**MANAGING WICKED PROBLEMS: THE NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE AND THE DEPOLITICISATION OF HEALTH CARE RATIONING**

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**Abstract**

*This paper considers how recent British governments have sought to deal with the ‘wicked problem’ of health care rationing. It argues that since 1999, politicians in Whitehall have managed this conundrum by depoliticising it. They have created an arm’s length body (the National Institute for Health and Care Excellence) and have transferred responsibility for this issue on to non-elected experts who enjoy autonomy to make decisions concerning which treatments should be made available on the NHS. This paper asserts that this depoliticisation strategy has been successful, although such an argument depends on a particular interpretation of ‘success’. It concludes by highlighting some political costs that accompany this particular governing approach.*

**Introduction**

‘Wicked problems’ are generally thought to be complicated, knotty and intractable issues. They can be difficult to define and resistant to solution – at least the usual repertoire of solutions that are operated by public officials. The literature on wicked problems originated from a critique of the rational-technical paradigm for understanding decision-making. The problem with rational-technical approaches (or so it was argued) was they required individual policy makers to achieve levels of goal clarity, co-ordination and information that were impossible in practice. The rational-technical paradigm ignores the fact that decision-making takes place in conditions of social and political complexity, which can, in certain circumstances, heavily constrain the options available to government. Policy problems become ‘wicked’ precisely because they involve a variety of stakeholders all with different and (sometimes) conflicting interests, beliefs and outlooks about the world. In this context, modern society is too differentiated and pluralistic to tolerate ‘artificial’ technocratic solutions imposed from above. Instead, the handling of wicked problems requires deft political judgment not the uniform application of ‘scientific’ methods irrespective of circumstance (Rittel and Webber, 1973; Alford and Head, 2017). Indeed, one might go further and suggest that wicked problems can never really be solved. Ultimately decision-makers are destined simply to manage these dilemmas, trying to keep them off the political agenda so that they do not adversely impact on their broader objectives.

This paper examines how recent British governments have sought to cope with the ‘wicked problem’ of health care rationing. It begins byelucidating why health care rationing might be thought of as a wicked problem, especially from the perspective of elected politicians. The paper goes on to describe the process whereby the National Institute for Health and Care Excellence (NICE) makes decisions concerning which treatments should be funded by the NHS, as well as the methodology it uses. It argues that NICE has helped to depoliticise this contentious issue, although whether NICE has actually rationed health care in England[[1]](#footnote-1) is a more debatable question. The paper concludes by considering some of the broader political ramifications of using arm’s length bodies to depoliticise wicked problems. It suggests that such a governing approach may be undermining the broader democratic framework within which public management takes place.

**Health Care Rationing as a ‘Wicked Problem’ in British Politics**

What does it mean to argue that health care rationing in Britain represents a ‘wicked problem’? First, such rationing has been an ongoing issue for successive British governments over the last 70 years or so. As has been well documented in the academic literature on this subject, almost from the National Health Service’s (NHS) inception, British politicians have had to accept privately (and increasingly admit publicly) that the health care an individual receives on the NHS will always be constrained by financial considerations (Klein, Day and Redmayne, 1996: 37-42). Levels of public expenditure will never be high enough to keep up with rising costs in this area. New and ever more expensive advances in medical science are part of the problem. A rapidly ageing population (linked of course to improvements in the standard of health care as a result of these advances in medical science) is another source of this quandary. Just as importantly, health policy contains its own peculiar dynamic which adds to the difficulties of containing costs. The supply of expensive but effective treatments tends to create its own demand. As patients begin to experience an improvement in the health service they receive, they want more of it, leading to a higher bill for the Treasury. From the perspective of elected politicians, health care rationing would appear to be a problem with no obvious solution.

The rationing of health care has also become a ‘wicked problem’ because of the social and political context that surrounds the NHS in Britain. It has been suggested that the NHS is the closest thing the British have to a ‘national religion’. In particular, the totemic promise, maintained by every government since 1948, that health care should be free at the point of use for everybody who needs it, has become especially popular with the public. Yet this promise can sometimes obfuscate the fact that financial considerations cannot be eliminated from the management of the NHS. The message ‘free at the point of use’ can become conflated with a belief that every individual has the right to any treatment he or she wants without having to pay. This expectation can, in turn, make questions concerning the rationing of health care even more politically sensitive (Salter, 1998: 11-16). Such a combination of material and ideological forces leaves British politicians in a very uncomfortable position: rationing is something they must preside over, yet to be seen to be rationing can be the equivalent of electoral suicide.

