interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Governance and financing of long-term care

National Report Switzerland

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1 Introduction and background

In its most general usage, governance – in French the term "gouvernementabilité" proposed by Michel Foucault (Lemke, 1997) is an alternative to this word borrowed from the English – means a way to lead men, society, or a sector of society. It is the art of governing, to aim for a specific goal; this goal, however, must be defined by the political realm. While the concepts of governance and of policy are distinct, they are also linked, as if governance contained, by anticipation, the aim it pursues. All paths lead to Rome, but this is only true as long as Rome is the only destination. For this report, we will use this view of the term governance, which is at once distinct from and dependant upon the political realm.

In the social/health field, three models of governance are found side by side: the *integrated care network model*, the *administered market or managed care model,* and the *competitive market model*. The first two models are at work in the regulated field of health and social care, i.e. in the field of services financed or subsidised by the state or by social security. They focus on stated goals of public policy in the long-term field, which aim to sustain and promote the autonomy of older people in order to delay, or avoid nursing home placement, a goal on which a broad consensus exists (Egger, 2007: 10). The third model belongs to the governance of the private sector of services for older people. Characteristic of for profit enterprises in that field, it is oriented towards satisfying the demand of those who can pay for services, without pursuing global policy goals in the field of long-term care.

The integrated care network model is founded on the rights of older persons, and it seeks to provide services consistent with those rights in an economically rational manner. Thus, this type of governance model does not primarily focus on costs, but considers the specific needs of individual users. In practice, it concentrates on *planning* on the basis of an evaluation of need for services for the population concerned, as well as on *coordination* of service providers. On the other hand, the managed care model adapts principles derived from the competitive market in order to transpose them into a regulated environment. Thus, it is based on competition, yet on cannot speak of true competition, which could only take place between private organisations and whose failure would be sanctioned by bankruptcy and by plain disappearance from the market. We are describing here a mode of *artificial competition,* the result of which usually takes the form of an administrative sanction, or of mandated reform of organisations which may be public or private. Competition is simulated by *benchmarking* mechanisms. In this area, services are financed on the basis of a reference price or benchmark, set by the purchaser according to the economic or policy goals which have been defined. Competition is then characterised by the efforts providers must furnish to function within the context set by the benchmark. Providers who are producing at a cost higher than the benchmark will incur losses and must reduce their production costs, whereas those who manage to produce at a lower cost will be rewarded by moderate profits. Since cost control requires not only controlling prices, but also the quantity of services furnished, managed care introduces, along with benchmarking, a mode of *prospective financing* through global budgeting. Purchasers can thus define in advance the quantity of services for which they are prepared to pay within a set budgetary period – i.e. before the services have been rendered. Beyond a predefined volume, services will not be reimbursed. Global budget setting implies, just as in the integrated network model, that planning must take place. However, planning is not carried out here with the primary goal of determining needs to be satisfied, but rather with the goal of meeting the financial objectives set by the purchaser or purchasers.

The role of the State is fundamental in both models. In Switzerland, the action of the state is guided by two essential principles – those of federalism and of subsidiarity. The federalist Swiss system distinguishes three institutional levels (Confederation or central state, cantonal authorities and communes or municipalities) which carry out distinct tasks which are conferred to them by the constitution. The subsidiarity principle requires that public tasks be entrusted the smallest entity – i.e.

the entity closest to the citizenry - capable of carrying it out in an autonomous manner. In the field of service financing the subsidiarity principle means that the State should only intervene where persons or entities do not have the means to meet their needs.

These two principles have led to entrusting the development of policies for older people and long-term care services primarily to *cantons*, which may then coordinate their actions at the regional and national levels.

The role of the state takes a different form in each of the two models we outlined above. In the integrated care network model, the federalism principle is foremost. The responsibility of the state is formally engaged, specifically at the canton level. Planning by the state has a central role, and the state is involved in running the care system. In the managed care model, on the contrary, the emphasis is in the subsidiary character of the role of the state, which only has an indirect role through defining the framework of rules and regulations which providers – individuals as well as organisations – have to follow.

Each of the two models may be said to foster integration of services. However, integration is defined differently in each setting. In the integrated care network model, integration is viewed as coordination of the action of care organisations, which may be legally and economically independent but function as part of a network led by state agencies. Within this perspective, integration is territorial. Unless intercantonal policies at regional or even national level are agreed upon, the territorial boundaries are those of each of the 26 cantons. On the other hand, in the managed care model, integration takes the form of *concentration*, with a limited number of provider organisations dominating an "artificial market". Concentration is said to be vertical when a provider – or firm – controls all stages of the process of care production; it is called horizontal when it dominates a specific sector of production. In that case, integration is the result of economic forces, and it results from fusions or acquisitions.

Let us now see how the three models of governance (integrated network, managed care and true competition) play out in the LTC field and how they fashion the modes of integration of care services. But first, some contextual factors must be examined.

2 Key contextual factors

The way LTC is implemented is conditioned by three important contextual factors. They are: the new financial equalisation system between confederation and cantons ("réforme de la péréquation financière et de la répartition des tâches or RPT"), the legal changes introduced into health insurance coverage of LTC, and the introduction fo financing through Diagnosis Related Groups (DRG) in the field of acute hospital care.

2.1 The new equalisation system (RPT)

RPT was introduced with two main goals. First, it was to simplify existing public finance equalisation intruments between economically stronger and weaker cantons. Second, it had to redefine collaboration mechanisms between the central state and the cantons in terms of tasks to be carried out by each entity. RPT, which is viewed as "one of the most important institutional reform programs that both level of state authorities have put forward in the last few years" (Département fédéral des finances, 2007: 5) It came into force on January 1st 2008. It replaces legislation dating back to 1959.

Before RPT, 3,6 % of revenues of Old Age Insurance (AVS) were covered by canton subsidies. On the other hand, LTC services for persons living at home, including home health and social care, day care, meals on wheels etc, received subsidies from AVS. NEP members emphasized that around 16% of the cost of home support services were covered by these subsidies.

Since the implementation of RPT, cantons no longer participate in AVS financing. AVS, on the other hand, is no longer involved in covering part of the costs incurred by local LTC organisations of the home care/home support field. The modified article 101bis of AVS legislation now only enables AVS to contribute to some tasks carried out by national level non-profit organisations in the field of care for older people; it can thus now only give financial support to the central secretariats of the LTC field such as the national nursing home and care home association (CURAVIVA) or the national home care services association (SPITEX/ASSASD).[1]

2.2 Health insurance reform: coverage of LTC

The LTC health insurance reform, which will come into force in January 2011, is the second important contextual element to be taken into consideration when examining the development of LTC. Changes brought about by this reform pertain to the sector of care services of nursing homes (EMS) and home care services which give rise to financial participation from health insurers on the basis of compulsory health insurance legislation (LAMal, AOS).

