

Are we willing to pay for a happy patient?

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Topics

- Role of CVZ in reimbursement system at the moment;
- Future task in Dutch Institute of Health Care; quality assurance
- Reimbursement criteria
- Role of criteria in decision process; reality of policy making. Some examples
- Future developments; what do they mean for research on outcome measures and patient preferences
- Discussion

Role of CVZ at the moment

- CVZ is responsible for advice on reimbursement (with or without conditions) of health care interventions
- Minister of Health decides
- CVZ is assisted by a assessment committee (on pharmaceuticals) and by an appraisal committee

Future: Dutch Institute of Health Care

New additional tasks (2013?):

- **Stimulate professonial standards**
- **Stimulate the implementation of standards, best practices and innovations**
- **Provide transparency in quality of health care and gather information to facilitate choices and surveillance**
- **Stimulate appropiate care**

Criteria for reimbursement

- **necessity: two dimensions**
  - burden of illness
  - own responsibility/affordability
- **Effectiveness**
- **Cost effectiveness**
- **Feasibility**

Effectiveness

- Safety
- Side effects
- Ease of use
- Qality of life
- Compliance

Evaluated according principles of EBM

Level of evidence must be appropiate for positive decision

How to measure QOL in long term care groups?

Research by EMGO

AWBZ (Particular Diseases Insurance Fund)

Four care groups:

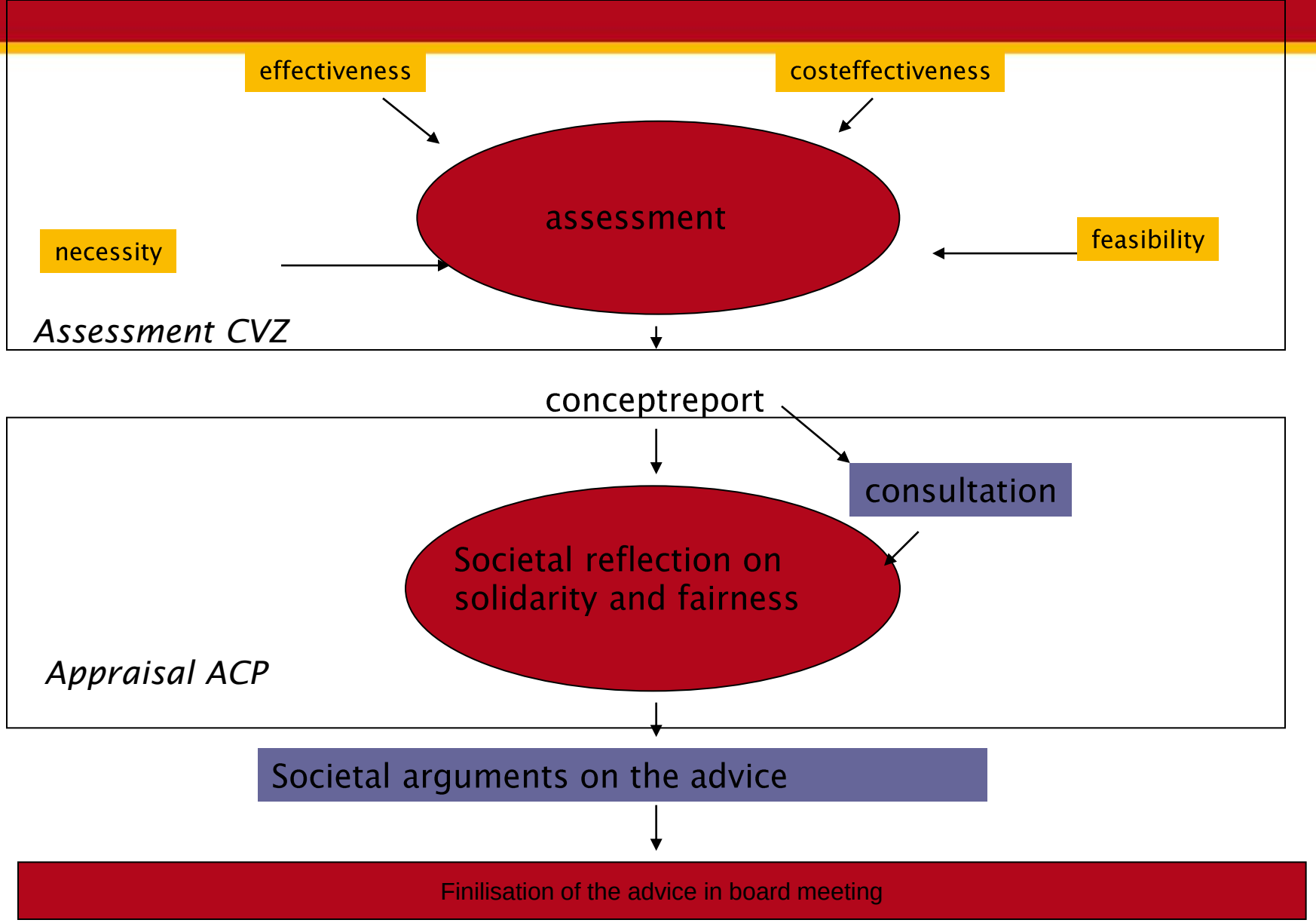
- Long-term Psychiatric
- Mental disabled
- Physical disabled
- Elderly

