THE WALL STREET JOURNAL

# OF NICE AND MEN

EDITORIAL

JULY 7, 2009

Speaking to the American Medical Association last month, President Obama waxed enthusiastic about countries that "spend less" than the U.S. on health care. He's right that many countries do, but what he doesn't want to explain is how they ration care to do it.

Take the United Kingdom, which is often praised for spending as little as half as much per capita on health care as the U.S. Credit for this cost containment goes in large part to the National Institute for Health and Clinical Excellence, or NICE. Americans should understand how NICE works because under ObamaCare it will eventually be coming to a hospital near you.

President Barack Obama speaks about health care during a town hall meeting at Northern Virginia Community College last Wednesday.

The British officials who established NICE in the late 1990s pitched it as a body that would ensure that the government-run National Health System used "best practices" in medicine. As the Guardian reported in 1998: "Health ministers are setting up [NICE], designed to ensure that every treatment, operation, or medicine used is the proven best. It will root out under-performing doctors and useless treatments, spreading best practices everywhere."

What NICE has become in practice is a rationing board. As health costs have exploded in Britain as in most developed countries, NICE has become the heavy that reduces spending by limiting the treatments that 61 million citizens are allowed to receive through the NHS. For example:

In March, NICE ruled against the use of two drugs, Lapatinib and Sutent, that prolong the life of those with certain forms of breast and stomach cancer. This followed on a 2008 ruling against drugs -- including Sutent, which costs about $50,000 -- that would help terminally ill kidney-cancer patients. After last year's ruling, Peter Littlejohns, NICE's clinical and public health director, noted that "there is a limited pot of money," that the drugs were of "marginal benefit at quite often an extreme cost," and the money might be better spent elsewhere.

In 2007, the board restricted access to two drugs for macular degeneration, a cause of blindness. The drug Macugen was blocked outright. The other, Lucentis, was limited to a particular category of individuals with the disease, restricting it to about one in five sufferers. Even then, the drug was only approved for use in one eye, meaning those lucky enough to get it would still go blind in the other. As Andrew Dillon, the chief executive of NICE, explained at the time: "When treatments are very expensive, we have to use them where they give the most benefit to patients."

NICE has limited the use of Alzheimer's drugs, including Aricept, for patients in the early stages of the disease. Doctors in the U.K. argued vociferously that the most effective way to slow the progress of the disease is to give drugs at the first sign of dementia. NICE ruled the drugs were not "cost effective" in early stages.

Other NICE rulings include the rejection of Kineret, a drug for rheumatoid arthritis; Avonex, which reduces the relapse rate in patients with multiple sclerosis; and lenalidomide, which fights multiple myeloma. Private U.S. insurers often cover all, or at least portions, of the cost of many of these NICE-denied drugs.

NICE has also produced guidance that restrains certain surgical operations and treatments. NICE has restrictions on fertility treatments, as well as on procedures for back pain, including surgeries and steroid injections. The U.K. has recently been absorbed by the cases of several young women who developed cervical cancer after being denied pap smears by a related health authority, the Cervical Screening Programme, which in order to reduce government health-care spending has refused the screens to women under age 25.

We could go on. NICE is the target of frequent protests and lawsuits, and at times under political pressure has reversed or watered-down its rulings. But it has by now established the principle that the only way to control health-care costs is for this panel of medical high priests to dictate limits on certain kinds of care to certain classes of patients.

The NICE board even has a mathematical formula for doing so, based on a "quality adjusted life year." While the guidelines are complex, NICE currently holds that, except in unusual cases, Britain cannot afford to spend more than about $22,000 to extend a life by six months. Why $22,000? It seems to be arbitrary, calculated mainly based on how much the government wants to spend on health care. That figure has remained fairly constant since NICE was established and doesn't adjust for either overall or medical inflation.

Proponents argue that such cost-benefit analysis has to figure into health-care decisions, and that any medical system rations care in some way. And it is true that U.S. private insurers also deny reimbursement for some kinds of care. The core issue is whether those decisions are going to be dictated by the brute force of politics (NICE) or by prices (a private insurance system).

The last six months of life are a particularly difficult moral issue because that is when most health-care spending occurs. But who would you rather have making decisions about whether a treatment is worth the price -- the combination of you, your doctor and a private insurer, or a government board that cuts everyone off at $22,000?

One virtue of a private system is that competition allows choice and experimentation. To take an example from one of our recent editorials, Medicare today refuses to reimburse for the new, less invasive preventive treatment known as a virtual colonoscopy, but such private insurers as Cigna and United Healthcare do. As clinical evidence accumulates on the virtual colonoscopy, doctors and insurers will be able to adjust their practices accordingly. NICE merely issues orders, and patients have little recourse.

This has medical consequences. The Concord study published in 2008 showed that cancer survival rates in Britain are among the worst in Europe. Five-year survival rates among U.S. cancer patients are also significantly higher than in Europe: 84% vs. 73% for breast cancer, 92% vs. 57% for prostate cancer. While there is more than one reason for this difference, surely one is medical innovation and the greater U.S. willingness to reimburse for it.

The NICE precedent also undercuts the Obama Administration's argument that vast health savings can be gleaned simply by automating health records or squeezing out "waste." Britain has tried all of that but ultimately has concluded that it can only rein in costs by limiting care. The logic of a health-care system dominated by government is that it always ends up with some version of a NICE board that makes these life-or-death treatment decisions. The Administration's new Council for Comparative Effectiveness Research currently lacks the authority of NICE. But over time, if the Obama plan passes and taxpayer costs inevitably soar, it could quickly gain it.

Mr. Obama and Democrats claim they can expand subsidies for tens of millions of Americans, while saving money and improving the quality of care. It can't possibly be done. The inevitable result of their plan will be some version of a NICE board that will tell millions of Americans that they are too young, or too old, or too sick to be worth paying to care for.