According to the terms of initial LAMal legislation, basic health insurance (AOS) had to cover the actual costs incurred by providers of home care and nursing home providers for acts prescribed by doctors and falling into the categories of care costs related to health problems. Health insurers however refused from the beginning (1996) to implement this complete coverage which, in their view, would have led to an unsustainable increase in premium levels. The federal government took their objections into consideration and enacted transitory dispositions in 1998. After governmental edicts which fixed rates for reimbursement, health insurance in fact only covered about 55 à 60% on average of the actual costs they should have covered if the initial legislation had been fully implemented (Wächter/Stutz, 2007: 2).

From 2004 on, Parliament worked on new legislation, carrying out a mandate form the government, which is to introduce a new mode of coverage of long-term care. The new *Loi fédérale sur le nouveau régime de financement des soins* is voted four years later in June 2008. Limiting health care costs is a major goal, as the newly elected minister in charge of health and social security, Didier Burkhalter, emphasises in a speech on November 19th 2009: “La nouvelle réglementation du financement des soins prévoit de limiter la contribution provenant de l’assurance maladie et de juguler ainsi la hausse des coûts dans ce secteur”.[2] A distinction between care due to illness and care due to old age, which had been briefly envisioned, has been abandoned. However, a differentiation between acute and transitional care on the one hand and long-term care on the other hand, has been introduced.

Care services will be reimbursed on the basis of a nationwide scale which contains 12 care levels. The portion paid for by insurers, which is set in absolute Swiss franc terms, will not be adapted to cost of living increases. It has been calculated on the basis of the total amount insurers actually used to pay under previous LAMal legislation. The new law then gives a legal foundation to practices which had only

[1] OFAS. Réforme de la péréquation financière et de la répartition des tâches entre la Confédération et les cantons RPT: conséquences pour l’aide aux personnes âgées (www.bsv.admin.ch/themen/gesellschaft/01643/01645/01685/index.html?lang=fr).

[2] Les autorités fédérales de la Confédération suisse. Allocution du Conseiller fédéral Didier Burkhalter. 19 novembre 2009 (www.edi.admin.ch/aktuell/00707/01298/index.html?lang=fr&msg-id=30211).

been temporarily decreed, and states that insurers only have to *contribute* to the coverage of costs, not cover them.

The new law also defines the maximum contribution which may be charged to LTC patients as "at most 20% of the total maximal insurers' contribution" (Art. 25a, Federal law on care financing, LAMal reform) over and above the usual 10% patient participation. The total amount patients may be liable to pay for LTC services falling within the purview of health insurance is about CHF 7,700 per year. According the same article, cantons are responsible for coverage of any remaining uncovered costs. Cantons are currently revising their legislation and devising modes of coverage for these amounts.

2.3 Introduction of DRG's

The introduction of DRGs as a means of financing acute care hospitals in the whole country will be implemented in the entire country from January 1st 2012. This new mode of financing acute hospital care will further reduce the average length of stay and will cause an increase in the volume and intensity of ambulatory care and home health care needed (Egger, 2007: 10). The new law on care financing has to some extent anticipated this situation. It states that health care provided by LTC organisations such as nursing homes and home care will be reimbursed, if they are prescribed by the hospital and immediately follow a hospital stay, in the same way as acute care in general, this for a maximum duration of two weeks. Health insurers and canton authorities thus are responsible for respectively 45 % and 55 % of costs, and users are not subjected to extra co-payment during this period. After the two week period, care is covered under the new financing arrangements for LTC.

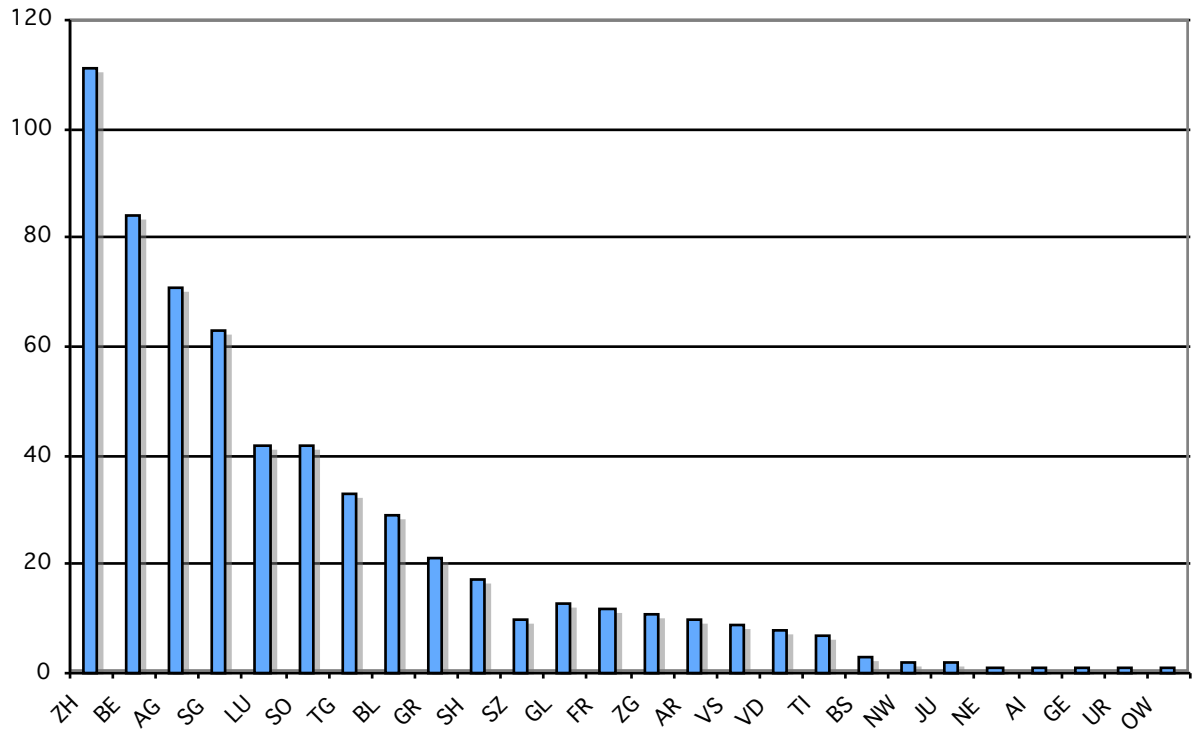
In conclusion, we may underline that RPT as well as the new health insurance LTC legal dispositions tend to reinforce decentralisation of the system, by entrusting cantons with additional responsibilities and costs in a field where centralised social security was previously more present. We may also note that health insurance reform does set apart long-term care and specifies dispositions concerning LTC. It may thus be a first step towards a future specific system of LTC coverage, which would be distinct from medical and acute care coverage in general; such a distinction would be new for Switzerland.

3 The governance of long-term care services for older people

3.1 Centralisation vs decentralisation

The German speaking and French speaking parts of Switzerland tend to organise governance in the field of LTC in different ways. In German speaking regions, cantonal authorities usually delegate the responsibility of managing home health and social care and nursing homes to municipalities. Consequently, large numbers of organisations usually exist in these regions. In French speaking regions however, we find a much stronger centralisation of services; the number of providers is much smaller and their size much larger, at least in the home care field. The figure below clearly illustrates this important regional difference.

