Evidence and Australian health policy

Health policy decisions are based on more than evidence

BENJAMIN FRANKLIN'S 18TH-CENTURY slice of wisdom that "In this world nothing can be said to be certain except death and taxes" still rings true today. But, in these modern times, adding "and rising health costs" would not be inappropriate. The inexorable increase in public spending on healthcare is a political issue for much of the developed world, and Australia is no exception. Our healthcare expenditure rose from 7.5% of GDP in 1989 to 8.5% in 1999, and it shows no sign of abating.[1] Indeed, the federal treasurer recently observed that "When we look across the next forty years we find that the largest area of pressure in relation to Government spending is going to be in the health area."[2]

So what are we to do?

Commenting on a North American view of the United Kingdom's National Health Service,[3] the President of the Royal College of Physicians recently wrote:

> To contain the costs of growing needs and expectations for health and care services, there is an increasing emphasis on the clinical and cost effectiveness of health care, with evaluation of procedures and technologies, targeting of resources to services and interventions of proven effectiveness . . .[4]

This endorsement of evaluation of evidence, effectiveness and efficacy is the stuff of which evidence-based medicine (EBM) is made, and must be a godsend for governments, health ministers and their public servants. For, as noted by a UK social scientist, "EBM offers the vision . . . of solving all health care funding problems by eliminating unnecessary and unproven health care."[5] In short, stringent evidence is required if the public purse is to pay for new drugs, medical technology or other interventions.

Policing bodies exist to effect this policy. For decisions regarding government funding support in Australia, the Federal Minister for Health seeks the advice of the Pharmaceutical Benefits Advisory Committee (PBAC) for new drugs and the Medical Services Advisory Committee (MSAC) for emerging medical technologies or procedures.

How do these committees arrive at their advice? What are their *modi operandi* and tensions? Answers to these questions have not been readily forthcoming, as these bodies work behind closed doors, the details of their deliberations are confidential, and participants are bound by a code of silence. In this issue of the Journal (*page 627*), the door of a bureaucratic conclave is opened slightly as Ware and his colleagues examine the government's deliberations regarding public funding of positron emission tomography (PET) services.[6] Much of their information was obtained through freedom of information requests and, despite its inherent limitations, their account was of sufficient interest to the Journal for us to pursue the long road to publication. Each story has two sides and we also sought the views of the Australian Government Department of Health and Ageing (*page 633*).[7]

The "exposé" by Ware and colleagues raises issues about the political pressures that come to bear on potential "big ticket" medical technology roll-outs, the processes involved in technology assessment and the values attending this exercise.

As certain as death and taxes is that new technology spawned by research and commercial concerns will increase pressure on the already runaway cost of healthcare. PET is one such technology. It is the latest in a stream of imaging modalities, following computed tomography and magnetic resonance imaging. PET capitalises on the differential metabolism of glucose by malignant cells and is of significant clinical utility in cancer diagnosis and staging, and for following the effects of treatment. But it is expensive, and not readily seen as cost-effective if judged exclusively through standard outcomes such as survival or mortality. PET fell victim to the health bureaucracy doctrine that new technology should not be comprehensively funded by the public purse in the absence of high levels of evidence of both clinical and cost effectiveness. Supposedly because of this, and much to the disappointment of Ware and colleagues, the current Commonwealth government funding arrangements for PET limit the number and location of publicly funded PET services[8] and the clinical indications for its use.[9]

Ware's qualms about MSAC's deliberations raise questions about the hype of EBM in health policy. Nobody would disagree with the then Health Minister's ideal that with the establishment of MSAC "the gap between research knowledge and clinical practice will narrow and patients will benefit earlier from the most advanced procedures drawing on the best scientific medical evidence"[10] — in short, EBM. But it appears that the rhetoric surrounding EBM has led to a misunderstanding of policymaking. Indeed, the certainty value of EBM in this setting is more fanciful than real, as other considerations are involved.[5,11] These include:

- competing goals other than clinical effectiveness (social, financial and political);
- beliefs that some of the research is irrelevant to circumstances in which assessments are taking place;
- lack of consensus in understanding, interpretation and applicability of the research;
- other types of competing evidence (personal experience, local information, eminent opinions and evidence provided by advocacy groups);
- a social or political environment that is not conducive to policy change; and
- scientific information being poorly presented to the policymakers.

Ware et al's critique of MSAC's deliberations is not unique. Similar concerns have been raised about Britain's National Institute of Clinical Excellence in its regulatory role for the introduction of new technology, interventions and pharmaceuticals in the NHS.[12]

Finally, the experience of Ware et al in extracting information through freedom of information provisions raises the issue of transparency and accountability of health-policy formulation. Most Australians would accept that even healthcare resources are finite. Most would expect our governments to make the tough decisions about how public funds are spent, however unpalatable the decisions may be to sections of the community. But the public is not impressed by the secret milieu in which this occurs. It leads to mistrust and suspicion. Professional disquiet can also arise when expert opinions proferred in committees are not reflected in the final outcome. Onora O'Neill, in the 2002 BBC Reith Lectures, counselled that, to confront society's burgeoning culture of suspicion, "We need *genuine* rights, *genuine* accountability, *genuine* efforts to reduce deception and *genuine* communication".[13] More transparency in decision-making that affects the public is not unreasonable.

Meanwhile, for the foreseeable future, rising healthcare costs will remain one of life's certainties. Evidence-based medicine alone will not contain this.

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