

defining a core package for the NHS

THE SOCIAL MARKET FOUNDATION
HEALTH COMMISSION – REPORT 2C

The Commission would like to thank Niall Maclean for his hard work in preparing this report.

Members of the SMF Health Commission



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Defining a core package for the NHS

KEY POINTS:

- Constructing and justifying a ‘core package’ of NHS services would bring significant benefits. Central amongst these benefits is the gain in honesty and transparency that would result from any attempt to draw the boundaries of NHS provision. Furthermore, the taking of hard decisions about the scope of provision allows for resources to be directed at those services deemed most important.
- However, the task of constructing and justifying a core package confronts serious problems of principle. In addition, research from abroad suggests that the task also faces important practical problems.
- In the face of these difficulties, we should adopt a cautious and pragmatic approach – we ought to create the appropriate kind of environment in which the boundaries of NHS provision could gradually become clearer over time.
- In the UK, NICE ought to be an important part of this environment. However, it ought to be adequately resourced, be free of unnecessary political interference, become better at including wider societal values in its decision making, and be encouraged to link more closely with National Service Frameworks.

When the NHS was set up in 1948, it was on the basis of treatment according to medical need, rather than ability to pay. Doing justice to this principle was thought to require three things. Firstly, it was thought that the health service ought to be universal – all citizens were to be covered. Secondly, treatment was supposed to be free at the point of delivery. Thirdly, the service was supposed to be ‘comprehensive’.

On the universality criterion, the NHS seems to have held up very well – all UK citizens are indeed covered by the service. Regarding the second criterion, most treatment is free at the point of delivery, although the introduction of various user charges has meant that this does not apply in all instances.

What of the third criterion – that the NHS provides a ‘comprehensive’ list of services? While ‘comprehensiveness’ is a beguiling term that invites different interpretations, it is clear that a ‘comprehensive’ range of NHS services has never meant providing absolutely everything that has any medical benefit, no matter how small. The NHS has always excluded some treatments from its remit. At the inception of the NHS, when the range of effective medical treatments was still relatively small, the task of deciding what would be covered on the NHS might have been relatively straightforward. Much has changed over the last fifty years, however. Medical technology has advanced at an astonishing rate, and as a consequence the number of effective treatments has greatly increased. Organ transplants, new and more effective antibiotics, statins, new forms of chemotherapy for cancer – all these treatments are now commonly provided on the NHS. Continuing advances in genetic technologies suggest that the increase in the number of effective treatments in the medical armamentarium is very likely to continue well into the future.

The increased number of effective treatments has made the line between what is funded on the NHS and what is not – the limits to NHS ‘comprehensiveness’ – much more difficult to draw. Nevertheless, constructing and justifying a set of treatments that ought to be provided by the NHS – a ‘core package’ of services – would bring important beneficial consequences. In the first section of this report we will outline these consequences.

These beneficial consequences will, of course, count for nothing if the task of defining a core package of services is not feasible. We devote the second section of this report to assessing the feasibility of this task, by drawing on evidence from home and abroad.

In the final section, we build on our findings on the feasibility question in making some recommendations as to how the task of defining a core package of health care services ought to be undertaken in the UK. We focus closely on the workings of the National Institute of Clinical Excellence, and its links to the National Service Frameworks.

THE VALUE OF CONSTRUCTING AND JUSTIFYING A ‘CORE PACKAGE’ OF NHS SERVICES

The NHS Plan (2000) states: ‘The NHS will provide access to a comprehensive range of services throughout primary and community healthcare, intermediate care and hospital based care. The NHS will also provide information services and support to individuals in relation to health promotion, disease prevention, self-care, rehabilitation and aftercare.’ The stark reality is, of course, that the NHS cannot supply absolutely every treatment that has medical benefit. Nor has it ever been able to do so. And nor should it be ashamed of this fact – limitations on provision are an inherent feature of health services around the world (Honigsbaum et al 1995).

However, the line between what is provided and what is not provided has never received an explicit justification. These decisions have tended to be implicit, largely controlled by the medical profession, and rarely connected to agreed upon decision-making criteria. (New and Le Grand 1996). Some have argued that these decisions are inherently ‘messy’, and simply cannot be governed by agreed upon principles (Hunter 1995). This tone of pessimism has been sternly criticised by others, who argue that an ad hoc approach leaves the door open to inconsistency, and does not fully serve the interests of patients, clinicians, or the wider community (Kennedy 1988).

