Limiting the Dutch BBP

Chances and Challenges for Dutch Care Institute

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Outline

Limiting the BBP

- Why limit health care?
- Current decision model and decision process
- Current use

Challenges and Chances for new Care Institute

- Limiting through guidelines
- Setting a threshold
- Considering the entire 'package'
- De-politicization decision making
- Price negotiations and Value Based Pricing

Limiting health care?

- Health care expenditures growing rapidly – and likely will continue to do so
- Health technology important driver – limiting BBP logical choice and public responsibility
- Limiting BBP compatible with system of regulated competition
- Rationale to limit BBP is partly 'medical' (cutting out pointless or even harmful treatments), but largely economical (cutting out treatments that are too expensive for what they do)
- '*The first lesson of economics is scarcity…*'
- Especially in health care scarcity is denied ('money should not matter when it comes to health') by patients, suppliers and politicians
- "*… the first lesson of politics is to disregard the first lesson of economics…*"

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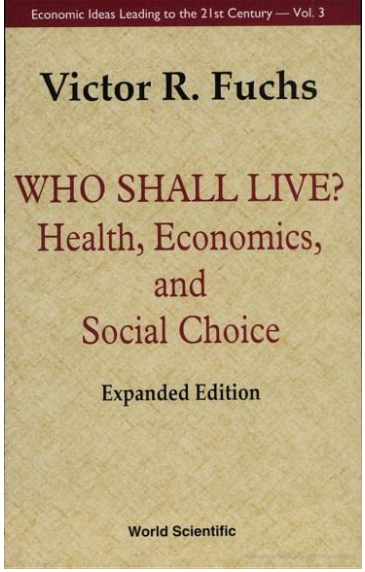
A cynic

is someone who knows the price of everything but the value of nothing

An economist

is someone who knows the price of everything but the value of nothing

Limiting health care!



- Saving money rather than lives?
- '*If a medicine works we should fund it.*' Really? At any price?
- Under a fixed budget spending more on one patient group has opportunity costs within the health care sector: the price of health is health forgone
- Under flexible budgets there are opportunity costs elsewhere: the price of health is 'wealth' (education, infrastructure, housing, international aid, …)
- We need to choose what to do… *and what not!*
- Instruments and processes for setting limits need to be optimal and justified given the issues at stake
- Limiting BBP is *explicit* rationing - who dares to draw explicit lines?
- Only one party that can draw them legitimately?

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Zeldzame ziektes worden te duur. Nu Pompe en Fabry. Welke volgt?

Nieuwsanalyse
Een duur medicijn voor de zeldzame spierziekte van Pompe wordt mogelijk niet meer vergoed. „Ergens moet je een grens trekken."

zag laatst een puberjongen met Pompe. Die zat in een rolstoel, stond opeens op en zei: „Dankzij het medicijn leer ik lopen."

Voor het eerst dreigen in Nederland twee medicijnen die al op de markt zijn op grond van kostenoverwegingen onbereikbaar te worden

het medicijn uit het basispakket verwijderen, kan dat ook gebeuren met een veertigtal andere dure medicijnen die alleen in ziekenhuizen door medisch specialisten mogen worden voorgeschreven. Die zijn de komende jaren voor een herbeoordeling aan de beurt.

levensjaar dankzij een medicijn hooguit 37.000 euro kosten. Preciezer gaat het om QALY's (*quality adjusted life year*). Dat zijn levensjaren waarin ook de kwaliteit van leven is verwerkt. In 2006 en 2007 adviseerde de Raad voor de Volksgezondheid en Zorg om in Nederland een maximum van 80.000 euro voor een QALY vast te stellen. Voor elke patiënt met de milde variant van de ziekte van Pompe kost een QALY 15 miljoen euro. „Onacceptabel", schrijft het CvZ.

Voor politici zijn dit lastige ethische afwegingen, zegt Leo Ottes, van de Raad voor de Volksgezondheid & Zorg, omdat deze patiënten een gezicht hebben. Zij zijn al ziek. Zonder medicijn worden ze nog zie
sterven ze zelfs. En ze
verhaal vertellen
Toch ver
medi

zame ziekte dan gewoon pech gehad? Aan de andere kant: we kunnen veel ándere behandelingen niet vergoeden als we voor één patiënt zes ton kwijt zijn."

