

Show me the evidence

How Else Borst-Eilers got the best out of a shrinking health budget

→ Anna Wagstaff

Haematologist Else Borst Eilers was handed a poisoned chalice as the Minister asked to make cuts in healthcare costs in the Netherlands. She found her salvation in the patient viewpoint, and evidence-based care.

Else Borst Eilers' first task, on becoming minister for Health, Welfare and Sport in the Dutch coalition government in 1994, was to cut public health spending. A medic by training, this was hardly the role she had envisaged when she stepped into public life. But if the job had to be done, then Dutch patients could be grateful that her hand was on the scalpel.

All over Europe, similar scenarios were being played out as two decades of spiralling public health costs combined with sluggish economies forced governments to ration health care. New accounting and budgeting systems obliged hospitals, specialist units and primary care providers to cut spending, but where and how the cuts were made was all too often the outcome of a battle between institutions and professionals defending their own territories.

Els Borst shared with most of her fellow European health ministers a desire to see the best possible health service for the money available. What gave her the edge was not so much her medical background as her work over two decades in asserting the interests of patient care over the conflicting pressures from the medical profession and the accountants.

SOFT-SPOKEN MOTHER

Els Borst is a slightly built soft-spoken mother of three, who chose not to work full time until her children were school age. A haematologist, specialising in blood transfusion, her career didn't properly begin until she was "between 35 and 40". While working in the department of haematology in Utrecht University Hospital she had her first, reluctant, taste of power. The medical director was ill. As head of the hospital's blood bank, Els Borst was one of the few department heads on the hospital, rather than the university, pay roll. So she took on some of the director's responsibilities.

Like most hospitals at that time, the board of directors consisted of one person with medical training (the medical director), a nurse, and someone with a background in economics or administration.

"At first I hated it, but after some time I thought ... well you can influence things here in this position. Everybody in a hospital is critical about how it is run. Everybody knows how to do it better. And then you are suddenly in a position where you can really make a change."

This marked the beginning of Els Borst's career in health policy, and it didn't take long for Utrecht University Hospital to start to feel the



“From time to time, it is necessary to leave
your bunker and enter the political arena”



With Queen Beatrix after a visit to the Kuria hospice for terminally ill patients, as Minister of Health, in 1997

effects. Departments that were dynamic and innovative – including radiotherapy and haem-oncology – found themselves with a greater share of the budget to fund pioneering research and trials. And strange things started happening to new appointments. Appointing new heads of department had traditionally been the domain of the university, but Els Borst argued that academics may not always be the best choice to run hospital departments. She overcame heavy resistance to win the right to sit on appointment panels, and Utrecht University Hospital became the first in the Netherlands to separate the heads of academic and hospital departments.

If an academic candidate could lead a clinical team, then the posts could still be combined. “I remember appointing the head of the neurology department. He had only published six papers in his life. He was an excellent teacher and a very good clinician, and he is still working there and is a very great success.”

But not everyone was happy. “Many people wanted to have it all. They wanted all the power. To be top in research and top in the clinic. It was men more than women who complained – some of them want all the power they can get.”

THE PATIENTS’ STANDPOINT

At the time she would probably have phrased this more diplomatically, because, as she says, somehow you have to keep medical staff on side. “If you are in permanent battle with your medical staff – which you often see in hospitals – you get nowhere.”

Her secret was always to argue her case from the standpoint of the patient. “It is not a question of making everything as cheap as possible, but how to make healthcare as good as we can.” And this, she argued, meant setting priorities and working more efficiently. “If you let all those professors have their way, they would all have their own CT scanners, and that is not efficient.”

Over a period of 10 years as medical director in Utrecht, Els Borst developed a great interest in how to evaluate efficiency within the health system. This was a field that was just beginning to emerge in a variety of forms in a number of countries.

Foremost among them was the guidelines movement, which started in the early 1980s in the US, and spread rapidly to Europe. Researchers in the US had been shocked to discover huge differences in rates of treatment. Most notoriously,

some doctors were five times more likely to perform a hysterectomy than others.

The medical profession suddenly found itself open to public scrutiny, as governments and health insurance providers called for guidelines. In the beginning these were drawn up through consensus. “You put ten cardiologists in a room and let them meet a few times, and they would draw up guidelines for instance for coronary bypass surgery.” But this method soon proved unsatisfactory and was replaced by evidence-based guidelines.

“You say: ‘Where does it work? How can you differentiate patients who will benefit from those who will not?’ Consensus is all very nice, but if you have 10 cardiologists who all love intervention, they will draw up guidelines that include a much wider range of patients than if you look critically at the evidence.”

