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Quality based social insurance coverage and payment of the application of a high cost medical therapy: the case of spinal cord stimulation for chronic non-oncologic pain in The Netherlands

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Abstract

This article describes a project in which a national continuous quality improvement system and a payment scheme were explicitly linked, while introducing an expensive treatment (Spinal Cord Stimulation (SCS)) in the social health insurance benefit package, in The Netherlands. By linking a national CQI system and a payment scheme in a conditional financing policy a steering instrument for future control of the quality of neuromodulation treatment through SCS is created.

Keywords: Continuous quality improvement; Financing policy; Coverage decision; Payment scheme; DTCs; Quality assurance; Cost-containment; Cost-consciousness.

1. Introduction

In current health care systems, many 'perverse' relations exist between financing policies and the quality of care [1]. Payment schemes for treatments or services, for example, are often unrelated to the question whether the treatment or service in question is evidence-based or of sufficient quality. Similarly, it has repeatedly been shown that payment schemes do not always stimulate quality of care, for example simple fee-for-service payment schemes can lead to overuse as well as underuse of care, tight budgeting schemes may stimulate underuse and so forth [2,3].

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Many countries have tried to rationalize the decision to include a new technology in the social health insurance benefit package by requiring a thorough cost-effectiveness analysis (CEA) of the new technology before allowing it on the health care market. The effectiveness assumed in such CEAs, however, is rarely systematically evaluated after a coverage decision has been made. In addition, although the coverage decision may be made 'more rational' in this way, the payment schemes may subsequently have an undesired impact on the quality of the application of the new technology in practice.

Ideally, payment schemes should be designed so as to reward high-quality care and to permit the development of more effective ways of delivering care to improve the value obtained for the resources expended [1].

This article describes a project in which a national continuous quality improvement (CQI) system and decision making of coverage through social insurance were explicitly linked, while introducing an expensive treatment in the social health insurance benefit package.

The treatment studied was Spinal Cord Stimulation (SCS) for chronic non-oncologic pain. In the next section, background information is provided about coverage, payment schemes and quality improvement in the Dutch health care system. The following paragraph focuses on SCS in The Netherlands. Subsequently, three parallel processes within this project are discussed. Firstly the development of the national CQI system for neuromodulation is described. Secondly the development of a payment scheme based on the costs of SCS treatment and the CQI system is described. The third process described is the decision making process on the coverage of the treatment neuromodulation in the social health insurance benefit package. The merits of linking a national CQI system and a payment scheme, while introducing a new treatment in the social health insurance benefit package are discussed in the final paragraph.

2. Coverage, payment and quality in The Netherlands

In The Netherlands, the Dutch Health Care Insurance Board advises the Ministry of Health, Welfare and Sport (VWS) on decisions of the composition of the social health insurance benefit package. Like other countries, The Netherlands tries to control health care costs and aims at efficiency and quality assurance while introducing new technologies. In The Netherlands, health technology assessment (HTA) approaches, such as cost-effectiveness analyses (CEAs), are given an important role in the rational underpinning of decisions concerning the introduction of new treatments in the social health insurance benefit package [4–8]. However, HTA has had no more than a moderate impact on the adoption and use of new technologies in the health services [5,9]. Its function in policy making has been suggested to be primarily symbolic through the emphasis on issues such as cost-awareness [4] After the acceptance of a treatment in the social health insurance benefit package the treatment is not systematically evaluated in terms of effectiveness or quality. Recently, the discussion on social health insurance coverage is shifting from national prioritizing policies towards enhancing efficiency on the level of medical practice [4]. It is argued that, "evidence based" care should not be based on "universal" figures but on locally collected empirical data. This is seen as a means of putting professionals, with patients and payers, in the lead in a more direct way.

Since 1987 hospitals in the Dutch Health Care System have been financed by function oriented budgeting. This meant the introduction of a cost-control oriented bureaucracy in the hospitals. Although consumer satisfaction and quality of care are considered important, the financial incentives from the financing system are mainly directed at efficiency and cost control. [10,11]. Medical specialists are paid based on a fee for service system that has over the past years been embedded through lump-sum arrangements in the hospital budgets. A new system of financing of hospital and specialist costs is planned to be introduced in The Netherlands in January 2005; the Diagnosis Treatment Combination (DTCs)[3] [11]. "The care product, the DTC, contains all activities which are carried out by hospital and medical specialists to meet the specific (care) question of the individual patient who consults the specialist" [12]. The DTCs are based on the ICD-9CM or the ICD-10 diagnosis registration, like the DRGs. However, the DTCs contain not only the hospital costs, as is common in the

[3] Dutch: DBC = Diagnose Behandel Combinatie/Diagnosis Treatment Combination.