Aan Fabry en Pompe, bijvoorbeeld, geeft Nederland elk jaar zo'n 55 miljoen euro uit, voor enkele tientallen patiënten. Het zijn allebei ziektes waarbij patiënten door een genetisch defect een belangrijk stofwisselingsenzym missen. Alleen voor baby's met de ernstige vorm van de ziekte van Pom blijft het medicijn volgens
beschikbaar.
Voor
t Ottes, advi-
d al een paar
timum voor
elk nieuw
mee gered
en recht-
fwegin-
dat het
weten
erven
. Al-

Pompe wel of niet in het basispakket, dat is de vraag

Werken de medicijnen voor de zeldzame ziektes Pompe en Fabry? En hoeveel mogen ze kosten? Die vragen behandelde het College van Zorgverzekeringen gisteren in een beladen hoorzitting.

Door onze redacteur
FREDERIEK WEEDA

DIEMEN. Het is doodstil in de zaal als

worden
Naast Po
van Fabry
ziektes lijd
landers. De
ten jaarlijks
200.000 en 90

Patiënten va
telden gisteren
hun leven hadde
kanten onderstree
cijnen vergoed mo
artsen van het AMC
Medisch Centrum m

Het draait altijd om heel moeilijke keuzes in de zorg

Bezuinigen op de zorg kan op verschillende manieren.
n de top: minder dure medicijnen voor zeldzame
Of aan de basis: mensen zelf laten betalen voor
ers of rollators. Maar kiezen is moeilijk.

rtaan alleen nog ervaren vak
raties mogen doen. E
ader die zo is op
klapband

Economic evaluation

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- Current decision framework described by CVZ (e.g. 2009) for delineation of the BBP basically is a (special) economic evaluation
- It considers whether the societal benefits of an intervention exceed the societal costs related to it (whether welfare improves by inclusion in BBP)
- $v_i \Delta Q_i - \Delta c > 0$ [benefits exceed costs] or $\Delta c / \Delta Q_i < v_i$ [cost-per-QALY lower than threshold; value of QALY]
- Underlying welfare economic notion: welfare maximization.
- This framework builds on a long history of thinking on limiting the BBP
- Landmark publication was the Report by the Dunning Committee (1991)
- Proposed four important criteria for delineation of BBP and a first idea of how to use them

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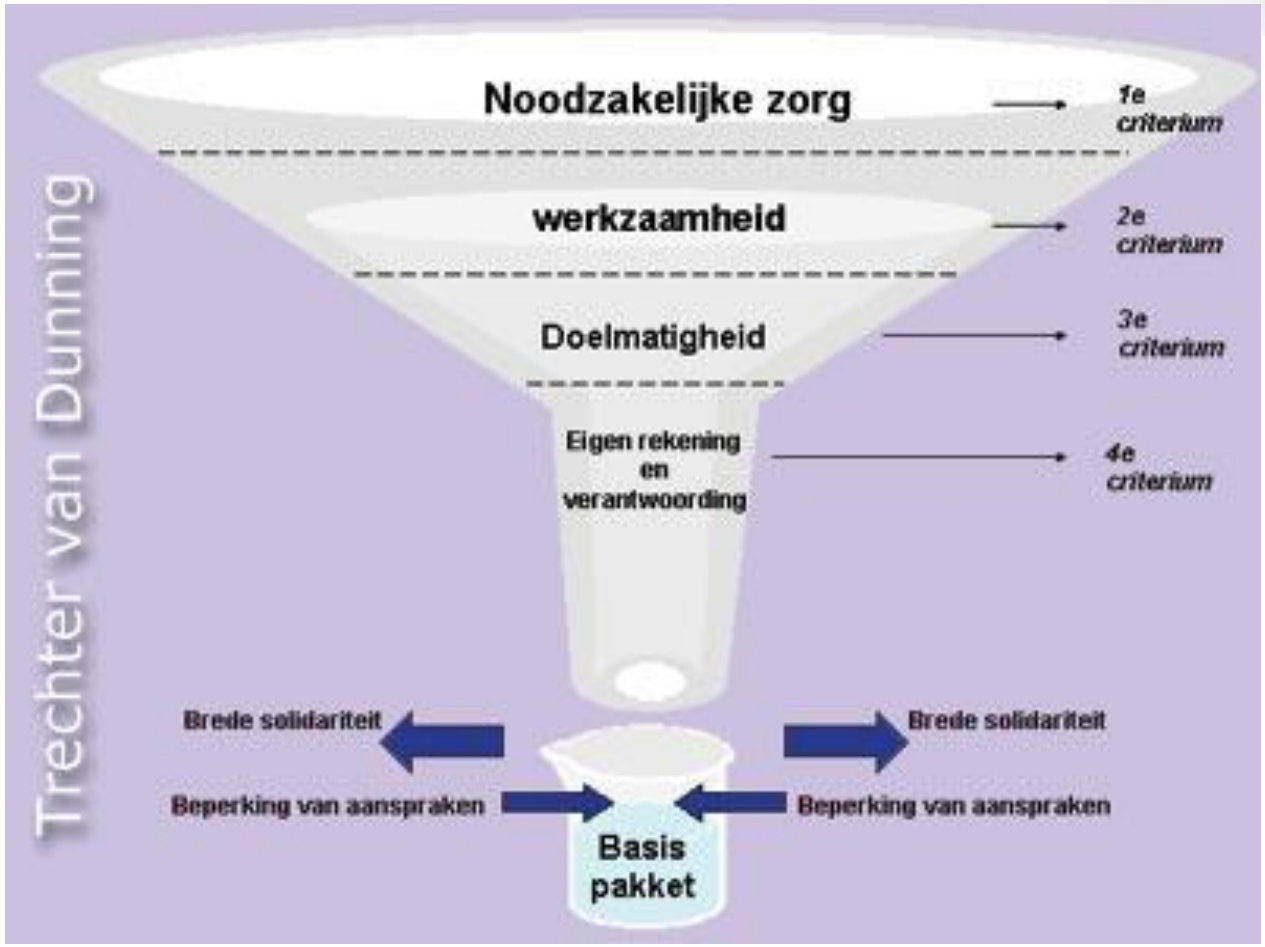
Funnel of Dunning



