Federal Social Insurance Office

Repercussions of the KVG on Service Providers

Summary

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Summary

Aims

The following study analyses the impact of the Federal Law on Sickness Insurance (Krankenversicherungsgesetz KVG) on service providers. It compiles the results of past evaluations with new ad hoc analyses and surveys, in order to find answers to the following questions:

- Has the introduction of the KVG modified the possibilities open to service providers and if so, in what manner?
- How is one to assess the implementation of the KVG with reference to providers?
- How have the new framework conditions modified the providers' behaviour?
- Have co-ordination and competition between providers changed, and if so, in what manner?
- What changes in the relationship between providers and the other players can be observed?
- What internal changes in the providers' behaviour are due to the KVG?
- To what extent have such changes helped to curb costs?

Methodology

The impact of the KVG on providers was analysed and assessed in two stages:

1. The situation as it existed under the previous legislation (KUVG) and the present KVG, was compared, analysed and assessed in terms of the leeway it gives to providers, of their behaviour and the costs they generate;

2. Observable changes in the providers' behaviour due to the KVG were assessed (causal analysis).

The study was based on the following investigations:

- An analysis of the new possibilities offered to providers as a result of the KVG;
- An evaluation of previous impact analyses;

- 27 personal and 10 telephone interviews (qualitative) with providers' associations and individual providers;
- Complementary interviews with four cantonal authorities, the Federal Office for Social Security, the Swiss Conference of Cantonal Ministers of Health (Schweizerische Sanitätsdirektorenkonferenz SDK) and the Association of Swiss Health Insurance Companies (Konkordat der Schweizerischen Krankenversicherer KSK).
- An evaluation of 63 interviews with cantonal bodies, service providers' associations, insurers' associations, and insurers, conducted as part of the analysis of the KVG's impact on rates (INFRAS 2000) and on insurers (INFRAS 2001).
- An analysis of the impact changes in providers' behaviour have had on health cost trends.

Effects of the KVG on service providers

The KVG has modified the possibilities open to providers in several ways. On the one hand, the authorisation of new providers and new services, the introduction of new instruments to make rates more competitive, and alternative insurance options (especially HMO and the family doctor model) have given them greater leeway. On the other hand, they are subject to increased financial pressure by the cantons and insurers, and to more stringent regulatory measures. A summary assessment of the implementation of the law and of its repercussions on providers is given below.

The authorisation of new providers and services

New providers and new services were included in the list as subject to obligatory coverage under the basic health insurance scheme. This has improved the quality of health care, while boosting the volume of services and generating additional costs.

Separating obligatory and supplementary insurance

The separation of the obligatory basic insurance scheme from supplementary insurance closed the gaps that used to exist in the list of available health services, and cut the volume of services to patients with supplementary insurance (private and semi-private). Private clinics in particular experienced a slump in revenue, which they at-

tempted to compensate by increased competition in the supplementary insurance market, and more offers relative to short-term in-patients.

Provisions for authorisation (including hospital and nursing home planning)

The new provisions regulating authorisations for outpatient care (ongoing training) did not influence all providers in equal measure. In certain cases they had no effect at all. But they upped the level of professionalism and organisation in Spitex home care services, and improved training among pharmacists and speech therapists, as well as the positioning of nutritionists and other complementary therapies.

With the financial pressure on the cantons, the KVG has also speeded up hospital planning processes, although their rate and details of implementation differ considerably from one canton to the next. Because of strong political resistance, only a few cantons have started using hospital planning as an instrument to close down hospitals and reduce overcapacity. Co-ordination between the cantons and other areas of health care is poor. Hospital planning and the resulting measures: closures, reducing the number of beds, hospital mergers or other forms of co-operation, as well as shifting costs to the remaining hospitals and similar moves, vary widely from canton to canton. Moreover, by focusing on cantonal hospital capacity, the plans have reinforced federalist trends, and not done much to improve co-ordination between the cantons. As a result of this and of the fact that plans tend to be not restrictive enough, the effects that have made themselves felt are too limited and weak. Impact on nursing homes was non-existent for the simple reason that nursing homes rarely suffer from overcapacity.

Assessing demand

The restrictions on coverage of services per doctor's prescription for certain providers of outpatient care did not reduce the volume of services. Certain instruments for assessing demand for nursing home and home care services have been improved and tested as a result of KVG provisions. Although they have yet to be fully implemented for nursing homes, they have definitely improved cost and quality awareness within Spitex.