EVIDENCE-BASED MEDICINE

Evidence-based medicine emerged as a defining concept in managing healthcare systems. It also gave rise to a new specialty – health technology assessment, where ‘technology’ included most aspects of diagnosis and treatment, as well as actual equipment. Assessors were not clinicians, but knew how to analyse the literature on clinical trials and how to do meta-analysis.

Els Borst was an enthusiastic advocate of evidence-based guidelines, and for establishing patient-led criteria for prioritising scarce resources. In the early 1980s, while medical director in Utrecht, she attended early international meetings on setting priorities and containing costs in healthcare.

As she became increasingly involved in wider policy issues, she began to move away from management. In 1986 she became vice-president of the Dutch Health Council, a government advisory body, and got her first taste of the political process. “I could see how reports I wrote were treated by the minister and by the

members of parliament, and I got a feel for how political life works.”

Now she was in a position to influence health policy at a national level, and she could set her own agenda. In 1987, she became the first secretary of the International Society for Health Technology Assessment, a network of organisations doing similar work – including the Institut National de la Santé et de la Recherche Médicale (INSERM) in France, the King’s Fund in the UK, and the Health Councils of Australia and Canada.

SPECIALIST CENTRES

She lost no opportunities to argue the case for evidence-based medicine, and must surely take some credit for the Netherlands’ good record on cancer treatment. In 1987, the Dutch Health Council became one of the first in Europe to advocate restricting certain cancer treatments to specialist centres with minimum annual case loads.

“We call it dividing and concentrating, and we asked the oncologists to make arrangements about how they divided the tasks between them.”

Some disciplines – ear, nose and throat specialists get an honourable mention – responded well. They got together, and decided who should specialise in what. Others were less compliant. “When you talk to doctors in small hospitals they say: well it is so interesting... I want to carry out my speciality as widely as possible. They are also afraid that if they haven’t treated a cancer patient for six years, they will lose their market value. Of course it is in their interests. But it is not in the patients’ interests.”

She cites cancer of the oesophagus as an example of an operation that is far more successful when a practitioner deals with at least 10 cases a year. But even 15 years later, a hospital was recently given a warning for continuing to operate on oesophageal cancer, despite seeing only two cases a year.

Els Borst recognises that the culture of the health service cannot be changed overnight,

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and has told other politicians that it will take time. But she does not accept that health professionals can continue to put their own self-interest first. In 1992, she wrote a report warning the medical profession that if they did not put their own house in order, politicians would do it for them, and she pointed out that politicians know more about cutting costs than providing healthcare.

FURIOUS REACTION

Her report, *Medical Specialists at a Crossroads*, provoked a furious reaction from the profession, not least because it revealed two-fold to five-fold variations in levels of treatment by different doctors – variations that called into question the quality of patient treatment. It found over-treatment in some areas and, possibly even worse for patients, under-use of other medical interventions.

The profession realised that unless it sorted itself out, health insurers would insist on US-style managed care, in which doctors would have to get the go-ahead from the insurer for every intervention on a case by case basis. “For the first time the medical profession began to understand that the guidelines were no longer a plaything. It was becoming serious.”

Politicians, desperate to find ways to economise on healthcare, loved this. Partly on the strength of the *Crossroads* report, one year later, the newly elected government offered Els Borst the poisoned chalice of Health, Welfare and Sports Minister – with a brief to cut the health budget.

Faced with the question of where to wield the axe, the issue of evidence-based treatments took on immense importance. If free healthcare had to be rationed, then clearly you want to know you are not wasting money on expensive treatments unlikely to be of benefit. “I always argued that before we set priorities in the sense of withholding treatment from those who need it, we

should try to make healthcare much more effective and efficient.”

DIFFICULT DECISIONS

She managed to get away with a series of small savings, mainly through withdrawing reimbursement from over-the-counter medicines for minor ailments – cough mixture for example. Medicines with no proven efficacy and homeopathic medicines were also taken off the list of reimbursed medicines, as were some medical aids such as elasticated stockings. Reimbursement for in-vitro fertilisation (IVF) treatment after the third attempt was also withdrawn.

Difficult decisions about serious conditions remained. Among them, the question of reimbursement for Taxol (paclitaxel), an expensive new drug that can offer around six months’ extra life for patients with ovarian cancer. Her advisors argued against the drug, but in the end Els Borst decided to pay for it. “If it had been a disease of very old people with a very short life expectancy, maybe you could make a case against it, but there are so many young women who have young children, for whom a half year living longer is still important.” She did, however, insist on strict guidelines on when to use the drug.

