Interview with Sir Andrew Dillon, Chief Executive, National Institute for Health and Clinical Excellence (NICE)

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National Institute for Health and Clinical Excellence (NICE)

Thank you for having us today to give our readers an overview of the capabilities and contribution of NICE in the UK. Dr Richard Barker of ABPI has already pointed out that NICE is admired globally for its evidence-based guidelines and the economic rigour of its Health Technology Assessments (HTAs). Do you believe these are the two main qualities of the Institute? How do you maintain such high standards?

I do agree. NICE has been active for more than ten years now and has always done more than simply evaluating pharmaceuticals. Over the years, we have developed programs that look at other forms of health practice to produce clinical guidelines, which are broader statements of clinical practice that go beyond a single focus on pharmaceuticals. We have also moved into advising those who are interested in effective public health interventions. And the recently published Government strategy for the National Health Service includes a proposal for NICE to extend its activities into social care.

Although NICEâ??s work on evaluating new pharmaceuticals is probably the best known aspect of what the Institute does, it is only part of the portfolio of advice that we have been able to give to the health service in the last decade.

As presented in the NHS reform White Paper of July 2010 and as you just mentioned, NICE will also go into social care. How do you see your contribution to the social- and healthcare sector in Britain to strengthen the competitive edge of the UK as a whole?

There has always been a reasonable degree of integration in the UK between public health, clinical practice and social care. For example, over the years, the responsibility for leading on public health has shifted between the NHS and local government. These shifts are quite good because people who work in health- and social care have a degree of familiarity with what their partners are doing, but this has also resulted in a loosening of the connections between different parts of the system. I think the real opportunity over the next few years with NICE extending its brief from public health and clinical practice into social care, is that we can apply our rigorous approaches, using and interpreting evidence to formulate crisp advice on how to get the most out of the available resources.

Our guidance can help to unify health and social care where it really matters. An example is the treatment of dementia, where although responsibility for delivering much of the care needed by patients rests inside the NHS, this part only relates to the acute stages of the illness, whereas much

care and support, both for patients and their relatives is by local government. We will be able to do more of this when our brief is formally extended into social care.

NICE has obviously been in the news following recent announcements on reforming the healthcare system in Britain. Some of our past interviewees have commented that they see a changing role for NICE as a good thing. What is your perspective?

What the government wants to do is to make sure that the price that the NHS pays for new pharmaceuticals properly reflects their value, which is an ambition that NICE shares. The Government has not yet published its proposals so itâ??s not really possible to make a comment on how things will work, and until they do, we can only speculate on what exactly is going to happen. The Secretary of State Andrew Lansley certainly sees NICE playing an important role in the new system.

Lord Howe stated that â??the price should reflect everyoneâ??s agreed perspective on valueâ?•. What role do you see for NICE when we move from PPRS to a value-based pricing system?

In many respects, I expect NICE will play a similar role to the one it does today. In the last eleven years, NICE has built up an international reputation for doing, in a way, a form of value-based analysis. Of course, the Institute does not negotiate the pricing which remains the decision of the companies.

Internally, will we see any changes in the structure of NICE?

Secretary of State Andrew Lansley has made it clear in recent statements in Parliament that he wants NICE to continue to assess the clinical and cost-effectiveness of new pharmaceuticals and NICE will continue to have the capacity in place to do so. I expect that NICE will continue to use independent external advisory committees. Their collective knowledge will still be important in making a judgement about the clinical and cost effectiveness of new medicines.

Just recently, NICE launched the â??referral adviceâ?• recommendations database, aimed at reducing unnecessary costs to the NHS. What drove you to deploy this initiative and what are the benefits that you hope to see?

This database is drawn from NICEâ??s catalogue of clinical guidelines where the groups have made recommendations about the triggers for referral from one level of care to the next. With close to 100 clinical guidelines published, it can be difficult for the NHS to systematically access and apply the recommendations. This is particularly important at the moment, now that the NHS is under great pressure to make the most out of the resources it has available.

A one-stop shop?

