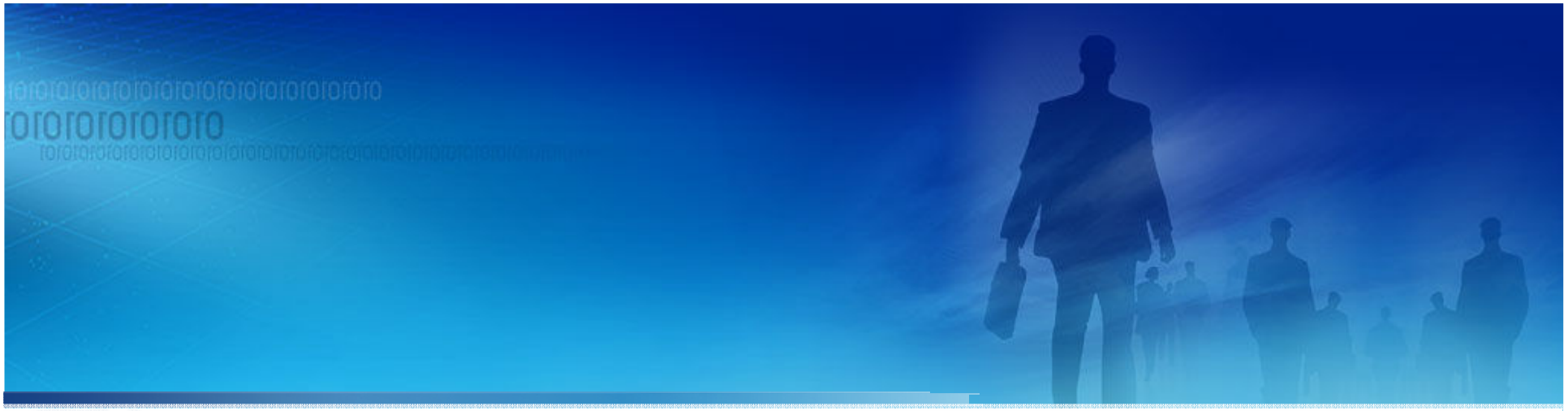


건강보험 급여의 최근 경향

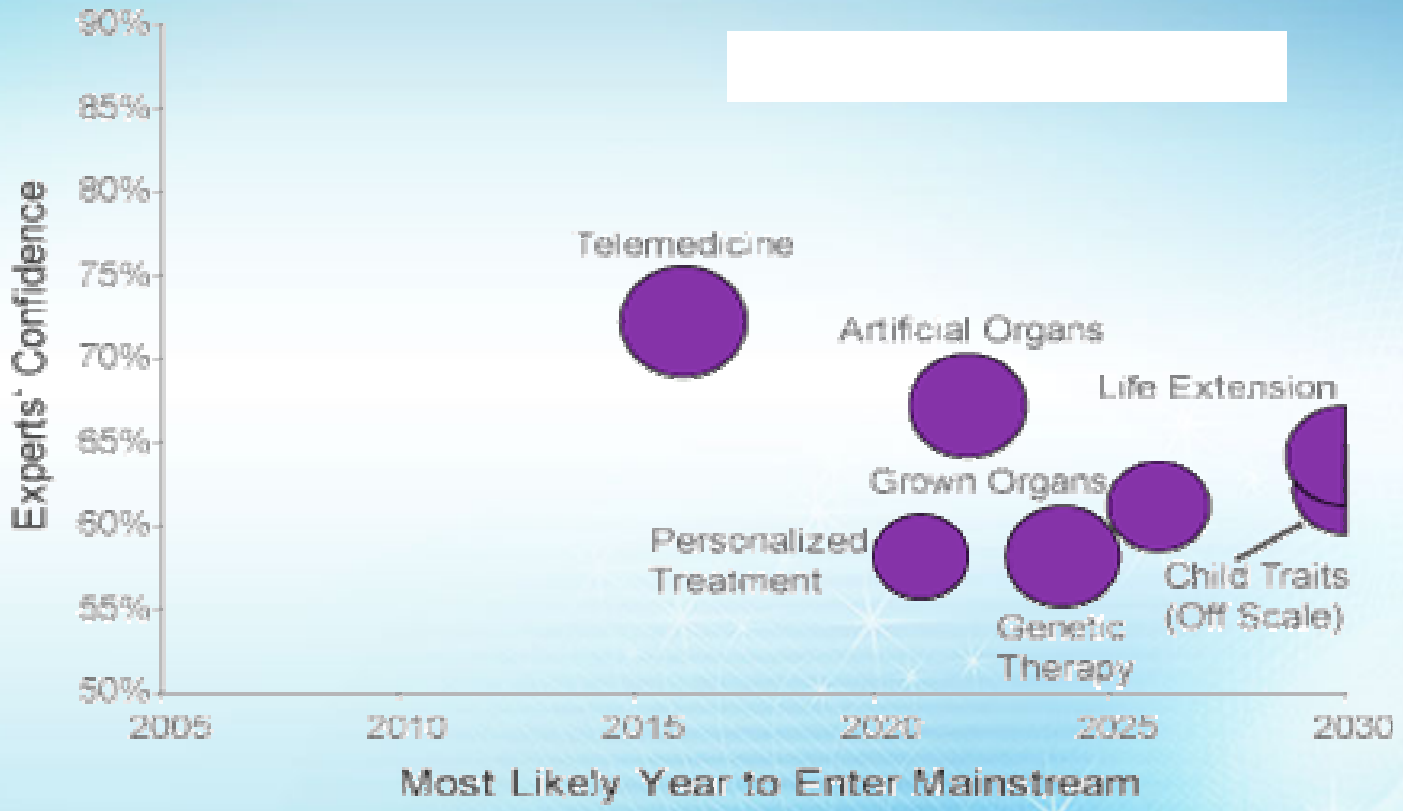
건강보험의 주요 이슈

- 보장성
- 효율성, 재정
- 형평성
- 의료 서비스의 질

급여(Benefit)와 관련된 건강보험의 과제

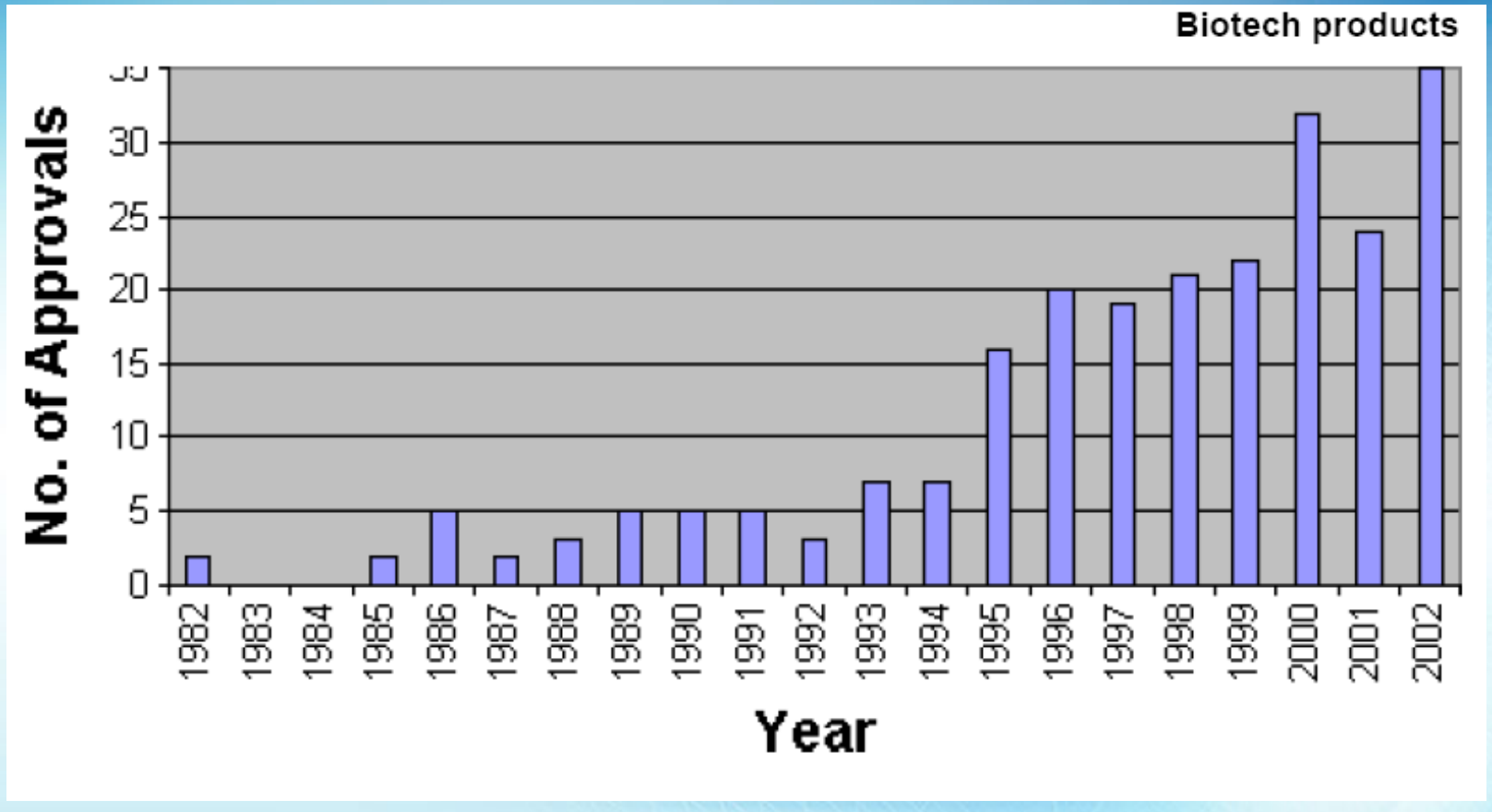
- 재정의 지속가능성(Sustainability)
- 자원의 적정화: 시설, 인력, 장비 등
- 의료기술 발전의 수용: 적정 수준?
- 국민/소비자/환자의 요구

의학기술 발전의 전망(예)

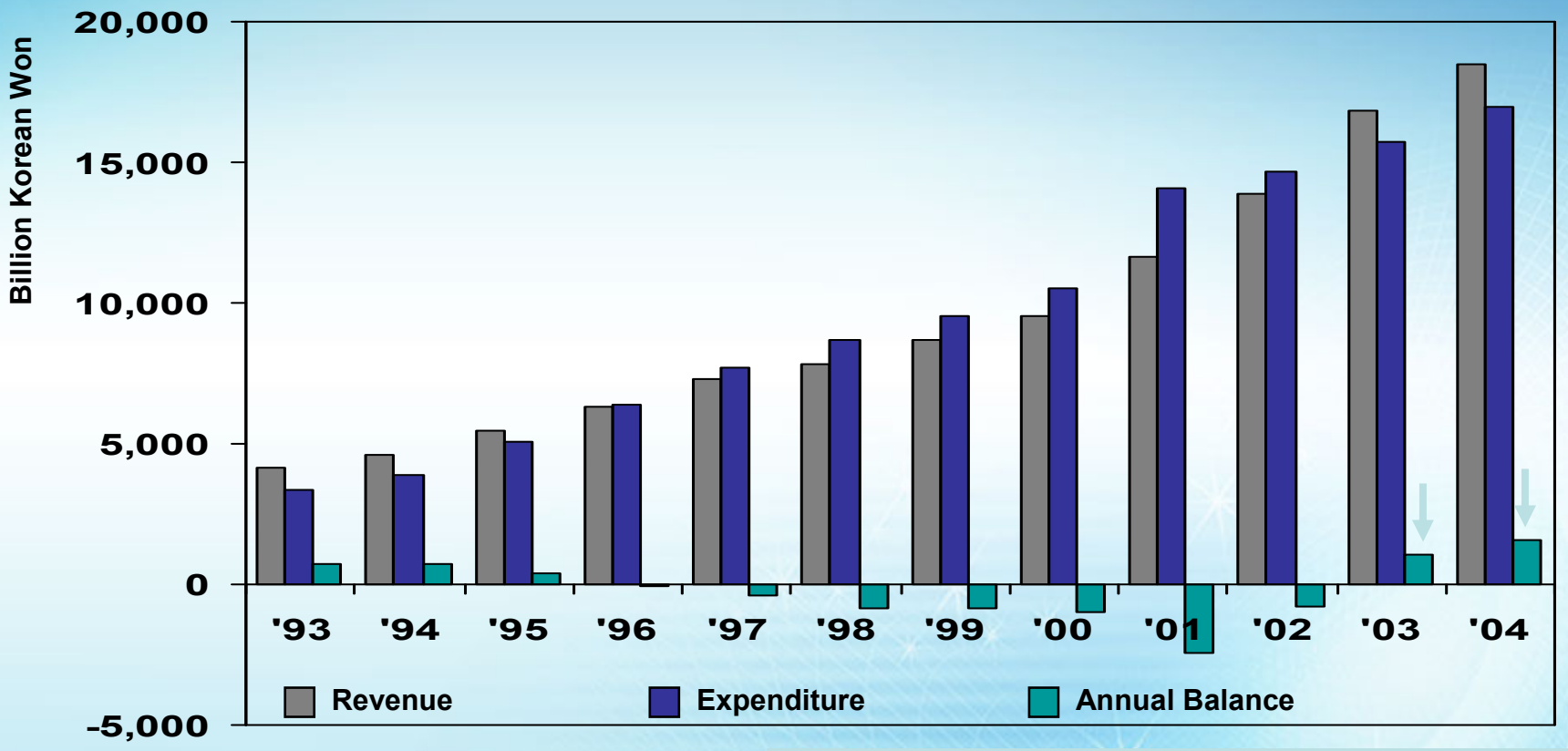

90%
85%
80%
75%
70%
65%
60%
55%
50%
Experts' Confidence
Telemedicine
Artificial Organs
Life Extension
Grown Organs
Personalized Treatment
Genetic Therapy
Child Traits (Off Scale)
2005
2010
2015
2020
2025
2030
Most Likely Year to Enter Mainstream

인공장기

- 현재: 관절, 혈관, 혈액, 심장판막, 건(tendons), 페이스메이커 (pacemakers)
- 자동 지능형 팔/다리
- 인공 눈(Eye cameras with chips)
- 신경조절장치(Neuromodulators)
  - 뇌, 척수 삽입: 파킨스씨병, 간질, 편두통 등
- 인공 심장 – 2010?
- 인공 신장 – 2015?
- 대부분의 장기를 대체가능 – 2020?


