NICE - HTA: external evaluation report published

Country: United Kingdom  
Partner Institute: London School of Economics and Political Science  
Survey no: (2)2003  
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Health Policy Issues: New Technology  
Current Process Stages

| Idea | Pilot | Policy Paper | Legislation | Implementation | Evaluation | Change |

Featured in half-yearly report: Health Policy Developments Issue 2

1. Abstract

Following a House of Commons Health Committee report in December 2002, NICE requested the WHO Regional Office for Europe to carry out a review of its Technical Appraisal Programme. The evaluation team concluded that: "NICE has developed a well-deserved reputation for innovation and methodological developments that represent an important model for technology appraisals internationally".

2. Purpose of health policy or idea

Following a House of Commons Health Committee report in December 2002, NICE requested the WHO Regional Office for Europe to carry out a review of its Technical Appraisal Programme. The team concluded that: "NICE has developed a well-deserved reputation for innovation and methodological developments that represent an important model for technology appraisals internationally".

This confirms that NICE has to date been a scientific success. The impact it has in the wider health context, particularly in areas such as health care priority setting remains to be seen.

The National Institute of Clinical Excellence (NICE) was established in 1999 as a special health authority to address problems associated with variations in the quality of care offered by the NHS and by the introduction of new technologies and medicines. It was set up to produce and disseminate clinical guidelines based upon evidence of clinical and cost effectiveness. NICE recommendations are made to the Secretary of State and if approved are mandatory on NHS organisations. The main organisations that are expected to respond to NICE guidelines are primary care trusts who have the responsibility for deciding whether or not particular treatments will be funded through the local NHS. NICE represents a commitment to evidence-based policy making and to national standard setting.

Main objectives
To promote the adoption of clinical and cost-effective health care technologies.

Type of incentives
Recommendations that, if adopted, become mandatory on purchasers.
Groups affected
Primary care trusts, providers, patients

3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Traditional</th>
<th>Innovative</th>
<th>Controversy</th>
<th>High Controversy</th>
<th>Systemic Impact</th>
<th>Marginal</th>
<th>Fundamental</th>
<th>Public Visibility</th>
<th>Low Public Visibility</th>
<th>Transferability</th>
<th>Strongly System-dependent</th>
<th>System-neutral</th>
</tr>
</thead>
</table>

Successful to date as a scientific endeavour, more work needs to be done on its social ramifications and implementation strategies:

4. Political and economic background

There was a change of government in 1997 when New labour was elected. Their plans for setting up NICE were set out in the document, The New NHS Modern, Dependable (1997). However, the previous Conservative government had set up the NHS R&D programme and the commitment to evidence policy-making was fairly bi-partisan, so it is not clear that a change of government was crucial, it may have been a natural progression. On the other hand, the Labour government was concerned about variations in standards of care around the country - thought to have been accentuated by the internal market - and NICE was one response designed to address these variations. The overall strategy was set out in the NHS Plan where National Service Frameworks and the Commission for Health Care Inspection were set up as important national initiatives alongside NICE.

Change of government
Yes ? probably a contributor to increased emphasis on national standards

Complies with
EU regulations - No
WTO/GATS - No
Other - No

Change based on an overall national health policy statement
NHS plan

5. Purpose and process analysis
Origins of health policy idea

The growth of the health technology movement in the UK was stimulated by concerns about cost pressures associated with new health technologies and by the often over-enthusiastic adoption of ineffective technologies by medical practitioners. The introduction of the internal market in 1991 was an important catalyst because it introduced purchaser organisations (i.e. health authorities) with budgets that they needed to spend cost-effectively. At the same time, the national government became concerned about variations in the standards of care around the country, particularly the so-called 'postcode prescribing' (i.e. the fact that some pharmaceuticals were available through NHS funding in some areas but not in others). The establishment of NICE in 1999 was a direct response to these concerns and mirrored the growth of a similar emphasis on health technology assessment in, inter alia, the Netherlands, France, Sweden, Canada and Australia.