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Criteria, interdependence, quality

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- Criteria well received, but use of Funnel proved difficult (consecutive approach & operationalisation criteria – especially necessity)
- Relevance of criteria themselves remained fairly undisputed: main criteria of necessity, effectiveness and efficiency still central (CVZ, 2009).
- Should ensure the BBP consists of *necessary, effective and efficient care for its user*. (This defines appropriate care – RVZ, 2004)
- Quality in KZi : *effective, efficient, patient-centered care, in line with need of patient* - Good BBP management enhances quality!
- Over the years, operationalisation of criteria (also necessity) and their decision making framework evolved (CVZ, 2001; RVZ, 2006; CVZ, 2009)
- Process of decision making evolved as well – assessment followed by appraisal

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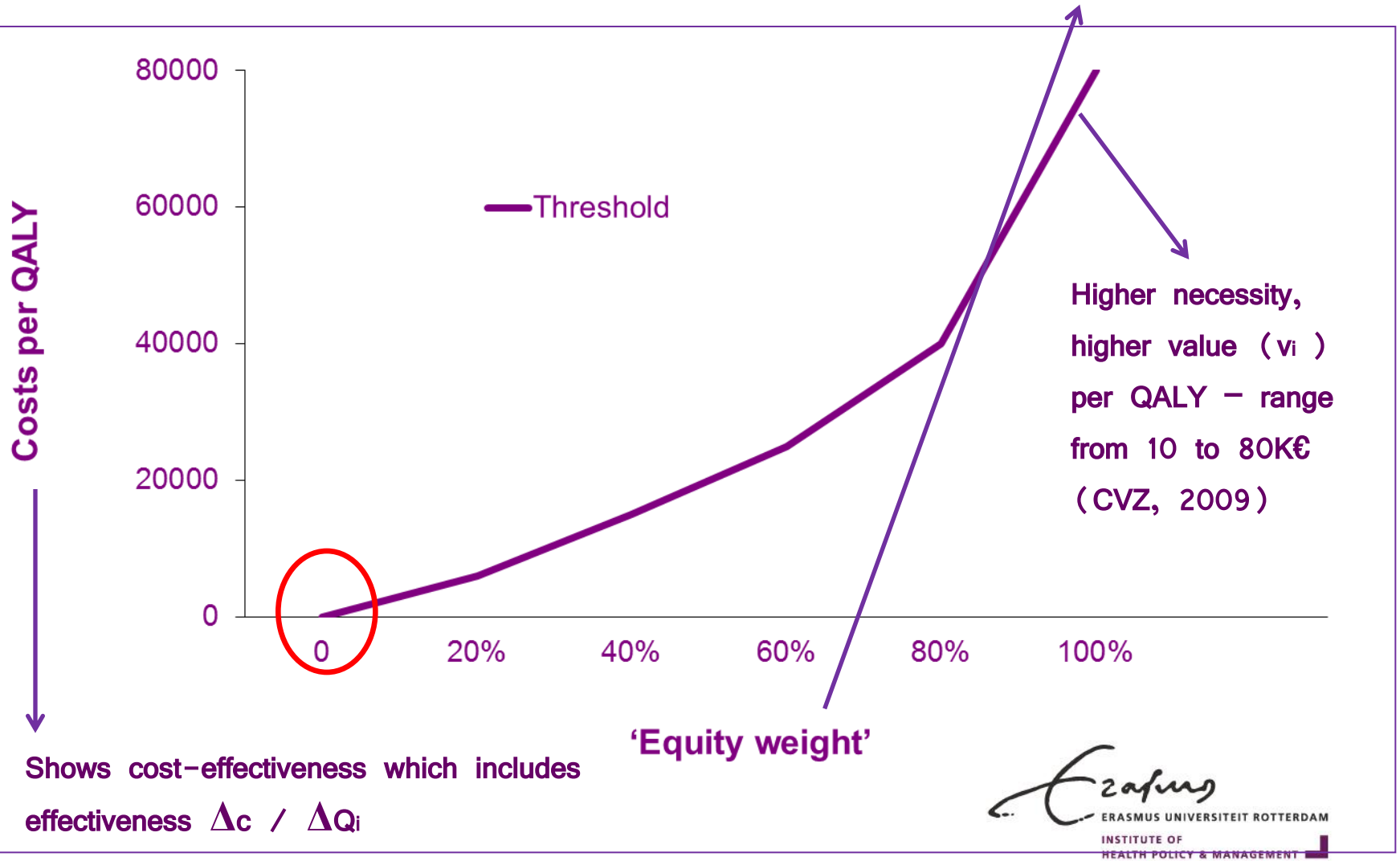
Intermezzo: Regeerakkoord

- Noodzakelijkheid (medisch-inhoudelijk en budgettair) wordt een apart voorliggend (en daardoor op zichzelf doorslaggevend) criterium. … **Daarnaast wordt het criterium (relatieve) kosteneffectiviteit wettelijk verankerd.**

- Het instrument van voorwaardelijke toelating/financiering tot het pakket in combinatie met risicogericht pakketbeheer wordt breed … ingezet. **Tijdens de periode van voorwaardelijke toelating/financiering (maximaal 4 jaar) wordt (kosten)effectiviteit in beeld gebracht.**