Setting rates

Rate agreements have been successfully adapted to the new KVG requirements, except for physicians' rates. Increased pressure from the insurance industry makes negotiations consistently long and difficult. For in-patient rates above all, financial pressure,

the dual hospital financing rule, lacking rules concerning practical implementation and – last but not least, the fact that certain relevant concepts are never clearly defined, negotiations are often strained and give rise to numerous complaints. The fact that the Federal Council has not yet introduced binding regulations to make cost calculations more uniform is a further obstacle to negotiating rates for hospital and long term care.

As a result of financial pressure, rates remained stable or increased only slightly for most providers:

- They remained largely stable for hospitals and physicians.
- Rates for nursing homes and Spitex care do not cover the full costs, and continue to be a problem.
- Providers of other forms of outpatient care, such as physiotherapists, nurses, speech therapists, have suffered some losses. The new drug payment scheme will induce pharmacists to stabilise costs; a new steering mechanism should keep them from compensating for lost income by boosting sales volume.

Financing

The dual system of hospital financing has caused rates negotiations to be highly conflict-ridden. It has also reinforced the trend towards privatisation, and the shift from inpatient to outpatient care, caused by the cantons trying to rid themselves of a part of their financial burden.

The new regulations concerning hospitalisation outside of one's canton of residence have had a mixed impact: they improved co-ordination between hospitals as a result of free movement agreements between the cantons, but increased the amount of red tape involved. Moreover, a ruling by the Federal Insurance Court encouraged certain cantons to extend their services to avoid having to cover costs of care somewhere else.

Alternative insurance options

Immediately after the KVG came into force, the number of policyholders who opted for a scheme with a limited choice of providers (HMO and family doctor) jumped sharply, but has grown less strongly since. This is largely due to the fact that insured partied do not like to have their freedom of choice curtailed and thus avail themselves of these

models quite seldom. Nor are they particularly interesting for physicians, whose services continue to be subject to obligatory coverage (Kontrahierungszwang). In fact, physicians are mostly unaware of the possibilities these schemes offer them. Their increased popularity could raise awareness among physicians, improve networks between them, and render them more attentive to the economic consequences of the treatment they prescribe or of the resulting follow-up treatment. Changes are most noticeable among physicians who are part of an HMO, or who assume a certain financial risk through capitation or through their own investments. By guiding patients and resorting to more cost-conscious medical treamtent, an HMO achieves savings of 10% to 15% on conventional medical treatment. Insurance schemes involving family doctors are less successful, due to insufficient economic incentives and a poor selection of participating physicians.

Cost and cost-effectiveness control

Cost control by insurers was reinforced in most areas of health care. Cost-effectiveness controls, on the other hand, are rare even in hospitals, due to insufficient data. As a result of controls, almost all providers have seen an increase in paperwork, but have not significantly reduced the volume of their services.

Quality assurance

Most providers are currently just embarking on a long-term process aiming for institutionalised quality assurance, either set off or stepped up by the KVG. Most are at the theoretical stage, or submitting their instruments to initial tests. Although in this area things are by no means satisfactory, the measures arising from the KVG have already improved quality management somewhat, for example in hospitals, nursing homes, Spitex services, and among pharmacists and nurses. However, it is as yet too early to expect a significant improvement in the quality of services, or notable savings.

Co-ordination and competition

The KVG aims to use both regulatory and market mechanisms to foster co-ordination and competition between providers, with a view to improving the use of available re-

sources and cutting costs. Results until now have not been very encouraging – the KVG has not really reinforced co-ordination between providers, or competition between them.

- Generally speaking, the co-ordination between providers is unsatisfactory. Physicians have failed to perceive the focal role that accrues to them in this area. Co-ordination between nursing homes and Spitex also leaves much to be desired. Co-ordination between hospitals in the same canton has improved slightly; inter-cantonal co-ordination has not improved at all. This is due mainly to the fact that the parties involved in hospital planning and in the alternative insurance options fail to make full use of the possibilities open to them.
- The competitive impact targeted by the KVG (alternative options, special policies) has not made a breakthrough. In fact, competition is virtually unknown among providers of both inpatient and outpatient care, and the KVG has not changed this situation. Competitive options for hospitals are strongly curtailed by current regulations, (service contracts and rates setting), and by distorted competition between public and private hospitals. Competition between nursing homes, Spitex services, physicians and other outpatient service providers is either non-existent, or extremely limited.