Figure 1 Number of home care services/provider organisations by canton*

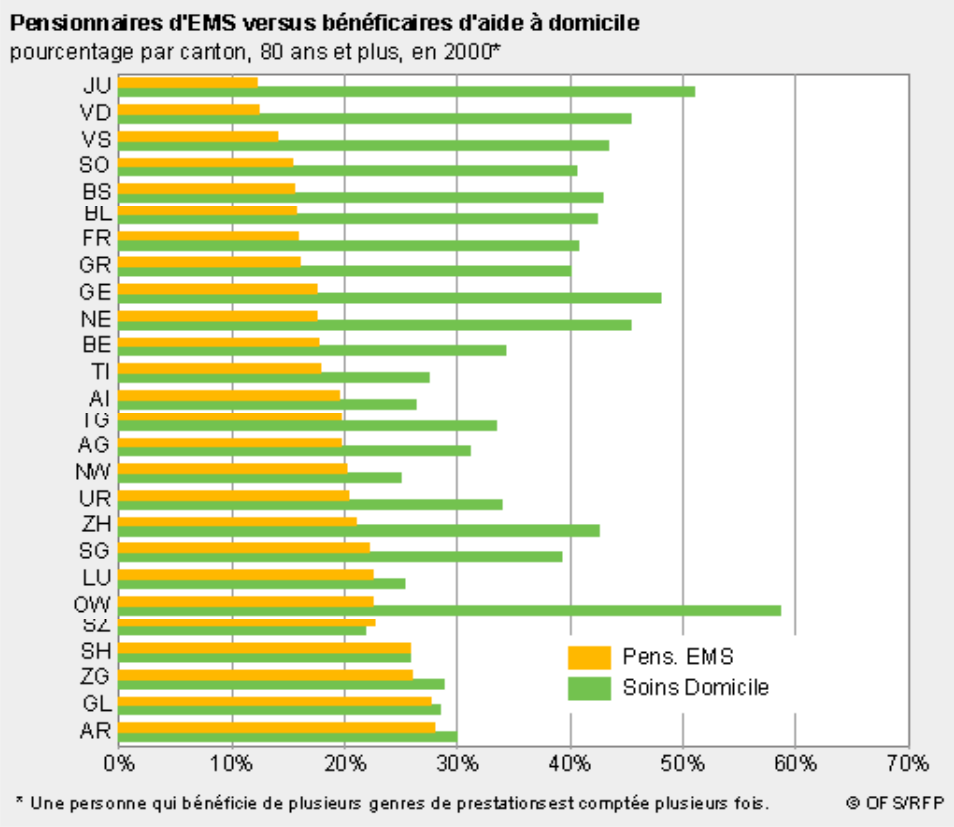


Source: Office fédéral de la statistique. Statistique de l'aide et des soins à domicile. Canton. 2010. (www.bfs.admin.ch/bfs/portal/fr/index/themen/14/03/03/data/07/04.html#a).- Note: *) each organisation can have several facilities or sites.

It is also worth noting that Swiss German and Swiss French cantons have different policies concerning nursing home placement. In the German speaking part of Switzerland, entering a care home or nursing

home is more frequent than in French Swiss regions, and the average stay is longer as elders move to institutions earlier (Jeanrenaud, 2005).[3] In French speaking cantons on the other hand, nursing home placement is generally seen as a last resort. During the last decade, French speaking cantonal authorities have focused LTC efforts on home health and home care. The difference in approaches may be illustrated by the figure below that displays the proportion of people above 80 living in nursing homes (upper bar in yellow) and the proportion of the same age group receiving home care services (lower bar in green) per canton.

Figure 2 Proportion of LTC users at home or in residential care: differences between cantons



Source: Office fédéral de la statistique (2009) Atlas de la vie après 50 ans. (www.bfs.admin.ch/bfs/portal/fr/index/regionen/thematische_karten/atlas_de_la_vie_apres_50_ans/la_vie_en_institution/vivre_en_institution.html, Accès du 29.06.2009).

3.2 Planning and "road maps" ("Leitbild")

All cantons carry out planning activities with the goal of adapting the supply of long-term care services such as home care and nursing homes to the needs of the canton's population. Planning is however not necessarily carried out within a framework of governance based on an integrated network model, or even on a managed care model. When planning is limited to a "road map", it may merely take the form of an inventory of institutions and services needed. Some cantons restrict their action to this type of

[3] Office fédéral de la statistique (2009) Atlas de la vie après 50 ans. (www.bfs.admin.ch/bfs/portal/fr/index/regionen/thematische_karten/atlas_de_la_vie_apres_50_ans/la_vie_en_institution/vivre_en_institution.html, accès du 29.06.2009.

governance, without putting forward a vision of reorganisation or integration of the LTC system. In such cases, planning itself could be viewed as a model of governance.

Needs are generally estimated on the basis of effective demand addressed to existing institutions and services. Until the end of the 1970s, the main response to increased demand has mostly taken the form of increased supply in quantitative terms, be it by building nursing homes or through the development of home care services. Since the 80s, needs are also estimated through statistical projections which attempt to quantify probable future evolutions (Weaver et al., 2008).

In canton Lucerne for instance, LTC governance is founded on straightforward planning of this type. The canton's road map provides an evaluation of needs in terms of infrastructure and services and encourages the creation of coordination and information centres for older people (Kanton Luzern, SD). It must be noted that the canton does not directly subsidise any nursing homes of home care services, all subsidies to such structures being exclusively provided by municipalities. The canton does not conduct quality control activities in the LTC field.[4] We were not able to find other documents outlining policies for older people for canton Lucerne.

The situation in canton Saint-Gall can be seen as similar. The most recent statement of a policy for older people dates back to 1996. Municipalities are in charge of management and oversight of LTC providers. Cantonal authorities do, however, issue recommendations addressed to municipal authorities (Berater im Gesundheits- und Sozialwesen, 1996). Also, the canton has set forth a concept of geriatric care integration, which has been developed since 2007, but it is specifically focused on acute care.

3.3 Global old-age policies

Some cantons have elaborated explicit statements of old-age policy. Such policies generally entail more ambitious programs of development of LTC which, while taking quantitative aspects into account, require qualitative reforms of the LTC system. As it has been emphasised, the main priority is home care. Two main reasons explain this choice. Firstly, care services which are delivered within the social environment of the older person afford the opportunity of maintain the contribution of informal care, which is often present. Secondly, this strategy is supposed to lessen the pressure on nursing home beds, thus leading to an economically more rational use of the existing health care system. Indeed, the lack of available beds in nursing homes leads to medically unnecessary days spent in hospital by patients who cannot return home.

Canton Geneva, for instance, has put forward a statement of public policy on ageing in 2005.[5] As far as long-term care is concerned, it contains several goals. The policy seeks to adapt existing structures so that older people can live in an adequate environment. The polarisation between home health care and nursing home must be defused, and the coordination between structures and stakeholders must ne intensified. The state seeks to limit the number of long-term nursing home placements, and to provide more opportunities for short stay and respite care. Home care must also be improved, especially through provision of services on a 24 hour, seven days a week basis. Clients must also have better access to information about services available (Conseil d'Etat du canton de Genève, 2005).