Biotech products
No. of Approvals
0
5
10
15
20
25
30
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
Year

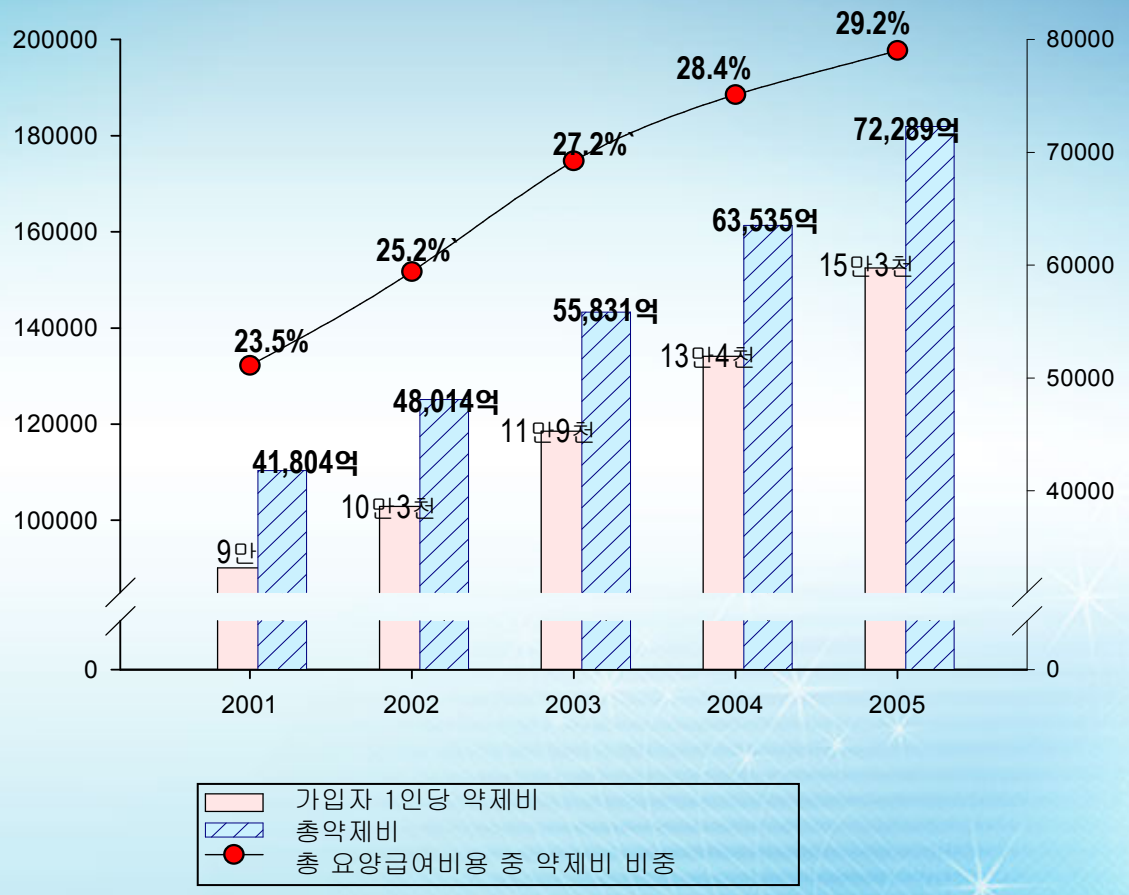
건강보험 재정 추이



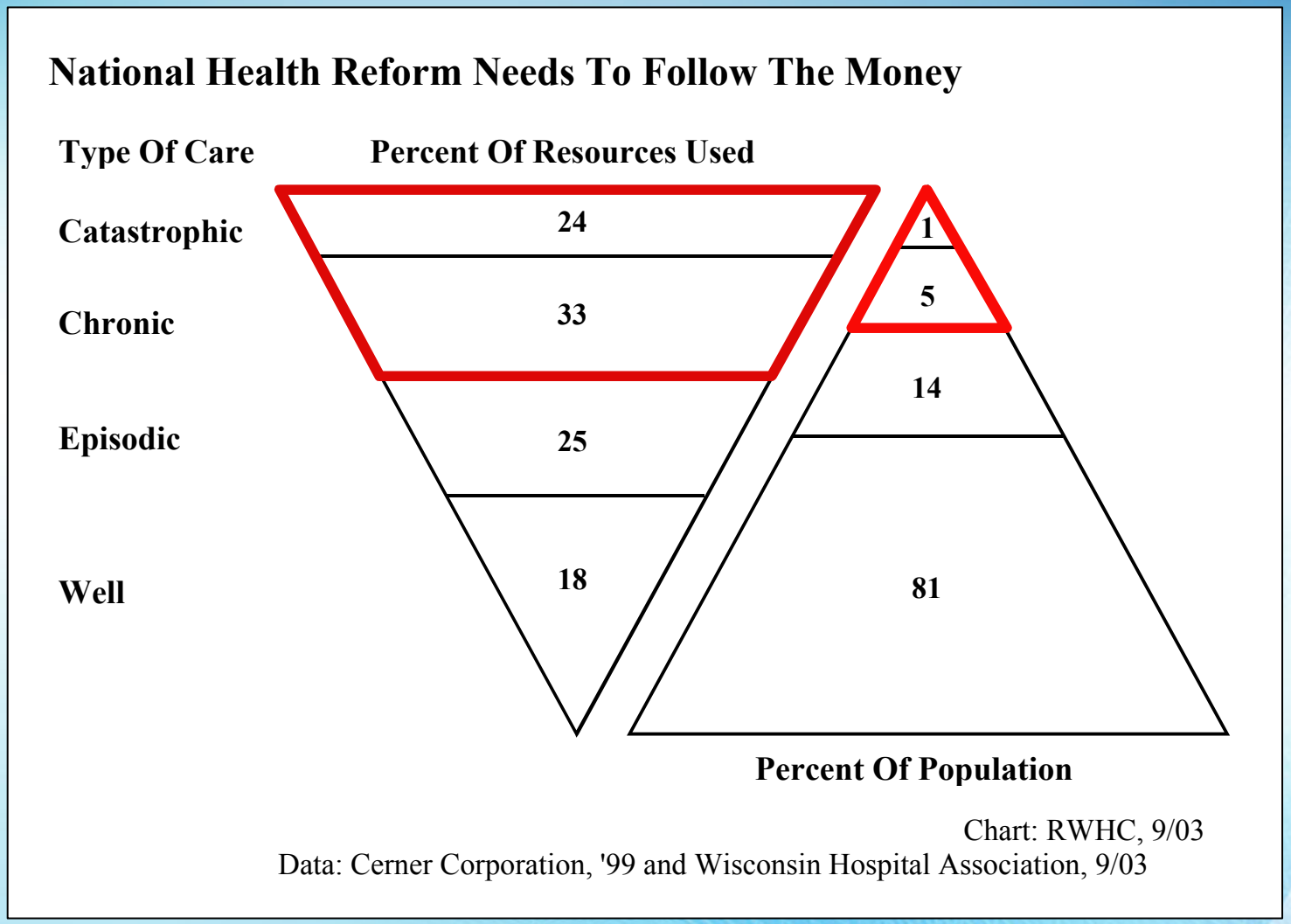
Special efforts to create surplus ’03 &’04