There is good reason to doubt whether a non-justified line between what is and what is not provided on the NHS will be tolerated for much longer. The public is becoming better informed about health care issues. They are up to date with developments in medical technology, and often have knowledge about the health care services available in other countries. In short, they have high expectations of the NHS. When it is made clear that some particular treatment will not be available on the NHS, discontent is inevitably expressed and often finds a ready media outlet. As the number of effective medical treatments grows, we can expect these instances of discontent to become more and more frequent. Commentators have warned of an impending ‘legitimation crisis’ for the NHS if these decisions are not seen to be made in a justifiable manner (New and Le Grand 1996). An important way to retain confidence in the NHS is to present the public with a set of NHS services that receives an explicit justification. By doing so, a coherent line of reasoning can be presented to justify the exclusion of certain treatments from the remit of NHS provision. We perceive the key benefits of defining and justifying a core package of services for the NHS to be honesty and transparency. Honesty begins with the open acceptance of the fact that the NHS never has been, and never will be, able to provide all services that confer medical benefit. Honesty will also be manifested in the process of constructing a core package, where difficult decisions are not shirked, and are dealt with in a justifiable manner. Transparency ought also be manifested in this process – the decisions ought to be justified clearly and openly, and in a way that allows for on-going scrutiny.

However, constructing a core package of NHS services will have additional benefits that go beyond these. The construction of such a package will, it is often argued, lead to better cost containment. As the

BMA remarks in its Healthcare Funding Review of 2001, defining a core of NHS services would 'enable the public component of healthcare spending to be contained, whilst allowing other services to be offered on a private basis to paying customers.'

In addition to cost-containment, getting clear on the scope of NHS provision would allow for priority to be given to those services deemed most important. Resources could be preferentially directed to ensure that these services are less rationed, and that their quality increases.

Defining clearly what is covered by the NHS means we will become clearer about what is not covered, and this latter form of clarity has the important benefit of allowing the private and voluntary health care sectors to become more clearly defined. Suppliers will be consolidated, quality would probably increase, and more efficient payment mechanisms could emerge. Various forms of 'top-up' insurance might also emerge.

Finally, constructing a clearly defined package of NHS services can be seen as an excellent way to secure the goal of uniformity in provision. If we have an explicitly delineated core package of services that ought to be available in all health authorities, geographical deviations should become much less commonplace. While some geographical variations in service provision are acceptable (e.g. those that reflect the particular needs of a specific locale), the blanket exclusion of some services from some areas clearly offends equity and ought not to be tolerated (New and Le Grand 1996).

CONSTRUCTING A CORE PACKAGE: IS IT FEASIBLE?

So much for the beneficial consequences that would come from the construction and justification of a core package of NHS treatments. What reasons are there for thinking that this task is feasible?

One important determinant of feasibility is the level of desire amongst the relevant stakeholders to see the task undertaken. Let us begin with the most important stakeholders – service users. The British public retain a strong belief that the NHS ought to provide an equal standard of healthcare across the country (BMA 2001, Health Which? 1999). Attitudes surveys also reveal that while the public would ideally like the NHS to provide all the treatments they need regardless of cost, they are aware of budgetary constraints and are accepting of the inevitability of some form of rationing (Bryson & New 2000). The public have been exposed to implicit rationing in the form of waiting lists almost since the inception of the NHS, and have occasionally been presented with high-profile cases of explicit rationing (the child B case in Cambridge, for example).

For its part, The British Medical Association (in its Healthcare Funding Review of 2001) described the idea of introducing a package of core services as 'superficially attractive', adding that 'if we acknowledge that rationing and denial of treatment already exist within the NHS, the definition of an explicit boundary seems a small step to take.' In addition to the BMA, the National Consumer Council (2003) has recommended a 'Core Services Commission' to decide what should be covered by the NHS.

