GENERAL ETHICS

NICE rejoinder

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The bottom line is that Claxton and Culyer believe, and are on record as saying, that a therapy or procedure is not cost effective if “the health benefits that it is estimated could be gained from the technology are less than those estimated to be forgone by other patients as other procedures are necessarily curtailed or not undertaken. It is this comparison of health gained and health forgone that is at the heart of the rationale of cost-effectiveness analysis”. To estimate whether the gains made are less than the gains forgone, NICE must therefore know which gains would have to be foregone, if the procedure or technology is approved or there can be no data for the required calculation. If they don’t know this they cannot know whether the gains might have been less or more than the benefits foregone in any particular case. Claxton and Culyer now say: “Our point was that neither NICE nor any other decision making entity ... can know precisely which NHS activities will be displaced by their guidance or prescribing decisions nor exactly who will forgo which specific health benefits. However, we do know there will be health forgone to real, albeit unidentified, patients and we maintain the value judgement that the consequences for those unidentified individuals ought to be valued in

the same way as the consequences for others who gain from the technology under consideration”. Of course they should! But unless it is known which consequences for unidentified individuals or indeed how many such individuals are involved it cannot be known whether costs outweigh benefits. This is disingenuous in the extreme! Although NICE do know that “there will be health forgone”, they admit that it is not and cannot be known whether this is more or less serious than the health foregone by the decisions of NICE. From this it follows inexorably that NICE is not and cannot be doing cost benefit analysis on Claxton and Culyer’s own definition of what this must be. End of story! That neither Claxton and Culyer nor NICE seem capable of seeing this is a tragedy for patients and the NHS and makes nonsense of the theory NICE uses to justify its decisions. Many patients clearly hope that this must also mean “end of story for NICE” and for the pretence that NICE is making decisions on the basis of the moral evaluation or indeed the cost effectiveness of alternative uses of resources. By their own admission they don’t know what the alternative uses are.

Competing interest: None.

This debate is now closed.

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