Outpatient hysteroscopies and endometrial biopsies are probably not performed more widely in Britain because of the lack of managerial support in providing the facilities to establish clinics specifically for these procedures. Finding the time to perform biopsy and hysteroscopy in a busy gynaecological clinic, with 15 or 20 new referrals, is difficult. Considerable financial savings may result, however, from treating women in outpatient clinics. The continuing widespread use of an operation that is diagnostically inaccurate and therapeutically useless is hard to justify.

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Assessing hospital technology in the Netherlands

New treatments are paid for only if they are part of an evaluation

Most developed countries struggle to control the influx of new and expensive technologies into hospitals by attempting to ensure—with varying degrees of success—that a technology is evaluated before it is widely diffused. In the Netherlands a system has now evolved that should ensure that no medical technology is introduced before clinicians and health planners know whether—and for which patients—it works.

Although health care in the Netherlands is financed by a mixture of public and private funding, the power to control hospital care lies with the minister of health and the Health Insurance Council, a national body representing all the parties responsible for providing and funding health care. A mandatory insurance system for everyone whose income is below a certain amount covers about 60% of the population and 65% of the total costs. Central government contributes about 10%, and the remaining 25% comes from private insurance and direct payments. Except for the eight university hospitals and a few municipal facilities Dutch acute hospitals are privately run non-profit institutions, but they need approval from the minister of health before they can be reimbursed for treating patients under the mandatory insurance scheme. The minister of health takes advice from the Health Insurance Council on what treatment will be covered by the insurance system. Private insurers usually also adopt the same policy.

Since 1979 the minister of health has taken explicit control over some expensive hospital technologies under the Hospital Provisions Act. Article 18 enables the minister to restrict certain services to certain hospitals on the advice of the Dutch Health Council. This independent scientific advisory body aims to reach a judgment about the effectiveness of a given service based on reviews of the literature and the knowledge of its members. It also provides an estimate of the need for that service among the Dutch population of 15 million and of the most effective way of providing it throughout the country. Currently 13 services are regulated in this way: cardiac surgery (provided in 13 hospitals), brain surgery (13), radiation treatment (21), clinical genetics (7), neonatal intensive care (10), in vitro fertilisation (11), and organ transplantation

(ranging from one hospital for lung transplantation to seven for kidney transplantation).

Article 18 combines the merits of cost containment and quality control. It is used for hospital technologies that need planning nationally because they are expensive or demand special skills, but it is not an appropriate mechanism for keeping all ineffective new technologies out of clinical practice. To achieve this the investigational medicine programme was introduced in 1986. The minister of health, the minister of science, and the Health Insurance Council created a fund of about fl36m (£12m) a year to evaluate both new and existing medical technologies. The aim of the programme is to identify those technologies that should not be reimbursed under the insurance system because they are ineffective or because their cost-effectiveness ratio is too high. For effective technologies the evaluation should also define which patients will benefit. The Health Council identifies the emerging technologies that need evaluating, and most of the studies are carried out in university hospitals, sometimes with methodological support from the Institute of Medical Technology Assessment at Rotterdam University.

So far more than 50 evaluations have been carried out or are under way on technologies ranging from cochlear implantation to laser treatment of haemangioma, support after suicide attempts, treatment with growth factor for neutropenic fever, and extracorporeal membrane oxygenation. The introduction of the programme has created a situation in which the costs of unevaluated new technologies are reimbursed only when they are offered as part of a properly designed research study to assess their effects. In this way the use of new technologies remains restricted to one or two hospitals until their worth has been proved. If it is not proved they can be removed from the scene painlessly.

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