WENNBERG INTERNATIONAL COLLABORATIVE
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STILL NOT EXPENSIVE ENOUGH? INTER-CANTONAL COOPERATION IN HOSPITAL PLANNING

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AGENDA

1. Introduction
    - Research puzzle
    - Conventional wisdom
    - Context and theoretical arguments
2. Empirical situation / what is out there
3. Theoretical cooperation categories
4. Findings
5. Conclusion

RESEARCH PUZZLE

Why is there little inter-cantonal coordination and cooperation among cantonal authorities in the sector of acute stationary care despite seemingly advantageous conditions (legal obligation, permitting federal institutions, economic pressure)?

CONVENTIONAL WISDOM

The context:

- Health costs explode
- “Jedem Täli sein Spitäli” / A hospital for every valley

Why is nothing done about it?

- „Kantönligeist“
- Politicians who close a hospital, or attempt to do so, will not get reelected
- It is still not expensive enough to trigger serious reform

➔ BUT: The cost argument misses the point!

CONTEXT

- Rising health costs: Stationary care accounts for 35 % of health costs in 2015 (BFS)
- Fragmented health system due to the Swiss federalism:
  - High cantonal autonomy: 26 cantons are responsible for planning and providing stationary care „at home“
  - Federal level (Bund) cannot directly interfere; some influence via health insurance act
  - High hospital density, but often small ones
- Reform of the health insurance act (KVG) introducing:
  - **New hospital financing** (case-based lump sum/from financing objects to financing subjects; cantons compensate at least 55% of the costs per case; **free**(er) **movement of patients across cantonal borders**), from 2012
  - Obligation to coordinate the cantonal hospital planning

TO SUM UP

- Cantons are legally obliged to coordinate their hospital planning
- Cantons struggle with rising health costs and need to adapt to the new hospital financing => change of strategy
- According to federalism researchers (Bolleyer 2013, Bochsler 2009), the Swiss system is favorable for horizontal coordination
- Downsizing of the welfare state, or closing a hospital, is politically difficult: clear losses, diffuse gains (Pierson 1996)
- Coordination among cantons is seen as one way to reduce over-capacities and improve quality (faute de mieux)

- How much coordination is going on?

WHAT IS OUT THERE?

What do cantons do to coordinate their hospital planning?

- Currently, no encompassing overview exists
- 28 semi-structured interviews (phone and e-mail) with cantonal administrative staff and GDK representatives (no data on Ticino)

THREE LEVELS OF COOPERATION

Cooperation level	Definition
Exchange of information	At least two actors share their information. It is left to each actor what he/she does with it. Basis for coordination.
Coordination	At least two actors exchange information and adjust their action to the other‘s action (positive or negative)
Collaboration	At least two actors engage in common action, e.g. common policy planning, common provision of services

Sources: Bolleyer 2013, Emmenegger/Graf/Trampusch 2016, Sager 2002, Scharpf 1994, Webb 1995

FINDINGS

Cooperation level	Number of different forms per level	Incidence per cooperation level
Exchange of information	16	27
Coordination	15	77
Collaboration	8	9
In sum	**39**	**114**

E.g. the canton St. Gallen participates in at least 3 information exchanges, 11 coordinative activities and 2 collaborations

Source: Own data.

COORDINATION

Form of coordination (what)	Incidence
GDK ministerial meetings	1
GDK committees (relevant for HP)	4
GDK recommendations	1
Regional GDK meetings	4
Regional GDK committees and working groups	7
Use of SPLG concept and the recommendations	24
Adaptation and development of SPLG grouper (meetings)	1
Consultation (hospital list, planning reports etc.)	26
Hospital lists of BL and BS formally recognize each other	1
Informal bi-cantonal collaboration at administrative and directorial level	1
External mandate for the analysis of the number of cases and hospitalization rates	1
Bilateral declaration of intent to put certain regional hospitals on each other's hospital list	1
Framework agreement with university hospital cantons	3
Bilateral agreement on capacity steering	1
Agreement to use same accounting standard by four cantons	1

MORE FINDINGS / CONCLUSION

- Cantons are well-informed on each other's situation, substantial informal information exchange on the administrative level
- The number of cooperation is surprisingly high, coordination happens on procedures, criteria, best practices, but far reaching (i.e. substantial) cooperation remains rare
- The new financing together with the free movement of patients leads to conflicting interests:
  - Cantons strive for a high degree of self-sufficiency in health care (keeping the money "at home")
  - Hospitals as location promotion
  - Expensive investments to compete on the emerging hospital market; attempt to attract extra-cantonal patients
- If all/many cantons follow the same strategy, we continue to have expensive over-capacities (collective action problem): structural incentives are too strong to overcome this dilemma
- As long as the money is spent within the canton, rising costs do not necessarily increase the pressure for more cooperation, but rather accentuate competition for patients between cantons

Thank you!

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