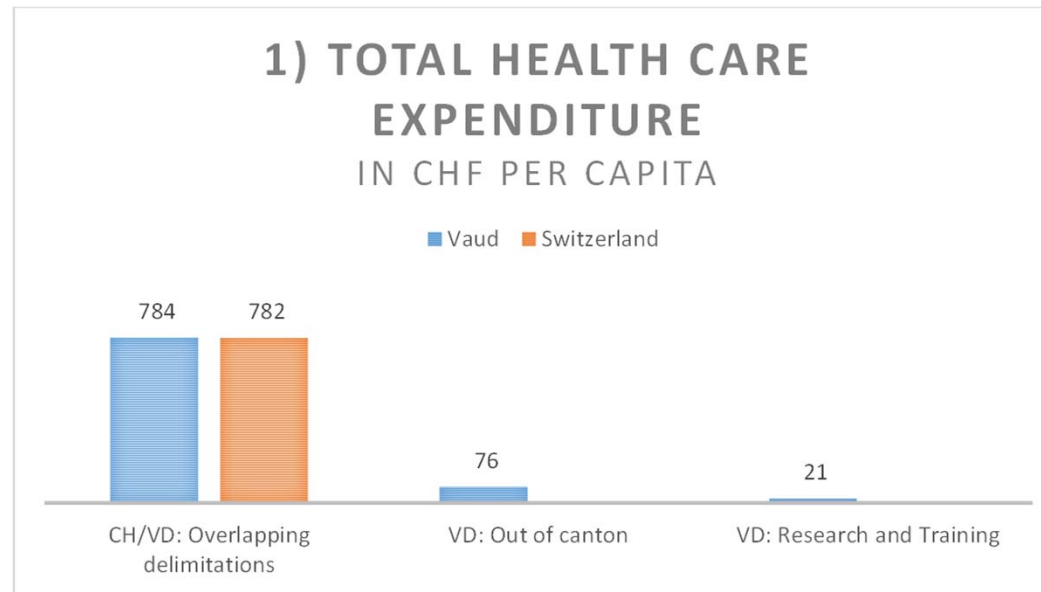




# Cantonal Health Accounts

## – current state of affairs (2)

- Results of the Canton of Vaud (VD) in comparison to national data (CH)

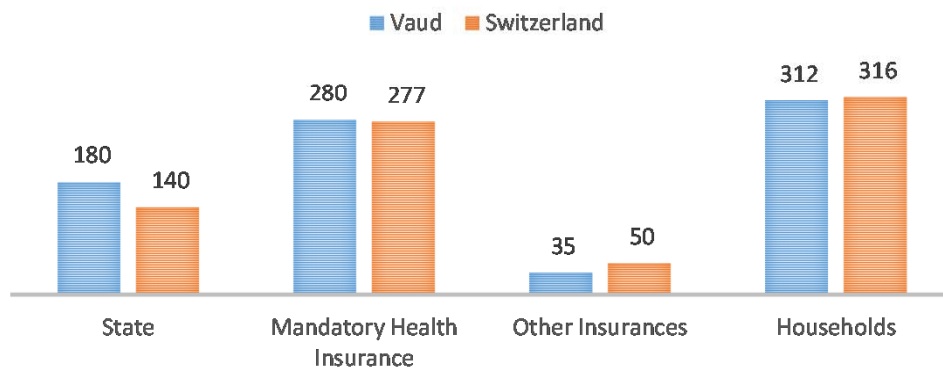


- → Very similar total of overlapping per capita expenditure (after delimitation corrections for “out of canton financing” as well as “research and training”)
- → Canton of Vaud possibly a “small Switzerland” / “microcosm”

