

Denying Care in Britain

By Helen Evans

For the British government, the practice of health technology assessment facilitates rationing by delay. It is a tool that aims to ensure that expensive new technologies are initially provided only in hospitals that have the technical capacity to evaluate them. While the National Health Service Research and Development Health Technology Assessment Programme is funded by the Department of Health and, according to its criteria, researches the costs, effectiveness, and impact of health technologies, the Medicines and Healthcare Products Regulatory Agency ensures that drugs and devices are safe.

In 1999, the government went a step further and set up the National Institute of Health and Clinical Excellence (NICE). At its heart is the Centre for Health Technology Evaluation that issues formal guidance on the use of new and existing medicines based on rigid and proscriptive “economic” and clinical formulas. With the NHS obliged to adhere to NICE’s pronouncements, criticism of NICE has been ceaseless, particularly from various patient organizations.

NICE is a controversial body. It has tried repeatedly to stop breast cancer patients from receiving the powerful breakthrough drug Herceptin and patients with Alzheimer’s disease from receiving the drug Aricept. The criteria by which this agency makes its decisions have been kept largely secret from the public. As is inevitable with any nationalized health care system, life-extending medicines such as those to treat renal cancers are refused on the grounds of limited resources and the need to make decisions based not on genuine market economics but on an artificial assessment of the benefit that may be gained by the patient and society “as a whole.”

In 2001, NICE deliberately restricted state-insured sufferers of multiple sclerosis from receiving the innovative medicine Beta Interferon. Claiming that its relatively high price jeopardized the efficacy of the NHS, NICE told patients with the more severe forms of the disease that they would have to go on suffering in the name of



politically defined equity.

In more recent years, patients with painful and debilitating forms of rheumatoid arthritis have been informed by NICE that in many instances they will not be allowed to receive a sequential range of medicines that have often been proved to be of significant benefit. Instead, the institute decreed that “people will be prevented from trying a second anti-TNF treatment if the first does not work for their condition.”

Similarly, in August 2008, patients with kidney cancer continued to be denied effective treatments designed to prolong their lives, often by months or even a few years. The calculations used by NICE have been systematically disputed by clinical experts who are more concerned with patient welfare than with vote-seeking, but the institute has also come under fire for not involving doctors who are active on the front line of medicine. “With Sutent, for instance,” noted cancer specialist John Wagstaff, “there was just one oncologist on the panel.”

In January 2009, patients with osteoporosis also fell foul of NICE. The institute declared that only a small minority of patients with this debilitating disease would receive the medicine Protelos, and even they would receive it only as an extreme last resort. While clinicians and osteoporosis support groups have pointed out that more than 70,000 hip fractures result in 13,000 premature deaths in the United Kingdom each year and that these otherwise avoidable episodes needlessly cost the NHS billions of pounds, not only are patients being denied necessary treatments, but taxpayers’ money is wasted.

Indeed, according to its annual reports and accounts, NICE is now spending more money on communicating its decisions than would be spent if it allowed patients access to many of the medicines it is so busy denying them. The money that the institute now spends on public relations campaigns “could have paid for 5,000 Alzheimer’s sufferers to get £2.50-a-day drugs for a year,” according to *The Daily Mail*.

Devoid of a market and the language of price, this top-down system ironically ignores many of the societal costs associated with failure to treat severe illness, such as illness-related unemployment. Moreover, the fact that preventing access to more costly medicines may save money in the short term overlooks the costs for the future. If older medicines lead to more rapid deterioration of a condition, the effect could be a more expensive hospital or nursing home episode later.

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