Decision framework simplified



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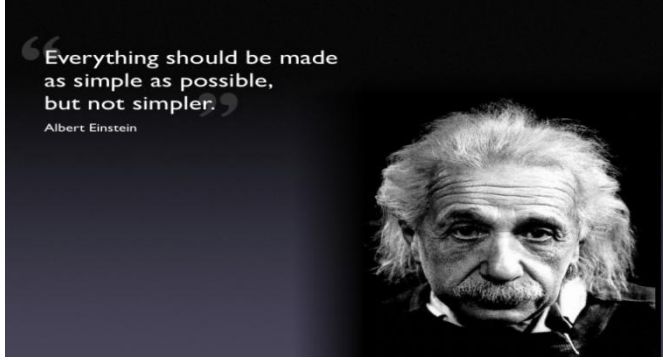
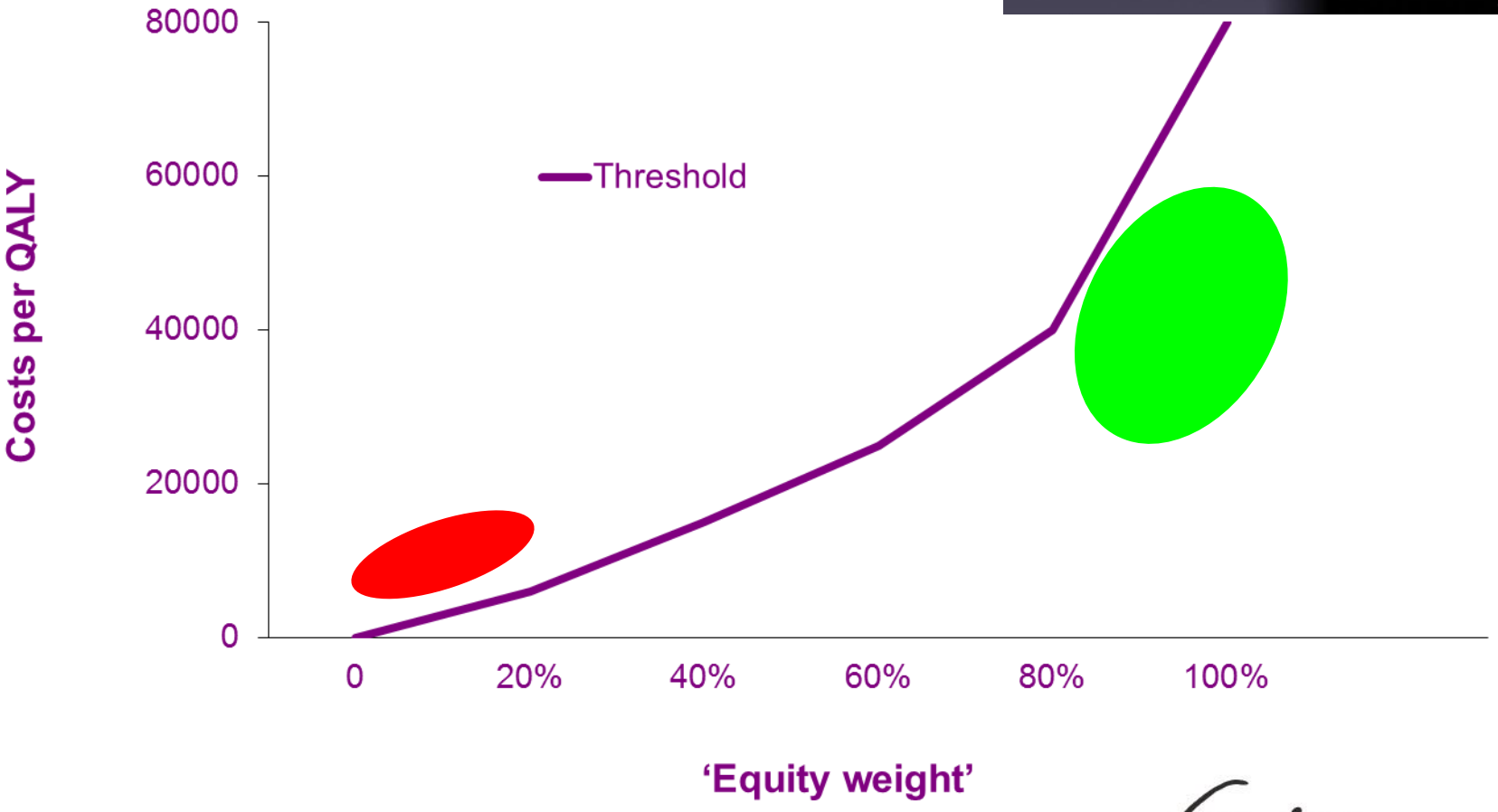