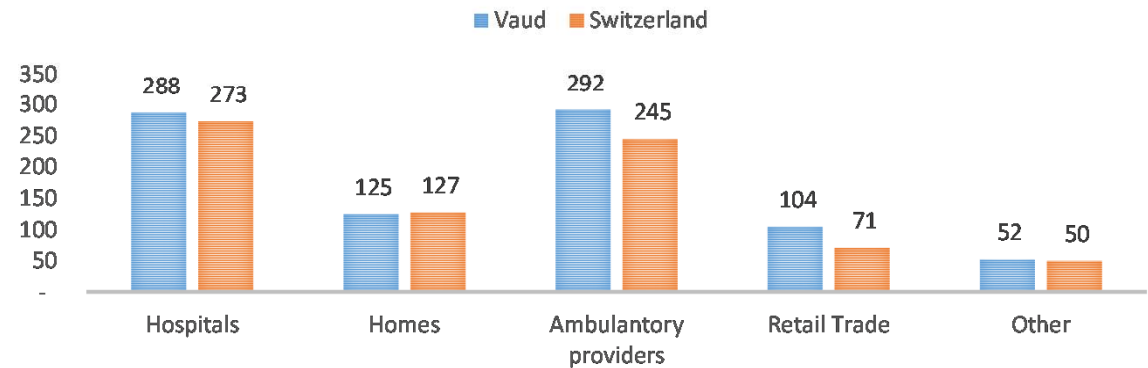
# Cantonal Health Accounts

## – current state of affairs (3)

### 2) HEALTH CARE EXPENDITURE BY FINANCING SCHEMES IN CHF PER CAPITA



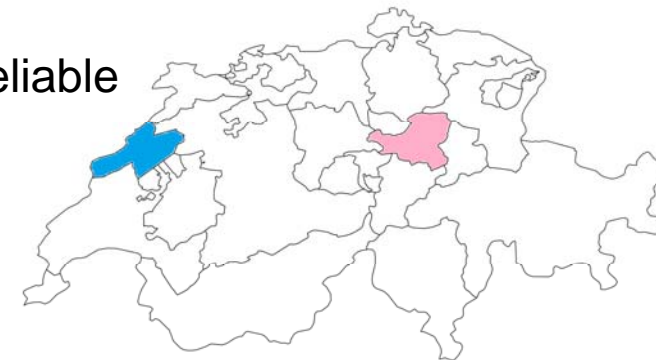
### 3) HEALTH CARE EXPENDITURE BY PROVIDERS IN CHF PER CAPITA



- → More similar (and probably precise) data for financing schemes than for providers
- → unclear whether real differences or because of different accounting standards

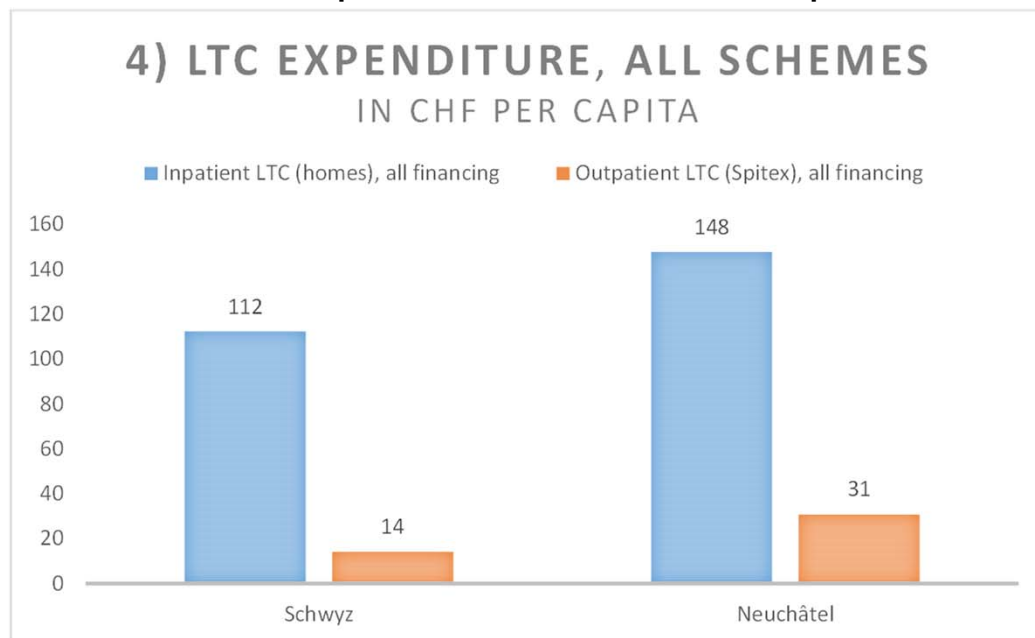
# Cantonal Health Accounts – clearer picture for Long Term Care and benefits of direct comparison (1)

- The cantons of **Neuchâtel** and **Schwyz** could be apt for comparison
  - Similar population size (178'000 vs 155'000)
  - Comparable structure (as measured by other indicators, e.g. age distribution)
  - But culturally very different (French vs. German, leftist? vs. libertarian?)
- Long Term Care with the most reliable data
  - practically no intercantonal patient fluxes, so data is quite reliable
  - Measured by full surveys conceptualized by the FSO
  - Political responsibility mainly by the cantons

