



## Medical measures in disability insurance

### Evaluation of implementation and analysis of cost development

#### Key facts

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Expenditure on medical measures in disability insurance has been increasing for more than ten years now. In 2010, medical measures cost a total of CHF 692 million, of which CHF 669 million was in relation to congenital disorders and CHF 23 million was for reintegration. Costs for congenital disorders grew by 61 percent in 10 years. In 2010, slightly more than 113,000 individuals received medical benefits for congenital disorders, a 12 percent increase relative to 2001. During the same period, the average cost per beneficiary rose by 43 percent to reach around CHF 5,920 in 2010. In almost 10 years, the costs of medical benefits for congenital disorders grew 1.5 times faster than healthcare costs. Since 2006, however, the cost escalation has followed the same rising trend as health insurance costs.

The Swiss Federal Audit Office (SFAO) sought to determine the reasons behind this cost escalation, the possible factors at play, and whether there are any significant differences according to the illness and the canton. It based its work on the guidelines drawn up by the Federal Social Insurance Office (FSIO) setting out the conditions for the assumption of costs as well as the implementation and handling of case files within the cantonal disability insurance offices. It also sought to determine whether the FSIO can manage this insurance efficiently and ensure its supervisory functions. Aside from a study of the archives available at the FSIO, the evaluation is also based on a statistical analysis, a survey of the disability insurance offices and detailed interviews.

#### **Hybrid nature of measures: between rehabilitation and a substitute for health insurance**

Medical measures were originally included in the benefits provided for under the 1959 Invalidity Insurance Act right from the beginning. While Article 12 concerns the medical measures required for occupational rehabilitation, Article 13 specifically refers to congenital disorders having a serious impact on future earning capacity. The list of recognised congenital disorders is compiled by the Federal Council. Article 13 has remained virtually unchanged since the original law, but Article 12 has been limited to young people up to the age of 20 since the fifth revision of the Invalidity Insurance Act. The provisions of the Invalidity Insurance Act were formulated at a time when health insurance was not yet mandatory. The Federal Act of 6 October 2000 on General Aspects of Social Security Law defines the distribution of powers between the various types of insurance, with disability insurance taking precedence over health insurance. If a case file is refused under disability insurance, it will generally be accepted under health insurance. In practice, the implementing parties have differing viewpoints on the arrangements of disability insurance, that is to say, whether medical measures are simply a substitute for health insurance or whether they also serve a purpose in rehabilitation or even social reintegration, in conjunction with the other individual benefits granted under disability insurance. The main problem lies in defining the scope covered by disability insurance, given the focus on integration in the fifth revision of the law.

#### **An outdated and inconsistent list of congenital disorders**

Although formally modifications can be made each year, the last major revision of the list of congenital disorders dates back to 1985. Consequently, the list does not necessarily meet current

medical standards and criteria. In fact, relatively few modifications were made since then. Moreover, the list was drawn up in the context of insurance medicine and does not correspond to international classifications of illnesses. It is not clear, for example, why premature infants are covered by disability insurance or why the sole determining criterion is birth weight. The distinction between a congenital disorder and an acquired illness is not always obvious. A Circular exists on medical measures, specifying the treatments and setting limits. This was compiled over the years and can contain certain inconsistencies, e.g. the length of treatment is specified for certain disorders while others are subject to very few limits. The legislation states that disorders of minor significance may be removed from the list and that the benefits must be straightforward and appropriate in nature. These concepts are difficult to define in practice.

### **A suspended committee and ad hoc changes**

Until 2005, a specialised committee for medical rehabilitation measures was tasked with submitting proposals to the FSIO for modifying the list of disorders or the Circular on medical measures. This committee existed in various forms but was suspended on the grounds that the FSIO's resources were stretched by the implementation of the fifth revision of the Invalidity Insurance Act and also that the committee members were primarily defending their own medical specialities. Instead, the FSIO chose to create ad hoc working groups to address specific issues, often in response to external pressure or demands. Thus, while the acceptance criteria for psychoorganic syndrome have been debated since 1974, it was only in 2011 that a directive outlining the conditions was issued, while the greatest increase in such cases occurred in the 1990s. Following a request by a specialised association, the conditions for autism were modified in 2010, resulting in a wider scope of acceptance for autism spectrum disorders. The FSIO noted that this modification was already consistent with existing practice and would not result in any cost escalation, which proved wrong. In practice, the process for modifying the list of disorders and the Circular has become quite opaque for many of those involved, including within the Confederation.

### **Case processing: straightforward case files according to the disability insurance offices, but it depends on their individual complexity**

The disability insurance offices process applications to decide whether they meet the required criteria. They keep track of case files for which benefits are granted and perform an initial check of invoices before forwarding these to the Central Compensation Office for payment. While the disability insurance offices regard case files for medical measures as being among the simplest to process, particularly in comparison with disability pensions, it all depends on the complexity of the individual cases. Certain case files may require a lot more resources before a decision can be taken, particularly in the case of mental illnesses – whether regarding rehabilitation measures or congenital disorders – and for cerebral palsy conditions. Such cases are demanding because they are often open to interpretation, and additional information may have to be sought. The disability insurance offices experience difficulties distinguishing between costs to be borne by disability insurance and those falling under health insurance, checking invoices (particularly for those hospitals now charging a flat rate per case), and approving psychotherapeutic measures, treatment apparatus or paramedical measures.