Basle-City canton, to use another example, has elaborated a road map for its old-age policy. The available report is recent (2007) and it focuses particularly on planning for necessary infrastructures. Municipalities are responsible for organizing infrastructures; however the canton is comprised of one

[4] Information transmitted by a member of our National Expert Panel.

[5] Canton Geneva official website. DARES. Politique en faveur des personnes âgées. 17 June 2005. (http://etat.geneve.ch/des/site/master-content.jsp?componentId=kmelia518&themeId=2964&pubId=5649).

main city only. (Kanton Basel-Stadt, 2007). At canton level, a LTC Department has been set up. It is a specialised state body which is in charge of questions relating to support and care for older people. It coordinates and supervises private providers of home health and home support services in the canton. It provides a wide range of useful information through its web site. The LTC Department also offers information and advice to users on the telephone.[6]

Canton Zürich has a "classical" approach to governance in the old-age policy field. Municipalities are responsible for organizing and overseeing local LTC structures and services. However, the canton does emphasize the importance of health promotion for older people, and it does seek to encourage home support at home and home care. Although both of these elements are seen as pertaining to individual responsibility, the canton did financially support the construction of sheltered housing by investing CHF 7.5 million, so that alternatives to individual housing as to care homes and nursing homes could be developed (Sicherheitsdirektion Kanton Zürich, 2009).

Bern canton has declared that it intends to conduct a real old-age policy for its older citizens. In a document entitled "Third-age policy in 2005", one of the stated goals is the "coordination of existing structures and the development of new services in order to create networks guaranteeing the highest efficiency of care and help supplied as well as the best use of limited financial resources" (Direction de la santé publique et de la prévoyance sociale du canton de Berne, 2004: 11). In fact, this goal has not yet been reached at canton level. At this, only a few 'Regional Forums' have been set up; their number should gradually increase.

The fact remains that municipalities and districts are responsible for organizing and coordinating LTC. The canton has helped in this process by financially supporting the creation of information centres for health professionals in the field of LTC. The eventuality of centralizing the governance of services has been rejected by the canton's Parliament; in 2003 it took a clear stand against the proposed cantonal planning of home care services, a task for which municipalities are responsible. Today home care services and day care centres remain under the joint responsibility of the canton and the municipalities. (Art. 68, Bern canton welfare law).

Bern canton does focus specific measures on prevention. It has followed the lead of canton Solothurn and implemented the prevention program known as "SO!PRA". The goal of this program is to advise healthy seniors on health promotion and prevention issues. Senior citizens are invited to fill out a computerised form with the help of their family doctor; the questionnaire covers various topics from physical activity to smoking habits, eating and drinking patterns etc. Results of this program have been viewed as positive and other endeavours of the same type have been encouraged (Directorate of public health and social affairs, Bern canton, 2004). The preventive focus, which remains, is now enriched by various regional projects, particularly in the area of support for informal carers.

Finally, Fribourg canton is working on improving coordination among different institutions and services in order to guarantee coherent care planning. Coordination centers may be useful to this end. They would "have the goal of proposing personalised solutions to meet the needs of older people, so that they can remain as long as possible in their usual living environment" (Fribourg canton, Directorate of health and social affairs, 2008). In this regard, it is also worth mentioning the project "Senior+" which was launched in September 2009 by the Health and Social affairs directorate of Canton Fribourg. (Fribourg canton, Directorate of health and social affairs, 2009). The 2004 canton Constitution, which states that « elders are entitled to participation, autonomy, quality of life and respect of their personality», gives this initiative its formal basis. This project has the goal of proposing a legal framework, to be adopted by canton Parliament, which would contain the main axes of governance in

[6] Basel-Stadt. Die Abteilung Langzeitpflege stellt sich vor. SD. <http://www.langzeitpflege-bs.ch/>.

the field of old-age policy. It also proposes the creation of a multi-sector interdepartmental program with the goal of « defining a global old-age policy». This projects thus deals with a variety of issues pertaining to old age, health issues among others. Stakeholders must carry out inventories in each sector concerned (including health care and LTC), assess needs, and make concrete proposals to a working group which has been set up (Fribourg canton, Directorate of health and social affairs, 2009).

3.4 Managed Care

Managed care is still relatively rarely found in the LTC field. No canton specifically refers to this type of governance model, and the Federal government does not allude to it in its report on "Strategy in the field of policies for older people" issued in 2007. To our knowledge, benchmarking and prospective financing are not yet found in the long-term care field.

However, some private initiatives may lead us to believe that managed care might yet find a significant place in the LTC. The national Association of care homes and nursing homes (CURAVIVA) states that several of their members are taking part in benchmarking. They are accompanied in this process by an association called Heim Benchmarking Schweiz (www.hebes.ch), specialised in benchmarking for nursing homes.[7]

3.5 The integrated care network model

We have identified two French speaking cantons (Vaud and Geneva) and one city (Zürich) which have chosen an integrated care network approach. These networks link together home care services, nursing homes, hospitals, etc. on a regional basis. They cover the fields of acute care as well as long-term care. They are set up to offer a complete range of services and to seek to improve the coordination of care, as well as to better orient older patients, to limit the necessity for institutional care and to allow older people who are losing their autonomy to stay at home as long as possible.[8,9]

Currently, canton Vaud is the most explicitly organised into networks, which are coordinated by the canton. It is subdivided into five regional care networks.[10] Since January 30th 2007, care networks are founded on a common legal basis: the *Vaud* l*aw on care networks*. This law "clarifies the mission of care networks and improves the political control exerted over them by further implicating municipalities. It introduces an obligation to join the network for care providers which are subsidised by the State; other providers may join if they so wish". Let us also note that "the networks are defined as instances which advise the health and social affairs department on matters of health and social policy, and react to new proposals it may put forward; they participate in the implementation of this policy on the regional level.[11] In canton Vaud, home health care and home support are organised by the Vaud Association of home care and home health care (AVASAD). All delivery centres for home care (CMS) are placed under its authority. AVASAD is a public law association, placed under the oversight of the state. It is charged

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7 Curaviva. Tiefere Kosten bei Gleicher Qualität. 30 novembre 2009. (http://209.85.229.132/search?q=cache:upYC1JdFb1QJ:www.curaviva.ch/index.cfm/346CA14C-9A0A-1C57-050D976BF7FBDFAC%26cfidx5230625%26cftx63675541/+HeBeS+heim+benchmarking&cd=1&hl=fr&ct=clnk&gl=ch&lr=lang_fr)

8 Canton de Vaud. Services de soins. Réseaux de soins (http://www.vd.ch/fr/themes/sante-social/services de-soins/reseaux-de-soins).

9 Loi sur le réseau de soins et le maintien à domicile (LSDom) (10058) du 26 juin 2008.

10 Canton de Vaud. Services de soins. Réseaux de soins (www.vd.ch/fr/themes/sante-social/services-de-soins/reseaux-de-soins/).

