may release new resources which could help rejuvenate cash strapped health sectors.

As Abbasi shows in his article,[1] the bank's individual projects are also under the microscope. An internal review revealed that only 17% of completed bank projects in the health, nutrition, and population division sector contributed substantially to the development of local institutions, and only 44% were likely to be sustainable.[5] Since becoming president in 1995, James Wolfensohn has emphasised the need for better "partnerships" between the bank and its borrowers. However, to build effective partnerships health partners need to make policy and hold budgets together. Change can be achieved here by renewed commitment to listening to and working with local partners, but the objective is compromised by unresolved structural issues. Since the rich nations wield the financial and political power within the bank, their objectives, not those of the poor, dominate the bank's decision making. The possibility of effective partnership is thus undermined by the structure of the institution itself.

More recently, Mr Wolfensohn has proposed a new framework for development which gives equal status to social and environmental as well as economic considerations. To be useful, this framework should be explicit about the extent of the impact of economic change on health and should lead the bank to put health concerns right at the heart of economic policy-making.[6] Is such a shift in perspective possible for the bank? Health professionals in those countries which control the bank have a public health duty to help it do so, by making representations to the bank and by putting pressure upon their governments.

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NICE: a panacea for the NHS?

No, but it should be useful for managing the introduction of new technologies

Harold Wallace Ross, the great editor of the *New Yorker*, had a continuing fantasy that the next person he hired would bring "grace and measure" out of chaos.[1] They never did. But his is a common fantasy, entertained at some time by most employers, secretaries of state, and prime ministers. The National Institute of Clinical Excellence (NICE),* which begins its assault on Olympus next week, makes me think of Ross. I have heard NICE mentioned as the solution of most of the NHS's problems: rationing, poor practice, the failure of good practice to spread, postcode prescribing, the mindless adoption of technology, the absence of a sensible mechanism to introduce new drugs, and variations in outcome. How much can we realistically expect?

Like any other institution NICE will evolve, but it begins with three main functions: appraising new technologies, including drugs, before they are introduced into the NHS; issuing and kitemarking guidelines; and encouraging national audit. Most of its initial energy will be put into the first function, and this is the beginning of explicit, national rationing. It is also the appearance of the "fourth hurdle" in that to become widely used in the NHS new drugs will have to prove themselves not only to be pure, efficacious, and safe but also better in some way than what is currently available. The mess over the introduction of sildenafil (Viagra) into the NHS—the delay and the botched criteria on who would get it[2]—shows that a better mechanism is needed. And the government's focus groups will have told it that the public doesn't like at all the fact that you can get new and expensive treatments if you live on one side of a street in one health authority area but not if you live on the other side, in another health authority.

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So the case is strong for NICE appraising new treatments and technologies, and it seems set to do it well. The discussion document produced by the NHS Executive in January on how NICE appraisal will work promises horizon scanning for new technologies; transparent, rapid, evidence based appraisal that considers effectiveness and cost; input from patients and companies; and a clear outcome.[3] There will be essentially three possible outcomes: use routinely in the NHS; use only in the context of trials; or don't use. Routine use may be recommended for everybody or for particular specialists. It will, however, be for ministers to decide exactly what the NHS should do, and here the system begins to creak.

There seems little point in NICE adopting a transparent process if its recommendations then disappear into a black box at the Department of Health only to emerge in garbled form six months later. Ministers do have the great advantage of accountability, but is the accountability of being a member of a tightly controlled party that gets elected every five years adequate for 1999? And what about the accountability of NICE? Who appointed its first chairman Sir Michael Rawlins, pleasant fellow that he is, and what process was used? There is an inevitable sense that although the government has learnt the rhetoric of transparency, accountability, and evidence based appraisal it would rather avoid living with it day to day.

And although NICE is to make a beginning with rationing (avoiding the words at all costs for fear of startling the horses) it won't achieve much by simply considering what's new. Intellectually sound rationing would mean weighing what's new against what's already there, and it would necessitate finding a way of

choosing among resources spent on new drugs and on the number of nurses at night in geriatric wards or on facilities in the community for people with learning disabilities. Rationing in Britain works mostly by dilution rather than denial: it's politically so much easier, particularly if you dilute services for the most marginal.