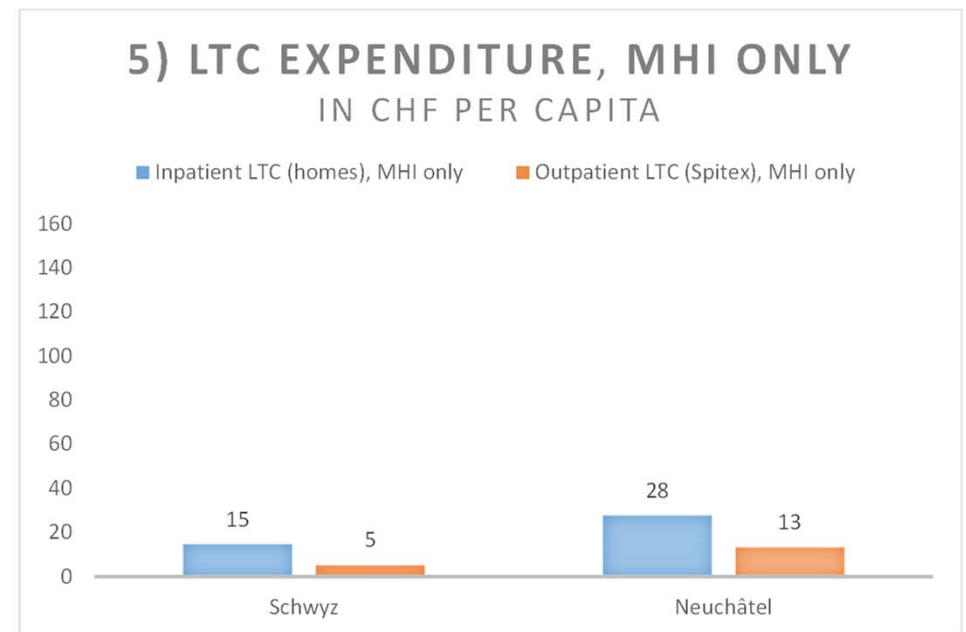


# Cantonal Health Accounts – clearer picture for Long Term Care and benefits of direct comparison (2)

- MHI data represent only a bit of total LTC costs → data not representative → similar phenomenon for other providers / functions



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Ulrich Wagner / Michael Lindner, Swiss Federal Statistical Office, April 13<sup>th</sup> 2018

# Cantonal Health Accounts – clearer picture for Long Term Care and benefits of direct comparison (3)

- Limitation: No data about:
  - privately financed long term care
  - household production (known on federal level, on cantonal level possible if sample would be enhanced)
- Hypothesis: “saving money for inpatient homes by promotion outpatient LTC home care instead of inpatient LTC homes” (OBSAN study with non-monetary data)
  - can be rejected for the pair Neuchâtel / Schwyz
  - not so clear for other cantons like Vaud (rank 4 of 26 for outpatient costs per capita, rank 20 of 26 for inpatient costs per capita)

# Conclusion (1)

- With the SHA – Framework an accepted and well introduced framework to systematize cost according to health providers, functions, schemes and sources is available and works as a benchmarking system. The structure and processes (methodologies) to collect and validate the data are at hand and not only Switzerland benefits from this
- On the Swiss Federal level many processes are already standardized to collect specific data on the cantonal level to use on the federal / intern. level
- A Data gap on the cantonal level seems evident (MHI finances only 35% of total health expenditure and is treated as the only reliable data source for policy) → insufficient from a holistic / systemic point of view, e.g. as shown with respect to LTC
- The canton Vaud has the cantonal health account and seems to be willing and able to formulate an holistic cantonal health policy with no non-observable shifts between providers and financing schemes

## Conclusion (2)

- First approaches to build up other cantonal health accounts to gain overview of money flows in the respective system can be recognized in two cantons
- The FSO would be able to realize a coordinating function to standardize the relevant methodologies in collection, sample and processes
- The relationship between the FSO and the Cantons can be similar to the relationship of OECD etc. to the respective nation states → a heavily standardized and possibly centralized set of data apt for benchmarking seems like the necessary collateral of a highly decentralized and federative structure and can preclude policy standardization forces. Thus the potential for decentralized policy innovation is safeguarded: **“centralized health care data with decentralized policy innovation” as an alternative to “centralized health care policy”**.
- A systematic approach has not to be based on a legal mandate [*which would address the commitment (duty) to benchmark on the cantonal subsystem level (not only on hospital level – like mentioned in Art. 49 of the health insurance law)*]. Of course this would stimulate a stronger comparative and evidence based health policy, but the innovation potential should give a broad enough hint.



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# Appendix: structural data in comparison

		Switzerland	Vaud	Schwyz	Neuchâtel
Population	in thousand	8'420	785	156	179
Age distribution					
0–19	in %	20.1	22.0	19.8	21.3
20–64	in %	61.8	61.6	63.1	60.0
65 and more	in %	18.1	16.3	17.1	18.6
Average household size in person		2.2	2.3	2.3	2.2
Economic activity rate	in %	81.3	78.3	82.9	79.3
Unemployment rate	in %	3.2	4.5	1.8	5.6
Employees, Total	in thousand	5'079	435	80	106
In 1st sector	in %	3.2	3.0	5.5	2.3
In 2nd sector	in %	21.4	16.8	25.7	33.4
In 3rd sector	in %	75.4	80.2	68.8	64.3
Rate of welfare benefits dependence	in % of total population	3.3	4.8	1.4	7.4
Medical practices	per 100'000 inhabitants	219	244	146	220
Hospitals					
Beds	per 1'000 inhabitants	4.5	4.8	2.0	4.5
Hospitalisation rate for acute care	per 1'000 inhabitants	147.2	127.7	151.0	147.2
Average length of stay for acute care	days	5.4	6.1	5.0	5.4