College voor Zorgverzekeringen

Coronary Heart Disease Package Scan

Discrepancies between requested care, provided care and insured care

Summary & Conclusions

Date October 15th 2013

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Registration number	201305023
Authors	Celeste van der Vliet, Pé Mullenders, Fransje van Vlaardingen +31 (0)20 797 87 76
Department	Care
Presented to	Ministry of Health on April 11th 2011 (Full report in Dutch)
Availability	http://www.cvz.nl/publications+in+english
Publisher	College voor Zorgverzekeringen Postbus 320 NL-1110AH Diemen The Netherlands Fax +31 20 797 85 00 E-mail info@cvz.nl Internet www.cvz.nl

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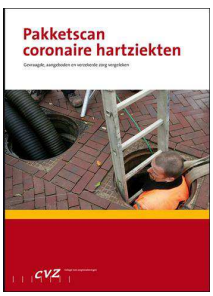


*The original text of the **Coronary Heart Disease Package Scan** of CVZ was in Dutch. Although great care was taken in translating the text from Dutch to English, the translation may nevertheless have resulted in discrepancies. Rights may only be derived on the basis of the Dutch version of CVZ's Coronary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

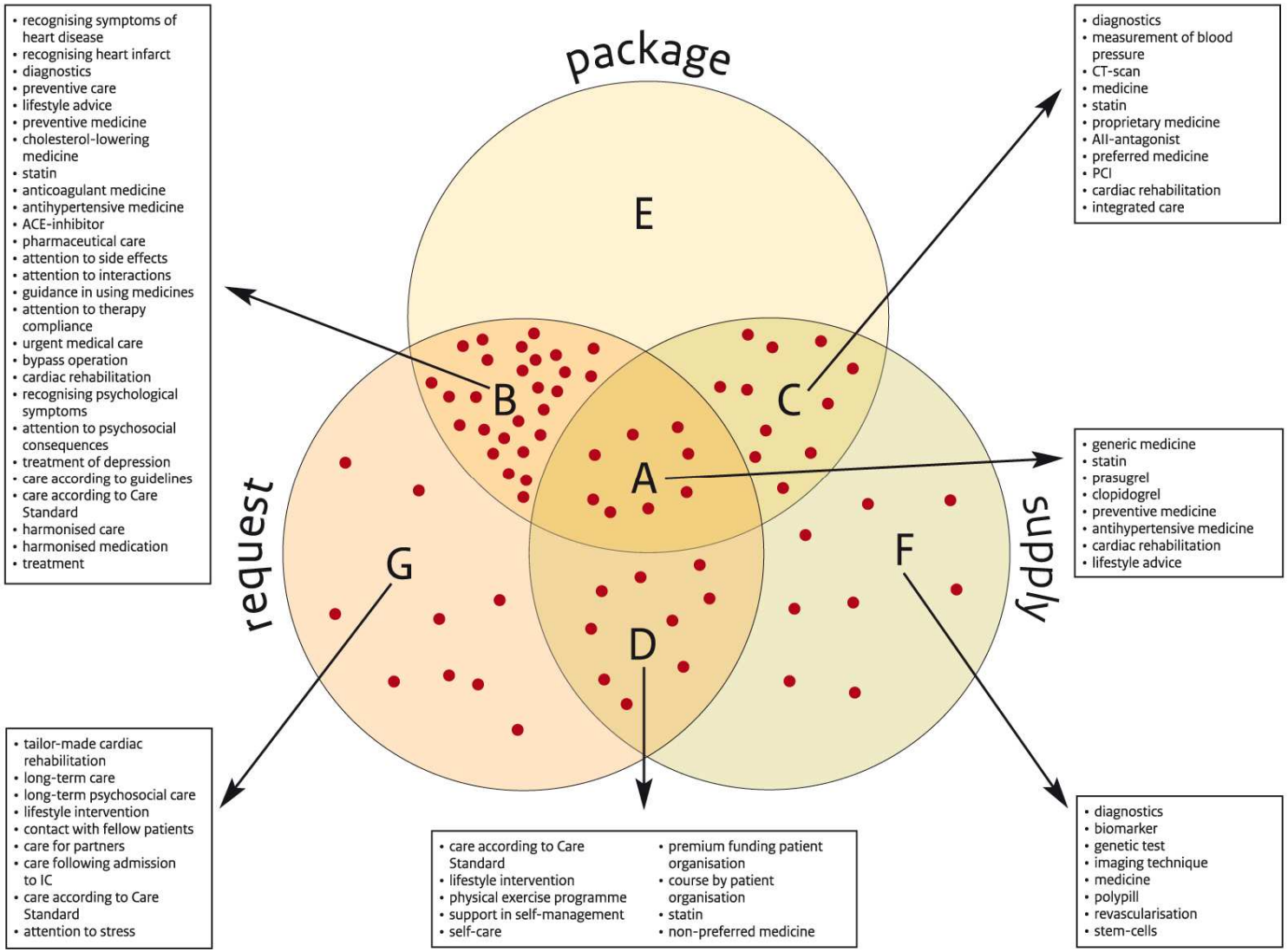
The Health Care Insurance Board in the Netherlands, CVZ, is the organization responsible for advising the Ministry of Health on the composition of the basic insurance package of health care covered by the Health Insurance Act and the Exceptional Medical Expenses Act. To find out whether the package of 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 Coronary Heart Disease 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 almost 550 sources, collected from 2009 to 2010. At various stages we had the results examined by experts and relevant organisations.