Source: National Health Insurance Corporation, 2005

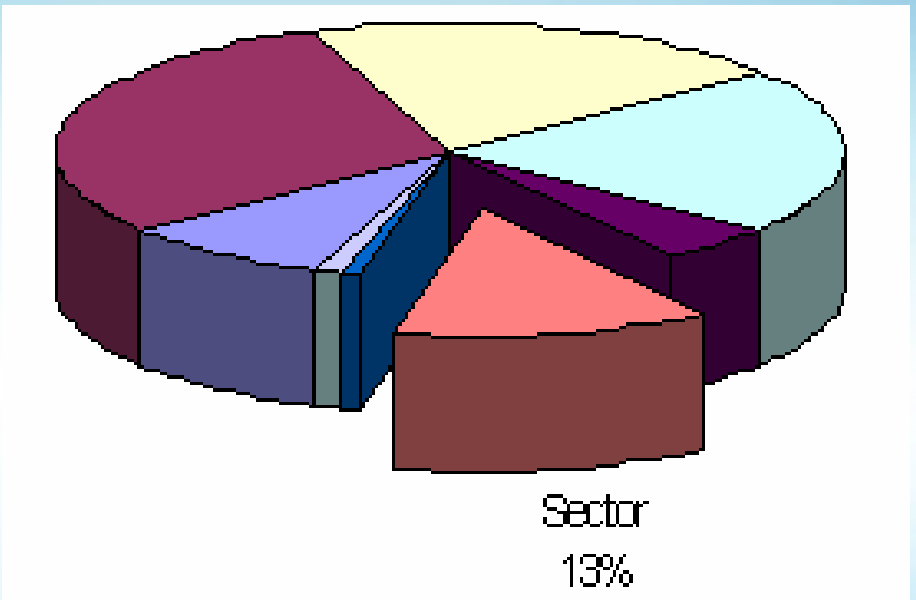
건강보험 약제비 추이


200000
180000
160000
140000
120000
100000
0
80000
70000
60000
50000
40000
0
2001
2002
2003
2004
2005
23.5%
25.2%
27.2%
28.4%
29.2%
41,804억
48,014억
55,831억
63,535억
72,289억
9만
10만3천
11만9천
13만4천
15만3천
가입자 1인당 약제비
총약제비
총 요양급여비용 중 약제비 비중

비용지출의 불균등 분포


National Health Reform Needs To Follow The Money
Type Of Care
Percent Of Resources Used
Catastrophic
Chronic
Episodic
Well
24
33
25
18
1
5
14
81
Percent Of Population
Chart: RWHC, 9/03
Data: Cerner Corporation, '99 and Wisconsin Hospital Association, 9/03

자원배분의 딜레마



질병/연령/지역/목적/……/영역

건강보험과 자원배분의 복잡성 사례

BBC NEWS

OPEN BBC News in video and audio

Last Updated: Friday, 9 June 2006, 11:23 GMT 12:23 UK

E-mail this to a friend Printable version

Herceptin: Was patient power key?

By Sanchia Berg
BBC Today programme correspondent

The breast cancer drug Herceptin has been approved for use on the NHS for the treatment of early stage breast cancer.

Herceptin has proved effective in trials

The decision by the National Institute for Clinical and Health Excellence (NICE) was made in record time following an emotional campaign, and a number of high profile court cases.

It all began in May last year.

That is when US doctors indicated a trial of Herceptin on early stage breast cancers had been promising - and was also when Professor Lisa Jardine received a call.

She had been suffering from breast cancer, and had written that she might benefit from Herceptin.

She said: "I was phoned within a day by somebody who asked if I would like help in getting my health service trust to get me Herceptin prior to NICE's authorising of it.

> **"The people who sit on our independent advisory committees are not for pushing around by anybody"**
>
> Andrew Dillon

"I asked who this person was, and they told me they worked for a PR company working for Roche (which makes Herceptin).

"I was rather obviously outraged that the pharmaceutical company should be trying to persuade me to go public in trying to get the drug - which incidentally my hospital would have given me, should I have wanted it - and I hung the