Decision framework simplified





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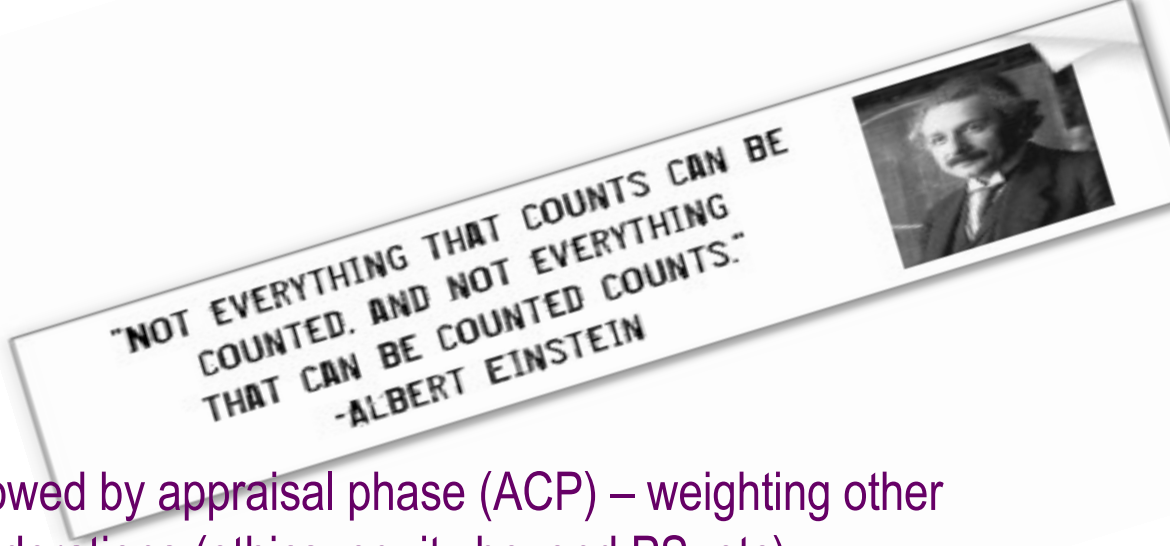
Current use