Thatâ??s right.

Looking ahead, the burden of lifestyle-related chronic diseases will continue to use a big chunk of the NHS budget. To what extent is it a priority for NICE to decrease this burden for society and the NHS?

The prevention of ill health is an important area for NICE, and we focus on this through two of our programs. We have been looking at behaviours and lifestyles that can shape health outcomes in our public health program. For example, we have looked at the evidence for ways in which people can be encouraged to change their diets and take more exercise, both of which have an effect on rates of obesity and the morbidity associated with it. The clinical guidelines program also contributes.

Smoking cessation is another challenge that is well represented in our public health program.

Because these conditions constitute a very significant burden on the NHS and many are avoidable, NICE can help to reduce this burden by encouraging people to live lives that are going to be much healthier in many ways.

To some extent, pharmacies might play an increasing role in this, as they have started taking more and more ancillary services on themselvesâ?¦

And the good thing is that a pharmacy is very accessible.

We have already covered your involvement in Health Technology Appraisal International (HTAi). To what extent do you see NICE exporting its expertise, setting itself as an example for the international community?

Our principal task is to assist the health services in the United Kingdom, but we are very happy to respond to international queries as best we can. In the last few years we have built a small team of people who provide this service. If a Ministry of Health or an academic institution outside the UK is interested in something NICE has done in the UK, we try to help. This has proven to be very successful, with examples of work done in China as well as places as far apart as Georgia and Turkey, Chile and Columbia. NICE is not the only organisation of its kind, but it does seem to be doing things in a certain way that is attractive internationally.

You have spent your entire career in the healthcare sector. What is your main priority at the minute and where is it that you would like to take NICE in the future?

The big job at the moment is to position NICE within the changing architecture of the NHS. The move to put groups of primary care physicians into the position of commissioning services for their patients locally is a big change. Although we have worked closely with general practitioners since we began, we now need to build a different relationship with them. NICE will use its quality standards and the guidance it produces, to try to help GPs in turning their commissioning role into a success.

The change to value-based pricing is also significant and clearly, we will co-operate with the Department of Health in constructively taking the new system forward once it is finalised.

We need to build on the experience and knowledge we have acquired over the past eleven years to help the NHS move through this period of big structural changes.

Personally, what is it about NICE that drove you to take up this role eleven years ago and what is it about the Institute that has kept you motivated?

Until I joined NICE, I had managed hospitals for more than twenty years, a very challenging job with a lot of pressure. Looking for a change, I was intrigued by the opportunity at NICE and while completely different from what I had been doing, it was still entirely relevant to my field.

Change is also what has kept me here these eleven years. Every year there has been something new and different, such as the proposed changes we are seeing now. I believe the health service in the UK is better because of the contribution that NICE has made.

While NICE is sometimes criticized for restricting access to treatments and pharmaceuticals in particular, everything NICE has done represents a net benefit to the NHS. Contrary to some beliefs, the vast majority (83%) of NICEâ??s recommendations are positive. Unfortunately, someone has to make the judgment as to whether the benefits of a new medicine justify its cost to the NHS. The

difference today is that NICE makes its decisions very publicly and is transparent about its decisions. It is therefore entirely appropriate and proper that we are scrutinized to the extent that we are.

Do you think this further promotes more effective innovation in order for research based pharmaceutical companies to stop thinking about what they would like to do and instead look at what is needed?

I think the fact that the Institute works in such a systematic and transparent manner has caused companies to consider how they make the case for their products to be adopted, in the UK and elsewhere. In the past, the big challenge for companies has been the regulatory hurdle whereas now there is the additional challenge of making the case for adoption by health systems. This thinking is now much further integrated in the upstream development phase of a product. An interesting example is the Scientific Advice Program that NICE established two years ago. Similar in many ways to the service the EMEA or the FDA provides, the Scientific Advice Program supports companies in making sure they deliver the data that NICE advisory committees need.

The fact that companies have been using this advice and returning to us for advice on subsequent products suggests that the program has been a great success so far.

Thank you very much!

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