House of Commons Health Select Committee

Inquiry into the National Institute for Clinical Excellence

Submission from the American Pharmaceutical Group

APG

January 2002

EXECUTIVE SUMMARY

- The UK is widely-acknowledged to be behind other similar countries both in the uptake of new medicines and medical technology and in health outcomes. The APG believes that a growing proportion of the extra resources going into the NHS should be devoted to the better use of the most effective and innovative medical technologies.

- There is a role for NICE, or a NICE-type body, with responsibility for helping improve the quality and value of health care and providing credible advice for the NHS.

- The APG welcomes NICE's overall aims of providing faster access to new technology and of ensuring that that technology is available to those in need of it regardless of where they happen to live.

- The Government has acknowledged that NICE can also help promote pharmaceutical industry innovation. This is an important objective, both for the potential benefits to patients and in improving the competitive environment for the pharmaceutical industry.

- There is little or no evidence that NICE is achieving the objectives that have been set for it. Increased expenditure on medicines endorsed by NICE is significantly below what was expected and uptake levels of new treatments do not approach those of other countries. "NICE blight" also means in practice longer delays until new medicines are available to patients.

- NICE is a *de facto* "fourth hurdle" that medicines must pass in order to gain access to the NHS. The APG agrees that medicines and medical technology should be able to demonstrate value for money. However, the way in which NICE attempts to do this is neither clear nor consistent, nor conducive to innovation.

- This lack of clarity has given rise to uncertainty about NICE that is damaging both to the process of bringing new and innovative medicines to NHS patients and to the competitive appeal of the UK for the pharmaceutical industry.

- The APG's main concerns with the nature of NICE are set out in this submission in the section "ten key questions about NICE".

- NICE should be both independent of political interference and openly accountable to Parliament for its performance against the objectives given to it. This could be done on the basis of a set of performance indicators relating both to the efficiency of the organisation and the difference it is making to the quality of health care.

- An annual review of NICE's performance conducted by the Select Committee would be an appropriate way of helping hold the Institute to account.

- The Kennedy Report made the fundamental point that there is a conflict of interest in the Government both setting quality standards for the NHS and paying for it. Many of the practical difficulties with NICE are the embodiment of this conflict. For this reason there needs to be a fundamental review of NICE, in the context of Kennedy. The Select Committee inquiry can provide an important catalyst to this review.

The American Pharmaceutical Group

1. The American Pharmaceutical Group (APG) represents 10 US-owned research-based companies each having a substantial presence in the United Kingdom. Together these companies account for over one-third of the prescription medicines supplied to and used by the NHS. These companies are also large investors in the United Kingdom.

Medicines, Technology and Quality

2. The APG is completely committed to the goal of improving health care in the United Kingdom. It is now widely-known, and generally accepted, that in key areas of health outcomes, the UK tends to perform worse than other comparable countries. On measures such as life expectancy, infant mortality and survival rates from cancer and heart disease, the UK is significantly behind the best performing country. While this results from the interplay of a number of different factors, the fact that, as the Wanless interim report recently noted, this country is behind best practice in adopting and using new technology – including new medicines – we believe does contribute significantly to generally mediocre health outcomes.

3. The National Health Service is now in a phase of unprecedented expansion in the level of resource being committed to it. This money is being especially targeted on increasing the capacity of the NHS – the number of beds, doctors and nurses – to treat more patients. This is clearly needed. It is also true that the ultimate benchmark against which the NHS, or any other health care system, should be judged, is not just the quantity of care it provides, but the quality.

4. Quality has many different aspects. Ensuring that patients are treated in line with internationally-recognised best practice and have access to the most effective medicines and technology for their condition is an important part of it. This encompasses not just the treatment of disease but also prevention where early intervention can be not just more clinically effective, but more cost-effective as well.

5. The APG believes therefore that a growing proportion of the extra resources going into the NHS should be devoted to the improved use of the most effective technologies. The Secretary of State for Health has said himself that he would welcome additional spending on medicines so long as, overall, it represented good value for money for the NHS.

6. It is impossible to state what the "right" figure for increased spending on technology should be, though the Wanless review is developing estimates of cost-pressures on the NHS arising from the impact of technology. What is common ground is that the long-term investment by the health service in medicines and medical technology should be on the basis of their proven effectiveness and value for money. It is here where the National Institute for Clinical Excellence has been advanced as having a crucial role.