- Assessment phase followed by appraisal phase (ACP) – weighting other important societal considerations (ethics, equity beyond PS, etc).
- *Accountability for reasonableness* (Daniels)
- Goal is to consider broad health technologies – currently especially medicines and some curative interventions
- Especially aimed at 'in/out' decisions, although other options are available
- Acceptable range for cost-per-QALY indicated as 10-80K€, increasing with necessity, but influence and strictness debatable (e.g. cancer drugs)
- Quality institute could use this framework and stimulate appropriate care use and (thus) quality of care – integration of activities with Care Institute!
- Five challenges and chances follow!

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(1) Guidelines!

- Care often is not inappropriate as such, but its use can be
- Already in 1991: *Medisch Handelen op een Tweesprong*
- Reduce undesirable practice variation and improve efficiency
- Plea for *evidence based guidelines* and protocols with important role for profession itself to initiate these
- Should ensure appropriate care in practice
- Quality institute in leading role for setting standards and guarding process; profession in lead in setting up guidelines
- Ultimate chance of combining BBP management with guideline development within one institute!
- Two reports from 1991 come together in Care Institute!

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(1) Guidelines!

- Guideline development ideally be based on criteria necessity, effectiveness, efficiency
- Advocated as more precise way of delineating the BBP – scalpel rather than an axe… (Rutten & Brouwer, 2002; CPB & iMTA, 2007)
- Good guidelines replace 'in/out' decisions – BBP limited, in practice, by ensuring appropriate use!
- *Necessary, effective and efficient care for its user*
- Congruent definitions of appropriate care rather than divergent ones!
- Integration BBP management & guideline development
- It is possible! – See UK experiences
- It is possible! - See Dutch experience with guidelines project (1997-2003) where economic evidence was integrated

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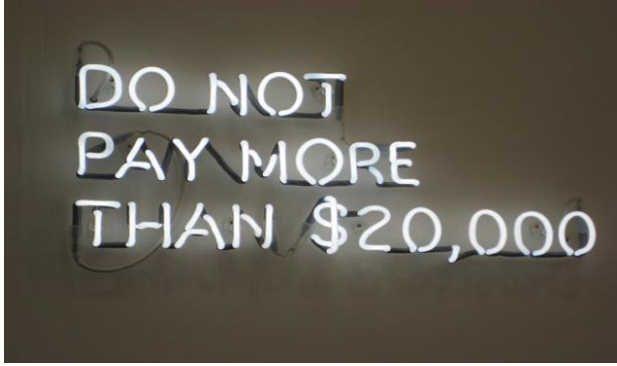
(1) Guidelines!

- Quick scan (Hakkaart et al., 2010) indicates that practice guidelines normally do not consider economic evidence
- What good is BBP management if complete exclusion is difficult (and undesirable) and guidelines can promote inefficient use of resources?
- Guidelines for everything?
- Moving from risk-oriented BBP management to risk-oriented guideline development!
- Insurers could subsequently stimulate adherence to guidelines
- Indicators of quality could include indications of this adherence and measurement of real outcomes (health gain, etc).