11 Canton de Vaud. Services de soins. Réseaux de soins (www.vd.ch/fr/themes/sante-social/services-de-soins/reseaux-de-soins/).

with “implementing, on the entire territory of the canton, state policy concerning home help and home health care, as well as measures concerning health promotion and prevention”. Its global mission is to “help persons who are dependent or in failing health to remain in their own living environment ». To this end, AVASAD “ensures that services are rendered which promote, maintain or restore their health, maximise their level of autonomy, enables them to remain socially integrated and facilitates support from, and to, informal carers”.[12]

In canton Geneva, the general directorate in charge of social action centres and of the care network (DGCASSRS) also governs the field of nursing home care. The new law on nursing home management (December 4th 2009) details the role of the state in this field. The canton government must specifically guarantee “the complementarity and the coordination of nursing home activities with other modes of care, hospital of home based, offered to older people”. The DGCASSRS also sets up social action centres in each area of the canton and collaborates with the Foundation for home care and home health care (FSASD).[13] Let us point out that this Foundation is now also in charge of implementing a system of patient orientation in the network, called PASS. The goal of this system is to evaluate needs for nursing home placement as well as to ensure that adequate home health care is supplied for elders who can stay at home if enough support is available. Currently, canton Geneva is set up as one network, divided into sectors. The goal, however, is to organise the territory into several regional networks similar to the orgnaisation which has been described for canton Vaud.[14]

Finally, the city of Zürich is also planning to develop care networks in order to strengthen the coordination between the partners in care for older people, and to limit the cost of the health care sector. The project should be fully implemented in 2025 only. At this stage, it is difficult to assess the concrete impact of its implementation, as it mostly reflects a vision for the organisation and management of the field in the future.[15]

3.6 The true competition model

Private initiatives in the LTC field are a growth sector. To our knowledge, at least four groups are active in the residential (nursing homes or care homes) field. They are: Senevita[16] (10 private residences), Tertianum[17] (19 private residences), Domicil[18] (about ten private residences) and BOAS[19] (about 15 private or semi-private residences). These groups are primarily present in the German speaking cantons, with the exception of BOAS which is mostly active in the French-speaking part of the country.

The activity of private for-profit home care services is difficult to document, but it also seems to prospering. Since April 2006, for-profit services can join the Swiss Private Spitex Association (ASPS) which has 20 members and claimed to cover 75% of the private market at the time of its creation.[20]

The field of LTC also seems to be of interest to the financial sector. A private insurance market may be mentioned in this regard, which is developing. Complementary insurance for LTC is proposed by most

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12 Loi sur l’Association vaudoise d’aide et de soins à domicile du 6 octobre 2009.

13 Site officiel de l’Etat de Genève. Direction général du CASS et des réseaux de soins. SD. (http://etat.geneve.ch/des/site/dgcass/master-main.jsp).

14 http://ge.ch/dares/reseau-de-soins/accueil.html

15 Gesundheitsnetz 2025 <http://www.gesundheitsnetz2025.ch/>.

16 www.senevita.ch

17 www.tertianum.ch/home

18 www.domicilbern.ch

19 www.boas.ch

20 www.spitexpriveesuisse.ch/de/index.php, accès du 30.03.2010.

major insurers who offer basic insurance (LAMal). Offers in this field are however not very attractive, and perspectives for its market seem limited (Jeanrenaud, 2005: 14). In the banking sector, one may note the launching, in December 2007, of the "LivingPlus" fund. Managed by Credit Suisse, this fund invests in "housing for seniors, modern apartment with services, and innovative housing solutions in attractive parts of Switzerland".[21] Early in 2010, this fund directly owns buildings which ascend to CHF 1.8 billions in value.

3.7 The governance of knowledge and professional competencies

In the field of knowledge management and professional competencies, the literature cites two types of governance. In a collaborative model, services are supplied within a strongly hierarchical system, dominated by the most powerful professional group, or groups. In the health care sector, this group is of course doctors. However, in the less medicalised realm of LTC, medical power is exercised much less directly, even though it does occupy key positions. Thus, for instance, care is only reimbursed by health insurance in the home health care sector when it is prescribed by a doctor. Basic care is still viewed as a delegated by doctors to nurses or auxiliary personnel, when doctors in fact do not intervene in the care process, nurses being specifically trained to evaluate needs and to intervene in this context.

The second model, the cooperative model, is less hierarchical. It is founded upon a horizontal division of labor, in which a field of knowledge and a specific area of competency is recognised for each profession, thus ensuring its autonomy. Within this framework, professional integration takes the form of interprofessional practice, which may however be difficult to implement as it requires that the most powerful professions give up some of their prerogatives.

3.8 Conclusion

It is difficult to define precisely the governance models at work in the LTC field. The exact contours of the "managed care" and "integrated care networks" are not cearly visible, with the possible exception of the Geneva and Vaud networks; even in the case of these two cantons, the true impact of these approaches on the day-to-day organisation of care remains difficult to assess. The various components of an integrated network approach are often implemented one by one, without fitting them into a coherent whole. However, it does seem that the German and the French speaking parts of Switzerland follow potentially different paths in terms of governance models, with a emphasis on managed care for the first and integrated networks for the second. In French speaking Switzerland, where home care services in particular are more centralised than in the German speaking area, the State is seen as a strong stakeholder, capable not only of ensuring the unity of the care system, but also of acting as an important direct provider. In Swiss German cantons, the state plays a more discreet role, leaving to public and private organisms the task of setting up models driven primarily by financial indicators. This mode of governance, which leaves a greater place for the development of for-profit activities of the private sector, implies a relatively decentralised organisation of care since the market, in more or less administered form, is supposed to confer it its coherence.

In practice, we have the impression that the governance model actually in place resembles a game of Black Peter, in which bad risks are systematically passed along to other actors. The financing system, which is particularly complex and lacks transparency, contributes to this feeling.

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[21] Crédit suisse Asset Management Fund AG (Suisse) (Février 2010). Credit Suisse Real Estate Fund LivingPlus. (http//:*ch.csam.com/dss/area_15/3164_9026_33.pdf, accès du 30.03.2010*).

4 Key barriers to joint working

A global old-age policy is gradually coming to the fore in Switzerland. Cantons carry the greatest responsibility for its development, which is thus strongly decentralised. To this day, the Confederation has not taken a leading role as a catalyst or as a coordinator; the approaches as well as the agenda thus vary widely between cantons.

The issue of LTC service coordination is not confronted in all cantons; when it is, it remains within the realm of the canton. The possibility of collaborations between neighbouring cantons is usually not even envisaged, although intercantonal bodies which could carry such a movement forward already exist. In this sense, federalism may be seen as an important barrier to the development of a policy for the ageing and to the implementation of supracantonal care structures.

However, this lack of coordination is not normally seen as a problem, but rather as an expression of respect for local specificities and for cantonal sovereignty. Collaboration between cantons may arise when the fragmentation of care structures leads to extra expenses as well as to lower quality, as is the case in the field of highly specialised acute care. In the LTC field however, these questions are not usually raised.

4.1 Structural

At national level, there are no instances charged with the design of LTC services as a whole, or entrusted with implementing such designs. However, within cantonal boundaries, there are no specific barriers to the integration of LTC services, as cantons are powerful instances which have the legal and financial means to implement their decisions, even in the face of opposition from influent stakeholders such as the medical profession or private health care institutions.