The Role of NICE

7. The APG agrees that there is a role for NICE, or a NICE-type body, charged with responsibility for helping improve the quality and value of health care, and providing credible advice for the NHS. We welcome NICE's overall aims of providing faster access to new technology and of ensuring that that technology is available to those in need of it regardless of where they happen to live.

8. However, simply setting up NICE with these aims is not the same as getting the job done. Our actual experience, and the experience of the pharmaceutical industry more widely, as well as of organisations representing patients, is that NICE is not achieving the objectives that have been set for it. In some cases, quite the reverse as the uptake of a new medicine is delayed while NICE carries out its evaluation- so-called "NICE blight". Moreover, the way in which NICE works, and the context in which it operates, means that there are real problems with the credibility of its guidance and the impact that the Institute has. It is on that basis that we believe that an external and fundamental review of NICE is timely. The Select Committee's contribution to that process will be extremely important.

NICE, Competitiveness and Innovation

9. A principal concern for the APG is that the UK remains an attractive and competitive location for investment by US companies. We therefore also have regard to NICE's impact on the competitiveness of this country as a location for pharmaceutical investment and on the climate here for innovation. In his foreword to *Faster Access to Modern Treatment* (Department of Health, January 1999), the then Secretary of State for Health, Frank Dobson, said that the result of NICE's work would be to "promote and encourage successful innovation on the part of clinicians, pharmaceutical companies and the medical devices industry". This is and important goal and one of the benchmarks against which we believe NICE should be held to account.

10. The general perception among our parent companies of the policy and regulatory environment is in a particular country is a material consideration in influencing investment decisions. It is our experience of our parent companies that, since its establishment, NICE has fuelled the impression that the environment in the UK is becoming more difficult. This is why the APG has argued consistently that NICE and its impact should be part of the work of the Pharmaceutical Industry Competitiveness Task Force, and its follow-up bodies, which have been established to deal with problems that undermine the UK's ability to attract pharmaceutical investment here.

11. There is no reason why the interests of the pharmaceutical industry and the interests of the NHS and its patients should not be aligned. The Government, the NHS, NICE itself, and we presume the Select Committee, want patients to be treated in the most effective way leading to the best outcomes for them. It is in the industry's own interest to meet this need and we would be clear beneficiaries from the NHS taking up new medicines much more quickly than it does at present. We accept that our products need to provide value for money (however "value" is defined). Indeed, it is part of our companies' competitive challenge to develop medicines that provide added value.

Ten Key Issues with NICE

12. The principle that medical technology, including medicines, should be of good value is not the root of the concerns we have about NICE. NICE is emerging as a *de facto* fourth hurdle – an additional barrier that new medicines have to negotiate before they can be expected to be used by the NHS. The real problem is that the true nature of this barrier is difficult to determine. Even after the experience (and arguably because of the experience) of 30 appraisals, it is still far from clear exactly what the hurdle is and what it is there to achieve.

13. This lack of clarity has given rise to a high level of uncertainty about NICE, and frustration with it. This is damaging both to the process of bringing the benefits of new and innovative medicines to NHS patients and to the competitive appeal of the UK for the pharmaceutical industry.

14. The principal areas of uncertainty and concern are captured in the ten questions and points we have set out below. These are directly relevant to the issues that the Committee itself has raised, such as the credibility of NICE, faster access to treatment and the independence of the Institute.

(i) What exactly does NICE mean by "cost-effectiveness" and how does it judge whether a technology is cost-effective or not? In the case of beta interferon, for example, NICE has (subject to appeal) ruled that this product is not cost-effective by reference to the shown cost-effectiveness of other treatments for entirely different conditions that the Institute has looked at. How can it be legitimate to lay down rules about how patients should be treated for multiple sclerosis by making cost-effectiveness comparisons with treatments for, say, influenza or breast cancer?

(ii) Appraisal "case-law" has given birth to a cost-effectiveness threshold of £30,000 per quality adjusted life year. In those technology appraisals where cost per QALY data has been cited in NICE's opinion, only one technology has been approved above this level (and most appraisals without cost per QALY data cited have been negative). Who determined the £30,000 cut-off and what was the evidence-base for doing so? Questioned recently in the House of Lords, the Parliamentary Under-Secretary of State, Lord Hunt, said that this was a matter for NICE itself.