In 2009 there were almost 679,000 people in the Netherlands with coronary heart disease, a disorder that results from the build-up of plaque in the coronary arteries, and results in, e.g., angina pectoris or a heart infarction. Coronary heart disease results not only in physical consequences, but also psychological consequences, and it is still one of the most important causes of mortality. As a result, coronary heart disease holds the number one position with respect to social burden of disease. Social burden of disease is defined as: the number of healthy life-years lost due to disease in the population.

Package questions

The following diagramme reflects the results of this *Coronary Heart Disease Package Scan*. 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, statin, advice on lifestyle). This is because these forms of care can involve different types of discrepancies, for example a (certain type of) statin 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).



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 coronary heart disease.

Package question A
In this area there is no discrepancy between requested, provided and insured care: 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 and therapy non-compliance. We label these type A problems. We found the following undesirable situations.

- *A number of medicines insured for coronary heart disease may be unsafe*

For instance, some generic products have been excluded from the market. Furthermore, several topics are still being debated: the risks of statins in relation to the development of diabetes, the risks of prasugrel in relation to the development of haemorrhages and a possible interaction between clopidogrel and stomach acid suppressants.

- *Patients with (a risk of) coronary heart disease are not always therapy-compliant when taking medicine*

Some patients do not take medicines in accordance with their prescription, reduce their intake or stop prematurely. This is more often the case with preventive medicines, such as antihypertensives. Therapy non-compliance is widespread and can have enormous consequences for the effectiveness of medicinal treatment of coronary heart disease and, therefore, for the health of the patients involved.

- *Patients do not always complete a cardiac rehabilitation programme*

This is also a form of therapy non-compliance. As a result, the care of patients suffering from coronary heart disease is less effective than it could otherwise be.

- *Patients often fail to comply with lifestyle advice*

Some sources mention that the lifestyle advice that care-providers give to patients is regularly ignored. Apparently, patients find it difficult to alter their lifestyle.

Package question B
Package question B is about care that is requested by patients with coronary heart disease 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 symptoms of heart disease or a heart infarction*

Patients do not always recognise the severity of their symptoms or care-providers see patients who present atypical symptoms.

- *Diagnostics for coronary heart disease are not always applied correctly*

Patients are not always correctly prepared for a diagnostic examination with an iodinated contrast agent. Moreover, hospitals differ enormously with regard to radiation dose given when a patient undergoes a CT-scan.

- *People with (an increased risk of) coronary heart disease receive insufficient preventive care*

Patients are provided with insufficient information about risk factors and insufficient

lifestyle advice. Furthermore, cholesterol-lowering medicines (statins) are prescribed insufficiently or in doses that are too low, and one can speak of undertreatment with respect to anticoagulant and antihypertensive medicines (including ACE-inhibitors).

- *Patients with coronary heart disease do not always receive sufficient pharmaceutical care*

Patients with coronary heart disease feel that insufficient attention is paid to several aspects of pharmaceutical care: negative side effects and interactions of medicines, administering medicines correctly, information about medicines, guidance when taking medicines or attention to therapy compliance.

