College voor Zorgverzekeringen

COPD Package Scan

Discrepancies between requested care, provided care and insured care

Summary & Conclusions

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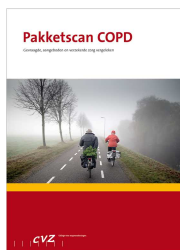


The original text of the ***COPD Package Scan*** *of CVZ was in Dutch. Although great care was taken in translating the text from Dutch to English, the translation may nevertheless have resulted in discrepancies. Rights may only be derived on the basis of the Dutch version of CVZ's COPD Package Scan.*

Furthermore, CVZ points out that only the summary and conclusions of this report were translated. A proper understanding of all relevant considerations and facts would require familiarity with the Dutch version of this report, including all appendices.

Summary & Conclusions

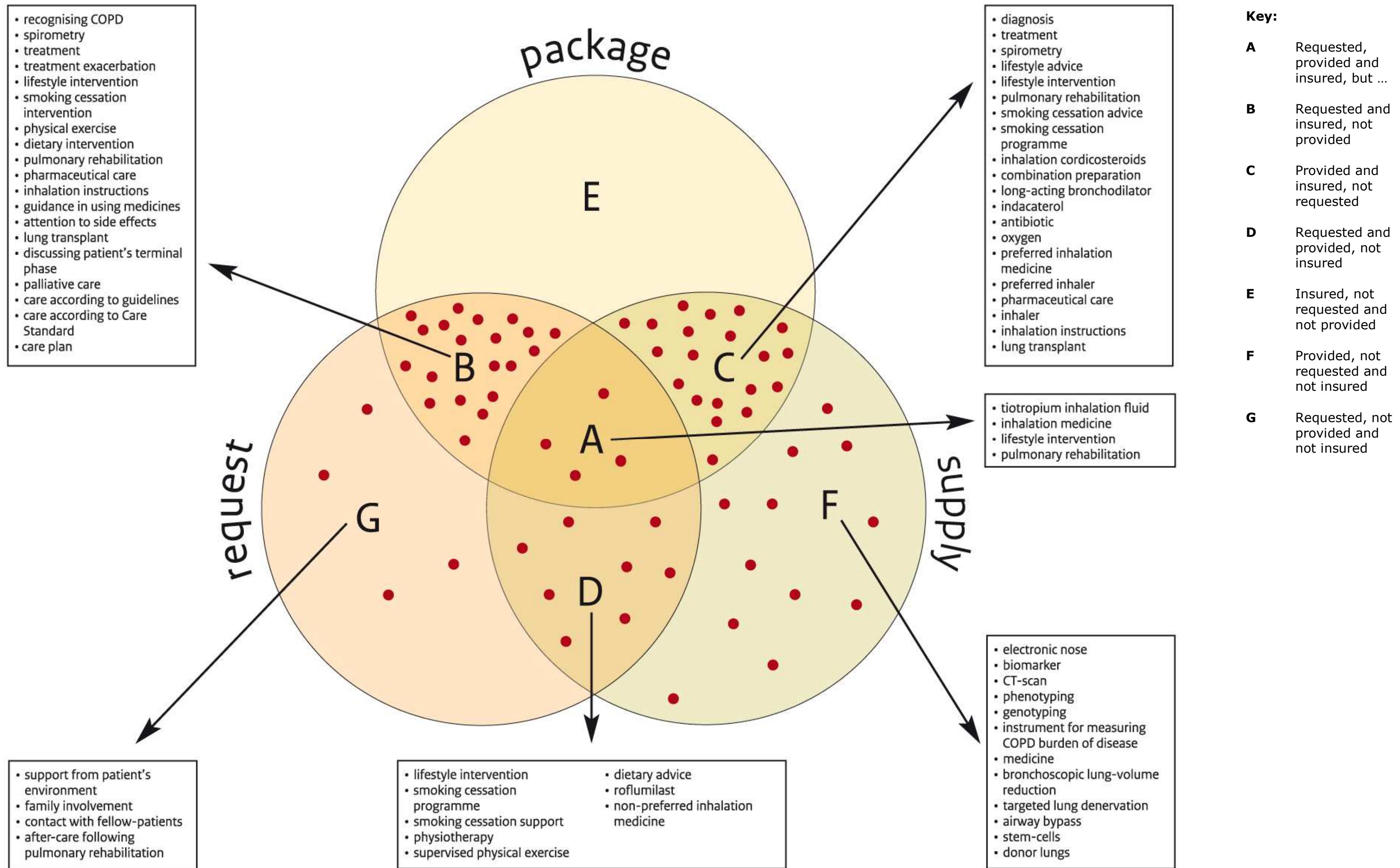
The Health Care Insurance Board in the Netherlands, CVZ, is the organization responsible for advising the Ministry of Health on the composition of the basic insurance package of health care covered by the Health Insurance Act and the Exceptional Medical Expenses Act. To find out whether the package of care is sufficiently adequate and accessible, CVZ developed the so-called package scan method. So far, we have applied this method to four of the top ten disorders with the highest social burden of disease in the Netherlands, namely Diabetes, Coronary Heart Disease, Depression and COPD. Below we summarize the findings of the COPD Package Scan.