We believe that, on the contrary, it should be a matter for ministers, accountable to Parliament, to argue the case for whether any such threshold should exist and, if so, what it should be.

(iii) Cost per QALY methodology is, in any case, a far less universal measure of cost-effectiveness than NICE seems to assume. It is noticeable from a number of the appraisals that different studies produce wildly different cost per QALY outcomes for the same product – itself suggestive that this approach should be treated with caution. Moreover, there are other recognised measures of cost-effectiveness than cost per QALY. Treating cost-effectiveness evaluation as an exact science, when it is far from being so, undermines the credibility of NICE's approach and the guidance it produces.

(iv) Where cost-savings are relevant to the argument about a particular technology, NICE nonetheless takes no account of savings that might arise outside the NHS or social services budget. There may, for example, be economic benefit associated with fewer days absence from work, or the impact on carers, resulting from the use of a particular technology. If NICE is to make a meaningful "cost-effectiveness" assessment, should these factors not be included?

(v) Even where the cost-effectiveness argument is clear (which is rarely the case), the balance between the weight that NICE puts on economic considerations versus clinical benefit is neither obvious nor consistent in the Institute's decisions. NICE's reasoning is often unclear. There have also been several instances (for example taxanes for breast cancer) where NICE recommendations have been successfully challenged on appeal because it is not clear how the evidence the Institute reviewed led to the guidance it wanted to issue.

(vi) There have also been cases (for example proton pump inhibitors) where NICE has taken a more restrictive view of efficacy data than the licensing authorities. This raises the question of NICE's role potentially conflicting with that of the Medicines Control Agency. NICE is also beginning to intrude into the question of safety, which is an important issue, but one currently for the licensing authorities. On what grounds is NICE's remit being thus extended?

(vii) What account does NICE take of quality of life factors that cannot be quantified? NICE has been inconsistent in this respect and has appeared to struggle with value judgments that are really beyond its proper remit. While no one wants medicines or technology used that are an obvious waste of money, is it always reasonable to expect such technology to "pay its way" in the NHS? There are numerous examples where the more widespread use of a particular medicine leads to cost-savings elsewhere in the NHS budget. But even if there are no such savings, is this a reason to deny a patient access to a medicine where it can improve his or her condition and quality of life? Value judgments enter here which take NICE beyond an appropriate role for the sort of body it is. Other than vague plans for a Citizens Council, we see no real attempt to grapple with this. Most disturbingly, ministers are reluctant to become involved. It is not satisfactory to say that "this is a matter for NICE".

(viii) This touches on the question of the independence of NICE from Department of Health and ministerial control. By comparison, the Medicines Control Agency, as an executive agency, though ultimately answerable to ministers, operates at far greater arms-length than NICE is capable of as a special health authority. It is also the case that the MCA has a reputation for objectivity and transparency that so far has eluded NICE itself. This is not intended as a criticism of either the chairman or chief executive of NICE, or any of their officials, whose integrity we respect. This is all the more reason to ask whether the way NICE is constituted and operates itself militates against the Institute's ability to be a credible and transparent organisation. The case for NICE remaining as a special health authority is marginal and should be reviewed against what the Institute is trying to do and its ability to do it.

(ix) The Wanless interim report stated that "the appropriate response to new technologies is for rapid and consistent diffusion across the health service once robust evidence of their cost-effectiveness is available". This, broadly, is the philosophy upon which NICE is based. It suggests, however, that the burden of proof is forever on new medicines and technologies to prove themselves cost-effective before they can be taken up: guilty at launch until proven

innocent. We question whether the burden of proof should not be reversed. NICE should not be entirely risk-averse and be prepared to back promising new technologies even when their cost effectiveness cannot initially be proven to the nth degree. Otherwise, there is a real danger that patients will be denied access to such technologies. Whether statins, for example, would have passed NICE's cost-effectiveness test at launch must be very much in doubt. Yet today, following exhaustive studies such as that recently carried out from Oxford, statins are widely-recognised as effective treatments, and are indeed endorsed in the heart disease national service framework. The option should always remain for NICE to review its guidance some years into a product's lifetime of actual use in the NHS.