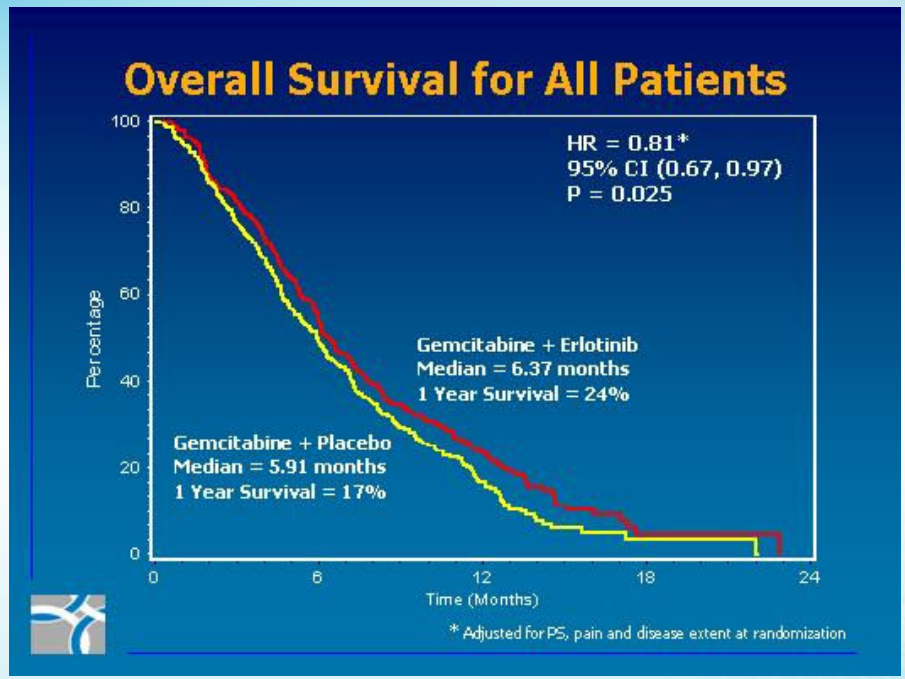
국내 타깃 항암제 현황

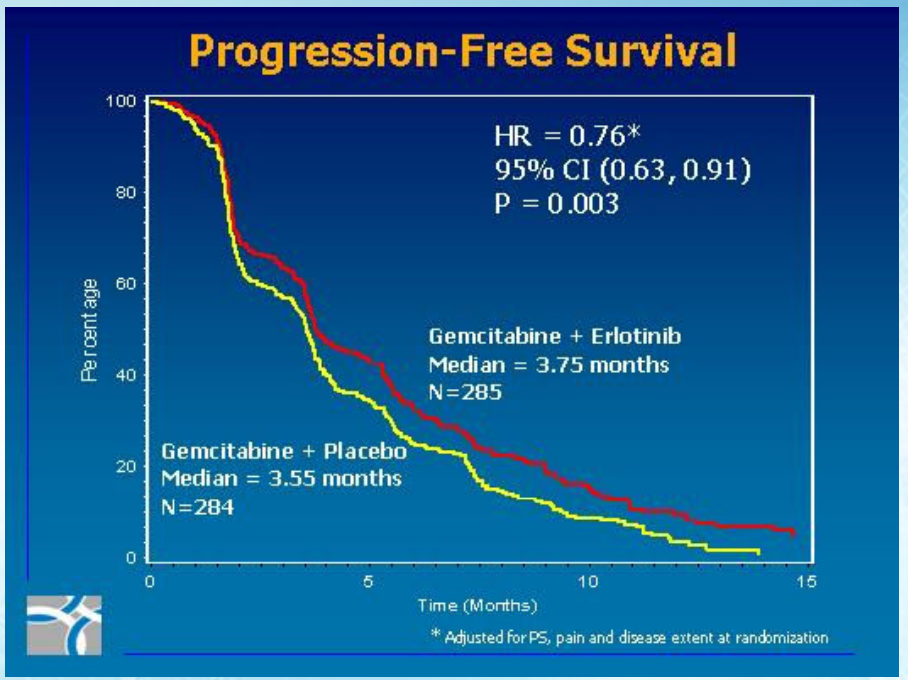
타깃 항암제	치료 대상 암	국내 출시	건강보험 적용
아바스틴	대장암, 폐암, 유방승인(미국) 대장암(한국)	○	×
벨케이드	다발성 골수증	○	○
얼비툭스	전이성 대장암	○	×
타세바	비(非)소세포성 폐암, 췌장암	○	○
이레사	비소세포성 폐암	○	○
제발린	악성 림프종	○	×
글리벡	만성골수성 백혈병, 기스트 (위장관기저종양)	○	○
막페라	악성 림프종	○	○
넥사바	신장암	준비중	–
수텐트	신장암, 기스트	준비중	–
벡사	악성 림프종	준비중	–
허셉틴	전이성 유방암. 수술 후 보조요법	○	○

조선일보 2006.5.18

Erlotinib in pancreas cancer

(response rate: 8.6%)





5.91 → 6.37 months

3.55 → 3.75 months

(Moore M; ASCO 2005) → FDA 허가 → 한국 식약청 허가→ 급여 ?

어떤 기준을 적용할 것인가

Key Concepts

- 한정된 자원과 우선순위 설정의 필요성
  - 국가적/사회적 차원
  - 체계 내
- Rationing =

  → 자원배분(resource allocation)

  → 우선순위 설정(priority setting)

  → 지속가능성(sustainability)

“Value for Money”

“Value for Money”를 위한 두 개의 전략

- Value-based Medicine
- Pay for Performance (P4P)

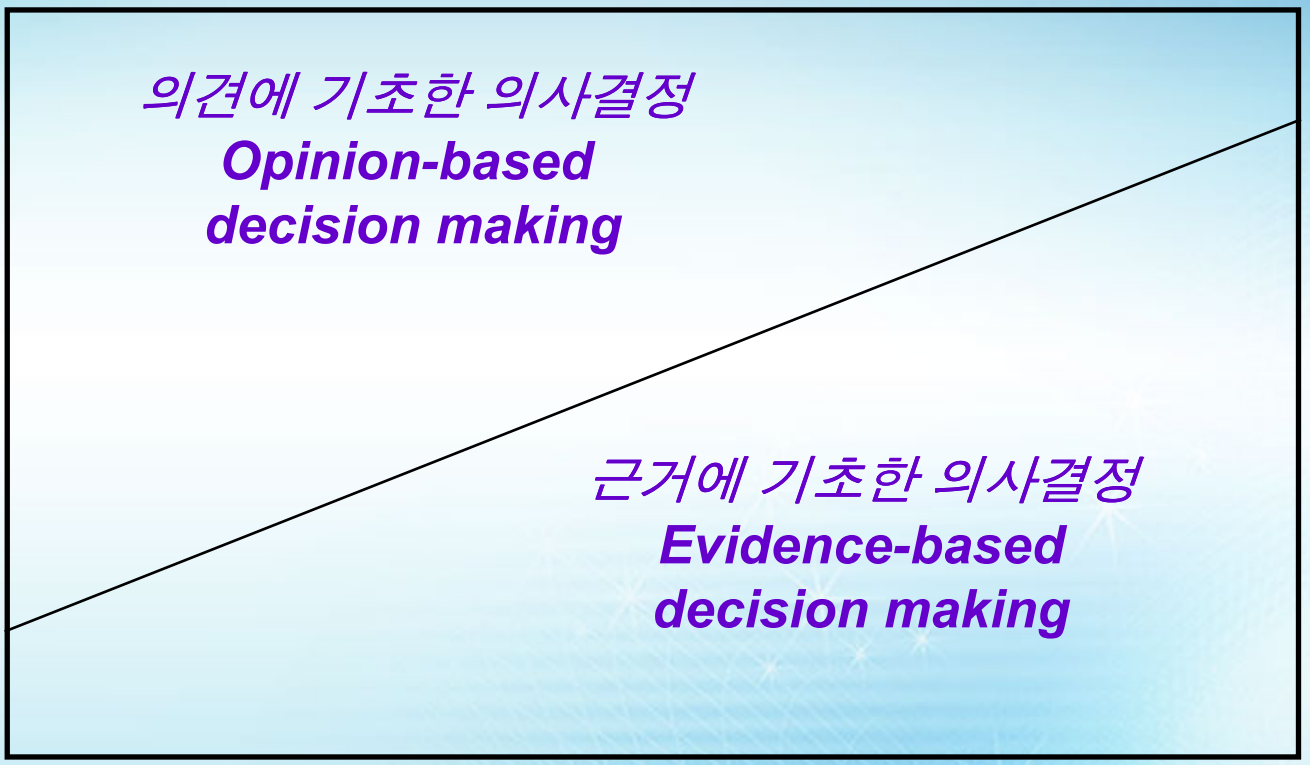
Value-based Medicine

- 근거 중심의 (Evidence-based) 의학/의료
  - *효과(effectiveness)* – "right treatment, right patient, right time "
- 경제
  - *효율(efficiency)* – best net "value" in allocation of scarce resources