### **Varying practices and levels of knowledge among the different disability insurance offices**

As the implementing bodies of federal provisions, the disability insurance offices are free to organise themselves as they see fit, for example, with a department specialising in minors. They

have some 130 FTEs at their disposal for handling the case files of minors. Knowledge of the medical measures varies greatly from one disability insurance office to another, and the size of the office is not necessarily a determining factor. Some offices have developed an information system that gives them a clear overview, while others find it hard to say what resources are devoted to certain case files, how many first applications are filed or how many are refused. Changes introduced in 2011 limited the role of the FSIO and its possibilities for intervening with respect to the regional medical services. The disability insurance offices are free to submit case files to be examined by the regional medical services. In practice, there are major differences in the case files that have to be forwarded to the regional medical services and those for which forwarding is only recommended. Depending on the disability insurance office, differences also exist in the extent to which invoices are checked and whether a doctor from the regional medical services is consulted where there are doubts concerning benefits. The regional medical services rely on the presence of a paediatrician or specialist who can more easily decide on individual case files or the appropriateness of benefits. However, it is not feasible to have specialists in the various illnesses at all regional medical services.

### **An inadequate management system and limited supervision by the FSIO**

Although the FSIO introduced a new management and supervisory model in 2005, this does not fully integrate medical measures; these are considered of secondary importance, with the priority on disability pensions and implementation of the fifth revision. The service level agreements with the disability insurance offices do not include any specific objectives or indicators for assessing the offices' activities with regard to medical measures. The FSIO has detailed statistics on medical measures, but these data are rarely used, despite being available for some time now. They could serve as a basis for a number of interesting studies on the differences between disorders or the level of cantonal differences or comparisons between invoiced benefits, for example. However, the statistics are rarely discussed with the FSIO's partners concerned by medical measures. The FSIO's information system is thus quite weak, given that it does not utilise the data available to identify risks and take corrective action if necessary.

### **Certain illnesses generate high costs**

Around 15 congenital disorders account for 60 percent of total costs. Three conditions – cerebral palsy, premature birth and psychoorganic syndrome – generate costs in the range of or exceeding CHF 60 million. With the exception of dental cases and neonatology, chronic illnesses understandably generate the highest expenses, as patients may require treatment over a number of years. The increase in the number of beneficiaries is well above average in the case of autism and growth defects. The average annual cost per beneficiary is highest for premature births (almost CHF 35,000) and for the treatment of cystic fibrosis (around CHF 32,000). The increase in this cost is above average for patients with cerebral palsy and for premature births. For epilepsy, psychoorganic syndrome, autism and cerebral palsy, disability insurance also provides other benefits such as assistive devices, allowances for the helpless or basic vocational training. In terms of the amounts invoiced, inpatient benefits account for 40 percent of costs invoiced but concern only 10 percent of beneficiaries, including complex cases. This is followed by outpatient benefits, which account for only 10 percent of the amounts invoiced, and then by dental treatments. In general, the SFAO found that the bulk of the cost escalation was due to the rise in costs per case. This results from the increase in the volume of benefits, stemming from developments in medical techniques.

### **Cantonal differences difficult to explain**

The SFAO also compared cost escalation by canton. The results show that the differences tend to follow the same trend as for healthcare (rate of hospitalisation, level of health insurance premiums). However, there are some significant differences between the cantons with regard to specific illnesses. The SFAO found that these differences were greater where the criteria for disorders and measures are open to wider interpretation (mental illnesses); here, the cost per case may be up to three times higher depending on the canton. The increase in medical services available also plays a role, particularly regarding the proximity of urban areas and high-end medical centres.

### **Considerable scope of action for service providers**

The issue of medical measures in disability insurance is a complex one, given the vast number of different illnesses concerned. The problems encountered are not the same for mental illnesses, cerebral palsy, facial and dental malformations, neonatology, or growth disorders. Obviously, the wider range of medical services available, progress made in research, a greater understanding of the illness, improvements in diagnosis and the introduction of new therapeutic treatments have improved patients' care and quality of life and have certainly also had an impact on costs. Advances in the care given to children with congenital cardiopathy or cystic fibrosis are quite impressive. However, there are also other, more specific cost factors, such as the difficulty in defining clear and objective criteria or determining the duration, intensity and frequency of therapeutic products or treatment. With such varied areas of medicine, it is simply not possible to know all about the latest developments. As the level of expertise at the FSIO and the disability insurance offices is often quite low, fragmented or concentrated in a small number of individuals, external service providers and specialised medical companies have a considerable scope of action in defining diagnostic and therapeutic standards. Disability insurance tends to be only marginally involved in such discussions, if at all.

### **Room for improvement and recommendations**

As a result of poor management by the FSIO, there are significant differences between the cantons, and service providers are given considerable leeway. The debate on transferring medical measures from disability insurance to health insurance has been ongoing for years, often boiling down to a transfer of expenses from one social insurance to another. However, no serious thought has been given to cost control or the management of medical measures by the disability insurance. As long as Switzerland maintains its segmented social insurance system, efforts should be made to optimise it. Given the results of this evaluation, the SFAO believes that improvements are necessary. It has thus made six recommendations to the FSIO. Two recommendations of a strategic nature concern the future of medical measures and the revision of both the list of congenital disorders and the Circular on medical measures. This is all the more important since the FSIO has acknowledged it does not have the resources or management tools needed to deal with this subject area, particularly the developments in medicine. Two recommendations on management and supervision concern the setting of objectives and specific indicators in the agreements with disability insurance offices, better utilisation of the data available, and identification of risks with respect to illnesses, cantons and service providers. Two recommendations on execution tasks entail the creation of specialised centres of expertise per medical domain and a more thorough examination of complex as well as expensive cases.

The FSIO has agreed with the recommendations and set its sights on implementing them within the next three to five years. For this purpose, as the FSIO has specified, an implementation strategy needs to be mapped out by the end of 2014, also taking into account possible modifications to the existing legal bases.

**Original text in French**