Letter to Editor

How NICE do we have to be? Lessons learned from the NICE experience

Dear Sir,

I read with interest the editorial published in your journal by Alkhenizan and Khoja, entitled: ‘Toward excellence in healthcare: A call for the Saudi Center for Health Excellence’. The authors summarized the recommendations of the workshop that was conducted during the meeting of the Saudi Society for Evidence Based Health Care, held in Riyadh, in 2010. The main recommendation was, “the urgent need to establish the Saudi Center for Health Excellence as a national center devoted to the development, monitoring, and implementation of EB Guidance in Saudi Arabia. Such a center is expected to have a significant positive impact in improving the quality and safety of care in Saudi Arabia”. The author’s description of the center is similar to the National Institute for Clinical Excellence (NICE) in the UK. Therefore, one would ask if the NICE model would be ‘nice’ for Saudi Arabia or not?

In Saudi Arabia, the Ministry of Health (MOH) is considered to be the leading Governmental agency responsible for the planning, management, financing, and regulation of the healthcare system. The MOH also undertakes the overall supervision and follow-up of healthcare-related services carried out by the private sector. Therefore, the Saudi MOH can be viewed as similar to the National Health Service (NHS) in the United Kingdom (UK). There are also other mini-NHS, so to say, responsible for the planning, management, and finance; and they deliver primary, secondary, and tertiary care to specific groups of the Saudi population. To coordinate between these sectors, the Council of Health Services (CHS) was established, to have one member from each sector and to be led by the MOH. The CHS can be viewed as similar to the Department of Health in the UK.

However, if we review the literature, we will notice that there are some problems in our health system, such as: Access to programs targeting chronic illnesses is found to be below target. For example, only a small proportion of registered patients who have hypertension come for treatment in primary healthcare centers. Low referral rates prevent appropriate access to specialist care and access to health education is also low.

A study of patient satisfaction showed that patients were dissatisfied with several aspects of access, including waiting time (74.9%), waiting areas (58.1%), and the physical environment of the premises (63.8%). Forty percent were dissatisfied with the opening hours, the lack of access to specialist clinics, and delays in accessing care. The programs targeting chronic disease management were often less effective. Several reasons were cited for this, including poor professional skills, which reflected in the misdiagnosis or mismanagement of major chronic conditions, such as, hypertension, diabetes, mental disorders, and asthma. Similarly, problems were documented in the diagnosis and management of common conditions such as upper respiratory tract infections.

The effectiveness of clinical decisions was reported in terms of prescribing patterns, as also diagnostic and referral practices. Studies reported over-prescribing due to the fact that medications were provided free of charge. An audit of prescribing for asthmatic children identified other concerns such as under-prescribing of the necessary preventive medications in 65% of the children, use of inappropriate medications in 27% of the cases, and overlooking of drug interactions. Prescriptions often lacked complete information, including dosage, strength, and duration of treatment. Poor diagnostic and referral practices were also observed, for example, despite a high prevalence of diabetic retinopathy, only 40–68% of the diabetic patients were referred to eye clinics.

National guidelines in SA have been established for only few common conditions; however, several studies indicate that clinical decisions are not sufficiently evidence-based. This has contributed to wide practice variations, inadequate diagnoses and management of a range of medical conditions, inappropriate clinical decisions, and unsafe prescribing patterns. Obstacles to the implementation of evidence-based medicine (EBM) include: Poor dissemination of guidelines and a low level of awareness among physicians of journals, review publications, and databases. Most physicians have limited access to the internet. By reviewing of the literature we have identified several factors that impede the achievement of quality healthcare in Saudi Arabia.

These include: management factors, organizational factors, implementation of EBM, professional development, problems at the interface with secondary care, and organizational culture.
In UK, NICE represents an essential and practical for health economy evaluations, trying to be transparent and independent, but it needs to articulate its decision-making process more evidently, be explicit and justifiable about the use of the value-for-money threshold. Furthermore, it is required to articulate social and ethical value judgments that they use in the development of their guidance. One of the major criticisms of NICE is that NICE technology coverage decisions are driven to a large part by the result of economic evaluation, but other relevant and pertinent factors such as equity and ethics are ignored. Economic evaluation is concerned with efficiency, if from a given budget, the objective is to maximize health improvement or to maximize welfare, then a resource allocation based on cost-effectiveness or cost benefit analysis will solve that. But is efficiency all that matters? What about other criteria such as ethics, equity, and needs, which may be or are being used to guide NICE decisions? The present criteria, other than cost-effectiveness, may mean that there is in practice no threshold at all; any new health technology has a finite chance of being accepted or rejected, whatever its threshold, if other factors are important enough to outweigh its cost.

We agree that there is an urgent need to establish The Saudi Institution for Health and Clinical Excellence, but we should be aware of the criticism mentioned for NICE, and I also recommend that the umbrella for this new institution should be independent of the Ministry of Health or other organizations that provide health services in Saudi Arabia. Moreover, the recommendations and guidance that will be produced by this organization should be mandatorily applied by governmental and non-governmental healthcare providers.

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