Proportion of Evidence-Based Healthcare

- BMJ Editorial: about 15%
- Kerr White: 15–20%
- Archie Cochrane: less than 10%

건강보험에서의 의사결정 추세



The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 APRIL 12, 2007 VOL. 356 NO. 15

Optimal Medical Therapy with or without PCI for Stable Coronary Disease

William E. Boden, M.D., Robert A. O'Rourke, M.D., Koon K. Teo, M.B., B.Ch., Ph.D., Pamela M. Hartigan, Ph.D., David J. Maron, M.D., William J. Kostuk, M.D., Merril Knudtson, M.D., Marcin Dada, M.D., Paul Casperson, Ph.D., Crystal L. Harris, Pharm.D., Bernard R. Chaitman, M.D., Leslee Shaw, Ph.D., Gilbert Gosselin, M.D., Shah Nawaz, M.D., Lawrence M. Title, M.D., Gerald Gau, M.D., Alvin S. Blaustein, M.D., David C. Booth, M.D., Eric R. Bates, M.D., John A. Spertus, M.D., M.P.H., Daniel S. Berman, M.D., G.B. John Mancini, M.D., and William S. Weintraub, M.D., for the COURAGE Trial Research Group*

ABSTRACT

BACKGROUND

In patients with stable coronary artery disease, it remains unclear whether an initial management strategy of percutaneous coronary intervention (PCI) with intensive pharmacologic therapy and lifestyle intervention (optimal medical therapy) is superior to optimal medical therapy alone in reducing the risk of cardiovascular events.

METHODS

We conducted a randomized trial involving 2287 patients who had objective evidence of myocardial ischemia and significant coronary artery disease at 50 U.S. and Canadian centers. Between 1999 and 2004, we assigned 1149 patients to undergo PCI with optimal medical therapy (PCI group) and 1138 to receive optimal medical therapy alone (medical-therapy group). The primary outcome was death from any cause and nonfatal myocardial infarction during a follow-up period of 2.5 to 7.0 years (median, 4.6).

RESULTS

There were 211 primary events in the PCI group and 202 events in the medical-therapy group. The 4.6-year cumulative primary-event rates were 19.0% in the PCI group and 18.5% in the medical-therapy group (hazard ratio for the PCI group, 1.05; 95% confidence interval [CI], 0.87 to 1.27; P=0.62). There were no significant differences between the PCI group and the medical-therapy group in the composite of death, myocardial infarction, and stroke (20.0% vs. 19.5%; hazard ratio, 1.05; 95% CI, 0.87 to 1.27; P=0.62); hospitalization for acute coronary syndrome (12.4% vs. 11.8%; hazard ratio, 1.07; 95% CI, 0.84 to 1.37; P=0.56); or myocardial infarction (13.2% vs. 12.3%; hazard ratio, 1.13; 95% CI, 0.89 to 1.43; P=0.33).

CONCLUSIONS

As an initial management strategy in patients with stable coronary artery disease, PCI did not reduce the risk of death, myocardial infarction, or other major cardiovascular events when added to optimal medical therapy. (ClinicalTrials.gov number, NCT00007657.)

Affiliations for all authors are listed in the Appendix. Address reprint requests to Dr. Boden at the Division of Cardiology, Buffalo General Hospital, 100 High St., Buffalo, NY 14203, or at wboden@kaleidahealth.org.

*Members of the Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE) trial are listed in the Appendix and in the Supplementary Appendix, available with the full text of this article at www.nejm.org.

This article (10.1056/NEJMoa070829) was published at www.nejm.org on March 26, 2007.

N Engl J Med 2007;356:1503-16.

근거에 기초한 의사결정

사례 1: 경제성 평가 (Economic Evaluation)

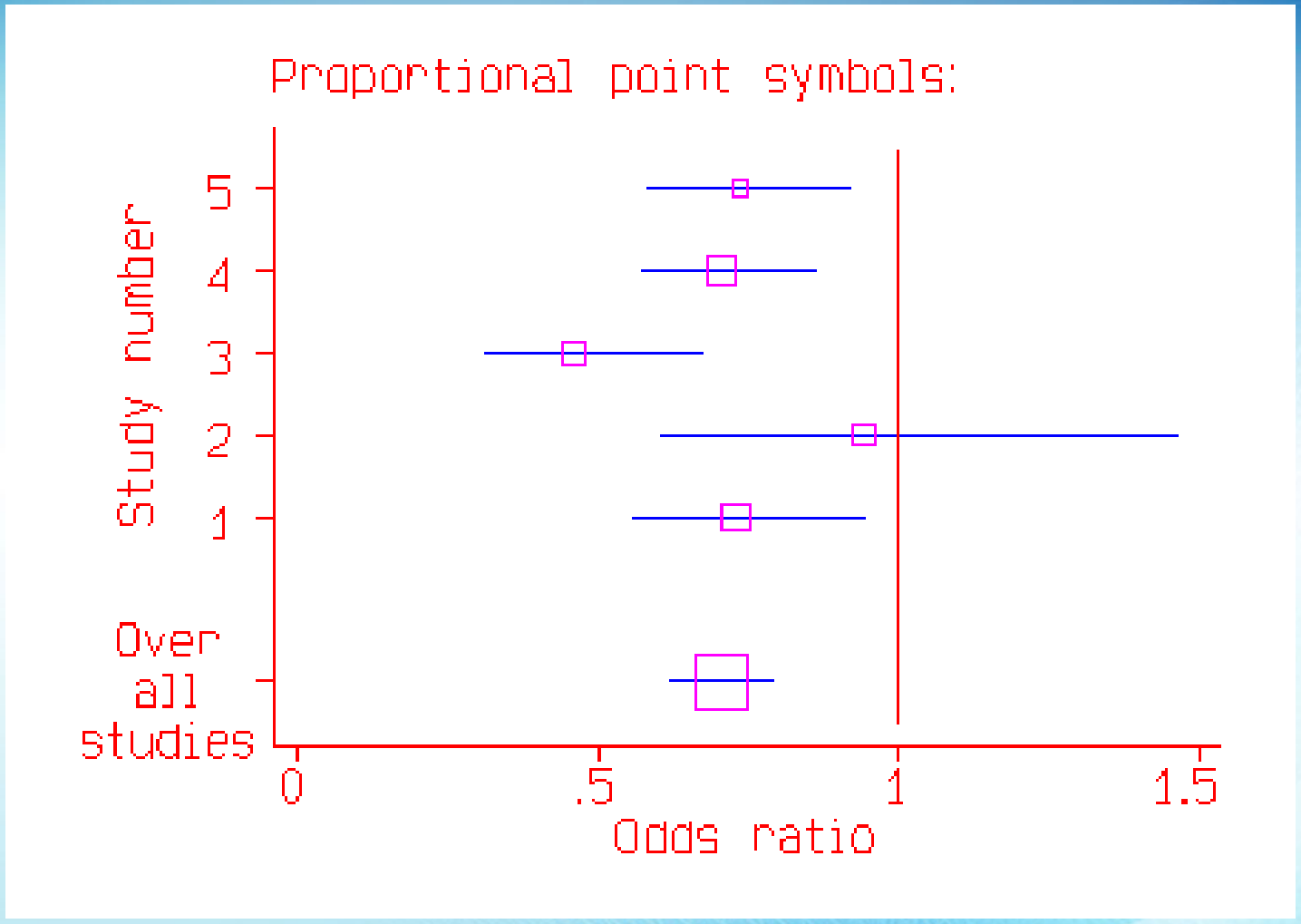
- **비용분석** Cost Analysis
- **비용효과분석** Cost-Effectiveness Analysis
  - cost-effectiveness ratio
    - cost1/outcome1 Vs. cost2/outcome2
  - incremental analysis
    - (cost1-cost2)/(outcome1-outcome2)
- **비용편익분석** Cost-Benefit Analysis
  - Net benefit approach
  - Cost benefit ratio