Legally, there seem to be few barriers to the construction of a core package. Although some consideration will have to be given to the Human Rights Act, analysts have concluded that, based on previous experience, it seems likely that UK courts will recognise the need for health authorities (and their successors) to set priorities, given limited resources. They are therefore expected to give some leeway in resource allocation decisions, as long as these decisions do not discriminate unfairly and can be shown to have been made in the best interests of the wider community (Thomson *et al.*, 2001).

The most marked resistance to the idea of constructing a core package comes from the Department of Health. It has several arguments against, presented in *The NHS Plan*. Firstly, it argues that advocates for defining a core service 'usually have great difficulty specifying what they would rule out'. The sort of treatments that commonly feature include varicose veins, wisdom teeth extraction, and cosmetic procedures; services that account for less than 0.5% of the NHS budget and are not major cost-drivers for the future. In reality, the vast majority of spending goes on childbirth, elderly care, and conditions such as cancer, heart disease, and mental health problems. It is certainly true that, when thinking about the boundaries of NHS provision, certain 'obvious candidates' for exclusion are easy to discern – cosmetic procedures, for example. When pressed to specify which services ought not to be available on the NHS, the UK public often cite these very treatments and services as the ones to be excluded (Kendall 2000; Bryson & New 2000; Mori 1998; Pollard & Raymond 1999; Kendall 2000). However, beyond these obvious candidates for exclusion that seem to service wants rather than medical needs, there is very little agreement. One good example of seemingly entrenched disagreement is over whether fertility treatment ought to be funded on the NHS (Mori 1999, ICM 1999).

The second objection to the very idea of defining a core package of services presented in *The NHS Plan* is that 'different patients under different circumstances often derive differing benefits from the same treatment' (NP 3.30). The underlying argument here is that because different patients can receive different benefits from the same treatment it is difficult to rank treatments per se as being more or less important. Genetic technology might, if it becomes sufficiently refined, be able to allow us to better target certain treatments to certain patients, and could make it easier to make accurate generalisations about the benefits wrought by specific treatments. This refinement of genetic technology remains some way off however, and even when refined it may be very costly to implement. As things stand at the moment, those who seek to define a core package based on relative rankings of the benefits wrought by different treatments face a very difficult task.

In addition to these problems confronting any attempt to define a core package of NHS services, there are also significant practical difficulties. One thing that sets the UK apart from other countries on the issue of health care provision is the degree to which the NHS is politicised. In social insurance systems, insurers will tend to define the core package at arm's length from government, or else government will provide only a broad framework of important treatments areas (allowing insurers to fill in the details regarding specific treatments). In the UK, defining a core package is seen as politically dangerous – it is perceived as being equivalent to a contract between government and citizens that could prove uncomfortable should the health service fail to deliver.

These political fears certainly count as one sort of practical difficulty standing in the way of any attempt to define a core package of publicly funded health care interventions in the UK. The experiences of other countries that have attempted the task highlight further practical problems. Perhaps the best-known attempt to define a core package of health care services was undertaken by the state of Oregon (USA) in 1989. The Oregon Health Plan was the result of a legal initiative undertaken by a group made up of service users, providers, insurers, business people, and labour representatives. Its aim was to ensure universal access to reasonably priced health insurance, partly by widening Medicaid coverage to all residents of the state. The driving idea was that universal coverage would only be achievable if cost-containment mechanisms were legally mandated. One of these mechanisms consisted in limiting the set of conditions for which treatment would be available. A Health Services Commission was established to rank conditions and treatments according to certain designated criteria. Universal coverage would be provided above a certain threshold (the threshold depending on actuarial estimates and budgetary constraints during any particular session of the state legislature). Mental health services have been included in the prioritization process since 1995.

The ranking criteria used by the Commission have evolved over the years. Initially, four criteria were used: cost, net duration of benefit, physician estimates of the probability that treatment would alleviate symptoms or prevent death, and citizen opinions concerning the severity of symptoms. The rankings that emerged from these criteria were so heavily criticised that the Commission decided to put primary weight on the values of citizens expressed at community meetings. As a result of this development, the federal government charged the Commission with violating the Americans with Disabilities Act, since the weights attached to conditions of people with disabilities depended on the opinions of the non-disabled. The methodology was revised once again, with most emphasis being put on the likelihood of a treatment's preventing death or alleviating symptoms, and on cost, with adjustments then being made in the light of citizen values. Such adjustments were later removed.