4.2 Processual

Athough the cantonal state does have the necessary means at its disposal to develop a coherent care system within its borders, its manoeuvering room is restricted by prevailing public policy orientations known as new public management, which incites it to base its actions upon microeconomic considerations rather than founding them on broader social policy objectives.

4.3 Financial

One of the main difficulties encountered when attempting to devise integrated care systems is that all stakeholders, be they provider or purchaser institutions, keep their own accounts and pursue their own financial goals. For this reason, they are not inclined to see the LTC system globally, as a project which they carry out together jointly as a team.

For similar reasons, cost containment strategies pursued by each actor in the LTC field often result in transfers of charges to other parties, without any real reduction of costs taking place. This is what happened with the reform of care financing within health insurance. The goal was to transfer a portion of LTC costs from health insurers to the state and to private households. Moreover, in this case, the transfer process notably heightens the degree of complexity of financial coverage of LTC, since cantons will devise different modalities to cover costs previously underwritten by health insurers.

4.4 Professional

The exaggerated dominance of one profession over others is a problem for the integration of services, which often necessitates a redistribution of tasks and responsibilities.

Another difficulty stems from an excessive division of labor, which increases the number of interfaces to be managed. For instance, a new type of training and qualification was introduced in the health care field at the apprenticeship level (care assistant or ASSC), and Bachelor and Master level nursing qualification were created in university of applied sciences; we now find no less than five distinct functions and qualifications just for the nursing field: basic federal level certificate of practical training (AFP), apprenticeship level - ASSC trained nurse with a diploma from a specialist nursing school (ES), Bachelor-level nurse trained in a HES and, soon, Masters-level nurse trained in a HES. These distinctions tend to bring with them a hierarchical organisation of labour based on collaborative models, within which tasks tend to be carried out by personnel with less professional training placed under the supervision of a small number of more highly trained professionals, whose role is focused on control. This model also rests on a functional division of labor, each staff person having only a partial view of the global care process in which they are engaged. This multiplicity of care functions allows a reduction of personnel costs, which is its primary raison d'être. On the other hand, it does not really make sense in professional terms, especially as the boundaries between roles are often unclear.

4.5 Issues of status and legitimacy

The health care system is seen as a dynamic sector, whose function in creating wealth is related to its high degree of integration into the economic system. On the contrary, the social and welfare system, while it is far from insignificant in economic terms, is viewed as an essentially non-productive sector relying on public funds. As for the status of the LTC system, it has not been clarified yet. The Confederation is being very careful about promoting a system of care which would specifically cover the needs of older people; this would seem to indicate that a relatively marginal economic potential is attributed to this sector. Providing aid to frail older people is apparently viewed as a field pertaining to the individual responsibility of older people themselves and of their primary network of carers, the support of the state remaining subsidiary in nature.

5 Key enablers

5.1 Shared vision

At the national level, no shared vision about LTC has been developed. Regional Conferences of health and social affairs ministers from various cantons may however provide a framework for the articulation of a vision of LTC shared by several cantons. For instance, the Latin Conference of health and social affairs is a body within which French speaking cantons as well as Ticino, the Italian-speaking canton, cooperate. It has set up a LTC Committee that includes representatives of concerned stakeholders. Its goal is to identify the bases of possible intercantonal collaboration in the LTC field. The Committee writes up recommendations for member cantons, the latter being free to put them into practice or not. Thus the sovereignty of cantons is not put into question by such a mechanism, but it does show their

willingness to limit their differences.[22] We are however still far removed from truly concerted policies on LTC at the regional level.

5.2 Clarity of roles and responsibilities

At the constitutional and legal levels, cantons are designated as the primary actors of the development of LTC. They do set political agendas which include policies on LTC, and thus acknowledge that they are, in fact, responsible for this field. Cantons are defined in a clear manner as central actors in charge of the LTC field, in formal terms as well as in political terms. The development of LTC thus rests on 26 different entities. Despite this clear devolution of power, coordination is obviously needed.

5.3 Appropriate incentives and rewards

We failed to identify any specific incentives for collaboration, or ways in which such collaboration is encouraged where it does occur.

5.4 Accountability for joint working

Again, we found no statutory dispositions for providers, purchasers or professional organisms which could be seen as holding them to account as far as joint working is concerned. A possible exception stems form Vaud and Geneva legislations and concerns LTC services and institutions integrated into care networks in these two cantons.

[22] Information obtained from Ms Anne-Claude Demierre, minister in charge of health and social affairs for canton Fribourg.

6 The funding of long-term care services

If we define LTC as comprising nursing homes and home health/home care, funding ascends to approximately CHF 8 billion, or about 15% of all health care spending. The financing structure is complex, as we have seen, and lacks clarity. Also, there is reason to believe that the portion of LTC costs paid directly by households is high in international comparison.

The table below shows the breakdown of costs by purchasers for the year 2005.

Table 1 Costs of the health and LTC care systems by type of service and by direct purchasers, 2005

	Health care		*LTC*		*Nursing Homes*		*Home health care*	
	CHF (Bil.)	*(%)*	*CHF (Bil.)*	*(%)*	*CHF (Bil.)*	*(%)*	*CHF (Bil.)*	*(%)*
Total	52.9	100%	7.7	100%	6.6	100%	1.1	100%
Public sector	9.1	17%	1	13%	0.6	10%	0.4	36%
Social insurance, incl. basic	22.5	43%	1.9	25%	1.4	21%	0.5	48%
Health insurance (AOS)	18.3	35%	1.7	22%	1.4	21%	0.3	30%
Complementary insurance	4.7	9%	0	1%	0	0%	0	4%
Households	16.2	31%	4.6	59%	4.5	68%	0.1	7%
Other private sources	0.5	1%	0.1	2%	0.1	1%	0	5%

Source: Egger, 2007: 16.

In 2008, nursing home costs reached CHF 6,820 million and home care costs CHF 1,141 million. LTC costs thus represent 15.1% of global health care costs, which were estimated for the same year at CHF 52,773 million (Interpharma, 2008: 47).

Within the LTC field, four types of services may be distinguished: medical costs, basic nursing care costs, home care, and nursing home costs (Jeanrenaud, 2005: 6).

Medical care, as well as basic nursing care at home and in nursing homes, is reimbursed in the way detailed under point 2.2. of the present report. As we have shown, basic health insurance covers about 55% of care costs. The remainder is currently shared by households, cantons and municipalities. Cantons are currently preparing to comply with the new legislation described above.

If older persons are severly dependant, they can obtain financial support from AVS in the form of “allocation d’impotence”. This benefit can be obtained on the basis of a definition set in social security legislation. It can be granted to “any person who, because of difficulties du to health problems, permanently needs the help or supervision of others to carry out the basic activities of daily living” (Art. 9, Droit sur la partie générale des assurances sociales/LPGA). In 2007, this benefit was 553 CHF/month for medium level impairment, and 884 CHF/month for severe impairment. The benefit is the same whether the beneficiary lives at home or in a nursing home (Despland, 2008: 117-119). There is no benefit for low level impairment, unlike in the fields of disability and accident insurance.