근거에 기초한 의사결정

사례 2: 체계적 문헌고찰 (Systematic Review)

Structured process involving several steps:

- Well formulated question
- Comprehensive data (all relevant literature) search
- Unbiased selection and abstraction process
- Critical appraisal of data
- Synthesis of data
- Structured report


Proportional point symbols:
Study number
5
4
3
2
1
Over all studies
0
.5
1
1.5
Odds ratio

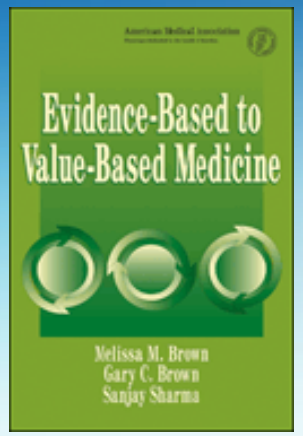
또 하나의 고려: 문제의 크기

- **몇 배(혹은 %)의 신화** "Myth" of Odds Ratio

신기술에 의한 발생률 감소 : **200/100,000 → 100/100,000**

– 배수: 2.0 (100% 변화)

– 발생률 감소: 0.2% → 0.1% (Δ = 1/1,000)



Physician's News DIGEST

Phila. Metro Eastern Pa. Western Pa. New Jersey edition

Local Medical News FREE

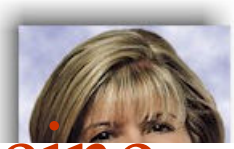
Home Page | Physician Recruitment | CME | About PND | Search | Discussions

Moving from evidence-based to value-based medicine

By Christopher Guadagnino, Ph.D.

Published July 2006

■ React to this article in



Melissa Brown, M.D., is Director of the Center for Value-Based Medicine, and is on the faculty at University of Pennsylvania

979

d Davis
ealthcare
author of
-Based to
ine.

ue-based

a scientific
. But the
ced-based
oblems or

Value-based Medicine

EDITORIAL

Photodynamic therapy

Value based medicine

M M Brown, G C Brown

Let's get it right

The article by Hopley and associates in this issue of the *BJO* (p 982) is a well performed study that utilises a form of healthcare economic analysis that is increasing in popularity throughout the healthcare literature. This instrument, cost utility analysis, has also been referred to by some as cost effectiveness analysis. A review of the healthcare literature using the key words "cost utility analysis" and "cost effectiveness analysis" reveals 386 hits for the years 1999 through 2003, 248

life. Utility values numerically quantify the quality of life associated with a health state. By convention, they range from 1.0 for perfect permanent health (or perfect permanent vision) to 0.0 for death. The higher the utility value, the better the quality of life associated with a health state. In ophthalmology, utility values are most highly correlated with the visual acuity in the better seeing eye.

The method of utility analysis, as well as the respondent source of utility values can make a dramatic difference

applicable across all specialties.[5] Utility analysis fits the criteria splendidly.

Until a standardised database of utility values is obtained from patients with diseases across all specialties in medicine, the great majority of cost utility analyses will not be comparable. Thus, the establishment of meaningful value based medicine standards will not be possible, and both quality of care and the efficiency of use of healthcare services will suffer.

Can it be done? Absolutely. The key is selecting a right preference based tool and sticking with it. After experimenting with multiple quality of life instruments, We believe time trade-off utility analysis is the most reproducible and well understood by patients. Once the standardised utility value database integrates the utility values associated with ophthalmic diseases with those associated with diseases across all of medicine, the value based sky is the limit.

Stay tuned.

또 다른 고려사항

- 과정 (Process)
  - 공정성
  - 투명성
- 윤리
  - 어떤 시각?
  - 상대적 약자에 대한 고려?
  - “rule of rescue”