The Plan has had some success: the proportion of uninsured Oregon residents fell from 18% in 1993 to 11% in 1996 (although economic growth must also be seen as playing a role in explaining this fall). However, it has also provided some stark examples of the practical difficulties that await any attempt to define a core package of clinical services.

Firstly, it is important that the values of citizens are reflected in the prioritisation process. This is a daunting task, since diverse societies such as ours are marked by a plurality of reasonable and competing values. The Oregon planners have relied on community meetings to draw upon popular values. Commentators on this process have questioned the representativeness of these meetings, and have highlighted the difficulties that surround any attempt to draw balanced conclusions from their findings (Klein 1999). In the UK, there has been some recent interest in the use of 'citizen juries' as a means of tapping into the relevant kinds of popular values (Leneghan et al 1996). As yet, however, there is no consensus regarding the best way to make such juries representative, or on how to draw justified conclusions from their deliberations.

Secondly, the Oregon experiment has shown that establishing an explicit limit on service coverage is very difficult in practice. Many Medicaid recipients are reported to continue to receive services that are supposedly excluded by the Health Plan (Oberlander et al 2001). Ham (1998) cites this as strong evidence in favour of the idea that the definition of a core package must be supplemented with clinical guidelines governing how the treatments in the package are to be provided. The necessity of such guidelines shows the clear difficulties in excluding entire categories of care from the remit of public provision.

Thirdly, Oregon has shown that the work of defining an explicit package of services must be ongoing. This is so because of the continued rapid advance of medical technology resulting in the continuous emergence of new treatments, and also because new information about the effectiveness of existing treatments is constantly being produced. An ongoing evaluation process is complex and time consuming. In January 1998, the Oregon Health Financing Commission still had to approve revisions to the priority list that had been drawn up in May 1997 (Ham 1998).

Other countries that have undertaken the task of defining which health care services ought to receive public funding have encountered similar practical problems. In 1992, New Zealand established the National Advisory Committee on Core Health and Disability Support services. In the same year, the Dutch government's Committee on Choices in Health Care produced its final report. In both instances, the significant practical problems that were found to attend attempts to define a core package led planners away from the construction of such a package towards the delineation of broader guidelines to structure decision-making.

CONSTRUCTING A CORE PACKAGE: A METHOD FOR THE UK

Thus far, we have argued that, while the construction and justification of a core package of NHS services is an attractive idea, it faces certain problems of principle, as well as practical difficulties. How ought the UK to proceed in the face of these difficulties? It would seem that there are two possible courses of action. The first course is to admit defeat – the difficulties are simply too great, and we should therefore give up on defining a core package. The second course could be described as cautious pragmatism. While acknowledging the seriousness of the difficulties that seem to attend any attempt to define a core package in the here and now, this approach would recommend that we attempt to move forward cautiously, in incremental steps. While we might not at the moment be able to construct a core package of NHS services, we can nevertheless take certain steps to at least allow the boundaries of NHS provision to become more clearly defined over time. This is the approach we favour.

How ought this incremental approach to begin? The best way to begin is not, it would seem, to focus straight away on the kinds of treatments that immediately arouse controversy (e.g. fertility treatment). Rather, we ought to begin by looking for areas of substantive agreement, and then work outwards until we reach disagreement. We ought to start by asking 'Which services do we think absolutely ought to be provided by the NHS?' In answering this question, we will most probably end up with a set of interventions comprising the majority of the services currently provided by the NHS. The number of treatments over which there would be disagreement is likely to be relatively small. As NERA & Norwich Union Healthcare (2000) state: 'It seems likely that most of what the NHS currently provides would be included and exclusions would focus on areas where there is already disagreement (e.g. as evidenced by geographical discrepancies in funding and provision across the UK).' The set of interventions they suggest would meet with broad agreement includes those that are of proven effectiveness and meet agreed value for money criteria, as well as intermediate care and elements of long term care, plus some elements of social care like residential care for the elderly (Nera & Norwich Union Healthcare 2003). Treatments of limited efficacy or for conditions that patients can reasonably treat themselves (e.g. colds, hay fever and minor injuries) are likely to be excluded.