- *Access to urgent medical care is not always sufficient*

For example, emergency calls are not always answered, or ambulances exceed the norms for ambulance driving times. Errors are regularly made by triage employees in emergency departments in categorising patients according to the severity of symptoms.

- *Insufficient bypass operations are being offered to patients*

It seems that in practice patients with severe coronary suffering, who should in fact have a bypass operation, do not always get one because doctors opt for percutaneous coronary interventions (PCI). Furthermore, the waiting lists for bypass operations can be long.

- *Cardiac rehabilitation is being offered insufficiently*

Cardiac rehabilitation is not being offered to all patients with coronary heart disease who qualify for this care.

- *Insufficient attention is paid to psychological symptoms*

Psychological and psychosocial symptoms or depression in people with coronary heart disease are insufficiently recognised, acknowledged and treated.

- *Guidelines on coronary heart disease are not always applied*

Patients do not always receive care for coronary heart disease in accordance with guidelines, and little use is being made of the *Care standard for Vascular Risk Management*.

- *Care for coronary heart disease is insufficiently harmonised*

For instance, insufficient communication takes place between the various care-providers, patients sometimes receive conflicting information and there are cases involving insufficient harmonisation of medication.

- *Women with (an increased risk of) coronary heart disease receive insufficient care*

Doctors fail to recognise symptoms of heart disease in women more frequently. Furthermore, women receive the necessary diagnostics less frequently, and the usual diagnostics for heart disease in women are less reliable. One can speak of undertreatment of women with coronary heart disease, both with regard to revascularisation and cardiac rehabilitation and with regard to preventive care with medicines.

- *The elderly with (an increased risk of) coronary heart disease receive insufficient care*

Coronary heart disease in the elderly is not always recognised and diagnostics are used less frequently. Furthermore, there are signs of undertreatment of the elderly with medicines for preventing cardiovascular disease. The elderly do not always

receive sufficient pharmaceutical care, and care for the elderly who have several concurrent diseases is insufficiently harmonised.

Package question C

Package question C is about care that is offered and is insured but which 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.

- *Patients are confronted with unnecessary diagnostics*

It seems that superfluous use of insured diagnostics is made, for example, measuring blood pressure unnecessarily or offering a cardiac CT-scan. Moreover, developments in the way health care is organised increase the chance of superfluous diagnostics.

- *Cases of overtreatment with medicines*

Overtreatment of people with coronary heart disease does occur. In particular with statins, but also other medicines. Elderly patients are particularly likely to be overtreated with medicines.

- *Doctors prescribe the more expensive medicines*

When doctors – particularly specialists – write prescriptions they opt unnecessarily for an expensive medicine: for proprietary statin medicines instead of generics, and for AII-antagonists where ACE-inhibitors would have sufficed. This means the inappropriate or inefficient use of insured medicines for patients suffering from coronary heart disease.

- *Preferential policy of health care insurers not always welcomed by patients*

The preferential policy of health care insurers may result in patients with coronary heart disease receiving care they do not actually want, i.e., the medicines their health care insurer has chosen.

- *Lack of therapy-compliance results in inefficiency*

Therapy non-compliance can result in medicines remaining unused in people's medicine cabinets, and, moreover, to overtreatment. In other words, therapy non-compliance is a form of inappropriate or inefficient use of insured care.

- *PCI may be applied too often*

Some sources indicate an overuse of PCI, particularly in people with stable angina pectoris. A role may have been played by the recent expansion in the number of hospitals granted a permit to carry out PCI. Perhaps the expectations patients have of PCI are sometimes too high.

- *Cardiac rehabilitation is not always in keeping with patients' wants*

Patients suffering from coronary heart disease are sometimes offered cardiac rehabilitation programmes from which they do not benefit, they do not always want or they fail to complete.

- *Funding problems may lead to superfluous or unnecessarily expensive care*

The introduction of integral funding or functional funding of care for cardiovascular risk management (integrated care) can lead to overtreatment, or unnecessarily expensive care.