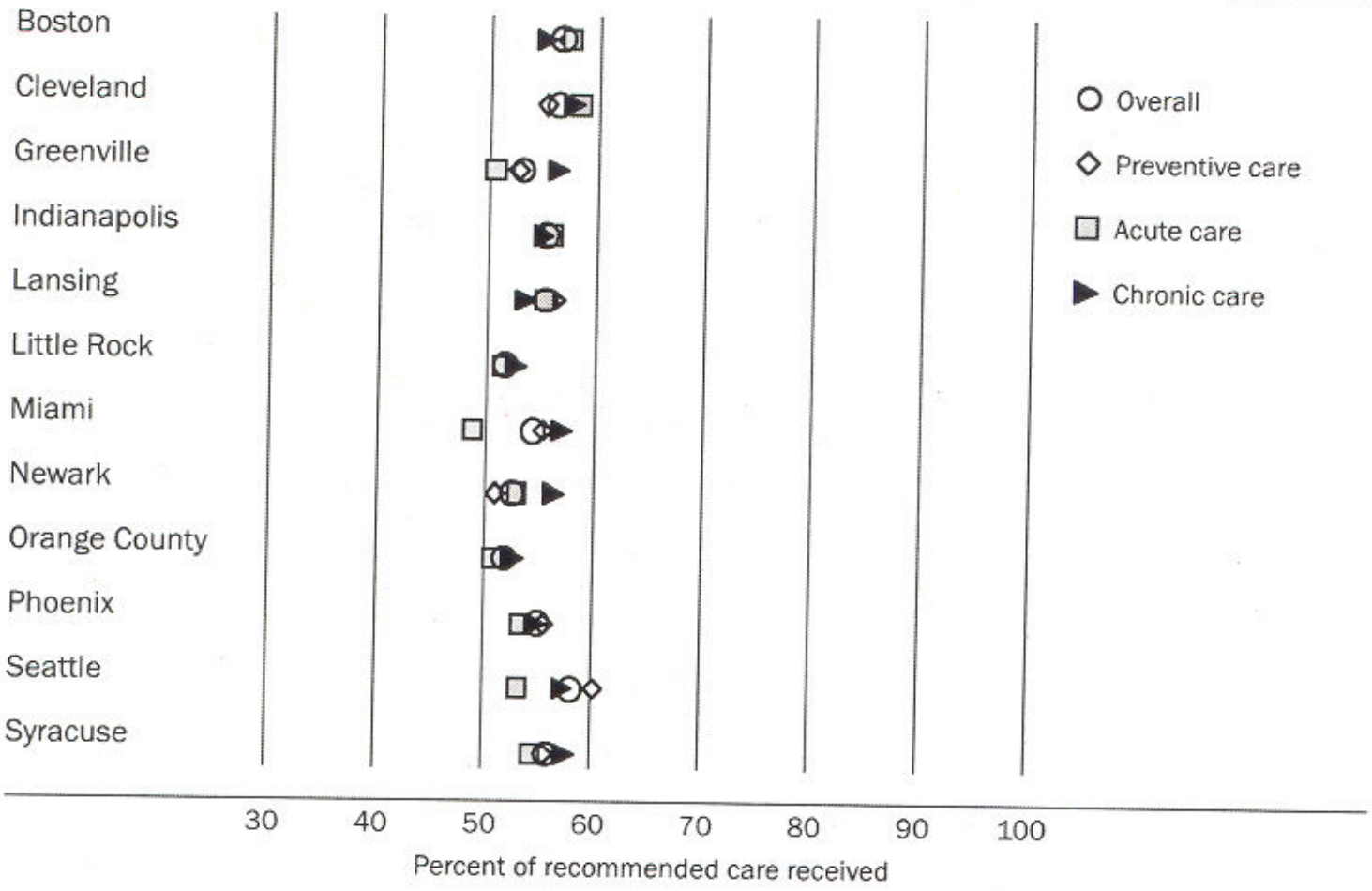
Pay for Performance (P4P)

"The use of incentives to encourage and reinforce the delivery of evidence-based practices and health system transformation that promote better outcomes as efficiently as possible"

American Journal of Managed Care, February, 2006

EXHIBIT 2

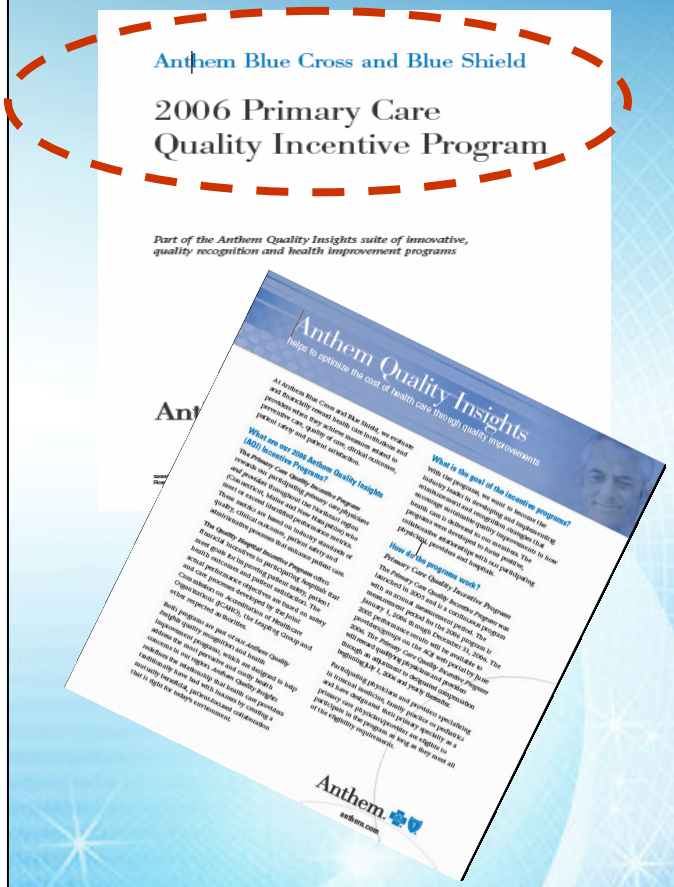
Quality Deficits Found In All Types Of Care And In All Twelve Community Quality Index Study Communities



SOURCE: Authors' analysis of original data from the Community Quality Index (CQI) study, 1998–2000.

Example of P4P: US

- Process Measures:
  - Diabetes
  - Asthma
  - Child and Adolescent well care
  - Cardiovascular Conditions
  - Appropriate testing for children with pharyngitis
- Outcome Measures:
  - Diabetes
  - Cardiovascular Conditions
  - Childhood & Adolescent Immunizations
- Technology Adoption (EMR, EHR, eRX, Electronic disease registry adoption or AQI Portal use)
- Generic pharmacy utilization Measure



Process Measures

- DM: Annual Dilated Retinal Exam, HbA1c Test, LDL-C Test
- Asthma: Appropriate Medication Use
- Cardiovascular conditions: LDL-C Test

한국의 사례: 요양급여비용 가감지급

- 의료제공자 행태 변화 유인체계: 재정적 인센티브 제공 시스템
  - 그 동안, 관련기준 및 기반미비로 미실시
- 가감지급 범위: 의약학적 타당성 및 비용효과성 정도를 고려하여 비용지급 차등(최대10%)
- 관련근거 : 국민건강보험법제42조5항,
  시행규칙 제11조, 가감지급기준 고시

가감지급 시범사업

- 가감지급시범사업 추진을 위한 T/F구성, 운영 ('06.3~8)
- 건강보험심평원 평가실 내 가감지급시범사업팀 구성

대상 항목	대상 요양기관
• 평가지표 개발, 개선가능성 등 고려 • 기존 평가 항목 중 2개 선정	• 의료공급자의 행태변화 가능성, 파급효과, 평가 용이성 등을 고려하여 대상기관 선정

결론: 건강보험과 의료

- 사회제도(시스템)으로서의 건강보험
  - 자원의 제약
  - 사회적 가치체계
  - 정치적 성격
- 건강보험과 의료
  - 가치와 근거(evidence)
  - 가치에 따른 보상
  - 연구와 practice