Home help, and “housing costs” in nursing homes are not directly covered by social insurance; they are normally paid directly by beneficiaries. When elders cannot cover these costs themselves, they may be eligible for complementary benefits (*prestations complémentaires*, or PC). The financing of these benefits has been modified by the RPT (see under 2.1. above). When people reside at home, the central

state contributes 5/8ths and cantons 3/8ths to the benefits which take the form of income support. However, "cantons entirely cover costs derived form nursing home stays. They also have to cover costs due to medical costs and home care costs". (Département fédéral des finances, 2007: 23). In 2008, 18.3% of nursing home residents, or 43,400 persons, received complementary benefits (Portmann, 2008).

6.1 Financial sustainability

The health insurance reform concerning LTC (see 2.2) gives cantons a greater role in LTC financing, without outlining the contours of their responsibilities in a precise manner. The way this responsibility will be fulfilled is not entirely clear yet. Moreover, the financial needs of the sector will be growing in the years to come. It has been estimated that costs will rise from the current CHF 8 billion to over CHF 17 million by 2030 (Weaver et al., 2008). Since the participation of insurers is frozen by the new law at its current level (about CHF 2 billion), new sources of financing may have to be found for LTC in the future.

7 Good practice

In 2007, the Federal Public Health Office (OFSP) formally adopted a national strategy called Cybersanté ("or eHealth"), which views information and communication technology as a central element for improving management in the area of medical care. This project has the following goals:

- The support, the coordination and the organisation into networks of management processes and partners,
- The guarantee of access to a high quality, efficient, safe and economically affordable health system,
- The simplification and coordination of rules and regulations.

This process thus seeks to improve coordination among actors, in order to reinforce the effectiveness of the health system and diminish error rates. However, it concerns the entire health policy system and is not specifically focused on LTC.

In its report on strategies in the field of old-age policy (Conseil fédéral, 2007: 14), the federal government refers to *Case Management* as a means to improve cooperation between ambulatory and residential care, as well as between medical and social services.

The hospital field is currently moving towards hiring case managers in order to manage patient discharge from hospitals to the LTC field; this development is due, in part, to the introduction of DRGs in Swiss German cantons.

Liaison nurses as well as social workers work in Geneva and Vaud hospital, as well as in Basle-City for instance. Their role is to handle effective discharge management. The specificity of the way this role has been set up is that professionals are based in hospitals but are employees of the network (Vaud), or of the home health/home care service (Geneva).

Let us finally note that recent reforms (RPT) have preserved the ability of the Federal government to financially support national organisations in the field of care for older people, such as SPITEX/ASSASD,

CURAVIVA, the National Red Cross or Pro Senectute. Through these organisations and the influence they can exert on them, the federal government can support coordination efforts.[23]

8 Ongoing tensions

As we have seen, stakeholders frequently try to limit their own spending by passing along costs to others ("Black Peter" strategy). It seems likely that tensions will be generated by this tendency in the future also.

9 Embedding good practice in everyday practice

We did not find any evidence that specific legal or economic incentives had been put into place with the goal of furthering good practice in the follow-up of daily work of LTC services in the field.

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[23] Loi fédérale concernant l'adoption et la modification d'actes dans le cadre de la réforme de la péréquation financière et de la répartition des tâches entre la Confédération et les cantons (RPT) du 6 octobre 2006. Article 24, and Conseil fédéral (2007).

10 References

10.1 Books

Interpharma (2008). *Santé publique en Suisse.* Bâle: Interpharma.

Lemke, T. (1997). *Eine Kritik der politischen Vernunft. Foucaults Analyse der modernen Gouvernementalität.* Hamburg: Argument.

10.2 Articles

Canton de Fribourg, Direction de la santé et des affaires sociales (2009). 'Senior+ veut valoriser la vie et les compétences des seniors' in: *Bulletin d'information de la Direction de la santé et des affaires sociales*, n° 7.

Depland, B. (2008). 'La prise en charge des soins de longue durée dans la loi sur l'assurance-maladie (LAMal)' in: *Cahiers genevois et romands de sécurité sociale,* Vol. 40: 113-127.

Kouri, K. (1999). *Autonomie et vieillissement.* Edisem.

Polito, V. (2009). «Conditions de travail précaires et bas salaires en Suisse», *Jahrbuch*, Denknetz, Zürich, 2009

Société Suisse de Médecine Générale (2006). 'Prise de position e-Health' in: *Primary Care*, n°37: 655-656.

10.3 Online documents

Basel-Stadt. Die Abteilung Langzeitpflege stellt sich vor (www.langzeitpflege-bs.ch, accès du 10.02.2010).

Canton de Vaud. Services de soins. Réseaux de soins. SD. (www.vd.ch/fr/themes/sante-social/services-de-soins/reseaux-de-soins, accès du 11.01.2010).

CDS. Nouvelle réglementation du financement des soins de longue durée (projet séparé). 23 août 2004. (www.gdk-cds.ch/fileadmin/pdf/Themen/KVG-Revision_und_Vollzug/KVG-Revision/Hauptanliegen_GDK/5_Pflegefinanzierung-Hauptanliegen-f.pdf, accès du 26.01.2010).

Confédération suisse. Régime de financement des soins: entrée en vigueur reportée au 1er janvier 2011. 4 décembre 2009. (www.news.admin.ch/message/index.html?lang=fr&msg-id=30538, accèsdu 26.01.2010).

Curaviva. Tifere Kosten bei Gleicher Qualität. 30 novembre 2009. (http://209.85.229.132/search?q=cache:upYC1JdFb1QJ:www.curaviva.ch/index.cfm/346CA14C-9A0A-1C57-050D976BF7FBDFAC%26cfidx5230625%26cftx63675541/+HeBeS+heim+benchmarking&cd=1&hl=fr&ct=clnk&gl=ch&lr=lang_fr).

Droits du patient. Neuchâtel organise le maintien à domicile. SD. (www.droitsdupatient.ch/services/nomad.htm, accès du 13.01.2010).

Fondation de l'Office bernois de médiation pour les questions du troisième âge et des homes. SD. (www.ombudsstellebern.ch, accès du 12.01.2010).

Gesundheitsnetz 2025. SD. (www.gesundheitsnetz2025.ch, accès du 25.02.2010).

H+. Financement des soins. 17 décembre 2009. (www.hplus.ch/fr/servicenav/la_politique_h/politique_sanitaire/financement_des_soins, accès du 2.02.2010).

Les autorités fédérales de la Confédération suisse. Allocution du Conseiller fédéral Didier Burkhalter. 19 novembre 2009. (www.edi.admin.ch/aktuell/00707/01298/index.html?lang=fr&msg-id=30211, accès du 26.01.2010).

Le Portail Suisse. Allocation pour impotent et moyens auxiliaires. SD. (www.ch.ch/private/00045/00046/00568/00576/index.html?lang=fr, accès du 2.02.2010).