A related aspect of this wicked problem is the position of the pharmaceutical industry in the health care sector. ‘Big pharma’ has historically enjoyed a powerful position vis-à-vis the government, reflecting the fact that even in the late 1940s, the prosperity of the British economy was perceived to be dependent partly on the export performance of drug companies. As a result, although the industry was regulated at this time, the regulatory regime was generous and the style was light touch. Agencies were set up to approve or reject drugs for the British market, but as Abraham (2009) has shown, they were dominated by corporate interests. Members of these bodies were allowed to have financial interests in pharmaceutical companies (whose products they could be appraising) while any industry data submitted as part of the assessment process remained confidential. The Pharmaceutical Price Regulation Scheme was also very favourable to the industry. Whitehall passed up the opportunity to control prices directly. Instead costs would be controlled indirectly as each major company was given a profit target that it was required to meet. If firms’ profits were 40 per cent above target, they would be deemed excessive and subject to correction, either through price cuts or a payment to the Treasury. However, if a company’s profits were 40 per cent below target, it had the right to apply to the government to increase prices. In short, such a regulatory structure did not confer on ministers the requisite policy instruments to control the drugs bill paid by the NHS. Moreover, any attempt to tighten up spending in this area was likely to provoke direction confrontation with a sector used to a privileged position in the political economy of health care in Britain.

Rationing as an issue became a matter for public debate in the 1990s. A key trigger was the setting up of the internal market by the Conservative Government at this time. As a result of this reform, health authorities and GPs became purchasers of services. They were required by the Department of Health (DoH) to publish plans assessing the needs of their local populations, as well as information concerning how they were intending to allocate their health budgets. This data started to highlight the difficult decisions facing administrators and doctors as they made tough choices between competing demands on their resources. The media picked up on this greater transparency and began to actively pursue stories where variation in the local availability of treatments could be detected (so-called postcode rationing) (Salter, 1998: 22-45; Klein, 2010: 201). When denied treatment, some patients resorted to litigation in an attempt to overturn these decisions, action that further fuelled media interest in this subject (Ham and Pickard, 1998). As a wicked problem, health care rationing had become particularly pressing by the time the Blair Government arrived in office.

**NICEly Does It: the Depoliticisation of Health Care Rationing.**

In recent years, there has been a burgeoning literature on the so-called depoliticisation of public policy (Wood and Flinders, 2014; Buller et. al. 2018). Depoliticisation is a term that is defined in different ways, but it is referred to here as the process whereby public officials place at one remove or disguise the political character of decision-making (Burnham, 2001). One popular depoliticisation technique used by British politicians has been to hive-off responsibility for awkward issues onto non-partisan arm’s length bodies (ALBs) staffed by experts in the field. Politicians remain in charge of the formulation of policy, including the broad objectives to be pursued by the government in office. ALBs are tasked with the day-to-day delivery of these objectives and are usually given resources and powers to help them carry out this implementation role. Politicians sometimes cheerfully admit that this depoliticisation of public policy is taking place, claiming that it is actually in the public interest. At a time when the electorate’s trust in the capabilities of politicians is said to be declining, devolving responsibility onto neutral and independent experts is presented as a good way of enhancing the authority and credibility of political institutions. Critics suspect that depoliticisation is a popular technique in government because it allows these self-same elected representatives to shift blame onto others as and when policy outcomes turn out in a way that is not expected or desired.

It is important to note that for many scholars writing on this topic, depoliticisation does not represent the direct removal of politics from the policy process. Politics – understood broadly as difference, contestation and conflict over the means and ends of government[[2]](#footnote-2) - will always be a feature of public administration in societies (Crick, 1964). Decision-making will always involve different groups or classes competing to get their ideas and interests accepted onto the political agenda. Policy outputs from that process will repeatedly require a redistribution of resources, which may in turn provoke division and dispute. This political dimension to governance is not eliminated simply because party leaders in office choose to divest responsibility for difficult issues onto other bodies. More accurately, elected representatives are just changing or shifting the arena in which these contentious political decisions are made (Flinders and Buller, 2006).

In 1999, the Blair Government set up NICE as an ALB to manage the wicked problem of health care rationing. Initially, NICE’s objectives were to: (a) conduct appraisals of the clinical and cost-effectiveness of new and existing technologies and to issue recommendations, and; (b) to develop clinical guidelines for a range of treatments covering different conditions. In 2004, the Blair government gave NICE the additional task of providing non-binding public health guidance, while in 2012, the Conservative-Liberal Democrat Coalition government instructed NICE to also provide guidance for social care services and users. Initially NICE’s decisions required approval by ministers before they could be funded on the NHS, however this requirement was dropped in 2001 (House of Commons Select Committee, 2002: 23). Similarly, when NICE was originally set up, primary care trusts were not obliged to abide by NICE’s recommendations, but the implementation of NICE’s advice is now mandatory. Over the years, NICE has become drawn into a debate not just about the clinical and cost-effectiveness of different treatments, but their *affordability*. Such a development was probably inevitable, especially as NICE’s evaluations would always be judged against the background of finite resources. This situation has been criticised by some stakeholders who argue that it should be ministers and minsters alone that make decisions concerning the affordability of health care (Ibid: 32-33; see also Landwehr and Bohm 2011).

