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New 'budget impact test' an unpopular and flawed attempt to solve a political problem

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A new "budget impact test", to be applied by the National Institute for Health and Care Excellence (NICE), is an unpopular and flawed attempt to solve a fundamentally political problem, argue experts in *The BMJ* today.

The test means that NICE-recommended technologies costing the NHS more than an additional £20 million a year will be 'slow-tracked', regardless of their cost-effectiveness or other social or ethical values, explains Dr Annette Rid, Senior Lecturer in Bioethics and Society at King's College London (KCL) and colleagues from the KCL / University College London Social Values and Health Priority Setting group.

They acknowledge that with hospital wards overflowing and trusts in deficit, the introduction of cost-effective but expensive new technologies places increasing strain on NHS finances. But they say that, while the change may deliver short-term savings, it is flawed.

They explain that budget impact is essentially the price per patient multiplied by the number of patients treated. Yet the prevalence of someone's condition should not determine their access to treatment.

The new test constitutes numerical discrimination, they argue. And if a large number of patients experience delays, the policy threatens widespread harms.

They also argue that the consultation on the policy was far from

supportive, with less than a third of respondents believing that a budget impact threshold should be introduced, and only 23% agreeing that technologies exceeding the threshold should be subject to delayed implementation.

And NICE's justification for pursuing its approach - that "no alternative solutions" have been put forward - "is invalid in our view," they add. The consultation did not ask for other options.

Perhaps the policy aims to pressurise industry to lower its prices when volumes are high, they suggest. "But this is to use large patient groups as a bargaining chip."

They believe that a systematic and transparent programme of disinvestment, though difficult, "could increase the resources available to fund new technologies" while a more widespread use of risk-sharing on costs "might also help to reduce total budget impact." A further alternative would be to update NICE's current cost-effectiveness threshold for all technologies, so treating patients equitably.

Or, most controversially, they say the 90-day funding requirement for NICE-approved technologies "could be removed entirely and the power to make decisions about affordability given back either to politicians or to NHS England."

These alternatives raise significant ethical and political challenges. But they should be considered before NICE commits to an inequitable approach which few support, they conclude.

"The recent consultation should have marked the start, not the end, of a more substantial debate about the role of affordability in the NHS. It is not too late to correct this mistake."

More information: Cost-effective but unaffordable: an emerging challenge for health systems, www.bmj.com/content/356/bmj.j1402