Office fédéral des assurances sociales. Réforme de la péréquation financière et de la répartition des tâches entre la Confédération et les cantons RPT: conséquences pour l'aide aux personnes âgées.SD. (www.bsv.admin.ch/themen/gesellschaft/01643/01645/01685/index.html?lang=fr, accès du 12.02.2010).

Office fédéral de la statistique. Statistique de l'aide et des soins à domicile. Cantons. 2010. (www.bfs.admin.ch/bfs/portal/fr/index/themen/14/03/03/data/07/04.html#a, accès du 17.03.2010).

Site officiel de l'Etat de Genève. Direction général du CASS et des réseaux de soins. SD. (http://etat.geneve.ch/des/site/dgcass/master-main.jsp, accès du 18.01.2010).

Site officiel de l'Etat de Genève. DARES. Politique en faveur des personnes âgées. 17 juin 2005. (http://etat.geneve.ch/des/site/master-content.jsp?componentId=kmelia518&themeId=2964&pubId=5649, accès du 13.01.2010).

Site officiel de l'Etat de Genève. Direction générale des CASS et du réseau de soins. Concept en matière de lits d'unité d'accueil. 21 janvier 2009. (http://etat.geneve.ch/des/site/dgcass/master-content.jsp?actuId=1&componentId=kmelia557&pubId=7469#1, accès du 6.02.2010).

Sanaprofil, Solothurn. Das Gesundheits-Profil Verfahren im Kanton Solothurn. SD. (www.sanaprofil.ch/Sanaprofil-Solothurn.9.0.html, accès du 16.02.2010).

10.4 Web sites

www.senevita.ch

www.tertianum.ch/home

www.domicilbern.ch

www.boas.ch

www.hebes.ch

http://ge.ch/dares/reseau-de-soins/accueil.html

10.5 Legal Documents

Canton de Berne. Loi sur l'aide sociale (LASoc) (860.1), du 11 juin 2001.

Canton de Fribourg. Ordonnance fixant le montant de l'indemnité forfaitaire en matière d'aide et de soins à domicile, du 14 octobre 2008.

Canton de Genève. Loi sur le réseau de soins et le maintien à domicile (LSDom) (10058), du 26 juin 2008.

Canton de Genève. Loi sur la gestion des établissements pour personnes âgées (10401), du 4 décembre 2009.

Conseil fédéral, Message (05.025) relatif à la loi fédérale sur le nouveau régime de financement des soins, du 16 février 2005.

Grand Conseil du canton de Vaud, Postulat Filip Uffer. Pour une politique d'action sociale gérontologique favorisant la participation et l'autodétermination des personnes âgées. Séance du mardi 8 septembre 2009.

Loi fédéral concernant l'adoption et la modification d'actes dans le cadre de la réforme de la péréquation financière et de la répartition des tâches entre la Confédération et les cantons (RTP) du 6 octobre 2006.

Loi fédérale sur le nouveau régime de financement des soins du 13 juin 2008.

10.6 Reports

Berater im Gesundheits- und Sozialwesen, *Altersleitbild für den Kanton St. Gallen*, Zürich, 1996.

Communauté d'intérêts Financement des soins, La CI Financement des soins à propos du nouveau règlement de financement des soins. Quelques améliorations obtenues, Berne, 13 juin 2008.

Conseil d'Etat du canton de Genève. Rapport du Conseil d'Etat au Grand Conseil sur la politique en faveur des personnes âgées dans le canton de Genève, 2005.

Conseil federal (2007). *Stratégie en matière de politique de la vieillesse,* Berne.

Canton du Valais, Service de la santé publique, Politique cantonale de prise en charge des personnes âgées, 2008.

Département fédéral de l'intérieur/Office fédéral de la santé publique (2007). *Stratégies Cybersanté (eHealth) Suisse*.

Département fédéral des finances (DFF) (2007). Réforme de la péréquation financière et de la répartition des tâches entre la Confédération et les cantons (RPT). Berne: DFF.

Direction de la santé publique et de la prévoyance sociale du canton de Berne, Politique du 3^{e} âge dans le canton de Berne. Rapport de planification et plan d'action pour la mise en œuvre des objectifs définis par le Grand Conseil dans le cadre de la Politique du 3ème âge 2005, 2004.

Direction de la santé publique et de la prévoyance sociale du canton de Berne, *Politique du 3^{e} âge dans le canton de Berne. Rapport intermédiaire,* 2007.

Egger, Theres (2007). Spitex- Umfeld-, Markt- und Konkurrenzanalyse. Literaturübersicht. Im Auftrag des Spitex-Verbands Schweiz. Bern: Büro für Arbeits- und Sozialpolitischen Studien BASS.

Jeanrenaud, C., « Soins de longue durée des personnes âgées », Université de Neuchâtel, Institut de recherches économiques, 2005.

Kanton Basel-Stadt, Leitlinien für eine umfassende Alterspolitik, Basel, 2007.

Kanton Luzern, *Altersleitbild 2010*, SD.

Office fédéral de la santé publique, *Stratégie de Cybersanté (*eHealth*) Suisse*, 2007.

Portmann, Statistique des prestations complémentaires à l'AVS et à l'AI 2008. Tableaux détaillés. Office fédéral des assurances sociales. Berne. SD.

Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen, *Koordination und Qualität im Gesundheitswesen,* Kurzfassung, 2005Sicherheitsdirektion Kanton Zürich, *Alterspolitik im*

Kanton Zürich, Beschlüsse des Regierungsrates des Kantons Zürich von 19.Oktober 2005 und vom 8.Juli 2009.

Stadt Zürich (2007). *Integrierte Gesundheitssysteme: Medizinische und soziale Dimensionen.* Zürich.

Wächter, M., & Stutz, H. (2007). *Kurzbericht der Studie: Neuregelung der Pflegefinanzierung.* Bern: BASS.

Waewer, F., Jaccard Ruedin, H., Pellegrini, S., & Jeanrenaud, C. (2008) *Les coûts des soins de longue durée d'ici à 2030 en Suisse.* Neuchâtel: OBSAN.

10.7 Other Documents

Agence télégraphique suisse, «Les cantons auront un an de plus pour se préparer», 24 juin 2009.

Agence télégraphique suisse, «Nouveau régime de financement des soins. La critique des cantons a ses effets: introduction reportée», 30 mars 2009.

Agence télégraphique suisse, «Nouveau régime de financement des soins. Les personnes les plus dépendantes pénalisées, selon H+», 31 mars 2009.

Canton de Fribourg, Direction de la santé et des affaires sociales, Communiqué de presse. Le canton prévoit une loi cadre comme base d'une politique globale de la personne âgée, 17 septembre 2008.

Canton de fribourg, Direction de la santé et des affaires sociales, Communiqué de presse. "Senior +": les membres du comité de pilotage ont été désignés par le Conseil d'Etat, 9 septembre 2009.

Dialogue de politique nationale de santé, «Mandat de prestations de l'Observatoire suisse de la santé», approuvé le 27 octobre 2005.

Observatoire suisse de la santé, Communiqué de presse, «Lancement de l'Observatoire suisse de la santé», 21 octobre 2001.