Are the Scots getting a better deal on prescribed drugs than the English?

Geoff Watts explains why Scotland's drug rationing body seems able to make more drugs available to its citizens than its English equivalent

Anger in England at the apparent austerity of its drug rationing body in comparison with its Scottish counterpart came to a head last week, when the English authority announced that it was not going to recommend the use of bortezomib (Velcade). The drug has already been approved for limited use in multiple myeloma north of the border.

The National Institute for Health and Clinical Excellence (NICE), which advises on the use of treatments by the NHS in England, was obliged to bring forward its draft guidance on the use of bortezomib after a leak to the press of its latest appraisal. It confirmed that it would not recommend the drug in monotherapy for relapsed multiple myeloma.

Leading the charge on this occasion was the *Daily Mail*. Under the headline "Medical apartheid as English cancer patients are denied life-extending drug" (www.dailymail.co.uk, 20 Oct) it explained that the "new wonder drug" was to be withheld from NHS patients in England while still being made available in Scotland.

The newspaper went on to report one patient's claim that the health secretary for England, Patricia Hewitt, had, "through the backdoor of NICE, encouraged a new policy that saves the NHS money by condemning patients to an early death."

What the story actually represents is less a conspiracy than a muddle: one that, nevertheless, shouldn't be allowed to disguise the real and chronic contradiction that underlies it.

The bortezomib muddle arises firstly out of a misunderstanding of what has actually been recommended about its availability in Scotland. In September the Scottish Medicines Consortium (SMC) issued a statement saying that it did not recommend bortezomib "as monotherapy for the treatment of progressive multiple myeloma in patients who have received at least one prior therapy and who have undergone or are unsuitable for bone marrow transplantation." It said that the economic case had not been shown. So even in Scotland bortezomib is not available to all patients.


Daily Mail

MEDICAL APARTHEID

Another life-extending drug joins list of medicines given to Scots but denied the English

CANCER patients are being condemned to death because they are English.

By Tim Shipman
Political Correspondent

However, as the result of a statement issued in 2004 the SMC does continue to recommend bortezomib for patients who have failed on at least two other treatments and who do not respond to alternative licensed treatments. In other words, it is recommended as a last resort. Whether an understanding of this endorsement of the drug is best served by the misleadingly unqualified use of the term "available" is surely debatable.

Either way, stung by the media coverage, NICE responded: "It is one thing to criticise our decision not to recommend the use of this drug but quite another to raise patient expectations about the use of this drug and its availability in other parts of the UK."

Underlying this particular spat, and unlikely to be resolved in the near future, is a fundamental contradiction created by the advent of devolution. The roots of the problem lie in territorial differences that long predate the creation of the Scottish Executive. Scotland has a history of greater public spending than England and in particular a history of spending more on health. Until the 1970s each increase in overall UK government spending prompted an argument over its distribution. The then chief secretary to the Treasury, Joel Barnett, sensibly decided that this annual wrangling could be avoided by adopting an agreed formula for shelling out additional cash.

The key word here is "additional." To wipe out historical differences in spending between the countries would have been politically and practically difficult. So the Barnett formula, while not determining the overall size of the budget, provided a means of distributing additions to it. Specifically, changes to programmes in England were to result in equivalent changes in the budgets of the devolved territorial departments, calculated according to the countries' share of the UK population.

The formula—which incidentally takes no account of comparative need—is still in use. But now the money is allocated not to specific departments of the devolved administration in Scotland but to the Scottish Executive as a whole. Ministers are not obliged to spend the extra money in the same way or even in the same area as their English counterparts. And this is a freedom they are using.

A report published last year by the Institute for Public Policy Research, *Devolution in Practice 2006: Public Policy Differences within the UK*, drew attention to the issue. Between 2000 and 2005, for example, spending on health in Scotland grew from £997 (€1490; $1864) per person to £1563: a rise of 57%. The corresponding increase in health spending in England, 65%, was substantially greater. But expressed in absolute terms the figures tell a different story: because the increase in England came on top of a lower expenditure per head, the present annual spending in England is still only £1350.

So Scotland has more resources than England and also the freedom to spend them in different ways, which chimes well with the widely expressed desire for local decision making. Unfortunately, this same freedom acts against another widespread preference: for common standards throughout the health services in the United Kingdom. Stripped of the muddle surrounding it, the bortezomib affair is a small illustration of this preference in action.

Speaking at the launch of the *Devolution in Practice 2006* report, Charlie Jeffrey, director of the Economic and Social Research Council's programme on devolution, said that common standards may eventually come to prevail. Maybe so. But even if they do we can expect more and worse bortezomib-type rows along the way. □

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