Thus, by adopting a method that begins by looking at treatments we absolutely want to be covered by the NHS and working outwards, we are likely to arrive at a set of interventions made up of many of the treatments currently provided by the NHS. This is far from a pointless exercise, since the set of NHS treatments can now receive a *justification* – it has been put together via a process where we think about what we absolutely want to be covered. The values of transparency and honesty we described above would be well served by this process.

The serious question that remains is how we proceed when we hit disagreement – when we are confronted with a treatment that *might* be worthy of inclusion in the NHS package. We know how the cautious incremental approach ought to begin – by working outwards from substantive agreement to disagreement. But how ought it to proceed when we hit these disagreements? It is our view that, while we might be some distance away from arriving at justifiable decisions in all these instances of controversy, we can however create the right *environment* that could allow these decisions to be made over time in an honest, transparent, and justifiable manner.

We believe that the National Institute for Clinical Excellence ought to form an important part of this environment. The central operative concept used by NICE is 'cost-effectiveness' – it claims to 'help the NHS to deliver the best possible health care from available resources, by focusing on the most cost-effective treatments (www.nice.org.uk/Article.asp?A=256). Thus, in deciding whether a treatment is

suitable for provision on the NHS, NICE considers whether the treatment is sufficiently cost-effective. This immediately begs the question: how cost-effective is 'sufficiently' cost-effective? Where exactly does the threshold lie? The recent much-publicised example of the multiple sclerosis treatments beta interferon (BI) and glatirimer acetate (GA) can bring out the issues that must be dealt with in properly cashing out the concept of cost-effectiveness.

In its 'provisional view' published in July 2000, NICE stated that neither BI nor GA ought to receive NHS funding because their 'modest clinical benefit appears to be outweighed...by very high cost.' The cost effectiveness of a treatment is equal to the clinical benefit of the treatment divided by its cost. NICE clearly believes the ratio in the case of BI and GA is not suitable, but is not clear exactly why it believes this. At section 4.15 in its Final Appraisal Determination on these drugs (produced in November 2001), NICE estimates that the mean cost per quality adjusted life year (QALY) gained by using these drugs is between £248,000 and £810,000 at five years, between £210,000 and £339,000 at 10 years, and between £35,000 and £104,000 at 20 years.¹ It is clear that NICE does not find these ratios of costs-to-QALYs to be acceptable, but what is lacking from the FAD is any attempt to explain *why* they are unacceptable.

Specifying a threshold ratio of clinical benefits versus financial costs might well be a good way of deciding which treatments ought to be provided by the NHS. However, exactly where the ratio should be struck, or even how it ought to be struck, receives strikingly little attention in NICE's self-documentation of its working practices.² While one NICE document states that 'Clinical guidelines should...address the cost effectiveness of treatments or management approaches (that is, how well they work in relation to how much they cost)' (*The Guideline Development Process: Information for the Public and the NHS*, p8), there is no specification of what sorts of cost effectiveness ratios are acceptable, and no systematic attempt to derive and justify these ratios.

The lack of clarity regarding exactly how NICE reaches its decisions is becoming increasingly well known – the Consumer's Association has recently published a study highlighting these issues (BMJ 2001;323:1324). An academic study of the 22 health technologies on which NICE had issued guidance by March 2001 'could not conclusively establish how the balance between clinical benefits and economics (cost per QALY) influences NICE recommendations' (Raftery 2001; parentheses in original). Even more recently, a World Health Organisation report on NICE's working practices (which was, in the main, complementary) has called for clarity regarding where NICE's cost effectiveness threshold lies, and the provision of an explicit justification for this threshold (World Health Organisation 2003). If NICE continues to make its decisions on the basis of cost-effectiveness calculations, the justification of particular cost-effectiveness ratios is imperative.

Although it is beyond the scope of this paper to suggest what these ratios might be, or how they might be justified, we can make some suggestions about how NICE as an organisation ought to be equipped to meet these challenges. We are committed to the continued existence of NICE as an important part of the environment in which decisions about the inclusion or exclusion of treatments we disagree about can, over time, be formed and justified. However, we believe it is important to recognise that NICE ought to be amended in various ways in order to become an effective part of this environment.

