

This reform of NHS drug funding is not a sweet deal for big pharma

Value-based pricing and risk-sharing agreements will provide hard data on efficacy



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Polly Toynbee ([Forget patients. Andrew Lansley is the servant of big pharma](#), 2 November) attacks the reform of the [National Institute for Health and Clinical Excellence \(Nice\)](#) as "offering a health service without limits just when the NHS is to be cut back as never before". This statement is misleading and deserves to be unpacked.

The announcement that Nice will no longer be the sole body deciding on the reimbursement of treatments that are available on the NHS does not mean it is being "stripped of its powers". It means treatments will now be considered not only on the basis of an educated estimate of their prospective cost per unit increase in life expectancy, but also on the desire to adopt a more patient-centric approach.

GPs will now be able to prescribe based primarily on clinical need – a huge improvement to patient care. But that decision will still have to be made within the limits of local health budgets agreed by a local consortium, accountable to the NHS commissioning board. In practice, GPs will also continue to consult Nice guidance as well as its new standards under an expanded remit.

Despite Toynbee's reference to "runaway drug costs" and implying a free-for-all, spending on medicines actually forms only about 10% of overall NHS costs. And according to OECD figures, the growth in UK pharmaceutical spending is actually decreasing as a percentage of GDP (down from 14% in 2000).

Is the NHS really being "cut back as never before"? While the NHS is indeed being asked to find productivity gains and savings due to the current economic crisis, it has nevertheless had a huge increase in its budget over the last decade. In real terms, health spending has doubled since 1999, reaching £103bn in 2010-11, and the coalition government has committed to a continued real-terms increase in the NHS budget.

Arguing that value-based pricing and risk-sharing agreements will undermine the way our public system considers the cost-effectiveness of treatment (tilting it towards the interests of industry) is simply incorrect. A key purpose of such a system is to assess over time whether the drug has achieved its intended goal and justified its cost. This is hardly a sweet deal for industry. Rather it is a commitment by all sides to come up with hard data on efficacy, compliance and so on.

[Patient access schemes](#) are an alternative way of trying to ensure British patients can access new innovations while holding the industry accountable for their effectiveness. [Stockholm Network research](#) shows that the evidence on these schemes is

patchy, although in some cases they do work well. The coalition should therefore look carefully at the outcomes of pilots as they emerge, before it goes ahead with finalising any change to Nice's functions. But it is not fair of commentators such as Toynbee to simply dismiss these schemes.

Ultimately the NHS's legitimacy comes from making decisions based on a combination of patients' needs, budgetary considerations and real-world evidence. Nice still has an important role to play, but that doesn't mean we should not modernise our system just for the sake of preserving the powers of present institutions.

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