Health Policy 119 (2015) 245–251

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health Reform Monitor

The basic benefit package: Composition and exceptions to the rules. A case study

Madelon Kroneman*, Judith D. de Jong

NIVEL (Netherlands Institute of Health Services Research), PO box 1568, 3500 BN Utrecht, The Netherlands

ARTICLE INFO

Article history:
Received 27 June 2014
Received in revised form 9 January 2015
Accepted 20 January 2015

Keywords:
Health systems reform
Basic benefits package
Health insurance
Policy development.

ABSTRACT

With the introduction of the Health Insurance Act in 2006 in the Netherlands, the basic package of the former sickness funds became valid for all citizens. The basic benefit package has been subject to change, responding to increasing health care expenditures, medical innovations and the economic crisis. In this paper we address the decision criteria used to assess the package annually since 2006 and describe some developments that do not follow the criteria, leading to a yo-yo effect. We discuss the formation of the decision for in- or exclusion and why some treatments seem to follow an, at first sight, arbitrary in- and exclusion pathway. We first describe the official way of establishing the basic benefit package and than will describe why some treatments follow a deviated path. We conclude that political pressure and pressure from interest groups may lead to inclusion or postponement of exclusion. Reform of the organization of certain forms of health care (in our example mental care) may lead to seemingly inconsequent changes. The yo-yo effect of some treatments or pharmaceuticals may have negative effects on health care providers, insurers and patients. The seemingly well defined criteria available for defining the basic package appear to be broadly interpretable and other influences may determine the final decision of inclusion or exclusion.

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1. Introduction

Countries with universal health coverage are confronted with the question which treatments and pharmaceuticals are included in the benefits basket. Most countries have some kind of rationale that guides the composition of the benefits basket (see for instance [1–6]). The economic crisis may put pressure upon the generosity of the benefits basket. For instance, new treatments or pharmaceuticals may be included only if it does not lead to extra expenditure. In this paper we describe the rationale behind the composition of the benefits basket in the Netherlands in a period of economic depression and the application of the rules for inclusion or exclusion.

Since 2006 all citizens in the Netherlands have to take out a mandatory insurance plan that covers for a predefined basket of health care. For medical care that is not covered by the basic package people can take out voluntary health insurance. The basic benefits package was initially based on the package that was insured under the former Sickness fund scheme, a compulsory health insurance scheme for persons under a certain income threshold. About two third of the population used to be insured under this scheme that was abolished in 2006. Demographic developments, such as the ageing of the population, developments in medical science and technology, leading to more and more expensive treatments and the continuous increase in health care expenditure resulted in a necessity to critically assess the basic benefits package. In this

* Corresponding author. Tel.: +31 30 27 29 640; fax: +31 30 27 29 729.
E-mail address: m.kroneman@nivel.nl (M. Kroneman).

http://dx.doi.org/10.1016/j.healthpol.2015.01.013
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Box 1: The composition of the basic benefit package in the Netherlands in 2014:

- Medical care by GPs, medical specialists and midwives
- Hospital stay
- Pharmaceuticals (provided that they are on the list of accepted pharmaceuticals)
- Specialist mental care, including care by a psychiatrist
- Medical aids
- Physical therapy (under the age of 18 or from the 21st session for some chronic conditions)
- Physical therapy for urine incontinence up to 9 sessions
- Speech therapy and occupational therapy
- Dental care for children up to the age of 18
- Transportation of sick persons
- Maternal care
- Dietary advice (max 3 hours)
- Care for dyslectic children (only severe cases)
- Quit smoking program

paper we address the decision criteria used to assess the package annually and describe some developments that do not follow the criteria, leading to a yo-yo effect. The Dutch Healthcare Insurance Board (College voor Zorgverzekeringen,(CVZ), since April 2014 the name changed in Dutch Healthcare Institute, Zorginstituut Nederland) advices the Minister of Health on the content of the basic package(see Box 1 for the content of the basic benefits package in 2014). The Minister decides upon these changes and the changes have to pass the House of Parliament [5].

2. Criteria for in- or exclusion in the basic benefit package: the official way

The Healthcare Insurance Board uses the following criteria to assess the content of the basic benefit package:

1. Care should be essential: Does the illness, disability or the care needed justify a claim on solidarity within the existing cultural context?
2. Effectiveness: Does the intervention do what it is expected to do? In other words: it is proven to be effective and evidence based.
3. Cost-effectiveness: Is the ratio between the cost of the intervention and the outcome acceptable?
4. Feasibility: Is it feasible to include the intervention in the basic package, now and in the future? [7–9]

These criteria are based upon an algorithm developed in 1991 by a commission that was chaired by Mr. Dunning. The algorithm, that became known as the Dunning Funnel, consisted of four cumulative criteria: (1) services should be essential, (2) effective, (3) cost effective and (4) unaffordable for individuals. “Essential” refers to its capacity to prevent loss of quality of life or to treat life-threatening conditions. The affordability criteria state that no services need to be included that are affordable for individual citizens and for which they can take responsibility [5,10]. Cost effectiveness is currently preferably expressed in QALYs (Quality Adjusted Life Years). The acceptable costs per QALY may vary with the burden of disease and some other arguments, such as rarity of the disease (orphan medicines), a positive impact on informal care takers and risk prevention for others (such as lower risk of infection) [11]. Although the budget impact of a new treatment is not explicitly mentioned in the four package criteria, the budget impact is often included in the decision to include or exclude a treatment. There is still discussion in how to incorporate future care expenditure into the packet decision [9,11]. An important question is furthermore the legitimacy of the decision to include or exclude a treatment from the package. This requires a permanent interaction between policy, science and (clinical) practice [12].

Since it is not feasible to evaluate all treatments, pharmaceuticals and medical aids that are covered under the basic benefit package, the Healthcare Insurance Board defines priorities in a package agenda that is set every two years. The Health Insurance Board establishes the agenda in cooperation with health insurers, healthcare providers, patient associations and medical scientific associations. Interviews with representatives of each of these groups provided a large list of subjects. In the first package agenda, the selected subjects were chosen for their influence on societal developments in healthcare demand, on their societal impact, and on their effect on developments in health care expenditure. The subjects were subdivided in six clusters: lifestyle, essential care, effectiveness and cost-effectiveness, large societal impact, long-term care, and practical issues [9]. In the following two package agendas, more broad themes were used to set the agenda, such as innovation of care and demand related care. Diseases with a large burden of disease will be evaluated for the demand for care, care provision and suitability of the insured package [13,14].

In this paper, we describe the changes in the basic package since the introduction of the Health Insurance Act in 2006. What is striking is that (the reimbursement of) some treatments, pharmaceuticals and medical aids showed a kind of yo-yo effect: they are introduced into the package in one year and removed from the package in another year and sometimes back again in a third year. This leads to the question how the decision for inclusion or exclusion is made and why some treatments seem to follow an, at first sight, arbitrary inclusion and exclusion pathway. In this paper, we will give a short overview of the changes in the package and the rationale behind these changes based on the package criteria described above. We will zoom into a few examples of package changes following the criteria and then will describe some treatments that followed a deviated path.

The question may rise to what extent the Dutch situation is internationally relevant. Van der Wees et al. [15] found in a comparison of eight European countries (including Belgium, France, Germany, England, the Netherlands, Scotland, Sweden and Switzerland) that defining the package and making it evidence based is increasingly used as a strategy to keep the package affordable in the long term. These eight countries have relative similar basic packages, whether there was a national health systems or

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