She also went against the advice of her staff in deciding to make available new anti-retroviral drugs for HIV before they had completed the full clinical trials. Even today, people still occasionally come up to her in the street to thank her for saving their lives with this decision.

However, she did exclude some treatments from reimbursement – including two that had been shown to delay the progress of Alzheimer’s disease by a couple of months, and an experimental surgical treatment for Parkinson’s disease.

THE PRICE OF LIFE

Els Borst has thought a great deal about what price can be put on an extra month or year of life.



On a visit to a home care patient

BRAM GERBYS

This was not just a professional question for her. Both her husband and her brother-in-law died of cancer, and both took the decision, near the end, to forego further treatment.

She believes that when patients have options clearly spelled out – side-effects, chances of response, how many months or weeks it could give them – an increasing number opt for palliative care.

The patient is weighing up the benefits against the burdens of treatment. The minister, however, has to weigh up the benefits against the costs. In practice, Els Borst tended to go with the benefits. “To say that a few extra months of life is not worth the money is a very hard and politically dangerous thing to say. Six months may mean something very different to a mother with a young child than to an older person.”

In an ideal world, she believes every patient would be correctly informed and able to choose.

“There will always be some patients who are so afraid of dying that they will do anything to stay alive an hour longer – but they are the real exceptions. I don’t think there are many who are asking for the stars.”

Els Borst knows better than most that this is not an ideal world. Doctors find it hard to spell out bleak options even when they know their patient is not going to survive. “A doctor who abandons hope too soon is not a good doctor,” she says. “But very often the patient knows that if the doctor is honest he or she is going to say that it is over. There is not much more to be done in terms of treatment. The box is empty. A good doctor starts that conversation at the moment the patient is ready for it. It is all very subtle, and it is one of the reasons why you should really have one and the same doctor during the course of your cancer.”

Els Borst also has an acute appreciation of the

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value of good nurses, and during her time at the ministry the nursing profession saw lasting improvements in both status and pay. "I opened possibilities to become nurse practitioners, and to specialise and get better training. I always argued their case and sung their praises whenever I got the chance. They should work on an equal professional level with the doctor. Nurses have their own professional expertise to bring to treatment plans. One of my children is a nurse and I hear that the way they get along has completely changed. They now call doctors by their first name. It's a small thing but symbolic of the change."

THE PATIENT VOICE

Another important legacy from her time in office is the agreement Els Borst won to provide 30 million euros a year to support the patient voice, allocated to active, democratic organisations that not only provide good information and support for patients, but also promote public awareness and engage with the political process.

She believes patient groups have risen to the challenge of their new roles and responsibilities, and are themselves beginning to think about cost-effectiveness and evidence-based treatment. Some patient groups were once seen as the patient arm of pharmaceutical PR campaigns; now they work increasingly with the medical profession to put well-researched and well-argued cases to politicians. And today Els Borst, retired from the front line of politics, works closely with those groups as President of the Dutch Federation of Cancer Patients Organisations.

With almost maternal pride she recounts how the chair of the Breast Cancer Association recently told her that members were against the routine use of a new radiotherapy technique on the grounds that the extra cost increased much faster than the extra benefit. The feeling was, explained the chair, that the money could be better used doing something else for breast cancer

patients. To illustrate her point she sketched a cost-benefit graph as she spoke!

This does not mean that state money has succeeded in co-opting the Breast Cancer Association to the government's cost-saving agenda. In fact it is running a highly effective campaign to force the Dutch health service to improve breast cancer treatment. It has given all hospitals until 1 January 2007 to comply with a set of guidelines on minimum standards of care – covering issues such as waiting times, levels of expertise and choices between different interventions. The Association warns that hospitals that fail to do so will be not be used by any woman with a lump in her breast.

Nor can anyone accuse Els Borst of begrudging money to cancer services. She oversaw the biggest ever revamp of Holland's radiotherapy services during her second term in office and she still takes every opportunity to encourage other medical professionals to campaign for similar cash injections.

Medic, politician and now, in semi-retirement, President of the Dutch Federation of Cancer Patients Organisations, Els Borst recently summed up her philosophy of health care in a speech delivered to the European Society for Therapeutic Radiology and Oncology (ESTRO) on opening their conference last year:

"From time to time, it is necessary to leave your bunker, step over the fence ... and enter the political arena for a short while. Because I think it is your responsibility to address the policymakers in your country when things threaten to go wrong. Your voice can be very powerful. In the first place, because you know what you are talking about. You can show the facts. And secondly, because you are not asking anything for yourselves, but for your patients. By joining forces, patient organisations and organisations of professionals can enhance their influence considerably."

State funding of 30 million euros a year to patient groups is a legacy of Els Borst's time in office