Firstly, it ought to be properly resourced. The generation and justification of cost benefit ratios, and the subsequent application of these ratios to all the treatments deemed to be 'marginal cases' for inclusion under the remit of the NHS, constitutes a significant amount of work. NICE ought to receive a proportionate amount of additional resources to undertake this work. Furthermore, we believe that NICE

ought to be equipped to make decisions about not only the marginal cases, or for new treatments. The values of transparency and honesty we discussed in section one would be greatly served were NICE to be equipped to give justifications for the inclusion of the treatments currently provided by the NHS. Undertaking this task would demand even more resources – but the benefits would be significant. We might reasonably expect this exercise to lead to the exclusion or more selective usage of certain treatments that are in fact of limited effectiveness (or are effective only with carefully selected patients).³ The saved costs could be diverted to more effective treatments.

Secondly, we ought to be prepared to accept that cost effectiveness considerations might not be the only ones that ought to feature in any attempt to give a justified account of where the boundaries of NHS provision should lie. One of the key lessons of Oregon is that the values of the wider community (which might include, but are surely not exhausted by, notions of cost effectiveness) must feed into the justification of decisions about what kinds of health care we want to make available. However, as we remarked above, the task of sampling of these values, and of arriving at agreed-upon decisions from the plurality of reasonable values that exist in our society, is an extremely challenging one.

It is not, however, an impossible task. Recent research has suggested that individual citizens can and ought to be consulted regarding the kinds of values (and trade-offs between values) that ought to shape the workings of the NHS (New and Neuberger 2002). It is important that the task of consulting wider societal values is undertaken, either under the auspices of NICE, or via another organisation that feeds its findings into the workings of NICE. Towards the end of 2002, NICE set up a Citizen's Council, made up of 30 members of the public drawn from a wide range of backgrounds and coming from different parts of England and Wales. The purpose of the Council is to feed the values of ordinary citizens into NICE's decision making processes. Although NICE is not bound by the Council's advice, it claims to be 'committed to this type of input' (NICE 2002). We welcome this move by NICE, but we also await with interest a forthcoming evaluation of the success of the Citizens' Council ('Evaluation of the Citizen's Council of NICE': National Co-ordinating Centre for Research Methodology, University of Birmingham. Due to report in September 2004). The success of the Citizen's Council is vital in allowing wider societal values to feed into NICE's decision making. We urge continued support for this group, and, where relevant, amendment of its practices to further the aim of referencing the values of the public at large.

Another lesson taught by Oregon is that the task of deciding which interventions ought to be provided must go hand in hand with the task of constructing guidelines to be used in the appropriate prescribing of these interventions, to decide on such issues as which patient groups are to receive which treatments, under what conditions, and for what duration. Nera and Norwich Union Healthcare (2003) rightly remark that any set of publicly funded health care goods should be well defined, comprehensive and consistent, so that there is no scope for shifting costs between different parts of the health system or for erosion of the set of goods. However, some element of clinical discretion ought to be preserved, so that doctors could offer certain treatments outside the set to carefully selected patients who have a capacity to benefit. This kind of flexibility over how publicly funded treatments are delivered is important.

A key challenge for NICE is to link better with existing National Service Frameworks (NSFs), which are designed to ensure national standards of care for specific services and disease groups. Recently, concerns have been raised over how well NICE links with NSFs ('NICE needs sweeping changes to maintain credibility, say MPs', BMJ 2002;325:5 [6 July]). Improving these links is an essential prerequisite in ensuring that the elements of any core package are supplied in a justifiable fashion.

Furthermore, there is some evidence to suggest that well-functioning guidelines for the treatment of specific conditions also facilitates the sort of comparisons in cost-effectiveness between different types of treatment that are the cornerstone of NICE's working practices. Citing the example of the Kaiser Permanente Health Plan in the US, Feachem et al (2002) describe how these kinds of close links between clinicians and administrators allow for a level of control and accountability across an entire health care system, which in turn facilitates trade-offs in expenditures based on cost effectiveness rather than 'artificial budget categories'.