Conclusion: none of investigated outcome measures can be used yet by CVZ. More research needed.

Appraisal process

Important questions:

- **What role does the current QALY play in the appraisal?**
- **Is it likely that additional information beyond the QALY will make a difference in this process?**



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Societal reflection: what is it?

Some important questions

- **How to combine integral evaluation with te use of cut off values?**
- **How to weigh the criteria: multi criteria analysis?**
- **What are all relevant societal apects on solidarity and fairness?**

Valuation of cost-effectiveness (JvB) inventarisation

- **Increasing**
  - Burden of illness
  - Rarity
  - Relates to much informal care
  - Risks for others

- **Lowering**
  - Limited relation to domain of health care
  - High budget impact
  - High future medical costs
  - Unsuitable for insurance because of high incidence
  - Unsuitable for insurance because of autonomy patient

Example: smoke cessation

Arguments:

Political desirability

Own responsibility

Appreciation of preventive care in health insurance

Effectiveness of treatment program

Effectiveness of reimbursement

Precedental effects on other comnined treatment programs

Precental effects on other addictions

More arguments

Damage to third persons

Is smoke addiction a disease?

Is it possibly that patients pay for this treatment themselves?

How many attempts should be reimbursed?

Is it legitimate in times of scarcity to reimburse this kind of intervention?

Conclusion of the committee

Most important are the following arguments:

Own responsibility and possibility to save money for the individual on smoking expenses

Not responsible to expand the package in times of scarcity with this intervention

Doubts about the effectiveness of the program: do more people stop smoking when the intervention is reimbursed?

Negative advice. Board is positive. It was in the package for one year.

Other examples

Anti-conception for teenagers: will there be more abortions among young girls when the interventions will be no longer reimbursed?

Expensive drugs for Pompe and Fabry deseases: what patients benefit the most from this drugs?

Concerta adhd: though for patients the drug has advantages, the higher price is not reimbursed because threre is no prove of superior therapeutical value

Conclusion: research and policy making

Its is very important to identify in an early phase what information is needed for the reimbusement debate

Role op QALY in decision making

At this moment poor cost effectiveness has not been a reason to reject an intervention for reimbursement.

Poor or lack of effectiveness often is a reason for rejection

Changing times

- Due to economic crisis less money available for health care
- more demand because people are getting older and spend more years in poor health at the end of their lives: more chronic diseases
- These developments ask for fine tuning the reimbursement critera

Developments 1

- More decisions of Coverage with evidence development
- cutting expenses: exclusion from package by strict application of criteria
  - threshold for burden of disease
  - threshold for cost effectiveness

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What does this mean for the use outcome measures beyond the Qaly?

- Only if they are “objective”
- Only on the level of populations, not individuals
- Patients preferences only if they point in the same direction as the “objective evidence”

Solidarity

Are Dutch premium payers willing to pay for?

- **Interventions that are “proven” by RCT’s?**
- **Interventions that are evaluated positive by patients?**
- **Interventions that make people happy?**

We don’t know!