Evidence-based rationing: Dutch pragmatism or government insensitivity?

Editorial

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The first International Conference on the Scientific Basis of Health Services was held in London in 1995 under the leadership of Sir Michael Peckham.[1] A multinational cross-section of health service scientists at that meeting heard a clear call for research that would inform public and clinical policy with the aim of achieving better-quality and more efficient health care. At the time and subsequently, there were public expressions of doubt about the view of "evidence-based medicine" as a panacea for all the ills of modern health care.[2–5] Even some of those most devoted to better health care services were dismayed by the reductionist view that scientific argument, appropriately heeded, might soon provide black-and-white answers to most of our complex questions. If evidence-based medicine is carried through to its inevitable conclusion as the only "true path," it seems to leave little room for some of the basic tenets of the health professions, such as compassion, caring and concern for the individual patient.

Despite these concerns, the London meeting represented a step forward. Attendees concluded that, with a sound research base, allocation of resources should be improved at the macro level of political decision-making and at the micro level of clinical care for individuals. There was general agreement that investment in research must be made now to preserve the quality of future health care. Indeed, before the London meeting, Sir Michael Peckham had brought off a formidable coup, to the envy of researchers everywhere, by persuading the then-Conservative UK government to allocate 1.5% of its total National Health Service budget to research supporting optimal care delivery.

Two years have elapsed, and a similar cast of researchers assembled in Amsterdam in October 1997 to hear of progress in the partnership between science and health services. The opening session was addressed by Dr. Els Borst-Eilers, a physician–scientist who is the highly regarded Dutch minister of health. Most meeting attendees attuned to the controversies of resource allocation in health care were unprepared for the dose of Dutch pragmatism that was offered. With a bluntness that defied misunderstanding, the minister called for "evidence-based rationing." She declared that restrictions in health care are inevitable and suggested that we now possess the research capabilities to facilitate choices between such alternatives as breast cancer screening and palliative care for those with the disease. She further argued that evidence-based decisions at the level of office care would preserve resources for other government priorities such as "future-oriented education." Nowhere apparent was the tacit commitment of the London meeting to overall quality of care. The minister argued unequivocally that some of the health care needs of today's citizens must be sacrificed so that there will be flexibility tomorrow.

Although some North American political leaders have demonstrated an understanding of health's broad determinants, they have so far been loathe to discuss the implicit trade-off between illness care and other resource demands on government. Some competing programs have the potential to influence health; others do not have a direct impact. The Dutch minister stated with candour that, in her view, the government's financial health and ability to fund social programs may, at this time, be as important as the well-being of individual citizens.

With remarkable assurance, she suggested that restrictions at the macro level could be derived from "evidence-based priority setting." Resources would be diverted from health care to other targets, such as education or deficit reduction, as required to appease the gods of the European Monetary Union. The minister's message — that governments will make the right choices because the rationing will be scientifically validated — was alarming and matched the fears of those most wary about the future applications of evidence-based medicine.

Dr. Borst-Eilers believes that research (or rather information that has been critically

appraised) will define what is and what is not covered in the basic health care package and that by this mechanism health care equity in the Netherlands will be preserved. Agreement or disagreement with her premise depends on the chosen definition of "equity" as equal access, equal use or equal outcomes. Indeed, Dr. Borst-Eilers urged that research goals in the face of rationing be switched "from efficiency to equity." The minister's enthusiasm for evidence-based rationing can lead only to equal access to core services. It will also lead most assuredly to income-based use of some health care services and probably to the perpetuation of wealth-driven differences in health. The minister pleaded for pluralism of the disciplines involved in research to include social and environmental concerns, but this vision is wanting in the face of her call for rationing, which is the antithesis of equity and of hopes for the ideal guidance that better research may provide.

According to OECD health data, the Netherlands spent 8.8% of gross domestic product on health care services in 1995. Given that this figure is very much in line with those of most countries of similar wealth, it is unlikely that the average Dutch voter will be quick to endorse the minister's call to arms for science in the service of cost minimization and health care cutbacks. For example, it would be interesting to know whether the voters agree that their health is less important than the ability of the government to meet the monetary criteria of the European Union, as was suggested by Dr. Borst-Eilers in her speech. The minister stated clearly that governments will inevitably take health care into a new age of restrictions. Although it is accepted that governments should reflect the will of their citizenry, no reassurance was offered that patients' perceived health needs or provider concerns would be a driver of rationing and reform.

Dr. Borst-Eilers is to be congratulated for her willingness to share a provocative view. Nonetheless, many in Canada would find her commitment to evidence-based rationing at best an unachievable ideal and at worst an inappropriate extension of an evolving science. Perhaps the minister has received a political mandate to reduce public funding of health care services, but even so, it must be recognized that rationing of services provided by government will almost certainly increase inequities in health. On the positive side, the minister's words may promote an increasingly broad-based debate as to what constitutes adequate or reasonable levels of health care service from the respective points of view of payers (governments and other insurers), providers (health care workers) and consumers (the public and patients). Dr. Borst-Eilers was probably guided in her remarks by the traditional Dutch sense of fiscal prudence. However, she also noted that "people are more interested in good-quality care than in scientific evidence. Patients still value compassionate, humane treatment very much." It is the recognized impact of these human values that is likely to make her future vision of evidence-based rationing unpalatable to most North Americans.

In these days of increasing homogeneity of political approach among OECD countries, Canadians should recognize that Dr. Borst-Eilers may well be voicing the thoughts of tomorrow of her Ottawa counterpart. The reality that remains unspoken in official circles is that the rationing of health care services and therefore of health care is already with us in Canada. As hospital budgets shrink and as hospitals are closed down on the basis of statistical criteria, important services are axed and waiting lists appear or lengthen. The services that everyone agrees should be provided, such as home care, step-down units and convalescent facilities, are not yet necessarily available in the community, so it is difficult to see how the dream of a truly rational, comprehensive and integrated health care system can be achieved. This is especially so when ministries of health act out the criticism that they are really only ministries of illness. After a decade of talking and numerous provincial reports on the subject, it is still difficult to find examples of coordination among the ministries responsible for the other major determinants of health, such as labour, housing, education and environment. Evidence-based priority setting and evidence-based rationing seem unlikely, in the Canadian context, to offer solutions to the imbalance of demand and supply characterizing our health care system. Although the health services research community would welcome an opportunity to participate fully in the policy arena, most scientists will likely not wish to be seen as instruments of budget restructuring without due regard to quality of care.

We are grateful to Sir Michael Peckham for starting the long-overdue discussion about the scientific basis of health services and to Dr. Borst-Eilers' for fuelling a debate about the appropriate use of health services delivery research. We can now look forward with anticipation to the third instalment of this discussion, which will take place in Toronto, from Oct. 1 to 3, 1999. The theme of the Toronto meeting, "Closing the Gap," is intended to encourage presenters to address the challenge of linking clinical and public policy to research-derived evidence. Perhaps the ideas of evidence-based rationing and priority-setting will still be on the agenda, but there will probably be greater acknowledgement of the underlying scientific complexity than was apparent in the Netherlands in 1997.

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