However, it is widely accepted by academics writing on this subject that NICE’s implicit objective was and is to depoliticise the wicked problem of health care rationing (see for example Syrett, 2003; Harrison and McDonald, 2007; Ettelt, et. al, 2010). In their account of the origins of NICE, Timmins et. al. (2016: 32-33) describe the story of Gerry Malone, Health Minister in the Major Government, who was in charge at the time of revising something known as the ‘limited list’. On this list was a range of treatments deemed to be ineffective and not to be used on the NHS. When asked to decide whether beta interferon (a drug for treating multiple sclerosis) should be included on the list, Malone reportedly did not understand why he was responsible for this technical by potentially controversial task. To quote Malone directly:

“My reaction … was … ‘how the hell am I meant to make that decision?’. The answer was ‘because you are the minister’. But I pointed out that I was probably the least equipped person to make the judgment around its [beta interferon] costs and benefits, even with the no doubt excellent advice of my civil servants” (ibid: 32)

Interestingly, his subsequent actions seemed to belie this initial response. Malone brought in a range of advisers and produced recommendations for the limited use of beta interferon that were widely accepted (although this did not stop Malone complaining that he never wanted to be put in that position again). When Frank Dobson (Health Secretary in the first Blair Government) was put in a similar position, his decision to ignore expert advice and limit the use of Viagra provoked a storm of protest, leading to the manufacturer successfully challenging the policy in court (Klein, 2010: 202. Both examples highlight the significance of depoliticisation concerns, and both are cited as key events leading up to the creation of NICE.

How does the Technology Appraisal Process (TAP) actually work? The DoH initially chooses treatments for appraisal and it then informs NICE of these choices. NICE consults with relevant stakeholders to produce both a scope and a timeline for the appraisal. It then appoints an independent academic group to carry it out. At the same time, a range of consultees (selected clinical experts: NHS Commissioning bodies; patient groups) are contacted for their input into the process. The independent academic group compiles an evaluation report assessing the clinical and cost effectiveness of the treatment, which is then sent to a Technology Appraisal Committee (TAC) comprised of practitioners from outside NICE. The TAC also receives opinion and evidence from other affected groups before producing a Final Appraisal Document which is conveyed to NICE’s Guidance Executive Council for approval.[[3]](#footnote-3) Groups have the right to appeal any decision made by NICE, although the grounds for such a challenge apply only to the process by which NICE arrives at its judgment, not the judgment itself. The number of occasions where NICE has had to revise its recommendations in response to an appeal is relatively small.

The TAP process also represents a broader invocation to science as a way of resolving the controversies that surround the question of which treatments should or should not be funded on the NHS. This approach is epitomised by its adoption of the QALY (Quality Adjusted Life Years) methodology. QALY provides a cost-benefit analysis of a particular treatment, taking into account the extra years of life that an intervention is likely to yield per person, adjusted for the quality of that life. Once calculated, the QALY score is integrated with the price of the treatment using an incremental cost effectiveness ratio (ICER) to come up with a ‘cost per QALY figure’. This figure then becomes the basis of a verdict concerning whether a treatment is cost-effective (Klein and Maybin, 2012: 11). There is an interesting paradox here, especially if we recall the opening comments about the concept of a wicked problem. As noted, the literature on the existence of wicked problems rejected the rational-technocratic approach to decision-making on the grounds that it failed to take into account the social and political complexities that often made such dilemmas so knotty and intractable. However NICE, with its QALY methodology would appear to reflect precisely such an approach. Elected representatives that preside over ALB’s like NICE cling to the ‘technocratic wish’ that they will somehow resolve the ‘wicked problem’ of health care rationing without any political cost. This point will be returned to in the final section of the paper (Belkin, 1997; Harrison, 1998).