(2) Setting limits



- The current framework and debates make 3 things clear: (i) we need a threshold, (ii) the need for a threshold needs to be explained and (iii) the threshold itself needs to be justified
- Without a threshold, decision framework is meaningless and the goal of doing the most with available resources (welfare maximization) is lost
- Current threshold range (10-80K€) is evidence nor consensus based
- More research and debate is required, also in relation to severity
- Like Weinstein (2008) wrote: *It is time to lay to rest the mythical $50,000 per QALY standard and begin a real public discourse on processes for deciding what health care services are worth paying for.*
- In the same process need for limit should be publicly debated

(3) De-politicisation of decisions

- It seems that the current process (advice of CVZ but decision by VWS) makes many decisions matter of political debate
- This may not be most effective for setting limits
- Perhaps politicians should decide on the decision making framework and processes, rather than its application (specific interventions)
- Stronger mandate to Care Institute to *make decisions* in line with agreed on principles, criteria and framework
- Political independence to say 'no' e.g. if the intervention is deemed inefficient (in some groups) '*… and bear the heat of such a decision'* (Claxton, 2006).
- Stick to justified and agreed upon principles.

(4) Broaden the scope

- Current emphasis is on curative care, especially medicines
- Goal is to come to 'overarching' management of the BBP
- Instruments to do so, especially in the context of LTC (AWBZ), or special cases (IVF, palliative care, etc) are lacking
- Good assessments require (i) understanding the goal of intervention, (ii) quantification of goal attainment and (iii) valuation of goals
- Care Institute and Quality Institute could stimulate the development of instruments allowing the use of the decision framework also in other areas – also can be used in context of indicators!
- Using QALYs in situations where health gains are not a (main) goal risks wrong decisions!

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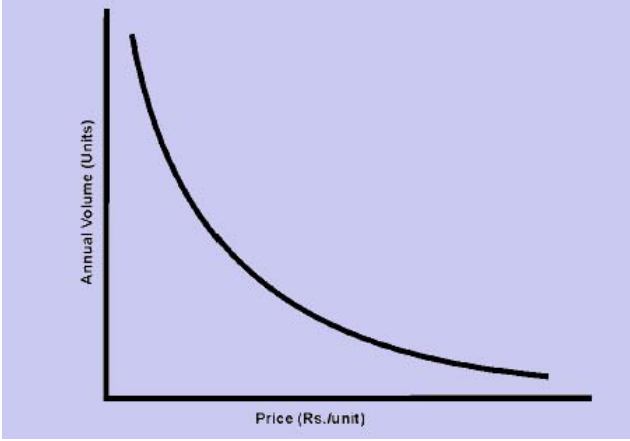
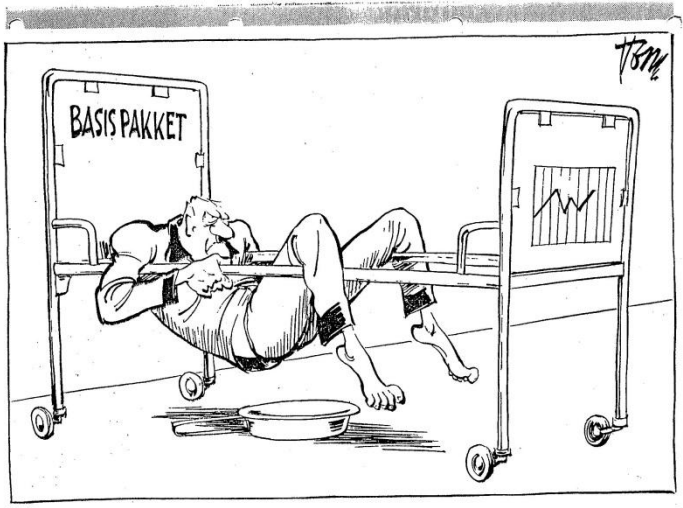
(5) Other instruments



- Currently, too little attention for pricing as policy instrument
- E.g., price-volume / risk sharing negotiations part of BBP inclusion
- Volumes can now increase without any price implication
- Moreover, economic evaluation could serve as basis for price negotiations (VPB UK)
- Indicate a reasonable price at which it inclusion / use would be appropriate…
- Outcome measurement to reconsider choices/prices/guidelines, based on real life data (coverage with evidence development)
- Outcome measurement does require sound methodology and a sound decision making process to deal with inherently less certain data!

Concluding



- Stringent BBP management remains crucial to control and justify expenditures
- Risk-oriented (health and cost-wise) assessment of *broad* health technologies
- Decision framework and process well developed but can be further refined
- Justified threshold required – drawing a line between appropriate and inappropriate care
- Consider broadening mandate and tools of Care Institute and integrate work performed in it!
- Limiting BBP through practice guidelines promising way forward
- Guideline development within Quality Institute based on principles of necessity, effectiveness and efficiency for the patient

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