

# Not so Nice news on rationing, by Helen Disney

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Ever since its inception, the National Institute for Health and Clinical Excellence (Nice) has been controversial.

Despite government rhetoric about assessment of clinical effectiveness, many saw it as a rationing body in disguise. In fact, Nice rejected very few medicines and treatments but decisions about those that were rejected were strongly contested by patients and the public, not to mention the media.

This week's news that Nice will no longer deny patients access to new medicines is a welcome move away from centralised rationing. It seems that even at a time of austerity, the British public does not want or accept the idea of rationed healthcare. But it would be shame if the Nice experiment were replaced by an equally unpredictable means of allocating resources.

Health Secretary Andrew Lansley has proposed using risk-sharing agreements between pharmaceutical companies and the NHS that offer 'no win, no fee' mechanisms as the new basis for extending access to medicines. However, new research by the Stockholm Network, which examines 27 risk-sharing schemes already in operation in various countries, shows that they are still very much in their infancy and should not form the basis for more widespread NHS use.

*Sharing the Burden* shows that the results of risk-sharing schemes are too varied to be relied upon and that, in most instances, such schemes have been used as a fig-leaf for imposing price cuts rather than for widening access or increasing innovation. When drugs are rejected for reimbursement, a risk-sharing scheme can act as a band-aid over the damage, yet this is not a sustainable system for the future.

An effective risk-sharing agreement must understand the specific reasons for including, or not including, a certain drug for reimbursement, for example are the concerns about cost or about clinical effectiveness?

Risk-sharing schemes need to adequately address both price and performance concerns. Current examples suggest that risk-sharing agreements aim to control costs rather than to deal genuinely with the issue of risk.

Risk-sharing agreements are a means to an end not an end in itself. If the intention is greater access to the best available treatments within finite budgets then risk-sharing should be considered as part of a wide range of policies aimed at serving this objective including the wider goal of health system reform.

There is a lot of food for thought for the coalition government as it continues to negotiate the terms of the value-based pricing agreement that will come into effect in 2013. Patients, doctors and the wider public feel very strongly about this issue and will be keeping a close eye on what the post-Nice future has to offer.

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