(x) Does NICE consider that it has a role in influencing pharmaceutical pricing and, if so, what are the implications here for the existing arrangements under the Pharmaceutical Price Regulation Scheme? This is a matter that has arisen in particular as a result of NICE's emerging view on beta interferon, though our concern that NICE could conflict with the current established regulatory regime is more generally-based.

Selection of NICE's Work Programme

15. The Consumers' Association among others, have noted there is a need for far greater transparency in how topics are selected for appraisal by NICE and the Institute's work programme determined. Indeed, the point has been acknowledged by the Department of Health itself. It is hardly conducive to faith in NICE's objectivity and independence that the process by which its work programme is determined is currently so hidden.

16. We support the view, which we believe NICE holds itself, that the Institute should have the power to select its own work programme, rather than this being imposed by the Government, through the operation of a committee, even the membership of which is a closely-guarded secret. Topic selection should be open and consultative, with interested parties having the opportunity to influence not just the selection of products to be appraised, but the scope and context of the appraisal and the optimum timing for making an evaluation. Ministers, of course, could, and should, feed into this process, not least because there is a strong case for overall topic selection to follow the pattern established by the Government's public health priorities.

17. We also believe that this issue of self-selection raises the question of the proper balance in the overall profile of NICE's work between technology appraisal, guideline development and other work. We return to this question below in our comments on NICE in the context of the Kennedy Report.

Implementation and Impact of NICE Guidance

18. The question of what difference NICE is making to the NHS practice on the ground is keenly debated. Ministers, and NICE itself, argue that the Institute's guidance is making a difference to so-called postcode prescribing, though we have yet to see their detailed evidence for this claim.

19. Data compiled by the Association of the British Pharmaceutical Industry, and which it is presenting to the Committee, show that the actual increases in sales to the NHS of NICE-endorsed products are well below those that NICE itself predicted:

- For taxanes, for example, NICE estimated an additional annual cost of £23 million from its guidance: the actual additional cost in the first year since the guidance has been only £9 million.

- For treatment for hepatitis C, NICE estimated a cost of £18 million against an actual increase of £4 million.

- For glycoprotein iib/iiia inhibitors, where NICE predicted increased costs of around £30 million, the actual observed increase has been only £8 million.

20. The above are typical examples. The overall pattern is that while a number of medicines that have been endorsed by NICE are increasing their sales to the NHS, in most cases this appears to be no more than an extension of the trend rate of growth. Certainly there is no compelling evidence of a dramatic "NICE effect".

21. Even where products with a positive NICE endorsement are increasing sales, the overall levels of use being achieved can still be well below what is common in other European countries. The data show, for example, that, at present rates of growth for treatment for hepatitis C, some 1,500 patients in the UK will receive this treatment in 2001. This compares to more than 20,000 patients treated in Germany and 20,000 in France for the year. NICE's guidance for hepatitis C itself only envisaged 7,000 patients being treated after three years, which casts a light on its lack of ambition against what is achieved in leading counties in Europe. It seems that even this modest target will not be met. We also note a recent letter in the *British Medical Journal* from Dr William Rosenberg at Southampton University who points out that out of 13 centres treating hepatitis C patients, only two have secured funding for all eligible patients as per NICE guidance.

22. The Government is putting primary care organisations under a statutory obligation to fund NICE guidance. This suggests that ministers themselves are concerned about the lack of response from the NHS to guidance that has emerged. The insistence that guidance should be funded is welcome, though this is not the same as requiring it to be implemented. It is unclear whether a particular primary care organisation might still be able to side-step NICE guidance if it could present a clinical (as opposed to cost) argument for doing so. This raises the question whether NICE's guidance is to be treated as "authoritative" in the sense of trumping all other guidance or expressions of collective clinical opinion. There remains considerable scope for ambiguity here.

Performance Indicators

23. One of the positive outcomes of the PICTF report, to which we referred above, is the development of a series of performance indicators against which the competitiveness of the UK environment for the pharmaceutical industry could be judged. These were published on 20 December 2001. The APG believes that this approach might usefully be extended to NICE itself.