In a package scan we analyse the adequacy and accessibility of the package of insured care for a particular disease. Does the insured package cover the care needed? And, in practice, do people receive the care for which they are insured? In a package scan we compare requested care, provided care and insured care with one another. We describe any discrepancies between them in what we refer to as 'package questions'. This results in an up-to-date picture of how the insured package in the Netherlands is functioning in practice. The package questions are described from the patient's perspective.
We have collected information on care not only from written and electronic sources, but also via interviews, visits to congresses and television programmes. The report is based on an analysis of more than 500 sources, collected from 2011 to 2013. At various stages we had the results examined by experts and relevant organisations.

In 2007 there were almost 324,000 people with COPD (Chronic Obstructive Pulmonary Disease) in the Netherlands. The quality of life of people with COPD is reduced in various ways. Furthermore, the life-span of COPD-patients is on average almost seven years shorter than that of healthy people. As a result COPD takes seventh place in the list of illnesses with the highest social burden of disease in the Netherlands. The social burden of disease is defined as: the number of healthy life-years lost due to disease in the population.

Package questions

The following figure reflects the results of this COPD Package Scan in a diagramme. The diagramme shows three circles which represent the requested care, the supply of care and the insured care. The three circles partly overlap one another, resulting in seven different areas: these are the package questions. The figure shows the discrepancies between requested, provided and insured care. Certain forms of care appear in more than one area in the diagramme (for instance, lifestyle intervention, pulmonary rehabilitation). This is because these forms of care can involve different types of discrepancies, for example (a certain type of) pulmonary rehabilitation may be unavailable for patients who need it (B) but at the same time may be provided for patients who do not need it (C).


package
request
supply
E
B
C
A
G
D
F
• recognising COPD
• spirometry
• treatment
• treatment exacerbation
• lifestyle intervention
• smoking cessation intervention
• physical exercise
• dietary intervention
• pulmonary rehabilitation
• pharmaceutical care
• inhalation instructions
• guidance in using medicines
• attention to side effects
• lung transplant
• discussing patient's terminal phase
• palliative care
• care according to guidelines
• care according to Care Standard
• care plan
• diagnosis
• treatment
• spirometry
• lifestyle advice
• lifestyle intervention
• pulmonary rehabilitation
• smoking cessation advice
• smoking cessation programme
• inhalation cordicosteroids
• combination preparation
• long-acting bronchodilator
• indacaterol
• antibiotic
• oxygen
• preferred inhalation medicine
• preferred inhaler
• pharmaceutical care
• inhaler
• inhalation instructions
• lung transplant
• tiotropium inhalation fluid
• inhalation medicine
• lifestyle intervention
• pulmonary rehabilitation
• support from patient's environment
• family involvement
• contact with fellow-patients
• after-care following pulmonary rehabilitation
• lifestyle intervention
• smoking cessation programme
• smoking cessation support
• physiotherapy
• supervised physical exercise
• dietary advice
• roflumilast
• non-preferred inhalation medicine
• electronic nose
• biomarker
• CT-scan
• phenotyping
• genotyping
• instrument for measuring COPD burden of disease
• medicine
• bronchoscopic lung-volume reduction
• targeted lung denervation
• airway bypass
• stem-cells
• donor lungs
Key:
A Requested, provided and insured, but …
B Requested and insured, not provided
C Provided and insured, not requested
D Requested and provided, not insured
E Insured, not requested and not provided
F Provided, not requested and not insured
G Requested, not provided and not insured

The following are our conclusions on package questions raised in connection with COPD.