Third-party relationships

The relationship between providers and the other health care players has not been fundamentally modified by the KVG. The most tangible effects concern insurers, who tend to shift the financial pressure they themselves suffer to providers.

Internal changes

The KVG set off or speeded up the following internal changes for providers:

- Increased professionalism and market orientation, above all for public hospitals, nursing homes, and Spitex;
- Organisational changes: hospital mergers, larger organisational units in Spitex, more physicians in group practices;
- A partial modification of the services on offer, above all in hospitals and for long-term care;

- Promotion of the development, testing and in certain cases implementation of new instruments relative to quality assurance, assessment of demand, rate-setting;
- Noticeable increase in administrative procedures as a result of rates negotiations and the development of new instruments.

Influence on health care costs and range of services on offer

Until now the KVG has not made a significant contribution to curbing health costs. These have grown steadily, primarily for structural reasons related to progress in medicine and relevant technology, to growing patient demands, more service providers, and population ageing. An analysis of cost evolution in individual areas of health care shows that newly authorised providers upped their rates subject to obligatory coverage, that the coverage of nursing home and Spitex costs shifted from private or public spending to insurers; that hospitals have compensated for their failure to cut costs primarily by evasive measures; that physicians compensated their loss of income by increasing the volume of care they dispense. Since Managed Care is still relatively unknown, the savings it generates are minimal.

The instruments introduced by the KVG to cut providers' costs have so far had little impact, having been badly implemented, made too little or wrong use of, or due to other obstacles:

- Giving in to political pressure, the cantons failed to implement sufficiently restrictive hospital planning.
- Positive developments relative to rates were largely compensated by evasive tactics. Few have seized the opportunity to sign special contracts.
- Alternative insurance options have not met with great success, due to minimal demand by the insured, lack of interest from physicians unwilling to take risks, the obligation for insurers to cover physicians' fees, and a general unwillingness to innovate which bedevils all concerned parties.
- The KVG does not offer sufficient incentives to, or puts too little pressure on, insurers to improve co-ordination and contribute to savings. The KVG has as yet not fostered cost-cutting competition.

By extending the service offer, the KVG has improved the quality of services in the newly authorised areas.

Overall assessment and recommendations

The KVG generated or started up various processes among service providers, without reaching the main aim, which was to cut costs. The following reasons thwarted the attempt to reach the targeted effects by the KVG:

- It takes time to fully implement the KVG, which influences and challenges players in the area of health care in many different ways.
- The concerned parties have made little use of existing alternative insurance options and hospital planning possibilities. A lack of precise definitions and implementation regulations for the KVG has also slowed down developments.
- The principal cost cutting instruments have had limited, i.e. unsatisfactory impact. For example hospital planning was not implemented restrictively enough by the cantons, alternative insurance options have not found enough takers, and partially positive results in setting rates and hospital planning were counteracted by evasive moves.
- The KVG has failed to introduce sufficient incentives for providers to improve co-ordination.
- Cost-cutting through competition is a delicate matter, since providers themselves determine the services they provide to patients (Angebotsfixierung). Generally speaking, the KVG has not done enough to foster competition.
- Providers and other health service players tend to optimise their own benefits, and act accordingly. This has led to several undesirable effects, such as overcapacity, insufficient co-ordination, increased volume of services to compensate for loss of income.

On the other hand, the approval of additional services has improved the offer and the quality of health care services.

To curb costs, we advocate the following three sets of measures:

- Stricter selection and reduction of the number of providers by more restrictive hospital planning and stronger competition, particularly among physicians (abolition of obligatory coverage by insurers and the implementation of Managed Care).
- Improved co-ordination between providers through better and more extensive hospital planning (at regional level, better contacts with other providers), new rate-setting models (for example, patient-pathway related flat rates, calculated on the basis of patient diagnosis), and the promotion and encouragement of Managed Care.
- In addition, existing obstacles to competition, such as the current dual hospital financing system, should be eliminated. Patients should be made more aware of cost issues and better informed of services on offer and of insurance options. Uni-

form quality benchmarks should be defined in view of increasing competition between service providers, while maintaining consistently high standards.