Innovation or pilot project

Local level - NICE was preceded by local initiatives such as the Development and Evaluation Committee (DEC) in the Wessex Regional Health authority which sought to assemble evidence on clinical and cost effectiveness for the benefit of local purchasers. Interestingly p

Stakeholder positions

NICE is a relatively small organisation (about 60 full time staff) based in London. It relies heavily on the unpaid input of its seven non-executive directors and the 46 members of its appraisal committee which is made up of doctors, NHS and commercial managers, academics, nurses and patient representatives.

Two groups that have been particularly interested in NICE judgements are the pharmaceutical industry and organisations representing patients in specific disease and disability areas affected by NICE judgements. Of the 62 technologies assessed in the first four years of its operations, the majority have dealt with pharmaceuticals. Pharmaceutical companies now tend to assemble evidence on the cost-effectiveness, as well as the clinical effectiveness, of their products as a strategy achieving a favourable NICE judgement. This is similar to the 'fourth hurdle' for public reimbursement as applied to pharmaceuticals in Australia. Some concerns currently centre on the confidentiality of pharmaceutical industry evidence which sits uneasily with the desired transparency of the NICE appraisal process.

Patient groups have been particularly active in lobbying in their members' interests particularly when NICE judgements recommend against NHS provision e.g. as in the case of beta interferon for MS sufferers. These lobbying activities have led some commentators to point out that NICE was set up as a scientific committee with insufficient attention paid to the social context of its judgements, a context that can be crucial for successful implementation.

Influences in policy making and legislation

The establishment of NICE was not controversial politically. It is broadly supported by all the main parties and by professional groups. In formal terms it was established as a special health authority and as such was covered by existing legislation. As a Special Health Authority it is managed by a board comprising executive and non-executive directors. Its judgements can however be controversial, particularly when recommending against a particular product or treatment. As explained above the pharmaceutical industry and patient groups are two of the main lobbyists. This means that influence on NICE is exerted more through pressure on how it goes about its business than through legislation. Moreover, from 2001 it has become mandatory on all local NHS purchasers to provide the funding for products that NICE recommends. This can pose local affordability problems.

Legislative outcome

Adoption and implementation

NICE recommendations are acted upon by local health purchasers (i.e. primary care trusts). Through the contracts
they place with provider organisations, and the prescribing protocols they provide for GPs, they are in a position to ensure that positive judgements are taken up and negative ones are enforced. Of course, the issue of the clinical freedom of individual clinicians can also play a part in the implementation process.

The fact that NICE is recognised as an expert scientific organisation provides it with credibility for its recommendations. However, as has already been pointed out, it probably paid too little attention to the social context of its decision making at the outset and has belatedly recruited an advisory group comprising members of the public.

To date, affordability of its recommendations has not been a major problem. But it may become so in the future. Also some economists have pointed out that the requirement to fund positive NICE decisions may distort priorities as even more effective treatments (not assessed by NICE) may be displaced in order to fund those that it has assessed.

6. Expected outcome

Most health policy experts see health technology assessment and the work of NICE as important instruments in the quest to spend scarce health care resources in an efficient manner. By recommending treatments of proven clinical effectiveness, s and ensuring national standards, both quality and equity can be expected to increase. Overall, NICE represents a way of developing evidence based practice that should be in the interests of professionals, patients and payers.

<table>
<thead>
<tr>
<th>Quality of Health Care Services</th>
<th>marginal - fundamental</th>
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<tr>
<td>Level of Equity</td>
<td>system less equitable - system more equitable</td>
</tr>
<tr>
<td>Cost Efficiency</td>
<td>very low - very high</td>
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Only 4 years experience to date, but already it has produced 62 technology Guidances (covering topics ranging from the extraction of wisdom teeth to the management of diabetes). Clearly NICE can be expected to exert even more influence as it scale of activity increases over time.

7. References

Sources of Information

http://www.nice.org.uk


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Suggested citation for this online article