Package question A
In this area there is no discrepancy between requested, provided and insured care: the patients receive the insured care they need. Still, we found some problems which are related to the delivery and use of care, like safety issues, the wrong use of medication and therapy non-compliance. We label these type A problems. We found the following undesirable situations.

- *The COPD-medicine tiotropium in the form of inhalation fluid that is administered via a spray is regarded as unsafe*

In fact, various studies indicate that use of this medicine is correlated with a considerably higher risk of mortality, particularly in patients known to have cardiac arrhythmia.

- *COPD-patients make errors when using inhalation medication*

COPD-patients do not always take their medication properly, even though they think they do. This results in less effective care for people with COPD.

- *Patients with COPD are not always therapy-compliant*

It seems that COPD-patients do not always complete lifestyle interventions or pulmonary rehabilitation. As a result these treatments are less effective than they could be. Also non-compliance in use of medication is an issue. Therapy non-compliance is widespread and can have enormous consequences for the effectiveness of medicinal treatment of COPD and, therefore, for the health of the patients involved.

Package question B
Package question B is about care that is requested by COPD-patients and which is insured, but which care-providers supply insufficiently, or not at all. This affects the accessibility of the insured package. However, package question B is also about the quality of the care provided. After all, where quality is lacking, good care, by definition, is not being given.

- *Patients themselves, and care-providers, do not always recognise COPD*

In particular the COPD diagnosis is often missed in women, as well as relatively young patients. The main cause of such under diagnosing is the gradual progression of COPD. Diagnostic instruments also play a role: GPs are said to make insufficient use of spirometry and when they do use it, the quality is said to be insufficient sometimes.

- *Not all patients with COPD receive sufficient treatment*

This relates in part to under diagnosing. Sometimes COPD-patients do receive treatment, but of insufficient quality, or there is insufficient harmonisation between care-providers. Exacerbations also face undertreatment or care that is of insufficient quality.

- *Patients with COPD do not receive sufficient lifestyle interventions*

They receive too little advice on smoking cessation, physical exercise and diet. Care-providers feel embarrassed or they have too little time to motivate COPD-patients to alter their lifestyle.

- *COPD-patients do not always receive the necessary pulmonary rehabilitation*

In practice, patients who should receive pulmonary rehabilitation seem not to get this indication and not to be referred. Sometimes, patients who are referred to a pulmonary rehabilitation programme subsequently face long waiting times and vagueness about what the programme entails.

- *Patients with COPD receive insufficient pharmaceutical care*

For instance, they receive insufficient instructions on inhalation and instructions are not always repeated. COPD-patients who take medicine do not receive enough guidance and care-providers pay only limited attention to the side effects of inhalation medication. There is also insufficient harmonisation between care-providers about medicines for COPD-patients.

- *COPD-patients regard lung transplant requirements as too taxing*

It is sometimes difficult for COPD-patients to cope with the strict requirements they have to fulfil in order to be eligible for a lung transplant. Furthermore, the waiting lists result in uncertainty.

- *Care-providers do not discuss the approaching end of COPD-patients' lives sufficiently with them*

Doctors seem to find it difficult to enter into this discussion and, moreover, the commencement of the palliative phase in COPD is unclear. The way palliative care is organised for COPD-patients also leaves much to be desired.

- *Guidelines on COPD are not always applied*

In practice, the COPD Care Standard (*Zorgstandaard COPD*) in the Netherlands is not yet used sufficiently either. For instance, some COPD-patients do not receive the recommended monitoring and only a few patients have an individual care plan.

Package question C

Package question C is about care that is offered and is insured but which COPD patients do not want or need. This refers to both overtreatment (patients receive care they do not want) and inappropriate or inefficient use of the package (patients receive unnecessarily expensive care). In this case the package is in fact too accessible and possibly even too adequate.

- *People are wrongly diagnosed*

People without COPD are sometimes wrongly diagnosed as having COPD. The reverse is also the case: that people with COPD are wrongly diagnosed with something else. This seems to happen because establishing COPD is not easy.

- *Cases of overtreatment*

Some patients with COPD are overtreated or receive treatment that is unnecessarily expensive. Lack of therapy compliance among COPD-patients can also lead to unnecessary care and unnecessary care expenses. Furthermore, the question is whether patients in their last life-phase actually want to be treated right up till the bitter end.

- *Questions have been raised about repeated spirometry*

Doubts have arisen about the usefulness of repeated spirometry during treatment, as there seem to be no clear effects on COPD-patients in terms of long-term health improvements. Furthermore, there are indications that GPs use spirometry too often.

