For those technologies for which cost per QALY or per life year was cited, all received positive recommendations, and all but one (riluzole) had cost per QALY below £30 000. The imposition of restrictions on recommended use generally reduced the cost per QALY. Patients' values were cited as the reason for recommending riluzole for motor neurone disease (amyotrophic lateral sclerosis form only), despite its relatively high cost per QALY of £34 000-44 000. NICE cited "the severity and relatively short life span of people with ALS and in particular … the values which patients place on the extension of tracheotomy free survival time."[10]

The provisional guidance that recommended against the use of beta interferons and glatiramer for multiple sclerosis cited their relatively high cost per QALY (£40 000 to £90 000 on the most optimistic estimates) and stated that NICE had in mind the cost effectiveness ratio of technologies it had previously recommended.[11]

The final element of each NICE guidance concerns the costs to the NHS of implementing the guidance (cost impact). Estimates of gross and net costs are provided, the latter taking into account any substitution of old technologies by new ones. The items that led to major increases in net costs were tribavirin and interferon alfa, both prescribed for hepatitis C (£55m in total, possibly spread over several years, and due mainly to a backlog of untreated cases) and glycoprotein IIb/IIIa inhibitors for acute coronary syndromes (net £30m-31m), with none of the others costing more than £20m. The impact on total net cost was reduced by projected savings for some technologies—notably, restricted use of proton pump inhibitors (projected saving £40m-50m annually). The combined net cost of the 22 judgments was £200m-214m or around 0.5% of annual NHS spending in England and Wales. This provides some indication, on the basis of individual technologies, of the extent to which new health technologies may change net healthcare spending. Increases of this magnitude should be readily achieved within the real increases in NHS spending of around 6% per year over the three years to 2004, although some local bottlenecks may become apparent.

Discussion

While NICE has been caricatured under the heading "it's easier to say yes than no,"[12] it would be more accurate to characterise it as saying "yes, but …" Its recommendations have all cited evidence of clinical benefits, while only around half have cited cost per QALY. Many of its recommendations have specified conditions for use, such as subgroups of patients most likely to benefit. This in turn requires guidelines covering the full range of treatment options for the different groups of patients. This second, guideline, function of NICE may prove more important and challenging over the longer term, given the magnitude of the task and the paucity of evidence. By October 2000 NICE had published four guidelines and was working on a further 31, often for the same diseases as those for which guidance on technologies has been issued.

The specification by NICE of conditions for use, which has generally enabled it to keep the cost per QALY below £30 000, could be seen as requiring rationing at a more detailed level, perhaps within some overall guidelines for use. Overall, however, NICE's guidance recommending use of most technologies appraised will arguably lead to "faster and more uniform access" to these technologies rather than to denial access.

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Corrections and clarifications

Prescriptions with potential drug interactions dispensed at Swedish pharmacies in January 1999: cross sectional study

In this paper by Juan Merlo and colleagues (25 August, pp 427-8) we mistakenly omitted from the figure legend the number of possible drug interaction pairs. The legend should have read: "Prevalence of potential drug interaction subtypes[3 4] among the 191 899 possible drug interaction pairs found in the 962 013 prescriptions containing two or more drugs dispensed to patients aged 15-95 from Swedish pharmacies in January 1999."

Revisiting the Cochrane Collaboration

Geographical gremlins muddled the authors' addresses at the end of this article by Mike Clarke and Peter Langhorne (13 October, p 821). Dr Clarke is associate director at the Cochrane Centre, Oxford OX2 7LG, and Professor Langhorne is professor in the academic section of geriatric medicine at the Royal Infirmary, Glasgow G4 0SF.

Prospective health impact assessment: pitfalls, problems, and possible ways forward

We have electronic gremlins too at the *BMJ*. This time they pushed off a note that should have appeared in the margin of this article by Jayne Parry and Andrew Stevens (17 November, pp 1177-82). The note would have alerted readers to the fact that additional references appear on bmj.com (these are cited in the main text as w1 to w17).