24. Such indicators should not only measure the efficiency of NICE as an organisation, but more importantly the impact that it is having on improving the quality of care for patients and health outcomes. They might include, for example, the length of time it takes on average to conduct technology appraisals and, in terms of impact, the effect that NICE is having on the uptake of new medicines and medical technologies. The development of performance indicators will need to be carefully considered and consulted upon. However, we would urge the Select Committee to consider the merits of this approach and to add its weight to the call for it to be explored.

NICE and the Kennedy Report

25. The Kennedy Report following the Bristol Royal Infirmary tragedies raised an issue that is central to the quality issues raised in *A First Class Service* and which has a vital bearing on the future of NICE. Government bodies, Kennedy noted, are currently responsible both for funding health care in this country and for setting quality standards for care. This presents an obvious conflict of interest.

26. In a state-funded health care system, where the Government is responsible for both paying for and delivering health care, it cannot be in the public interest for the same government to set the quality rules. A recent related example concerns the diabetes national service framework. The publication and implementation of this framework has been severely delayed for reasons that are widely-known to be the Treasury's concerns about the potential cost. Thus there is an in-built mechanism for standards to be set on the basis of what is affordable rather than what is best. It was this sort of conflict that led Kennedy to conclude that quality standards should be set independently of the Government, though in a way which remains accountable to Parliament.

27. The Kennedy Report therefore recommends that NICE should be a separate body with "overarching responsibility for the setting of [clinical] standards". In this model NICE would be at the hub of the authoritative standard-setting organisation "under whose aegis all standards for the care provided by the NHS would be issued". What Kennedy calls the "cottage industry" of guidelines issued by other bodies (eg Royal Colleges), and indeed the Government's own guidelines, such as those provided through national service frameworks, would be subservient to NICE.

28. The idea that there should be an independent and dominant quality-setting organisation for the NHS is a challenging one. Were NICE to become this organisation, the Institute would be the same in no more than name alone. A role for NICE as the single arbiter of what passes for high quality health care in the NHS is totally different from the Institute's current focus on determining the clinical and cost-effectiveness of medicines and medical technologies. The jobs are simply not the same. Indeed, trying to do both simply perpetuates Kennedy's conflict of interests.

29. These are questions that need to be considered through a fundamental review and we hope that the Select Committee will cover this ground in its own inquiry. Within such a review it will be legitimate to consider how the cost-effectiveness of medical technologies can be properly assessed, at what stage such assessments are best made and how information from such assessment can be fed into the wider quality picture. It will also be legitimate to consider how, in a finitely-funded health care system, "rationing" decisions can be transparently made.

Conclusions – A Fundamental Review

30. The UK has long spent less on healthcare than comparable European countries. This situation is now changing with a significant injection of new public money. The public will rightly expect this money to buy improvements not just in immediately visible measures, like shorter waiting times, but also in the quality of care available to them through the NHS. Part of this improvement, which will have an impact on health outcomes, will involve making the NHS more receptive to new and innovative medicines.

31. While NICE has recognised that faster access to medicines is an important issue in the UK, the Institute to date has made little overall difference. The APG doubts whether it is realistic to expect this to change. This is not as any reflection on those who run NICE, but because of the conflicts of interest that are inherent in what the Institute is expected to do.

32. The Kennedy Report has performed an important service by exposing this issue, in the wider sense of a conflict between standard-setting and funding, both of which cannot, in the public interest, be vested in the Government and its agencies. Such a fundamental point demands a fundamental review of how quality standards are set, maintained and monitored in the NHS. The APG continues to urge the Government to launch such a review.

33. We believe that the Select Committee can and should go into these issues and provide an important catalyst to a more widespread debate. The Committee's decision to hold a short inquiry into the operation and impact of the NICE is therefore entirely welcome. It will help meet what we see as an important need.

34. In our position statement on NICE issued in July 1999 we argued that the Institute should be subject to periodic, external review by Parliament. We also suggested that the Health Select Committee might have a role in this. Whatever else may be decided about NICE in the wider context of Kennedy and a fundamental review, we believe that there is much to commend the idea of the Committee carrying out an annual review of the Institute and its work.

35. The work of NICE is a matter of intense public interest. It is right that Parliament should take a direct role in monitoring and reporting on its performance against criteria that again the Committee could have an important role in establishing at this stage.