Before we do, it should be stressed that NICE has always tried to build opportunities for consultation and deliberation into its institutional structures, recognising that such features are crucial if its recommendations are to enjoy legitimacy. In this context, it set up a Partners Council as part of the TAP process. The Partners Council gave representation to a range of interested parties including the Medical Royal Colleges, drugs companies, health unions and patients, ensuring they were fully aware of the process by which technologies were appraised and clinical guidelines were developed. In addition, NICE has created a Citizens Council (CC) of 30 members to provide it with a public perspective on the ethical issues that inform its work. NICE initially selects topics for consideration by the CC and provides members with a background briefing on the subject. After that, the CC has the power to call expert witnesses, can initiate further discussions and produce recommendations which NICE must respond to. The Partners Council was disbanded in 2010, reflecting the fact that attendance on this body had been in decline for some time. However, NICE still engages in a range of separate annual meetings with representatives from the pharmaceutical industry and the professions, whereas a semi-independent Patients Council Involved in NICE Group has also emerged (Timmins, et. al 2016: 143-47).

**Has NICE Been an Effective Solution to the Problem of Health Care Rationing?**

Any attempt to answer this question of whether NICE has been an effective solution to the problem of health care rationing involves first negotiating a problem of analysis. Defining ‘effectiveness’ or ‘success’ in this context is not straightforward: any definition may have to account for different ways of conceptualising such a phenomenon. One way to judge the effectiveness of NICE might be to consider the *material* consequences of its decisions. In other words, has NICE achieved its objectives and prevented the NHS from spending money on treatments that are neither clinically or cost-effective? However, rather than just examining this material dimension, it may also be important to assess the *ideational* impact of NICE. What influence has its recommendations had on the beliefs (and ultimately behaviour) of those groups affected by it? Has NICE as a body for rationing health care been largely accepted by relevant stakeholders, or do they continue to disagree over the authority and legitimacy of its pronouncements? How these groups (including NICE itself) discursively construct the material significant of NICE may very well have a bearing on our overall understanding of NICE’s record (for a more general discussion of this issue, see Kettell, 2008).

If we begin with NICE’s material impact, the question of whether it has helped British politicians control health care costs is again not a straightforward one to answer. It is impossible to run the counter-factual and assess how much Whitehall would have spent on health care had NICE not been created. That said, Michael Rawlins (Chair of NICE from 2000-2013) has estimated that by 2005, NICE’s recommendations had added £890m to the NHS drugs bill (Timmins et. al., 2016: 93-95). It could be added that, according to its website, NICE has either fully or partially recommended approximately 80 per cent of all treatments appraised during the period March 2000 – October 2017 so that estimate is likely to be higher today (https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/summary-of-decisions). One longstanding complaint about NICE is its tendency to prioritise the evaluation of expensive new drug treatments, often at the margins of the everyday provision of health care. NICE has also been criticised for not being active enough in the area of disinvestment: the examination of treatments already used by the NHS, but which are no longer clinically or cost-effective (House of Commons Health Committee, 2002: 36-40; House of Commons Health Committee, 2008: 30-32). Viewed in these terms, it is possible to question the success of NICE as a body for rationing health care.

However, once we consider the ideational impact of NICE on the beliefs of groups within the health policy network, it can be argued that it has effectively depoliticised the wicked problem of health care rationing. NICE itself is certainly keen to promote the view that it has been a success. In what might be termed the ‘authorised’ account of the organisation, Timmins, Rawlins and Appleby (2016) judge NICE’s success in terms of its ability to preserve its independence and authority in the face of challenges from both the government and various stakeholders. They argue that NICE’s independence and authority has only been seriously challenged twice in its 18 year history. The first was in 2005, involving the case of Herceptin, a drug for treating breast cancer; the second in 2010 when the Conservative-Liberal Democratic Coalition Government set up the Cancer Drug Fund (after coming under political pressure) to finance cancer treatments that NICE had rejected as not being cost-effective.[[4]](#footnote-4) The pharmaceutical industry, while never enthusiastic about NICE, has learned to live with a body which, as we have seen, has recommended the vast majority of its new products for use on the NHS in some capacity. Also, GP attitudes have shifted from hostility towards NICE’s in the early years to one of broad support in more recent times. Where once doctors saw NICE as a challenge to their clinical autonomy (Davis, 2000), now they perceive it as important ‘institutional cover’ in difficult circumstances where they have to deny treatments to patients in order to make budget savings.[[5]](#footnote-5) Put in different terms, although its activities have generated controversy and criticism, NICE as a body has become accepted by the major stakeholders in the health policy community, if not necessarily the British public more generally.