- *Some COPD-patients do not want lifestyle interventions*

Some COPD-patients do not want to alter their lifestyle, which means they do not want care interventions that could contribute to this. Such patients will not comply with lifestyle advices. Lack of motivation is also one of the reasons for failing to complete programmes relating to lifestyle and pulmonary rehabilitation.

- *Advice on smoking cessation does not stroke with the patient's needs*

One-fifth of COPD-patients smoke and some do not want to quit. This raises the question of whether it makes sense to continue pressing the point. Furthermore, COPD-patients receive advice on smoking cessation that they do not understand or which is not in keeping with their personal situation. Some COPD-patients (may) want to quit smoking, but do not want intensive guidance in the form of a smoking cessation programme. Such patients prefer support in the form of devices only.

- *COPD-patients are treated too often with inhalation corticosteroids*

These patients experience insufficient effect, but do suffer side effects. Overtreatment with inhalation corticosteroids occurs mainly because too frequently doctors start COPD-patients on a combination preparation (a bronchodilator and an inhalation corticosteroid). Overtreatment can be dealt with by stopping treatment with inhalation corticosteroids, but doctors seem (too) reluctant to do this.

- *Long-acting bronchodilators are too easily prescribed for COPD-patients.*

These are much more expensive than short-acting bronchodilators. Furthermore, doubt exists about the added value of the long-acting bronchodilator indacaterol.

- *Antibiotics are prescribed too frequently for COPD-patients*

This is partly because the persistent coughing that brought them to the doctor is often wrongly interpreted as an indication of a respiratory infection. Antibiotics are also prescribed more often for exacerbations than is recommended in the guidelines.

- *COPD-patients receive oxygen treatment too frequently*

It is important that a patient does not smoke if oxygen treatment is to be effective. There are nevertheless signs that oxygen treatment is given to COPD-patients who smoke. Oxygen treatment is also often used within the framework of palliative care, even though its efficacy has not been proven. Furthermore, there are indications that patients receive oxygen in a form they do not want.

- *COPD-patients and care-providers are against preferential policy on inhalation medication and the associated inhalers*

The so called preferential policy of health care insurers sometimes results in patients receiving a different brand of inhalation medication and associated inhaler. Various patients report problems when the proprietary product, Ventolin®, is replaced by a generic product, salbutamol. Changing an inhaler can lead to errors in its use.

- *COPD-patients sometimes receive unwanted pharmaceutical care*

For instance, they receive inhalers that do not work properly or which are awkward to use. Sometimes they also receive contradicting inhalation instructions from different care-providers.

- *Not all COPD-patients want a lung transplant*

A lung transplant is a drastic intervention with a high mortality risk. A successful lung transplant does improve quality of life, but does not extend a patient's life. This makes it difficult for many COPD-patients to weigh up the advantages and disadvantages of opting for a lung transplant. Some of them therefore decide against it.

Package question D
Package question D relates to requested care which is provided, but which the package does not reimburse or not in full. As a result patients ask for this care to be included in the package. In other words: patients experience these aspects of the package as inadequate.

- *Patients with COPD ask for (more) reimbursement of lifestyle interventions*

Limiting the reimbursement of physiotherapy, dietary advice and support in smoking cessation resulted in a lot of commotion in 2011-2012.

- *Lack of clarity about the reimbursement of smoking cessation programmes*

The decision of the Dutch Minister of Health to stop reimbursing smoking cessation programmes in 2012 resulted in a great many misconceptions. In fact it meant that nicotine-replacements and medicines that support smoking cessation were no longer reimbursed. Reimbursement continued for care-providers' brief advice on smoking cessation and the intensive support that focuses on behavioural change when quitting smoking. This was not clear, however, either for patients or for care-providers and health insurers. Since 1 January 2013 the insured package once again includes smoking cessation programmes. Health insurers determine which programmes to purchase and set their own requirements. For patients this may lead to a renewed lack of clarity about reimbursement.

- *Patients with COPD want their basic insurance to provide more reimbursement for physiotherapy and supervised physical exercise*

They object not only to the (increasing) number of physiotherapy sessions they have to pay for themselves, but also to the supplementary criterion that the Health Insurance Act stipulates for eligibility for reimbursement. Furthermore, supplementary health insurance is not always regarded as adequate.