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 want full reimbursement of care in accordance with care standards*

People suffering from coronary heart disease feel that all care defined in the care standards, in this case the *Care Standard for Vascular Risk Management*, is necessary care and should therefore be included in the insured package.

- *Patients suffering from coronary heart disease ask for (more) reimbursement of lifestyle interventions*

In particular they ask for the reimbursement of physical exercise programmes or programmes for medically supervised physical exercise.

- *People suffering from coronary heart disease want reimbursement of support in self-management*

In fact, part of the support in self-management is already included in the basic insurance. This does not apply, however, to self-help and general education.

- *Patients want premium funding for patient organisations*

Patients suffering from coronary heart disease are in favour of premium funding for patient organisations. In addition, according to them, health insurance should also cover courses provided by patient organisations.

- *Patients encounter problems with reimbursement conditions for medicines*

Patients suffering from coronary heart disease sometimes encounter problems relating to the way in which care-providers and health care insurers deal with medicines that are only reimbursed under certain conditions, e.g., statins.

- *Preferential policy means that patients do not always receive reimbursement of the medicines of their choice*

As a result of the preferential policy of health care insurers, patients suffering from coronary heart disease do not always receive reimbursement for their preferred medicine, even though the product is included in the basic insurance. Patients feel that this limits their freedom of choice.

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 coronary heart disease*

There is no care for coronary heart disease 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 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 coronary heart disease*

In the field of diagnostics, for example, research is being done into new biomarkers, genetic tests and improved imaging techniques. Furthermore, a number of medicines are being developed that may be marketed in the Netherlands in the future, such as new platelet-inhibitors and anti-coagulation products, and the so-called 'polypill'. There are also various developments relating to revascularisation, e.g., in the field of catheterisation, PCI and stents. Lastly, research is taking place into stem-cells. This could also result in new forms of care. There is a lack of clarity about the extent to which all these new forms of care meet the needs of patients with coronary heart disease 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.

- *Patients suffering from coronary heart disease have a number of unfulfilled care requirements*

Patients suffering from coronary heart disease would like to receive tailor-made cardiac rehabilitation. They would also like more long-term care, particularly for psycho-social problems and for changing their lifestyle. Furthermore, they would like contact with fellow patients, care for partners and care following an admission to IC. Lastly, they would like more care in accordance with the *Care Standard for Vascular Risk Management,* with attention being paid to stress. Such care is currently insufficiently provided and is not included in the insured package.

Adequacy and accessibility of the package

We conclude that on the whole the insured package is adequate for coronary heart disease. 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 medicines for coronary heart disease that are being used in current practice can be reimbursed via the basic insurance.
Some care is not reimbursed, even though people with (an increased risk of) coronary heart disease do need it. This relates mainly to lifestyle interventions, in particular physical exercise programmes and support in self-management. The package for coronary heart disease is not excessively adequate: it does not include any superfluous insured care.

We do conclude, however, that the accessibility to insured care for coronary heart disease does leave a lot to be desired. On the one hand because the package is not accessible enough. In practice, patients with coronary heart disease do not always receive the care they need although it is insured via the package. Certain aspects seem to involve undertreatment or the quality and harmonisation of care is not quite sufficient. Furthermore, access to the insured package of care seems to differ between various groups of patients suffering from coronary heart disease. In particular, underdiagnosis and undertreatment occurs among women and the elderly.
On the other hand it seems that some aspects of the insured package of care for

coronary heart disease are actually too accessible. For example, there are signs of overtreatment: patients sometimes receive insured care they do not need. One can also speak of inappropriate or inefficient use of the package: patients suffering from coronary heart disease receive unnecessarily expensive insured care.

Furthermore, there are signs that a number of insured medicines for coronary heart disease are unsafe. In the future this could lead to asking whether the reimbursement of these medicines should continue. Another problem is the fact that patients suffering from coronary heart disease are not always conscientious when consuming their insured care, and insufficient attention is given to this by care-providers. Therapy non-compliance is widespread and can have considerable consequences for the efficacy of treatment for coronary heart disease 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 coronary heart disease is adequate, the same cannot entirely be said of the care itself. After all, patients with coronary heart disease 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 coronary heart disease. As yet it is not clear to what extent this new care will meet the needs of patients with coronary heart disease and whether this care should eventually be included in the insured package.