

Clinical guidance from the National Institute for Clinical Excellence. Timing and selection of topics for appraisal

Comments from the Health Development Agency

1. Introduction and summary of recommendations

The Health Development Agency welcomes the general approach presented in the consultation document.

The government's commitment to tackling inequalities in health, reinforced through *The NHS Plan*, the white paper, *Saving Lives*, and the *Tackling Health Inequalities* consultation document, is the main platform for our response. In our comments we present

- the rationale for making impact on inequalities an explicit part of NICE's selection process;
- recommendations for amending the selection criteria so as to build an inequalities perspective into both the selection and the appraisal processes;
- a recommendation that an independent adviser from outside the NHS and government is included in the Technology Appraisals Group to champion this perspective throughout the selection process;
- information about practical support that the HDA would be happy to provide – for example, Evidence Base Briefings, which could inform the selection process and help with promoting the availability of the web-based proposal system;
- points where we think clarification is needed.

2. Rationale

Tackling health inequalities is a top priority for the government, and the NHS's part in this is articulated within *The NHS Plan*, the white paper *Saving Lives* and the consultation document, *Tackling Health Inequalities*. The Acheson Report recommended extending the remit of the NICE to include equity of access to effective health care.

In addition, the Wanless Report highlights the structure and impact of inequalities in health as a significant factor affecting the future costs of health services.

That there are longstanding inequalities in health measured by morbidity, mortality, access to care, use of facilities, and life expectancy is well established scientifically and acknowledged officially. There are a variety of reasons why widespread and enduring inequalities may be thought to be undesirable, not least moral and social justice ones. However, future demand for health care and related social care services is a function of the nature and shape of health inequalities.

As inequalities in health arise for a number of different reasons, including the structure of health services and the consequences of medical interventions, it is absolutely vital that an inequalities perspective is brought to bear on all evaluations of clinical interventions including assessments of new medicines and technologies.

We want to highlight two aspects of inequalities – inequitable access and the social class gradient in health outcomes.

It is essential that NICE's procedures do not inadvertently reduce access to beneficial treatment for groups in the population. For example, it is conceivable that a new product might be effective for a condition that is especially prevalent in a relatively small section of the population, such as a particular minority ethnic group. If selection for appraisal were based solely on predictions about the size of the number of people in the whole population who might benefit, it is possible that the needs of particular sub-groups might be neglected.

Procedures should also enable NICE to select for appraisal products that might have a particular impact in sections of the population where a condition or health-threatening behaviour is particularly prevalent. The guidance on nicotine replacement therapy and bupropion is a positive example of how NICE can act in such circumstances.

In relation to the social class gradient in health outcomes, health inequalities are not a given. International data show that different types of policy, including macroeconomic policy, will affect the degree of health inequalities and the steepness of the social class gradient in health outcomes.

Governments can and do pursue policies which can make a difference to inequalities in health. Likewise, health service deliverers can make large differences. It is for this reason that we recommend that inequalities impact assessment is an explicit part of the decision making process. Specific recommendations on how this could be done are detailed below.

3. Recommendations

We recommend the following amendments and additions to the proposed selection criteria (emphasis added in each case):

- Criterion 1a should state: 'Does the proposed guidance relate to one of the NHS clinical priority areas *or other NHS priority (such as tackling health inequalities)*?'
- Criterion 1b should state: 'Does the proposed guidance address a condition which is associated with significant morbidity or mortality *in the population as a whole or in groups in the population (for example, particular minority ethnic groups)*?'
- Criterion 1c should state: 'Does the proposed guidance relate to one or more interventions which could significantly reduce avoidable morbidity or avoidable premature mortality *in the population as a whole or in groups in the population*, relative to current standard practice, or if used more extensively would do so?'
- Criterion 2b should state: 'Is there evidence and/or reason to believe that there is or will be inappropriate practice and/or significant variation in clinical practice and/or variation in access to treatment in the absence of guidance, *including practice and variations likely to result in differential uptake of health care by social groups in the population with a consequent widening of health inequalities?*'

The implication of the final amendment above is that there should be a prospective inequalities impact assessment as part of the appraisal process.

We also recommend that an independent adviser (from outside the NHS and government) be included in the Technology Appraisals Group to act as the 'conscience' of the group and ensure considerations of equity and health inequalities are integral to the scrutiny of proposals.

4. Possible support from the HDA

We would welcome the opportunity of formalising a system by which we can feed into the selection process the findings from our series of HDA Evidence Base Briefing documents. These Briefings review the effectiveness of interventions and provide information that could inform future topics for NICE or raise issues relevant to those already under review.

We suggest that when an Evidence Base Briefing document becomes available, the HDA meets with a small sub-group of the Technology Appraisal Group to discuss the implications for the NICE work programme. The sub-group could be made up of the DH Public Health Division member, the RDPH, and the independent adviser proposed above, and an appropriate member from the NICE team.

We suggest that the availability of the web-based proposal system should be promoted to organisations in the broader public health field (such as the UKPHA) and patients' forums, when they are constituted. We would be happy to help promote it through our *Health Development Today* magazine which goes out bi-monthly to 9,000 public health practitioners – including PCTs, some GPs, health visitors, school nurses, and environmental health officers.

5. Points for clarification

It would be helpful if future communications could clarify the following points:

- In paragraph 12, how are 'interested parties' and those 'with an identifiable interest' determined?
- NICE's remit includes health promotion. Will this specialty be included in the network of advisers?
- Does this process include the selection of topics for the clinical guidelines programme? If so, it would be helpful to clarify how this will affect the composition of the Clinical Priorities Group. We note that the draft new selection criteria are proposed for both.

Health Development Agency
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