Finally, NICE ought to operate free from unnecessary political interference. In the *Guide to the Technology Appraisal Process*, NICE states that the process of weighing the costs and benefits of a new treatment must take into consideration 'the Secretary of State's and the National Assembly for Wales' broad clinical priorities (as set out for instance in National Priorities Guidance and in National Service Frameworks...)' and 'any guidance from the Secretary of State and the National Assembly for Wales [NAW] on the resources likely to be available and on such matters as they may think fit' (*Guide to the Technology Appraisal Process*, p2). The Department of Health and NAW also 'provide NICE with a remit for the appraisal' (Ibid. p6), and NICE's appraisal is expected to be 'in accordance with the terms of the Department of Health/NAW's reference' (Ibid. p13). Since NICE makes recommendations about how NHS services – which are publicly funded – ought to be prioritised, it is important that its decisions are democratically accountable. This might require, for example, ministerial approval of its decisions. However, it is important that NICE enjoys (and is seen to enjoy) the freedom in its day-to-day work to make the kinds of decisions that might not meet with short-term political approval, but which are nevertheless necessary in the construction and justification of the boundaries of NHS care. Public confidence in NICE would be severely damaged were this freedom to be encroached upon by unnecessary political interference.

THE COMMISSION'S VIEW

There is much to commend the construction and justification of a core package of NHS services. We see the central benefits of such an endeavour to be the manifestation of honesty and transparency regarding what the NHS provides. In addition, the definition of such a package could bring the additional benefits of cost containment, prioritisation of services deemed to be essential (with less rationing of these services, and an improvement in their quality), the consolidation of more efficient and possibly cheaper forms of non-NHS medical care, and the facilitation of more uniform provision of NHS services across the country.

However, the task of constructing and justifying such a package faces serious problems of principle. In addition, the experiences other countries have had in their attempts to construct such a package provide clear examples of the sorts of practical difficulties that attend this task. The values of the community must be sought; how this can be done in a representative way, and how justifiable conclusions can be drawn from competing values, remains a difficult question. The task of evaluating the relative merits of different treatments must be on-going. And, even assuming a core set of NHS treatments can be defined, it must be supplemented with guidelines regarding how the elements of the set are to be provided.

In the face of these difficulties, we suggest a cautious and pragmatic way forward – the benefits of getting clearer about exactly what the NHS does and does not provide are simply too great for the task to be simply ditched as being 'too difficult'. While we might be some way off reaching agreement on where the boundaries of NHS provision ought to lie, we can in the interim create the sort of environment in which

these boundaries could – over time – become clearer. We believe that NICE must be a central part of this environment. However, it must be properly resourced, be given an appropriate amount of autonomy from unnecessary political interference, and adequately reflect wider societal values in its decision making. Initially, if NICE were to provide a clear justification for the inclusion of the bulk of the treatments currently provided by the NHS, this would constitute a significant gain in honesty and transparency.

Another key task in the short term is to make NICE link better with National Service Frameworks, in order to create guidelines for the appropriate provision of the treatments we agree ought to be within the remit of NHS provision.

By adopting this cautious and pragmatic approach we believe that the boundaries of NHS provision could become sharper over time. The advantages of undertaking this task are significant enough as to be worth waiting for – the 'comprehensiveness' of the NHS would become more clearly cashed out, rather than remaining in its current murky state.

- ¹ The QALY approach can be summarised thus: each year of perfect health is valued at 1 and each year of illness at less than 1, with more severe illnesses lowering this value by greater amounts. Treatments are then costed per QALY gained. The use of QALYs in the case of BI and GA is described by NICE in the Final Appraisal Determination in this way: 'The number of QALYs gained by using a particular treatment is a measure of its benefits in terms of improvements in the quality of life of patients (including physical performance, pain, distress, and psychological improvements, as well as changes in survival) summed over a period of time.' (Appendix E, A1.1.1).
- ² Some commentators believe NICE operates with a threshold ratio of £30,000 per QALY gained (e.g. Taylor [2001]). Even if this is the figure NICE has settled on (and there is no conclusive evidence to suggest it is), it ought to be justified.
- ³ When evidence about the effectiveness of grommets for persistent glue ear in children was distributed nationally in 1992, the rate of grommet insertion fell steadily. In the four years after the evidence was distributed, 89, 800 procedures were avoided, providing a theoretical saving of 27m GBP at 1992-3 prices. (Mason *et al* [2001])

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