

Summary of SCBH Action Lines

Prevention 2.0

Current health developments worldwide call for an increased focus on prevention. Preventive measures are vital to tackle the burden of non-communicable diseases and increase the sustainability of health care systems. The benefits of effective prevention are widely acknowledged but how prevention efforts should be organized is hotly debated.

At the core of the debate lies a trade-off between scale and scope. Large-scale interventions typically follow a one-size-fits-all approach. Everyone is assumed to make suboptimal decisions about their health and they receive the exact same intervention. This leads to a narrow scope of these interventions as they cannot cater to the varying needs, preferences and contexts of individuals. Individually tailored interventions are optimized for each individual. They are complex, tackle many different behaviours, and typically involve personal coaching or guidance. However, it is unclear if and how they can be scaled up to large populations.

Prevention 2.0 has the ambition to bridge this divide. Our goal is to gain knowledge on how to design large scale behavioural health interventions that consider people's unique needs and the context of their daily lives. The objective is to gain theory- and evidence-based insight into the design of impactful behavioural health interventions by considering the needs, preferences and contexts of individuals. We aim to advance scientific knowledge on the extent to which the effectiveness of behavioural health interventions can be improved by tailoring to (i) individual-level needs and preferences, including psychological traits and states, and to (ii) environmental-level contexts, such as economic, social, cultural, and institutional factors.

Outcome-Based Health Care

Healthcare systems are under pressure and face important challenges. In a context of rapidly expanding diagnostic and treatment options and increasing concern about the unsustainability of health spending growth, policymakers have been looking for methods and approaches to increase value for money, that is, realizing the best possible outcomes for patients, delivered in a patient-centred way at the lowest possible costs. To achieve this, policymakers aim to reduce waste, unwarranted variation in patient outcomes and fragmentation in care delivery. Two specific focus areas that are crucial to develop adequate policies are (1) gaining insight in patient outcomes and using this information to improve quality of care, and (2) developing and evaluating reform of the incentives embedded in the methods used to pay for health care, which currently tend to reward volume instead of value of care. Despite many efforts, insight in outcomes and their link with quality and costs of care remains limited for many diseases. In addition, knowledge is lacking on appropriate methods for quantifying and reporting outcomes and variation therein between providers. Moreover, the 'actionability' of aggregated outcome measures for providers to improve quality of care is being questioned. Furthermore, little is known about how outcome information can best be incorporated in alternative payment models, and what implementation of these models can achieve.

Outcome-Based Health Care aims to contribute to the scientific basis for the drive towards more effective health care. Specifically, we address the following two main objectives:

1. Development of methods for quantifying (between-provider differences in) outcomes, and assessment of the reliability (e.g., the role of random variation) and validity (e.g., the role of case-mix) of the resulting measures as indicators of quality of care.
2. Development and testing of feasible methods for steering on aggregated outcomes (both internally and externally) and costs – incl. benchmarking and alternative payment models (e.g., bundled payment, pay-for-performance) – and assessing their impact in terms of improvement in care processes, redesign of workflows, multidisciplinary collaboration, and quality and costs of care.

Evaluation of Health Care

In recent years, the interest in valuing the benefits of health interventions has shifted from the common health-focused quality-adjusted-life-year (QALY) model towards capturing the full benefit of interventions by identifying additional dimensions of value beyond health. This shift has led to the exploration of more appropriate and broader outcome measures in terms of overall quality of life (i.e., wellbeing and the wellbeing-adjusted-life-year 'WALY' framework). Such an outcome measure would allow (i) the evaluation of a wider scope of interventions in and between health sectors (i.e., prevention, cure and care), (ii) improve welfare economic evaluations in health care, and (iii) optimize HTA decision making. However, the exploration of such a broader outcome measure is still in its infancy.

Evaluation of Health Care has the ambition to pave the way for a full benefit HTA decision-making framework, to enable a fair and transparent evaluation of a wider scope of interventions in and between health sectors, i.e., prevention, cure and care. In *Evaluation of Health Care*, a first important step towards a broader outcome measure has been made that should make measuring benefits beyond the QALY possible. However, several urgent and relevant research questions still must be tackled before this new instrument can be used in policy-decision making. Additionally, full benefit assessment requires insights into patients' preferences and uptake predictions. When health interventions are not aligned with patients' needs, limited resources may be squandered. However, only little guidance still exists concerning systematic elicitation and incorporation of patient preferences in a scientifically valid way. Our goal is to set the landscape for a full benefit HTA decision-making framework by measuring benefits beyond the QALY, incorporating preferences and distributional considerations, and setting policy-related preconditions.

Health Equity

Despite efforts to reduce inequalities in health, large health disparities by socioeconomic status (SES) persist. The Netherlands has a strong social safety net and comparatively low financial barriers to preventive and curative health care, but the difference in life expectancy between the least and most educated is around 4.5 years, while the difference in (self-perceived) healthy life expectancy amounts to 13.5 years. These inequalities are partly due to preventable or treatable causes. This raises the question whether public health policies reach those who need them most. And if not, how access can be improved.

Health Equity contributes to breaking down the barriers that prevent low-SES individuals from obtaining better health in two ways. First, we will document trends in inequalities in health over different parts of the lifecycle and their relationship with and impact on inequalities in other societal domains like education, employment, and housing. Second, we will identify specific mechanism underlying inequalities in health using (natural) experiments. We will design, evaluate, and compare policies that try to tackle these mechanisms. Specifically, we will focus on interventions that increase the uptake of existing preventive services in vulnerable populations. These aims require integration of expertise in epidemiology, public health, clinical practice, health economics, and applied econometrics of these four schools. We work with societal partners—such as policy makers, health insurers, and health care providers—to turn this new knowledge into action. We build on and extend our network of national policy makers and research institutes (RIVM, CPB, TNO, Verwey-Jonker Instituut), health insurers, local governments (*Nationaal Programma Rotterdam Zuid*), and health care organizations (NCJ, preventive youth health care organizations, the regional consortium pregnancy and birth South West Netherlands) to create opportunities to design and evaluate interventions and to increase the impact of our findings on policy.