

Can the NHS buy fair access to drugs?

As a parliamentary committee concludes its inquiry into the work of the National Institute for Health and Clinical Excellence, Tom Moberly looks at some of the issues raised over the course of the inquiry and the problems to be overcome if the NHS is to provide fair access to resources and medicines

Since it was established in 1999, the National Institute for Health and Clinical Excellence has made considerable progress towards reducing regional variations in access to medicines across England and Wales.

According to Healthcare Commission figures published last month, 85 per cent of health care organisations report that they conform to NICE technology appraisals and take into account nationally agreed guidance when planning and delivering care. However, it is likely that these self-reported figures fail to represent accurately the situation in practice, since anecdotal reports and clinicians' experience suggest that implementation of guidance can still be slow and patchy, resulting in wide regional differences.

Variations

At the recent Health Select Committee inquiry (see Panel), Andrew Dillon, chief executive of NICE, said he recognised that it is disappointing when service provision and the availability of technologies vary regionally for no reason. He emphasised the work that NICE has done to support NHS organisations and individual health professionals to put NICE guidance into practice.

However, he also stressed that each primary care trust is in a unique position, in relation to what it has to do and the money it has to do it with. It therefore cannot be assumed, he said, that all organisations start from the same position, or that they can reach the same targets in the same time. What was important, he said, was to know how each is planning to fulfil its obligations under NICE.

In fact, there can never be complete uniformity of service provision, Dame Gill Morgan, chief executive of the NHS Confederation, argued. Health services have not developed in a rational, planned way, but in response to how decisions have been made locally and the geography of particular areas, she said.

Even if uniformity were possible, it would be a bad thing, she argued, because delivering all services and care in the same way across England and Wales would mean services were delivered inappropriately in many areas. She argued that there is a basic problem with the notion that postcode prescribing needs to be eliminated, because it is difficult to establish which regional differences are a result of innovation and local tailoring of services and which are the result of inappropriate variations.

Costs

One reason cited for patchy or delayed uptake of NICE guidance is the cost of implementing it. Primary care trusts make a number of complaints: the medicines that NICE approves are too expensive; NICE



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tends to focus on assessing new medicines rather than treatments used by the NHS day-in, day-out; and implementing NICE guidance means other treatments, which may represent better value, are forgone.

The cost of implementing NICE guidance represents a small proportion of the increase in costs to the NHS, Simon Reeve, policy lead for NICE, revealed. The cost of all the technology appraisals and clinical guidelines so far issued by NICE is now £1.2bn a year. This accounts for only 3 per cent of the growth in NHS costs over the same period.

Nevertheless, NICE's approval of a number of expensive medicines has proved controversial and the inquiry heard a number of criticisms of the institute's use of the price per quality-adjusted life year (QALY) to assess cost-effectiveness of medicines. NICE says that it uses QALYs as a tool, not as a rule, but that medicines with QALYs of £20,000–£30,000 are usually approved, while those costing more need special justifications for approval.

However, Raymond MacAllister, chairman of the use of medicines committee at University College Hospitals London, pointed out medicines could easily have

QALYs in this range and not themselves be cost-effective compared with other products for the same indication.

In addition, figures of £20,000–£30,000 appear to be far higher than those primary care trusts routinely pay per QALY. Analysis by Peter Smith of the centre for health economics at the University of York has shown that PCTs spend around £12,000 to secure an extra QALY in vascular diseases and £19,000 in cancer. John Appleby, chief economist at the King's Fund, questioned the reliability of these figures, but stressed that the current NICE threshold has no empirical evidence supporting it and no real theory behind it, even though the issue of the cost effectiveness threshold was fundamental to delivering equity in the NHS.

The issue of affordability and the overall size of the health budget cannot be unrelated to the appropriate level of threshold, argued Stirling Bryan, of the Birmingham University health services management centre. In thinking about how to establish a cost-effectiveness threshold, one would, he suggested, start with the overall level of expenditure, then calculate the cost of providing each treatment, working through each in order of cost-effectiveness until the budget is exhausted.

Such a calculation is only possible, however, if the value of treatments currently provided is known. At present, it is often perceived that treatments approved by NICE are taken up at the expense of established treatments. And, even if NICE concentrated more on the assessment of established treatments, an evidence bias would still favour the approval of new medicines, which have been through extensive clinical trials, over treatments whose value and cost-effectiveness may not have been examined so rigorously.

No escape

The evidence heard by the Health Select Committee inquiry underlines the fact that the NICE system is not without its faults, in both its design and its execution by NICE itself and by PCTs. However, Mr Dillon emphasised, the problems that NICE was established to tackle are not likely to melt away any time soon.

The industry will continue to develop new and valuable medicines, even if it is a challenge for health systems to pay for them, and NICE does not allow England and Wales to escape from that problem. But, he argued, the NHS is in a far better place to make the right decisions about how to apply resources, however limited they might be at a local level, with the benefit of the kind of evaluation that NICE does, than it would be without that evaluation, struggling to make decisions with inadequate information.

Select Committee inquiry

Since February, the House of Commons Health Select Committee has been conducting an inquiry into the work of NICE and last month it heard its last scheduled evidence. Over five oral evidence sessions, the committee has been examining, among other issues, the consistency with which NICE's recommendations are implemented and the reasons for failures to put them into practice. The committee is due to publish a report of its findings within the next few months.