**Conclusion: Science, Democracy and the Political Ramifications of Depoliticisation**

NICE may have become accepted as a permanent feature of the health policy community, but criticisms of the use of ALBs to place at one remove the political character of decision-making remain. If NICE has successfully depoliticised the ‘wicked problem’ of health care rationing, it has not eliminated the play of politics in this area. NICE’s appeal to evidence based medicine would seem to offer a rational, technocratic answer to the conundrum of which treatments to prioritise on the NHS, but rationing remains an inescapably political process involving trade-offs between different groups with different needs. For example, it is often argued that QALY methodology prioritises physical functionality over the social and emotional costs associated with suffering from chronic illness, meaning that over the years its appraisals have automatically favoured some patients over others (Crinston, 2004: 38; House of Commons Select Committee, 2008: 33, 58-61). Even if it is accepted that QALY is the best way to evaluate a treatment’s clinical or cost-effectiveness, a question remains: how does NICE calculate the limits of acceptable spending? NICE’s response has been to develop a threshold of £20 – 30,000 per QALY[[6]](#footnote-6) but as NICE itself admits, this threshold is essentially arbitrary and has no empirical basis (Rawlins and Culyer, 2004). Even then, such considerations do not negate the more fundamental ethical issue of whether a price (calculated by QALY or any other method) can really be placed on human life? Should we be denying certain groups access to drugs (and potentially shortening their lives) simply because they do not offer ‘value for money’? Isn’t such an approach morally reprehensible (Milewa and Barry 2005; Brown and Calnan, 2013)?

It is not just that NICE (a non-elected body) is making judgments with political and ethical ramifications. For many, NICE’s decision-making process suffers from an ‘accountability deficit’, despite its attempts to offer stakeholders a consultative role. Take for example, NICE’s Citizens Council discussed above. With a membership of 30, the CC is hardly representative of the British public, a point that NICE fully recognises. It is true that the CC has deliberative powers and can issue recommendations which NICE must respond to. But the CC is only an *advisory* body: NICE is not obliged to actually accept any suggestions it makes. Moreover, the fact that the CC only meets once a year for two days inevitably places real limits on the impact it can have, even if NICE were required to take its advice on board. With the best will in the world, any governing philosophy which places a premium on technical expertise for solving problems is never going to sit comfortably with genuine participation by the public, and while NICE’s attempt to combine the two is laudable, it is also problematic (Syrett, 2006).

Finally, the use of NICE as an ALB to depoliticise the wicked problem of health care rationing highlights a broader concern. Some academics now suggest that a direct connection exists between the increased use of depoliticisation as a governing technique and the mood of disenchantment towards the political establishment that currently exists in Britain (Hay, 2007; Flinders, 2012: 89-109). Non-elected and unaccountable bodies should not be making decisions that have political and moral consequences. It is our political representatives who should be tackling these wicked problems: that, after all, is why we elected them to represent us in the first place. It is politicians who should be grasping the nettle (however painful it may be). It is politicians who should be encouraging a more open and frank discussion about the intractable nature of some issues, while at the same time shaping expectations concerning the tough choices that will need to be made if such issues are to be addressed. Conversely, if our elected representatives are going to place themselves at one remove from governing (or to hide behind a veil of technocratic rationality), why should the public vote for them in the first place? In short then, for some, depoliticisation as a solution to wicked problems threatens to undermine the very democratic foundations on which governance takes place.

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1. NICE’s guidance on health technologies and clinical practice applies to England and Wales, although its guidance relating to intervention procedures also applies to Scotland. Its advice on public health only applies to England. [↑](#footnote-ref-1)
2. It is not being suggested here that this is the only of the ‘right’ way of conceptualising the subject matter of ‘politics’. The question ‘what is politics’ is one that has been answered in a variety of different ways over the years (see for example Leftwich, 2004; Hay, 2007: 61-70) [↑](#footnote-ref-2)
3. NICE conducts both a Single Technology Appraisal (STA) and a Multiple Technology Appraisal (MTA). The latter involves evaluating a technology against all other treatments for the condition and/or more than one possible use for it. An STA is a quicker process that judges a technology against one other treatment and for a single purpose. On the 1st April 2017, NICE introduced a ‘fast track’ appraisal for technologies deemed to offer exceptional value for money. The aim is to provide patients with quicker access to these treatments. [↑](#footnote-ref-3)
4. For a slightly more critical account of the record of NICE, see the House of Commons Health Committee (2002; 2008) [↑](#footnote-ref-4)
5. See for example the reaction of Dr Lawrence Buckman (Chair of the GP’s Committee of the British Medical Association) in response to rumours that the Coalition Government was going to abolish NICE after the 2010 General Election (Jack 2010). [↑](#footnote-ref-5)
6. In 2009, NICE introduced a more generous threshold of £50,000 for ‘end of life’ treatments, after complaints that this methodology discriminated against patients with such conditions (i.e. cancer). [↑](#footnote-ref-6)