

# From pilot projects to routine care: Financing and reimbursement of hospital-substituting acute somatic care in Switzerland

## Key messages

### *Background and context*

Switzerland faces a dual challenge: demographic ageing – with the share of people aged 80 and over set to double by 2050 – is meeting strained hospital finances (EBITDA margins of 1–2%) alongside high healthcare expenditure (11.7% of GDP). Against this backdrop, hospital-substituting acute somatic care is gaining importance, as it enables the treatment of acute illnesses at home instead of in hospital. Since 2021, around 14 care models have been established across 10 cantons; in the canton of Zurich alone, more than 750 patients have already been treated at home. International reviews of hospital-substituting acute somatic care models frequently report shorter lengths of stay, reduced rehospitalizations, and high patient satisfaction. In international comparison, countries such as France and Singapore show comparatively strong institutional anchoring of hospital-substituting acute somatic care models – in particular through clearer national definitions or regulatory anchoring and routinised reimbursement pathways. The reform on the unified financing of outpatient and inpatient care (EFAS, effective from 1 January 2028) creates a policy window for embedding cross-sector reimbursement and accountability logics for hospital-substituting episodes within mandatory health insurance.

### *The challenge*

All pilot projects are reaching the limits of the current tariff system:

- **Sectoral fragmentation:** Switzerland reimburses separately (SwissDRG for hospitals, TARMED/TARDOC for outpatient physician services, KLV for home nursing/Spitex). Hospital-substituting episodes, however, combine all three sectors, for which no reimbursement structure exists.
- **Non-scalable financing:** Pilot projects are financed through foundation funding, special flat-rate payments, or cantonal project funding, none of which are transferable or sustainable in the long term.
- **Lack of a shared understanding:** Without a national definition, pilot models remain fragmented, financing negotiations remain inconsistent, and integration into mandatory health insurance is unlikely.

### *Recommendations for action*

#### **1. Establish a national definition and indication catalogue**

A national working group led by the Federal Office of Public Health (FOPH), involving

insurers, cantons, Spitex organizations, hospitals, the Swiss Hospital at Home Society (SHAHS) as a representative of providers of hospital-substituting care, and patient organizations, should develop a binding definition of hospital-substituting acute somatic care together with a clearly delimited indication catalogue as an outpatient benefit under the Health Insurance Act (KVG), aligned with EFAS 2028. This would create the basis for comparable episodes for price calibration and quality evaluation.

## **2. Introduce an episode-based tariff with integrated coordination payment**

A bundled payment per episode should reimburse the entire care pathway during the acute episode (medical and nursing care, coordination, logistics, 24/7 availability, diagnostics, medication, and materials). Provider-neutral reimbursement should be positioned between the outpatient and inpatient corridor. Coordination tasks should be reimbursed explicitly. A lead provider should bill the episode, and subcontracting between providers should be permitted.

## **3. Make episodes identifiable within the existing data infrastructure**

Hospital-substituting episodes should be made identifiable through episode markers in existing billing data (TARDOC/outpatient flat-rate payments, KLV), without separate data collection. Linking the episode to a principal ICD-10 diagnosis would enable identification in routine data and comparison with hospitalizations

## **4. Ensure KVG integration and equity safeguards**

A guidance document for applications for coverage under mandatory health insurance (OKP) should be developed; the process for classifying and anchoring hospital-substituting acute somatic care as an outpatient KVG benefit should be defined with EFAS 2028 in mind. Equity monitoring should prevent unintended financial barriers and identify differences in cost-sharing, underlying cost structures, utilization, and outcomes by region, insurer, and demographic characteristics at an early stage.

### *Implementation considerations*

#### **Barriers to implementation include:**

- the complexity of tariff negotiations between multiple actors (insurers, cantons, tariff partners);
- the risk of an overly narrow definition that could hinder innovation or ignore regional variation;
- the lack of systematic cost data from pilot projects for precise tariff calibration;
- cantonal autonomy without intercantationally coordinated guardrails.

#### **Implementation may be facilitated by the following factors:**

- EFAS 2028 offers a window for cross-sector episode-based reimbursement;
- pilot projects provide practical experience and initial evidence;
- the international comparison shows that scaling is more likely when definitions and roles, a routinizable episode-capable reimbursement pathway, and episode transparency in routine data/monitoring work together;
- there is broad agreement on key design principles (provider neutrality, coordination payment, equity protection);
- substantial shift potential (e.g. 6,272–12,545 avoidable hospitalizations for five acute diagnoses in 2023 among adults aged 20+ under assumed shift rates of 10–20%) reflects the potential for efficiency gains and more patient-centered care.