- *In 2012 COPD-patients regarded the basic insurance cover for dietary advice as insufficient*

It seems that problems resulted from the decision of the Minister of VWS to reimburse dietary advice only as part of coordinated multidisciplinary care for – among others – COPD-patients. It is as yet not clear whether these problems will be solved by the separate inclusion of dietary advice in the basic package as of 1 January 2013.

- *The Dutch Lung Fund is requesting the reimbursement of roflumilast*

The Health Care Insurance Board, however, has advised that this medicine should not be reimbursed, and the Minister of VWS has adopted this advice.

- *Patients feel they should have free access to the brand of inhalation medication that suits them best.*

However, as a result of the preferential policy of health care insurers, the preferred medicine of COPD-patients is not always reimbursed by their particular insurance company, even though the product is included in the basic insurance.

Package question E
Package question E relates to superfluous insured care. This is care for which there is no request, nor is it available, but it is still insured.

- *The package does not contain any superfluous insured care for COPD*

There is no COPD care that is reimbursed, but which is not (or no longer) provided by care-providers and which is not required by patients.

Package question F

Package question F is about care that is offered but which COPD patients do not (as yet) request and which is not (yet) insured. This relates in particular to new forms of care.

- *Various new forms of care are being developed for COPD*

For example, in the field of diagnostics there is on-going research into molecular respiratory analysis with the help of an 'electronic nose', biomarkers, a CT-scan, phenotyping, genotyping and an instrument for measuring COPD burden of disease. Research is also being done into new medicines for COPD. There are also various developments in the field of medical-specialist care, such as bronchoscopic lung volume reduction, Targeted Lung Denervation and airway bypass. Research is also taking place into COPD-treatments that make use of stem-cells and into ways of making use of donor lungs which in the past were deemed unsuitable. There is a lack of clarity about the extent to which all these new forms of care meet the needs of COPD-patients and whether such care should eventually be included in the insured package.

Package question G

The unfulfilled care needs of patients are central to package question G. These forms of care are not (yet) available nor are they insured.

- *COPD-patients have a number of unfulfilled care needs*

They want support from their environment, the involvement of their family in their treatment and contact with fellow-patients. In addition, patients who have participated in pulmonary rehabilitation require follow-up care after completing the programme. Such care is currently insufficiently provided and is not included in the insured package.

Adequacy and accessibility of the package

We can conclude that on the whole the insured package is adequate for COPD. After all, the package covers most of the care that is necessary according to the guidelines and that is requested by patients. GP care and care from medical specialists that is necessary is fully reimbursed, and almost all COPD medicines that are being used in current practice can be reimbursed via the basic insurance. Some care is not (fully) reimbursed, though COPD-patients do request it. This involves mainly lifestyle interventions, in particular physiotherapy and supervised physical exercise.
The COPD package is not excessively adequate: it does not include any superfluous insured care. However, there are indications that one of the insured COPD medicines is unsafe. In the future this may raise the question of whether the reimbursement of this medicine should be continued.

Furthermore, we can conclude that accessibility to the insured care for COPD leaves a lot to be desired. On the one hand because the package is not accessible enough. In practice, patients with COPD do not always receive the care they need although it is insured via the package. Certain aspects seem to involve undertreatment or an inadequate quality of care.
On the other hand it seems that some aspects of the insured package of COPD care are actually too accessible. In fact, one can speak of both overdiagnosing and overtreatment. Some COPD-patients receive insured care which they do not need,

which is unnecessarily expensive or the efficacy of which is dubious. Overdiagnosing and overtreatment with insured care implies an inappropriate or inefficient use of the package.

Another problem is the fact that not all COPD-patients inhale their medication properly, though they often think they do. This results in care for COPD-patients being less effective. Not all COPD-patients are therapy-compliant. Therapy non-compliance is widespread and can have considerable consequences for the efficacy of COPD treatment and, therefore, for the health of the patients involved. Furthermore, therapy non-compliance can result in medicines remaining unused in patients' medicine cabinets, or in unnecessarily expensive care. In fact, therapy non-compliance is a form of inappropriate or inefficient use of insured care.

Lastly: though it is true that on the whole the package for COPD is adequate, the same cannot entirely be said of the care itself. After all, patients with COPD have certain unfulfilled care needs. Care-providers will first have to develop such care before it can be incorporated into the insured package.
At the same time, care-providers are developing various new forms of care for COPD. As yet it is not clear to what extent this new care will will meet the needs of COPD-patients and whether this care should eventually be included in the insured package.