NICE will be concerned with what's already there through its work on guidelines, and Sir Michael has a vision that "doctors will go to work with the *British National Formulary* in one pocket and a copy of NICE guidelines in the other."[4] Sadly, this vision may reflect Sir Michael's naivety about guidelines. Firstly, guidelines that covered every eventuality would be carried in a wheelbarrow not a pocket. Secondly, guidelines are difficult and expensive to produce, and the most tricky part is making the jump from evidence to recommended actions. Those making that jump resort not only to wisdom but also to prejudice and self interest. Thirdly, guidelines on their own change nothing.[5]

Here we arrive at what may be the biggest failing of NICE. Centralist direction is a poor way of solving the NHS's biggest problem, the fact that good practice may flourish in one clinic and fail to spread even to the clinic next door let alone the rest of the NHS. Meanwhile, poor practice gaily continues. Those who try to run the NHS are understandably frustrated by these failures and naturally turn to organisations like NICE and its less often mentioned brother CHI (Commission for Health Improvement, or "nasty" as it's widely known) to put things right. But their controlling instincts are probably wrong. "Over the long run," writes Peter Senge, an academic at the Massachusetts Institute of Technology and one of the originators of the idea of the learning organisation, "superior performance depends on superior learning."[6] And control limits learning. "Control limits space. Learning needs space," said Arie de Geus, probably the originator of the learning organisation.[7] "It is simply no longer possible for anyone to 'figure it all out at the top' "[6] and "little significant change can occur if it is driven from the top."[8] Ironically, both Senge and de Geus were speaking at a symposium organised to identify how to sustain the NHS for the next 50 years.

In conclusion, NICE should help with rationalising the introduction of new technologies into the NHS, and the less politicised and more transparent its process the better. It might develop into an effective means of rationing all health care, but it is likely to struggle with solving the important problem of variable performance throughout the NHS. No one institution could produce so much.

Richard Smith *Editor, BMJ*

*NICE covers only the English and Welsh NHS; in Scotland similar functions will be performed by the Clinical Resource and Audit Group and the Clinical Standards Board; and Northern Ireland is still consulting about its structures.

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The evidence for β blockers in heart failure

Equals or surpasses that for angiotensin converting enzyme inhibitors

Heart failure is a common, malignant condition for which hospital admissions are rising rapidly.[1–3] Despite the evidence that angiotensin converting enzyme inhibitors improve the morbidity and mortality of heart failure secondary to left ventricular systolic dysfunction, the prognosis of heart failure in the community has improved little over the past 30 years.[4] This may reflect a reluctance to prescribe angiotensin converting enzyme inhibitors.[4] Now, however, evidence has accumulated to show that β blockers, when used in addition to angiotensin converting enzyme inhibitors, also reduce mortality in heart failure. Will this be another lost opportunity?

The CIBIS-II study,[5] comparing bisoprolol with placebo, recently reported a highly significant reduction in all cause mortality. When these data and those from other smaller trials[6–8] identified from searches of Medline and Embase and recent meetings[9] are added to those reported in previous meta-analyses[10] there are now 25 trials that have randomised patients with heart failure to β blocker or control, comprising 6511 patients and 810 deaths. Overall β blockers reduced the odds of death by 36% (95% confidence interval 25% to 45%) (fig 1). There is no evidence of heterogeneity between the trial results ($Q = 12.7$; $df = 24$; $P = 0.97$) and no evidence of publication bias. Also, the MERIT trial, which randomised 3991 patients, was recently stopped because of a large treatment effect (provisionally a 35% reduction), lending further support for the benefits of β blockade. By comparison angiotensin converting enzyme inhibitors were associated with a 24% (13% to 33%) reduction in the odds of

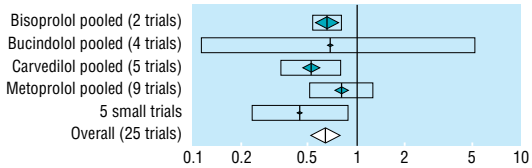

Fig 1 Pooled odds ratios (and 95% confidence intervals) describing the effect of β blockers on mortality in patients with heart failure (fixed effects model[11])

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