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REPORTER: Gerry Northam

PRODUCER: Bill Law

EDITOR: David Ross

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NORTHAM: Britain is way ahead of the rest of Europe in research and development of new cancer drugs. But when it comes to getting them from the laboratory bench to patients' bedsides, we lag far behind. And for many, delay can prove fatal.

HAINY: Time is of the essence, because the longer I have the tumour and the drugs aren't working on it, the bigger it will get and the less chance I have of it shrinking to have an op. I haven't got that time. It's going to be too late.

NORTHAM: Decisions about new drugs for the NHS are taken by a quango, the National Institute for Health and Clinical Excellence, known as NICE. A survey for File on 4 of doctors in England finds widespread criticism of the length of time NICE takes, particularly since in Scotland the NHS can make the same drugs available many months, even years, earlier.

RULE: If people in England knew that in Scotland cancer treatments have been approved this summer that NICE wasn't going to look at until next year, they would be appalled.

NORTHAM: The government has just announced a new fast-track through NICE for selected new treatments. But will this be enough to get them to patients before it's too late?

SIGNATURE TUNE

KENNEDY: I'm Sheila, and Peter is ...

NORTHAM: Your husband?

KENNEDY: My husband, yes, yes, and we both manage very well together, the two of us. We've had four babies. What else shall I say?

NORTHAM: What do you like to do?

KENNEDY: What do we like to do? Oh well, you know, we had those children and we still like to get out and about as best as we can, and I hope you do.

NORTHAM: Now in her early seventies, Sheila Kennedy is on an NHS prescription for Alzheimer's disease. She's gradually lost the ability to look after herself. Her husband Peter cares for her constantly, doing the cooking and housework. She can no longer drive and flicks through the pictures in the newspaper rather than reading the text. But though painful to watch, her decline has been more gradual than Peter expected, and he credits the medication she's on.

PETER KENNEDY: The Aricept has definitely slowed down the Alzheimer's disease. I mean, it doesn't cure it, but it's slowed it down, and so over the assessments at the hospital, the decline was very slow and much slower than you would expect if you hadn't been taking the drug.

NORTHAM: And how can you be sure that the drug has had that effect?

PETER KENNEDY: Well only my experience. I have an aunt who had Alzheimer's, and Aunt Hilda probably, that was five years or less. Sheila's mother had Alzheimer's disease, also my son-in-law in Bath, his mother had Alzheimer's disease and lasted about five years. None of them had any treatment.

NORTHAM: And Sheila has had Alzheimer's diagnosed for?

PETER KENNEDY: Eight years, and has been taking the drug for, it'll be eight years, I think, in the spring.

NORTHAM: At first, Peter and Sheila Kennedy paid for the drug themselves, then they were able to get it on the NHS. Four years ago, Aricept was one of three drugs NICE approved for general prescription to suitable Alzheimer's patients. But in March this year NICE had second thoughts. Its job is to calculate the net cost of a treatment, weigh that against its known benefits, and then to judge if it represents value-for-money. With the evidence of four further years of use, NICE failed the Alzheimer's drugs and suggested they be unapproved for new patients. The result is a big political row. Many carers, like Peter Kennedy, are campaigning for the retention of the drugs on the NHS.

PETER KENNEDY: I was extremely cross. I don't see why elderly people should be put in the position of having to go into a nursing home and either pay or have a nursing home imposed on them. Fees would be £25,000 or £30,000 a year, and the drug cost to the NHS, I suspect, would be less than £1,000 a year.

NORTHAM: But NICE have to consider this drug if they don't think it does enough good to justify its cost, their job is not to approve it.

PETER KENNEDY: That's correct. But I don't believe that they have taken the monetary considerations into account. You have to compare the cost of a nursing home versus the cost of the drug, and if you delay somebody going into a nursing home for only two years, that's £50,000 or £60,000 versus £2,000 or £2,500 worth of drug. It's a no-brainer, isn't it?

NORTHAM: NICE's calculation of cost-effectiveness works out the cost in pounds sterling per added year of healthy life, measured in an arcane health economist's unit - the QALY, quality adjusted life year. The costs it takes into account are those met by the NHS and Social Services. At the Alzheimer's Society, the Director of Information, Clive Evers, argues that this overlooks other factors, which can be very important to the families affected.

EVERS: They have not taken into account the effect of the drugs on carers' time. For example, we know people who have been on the drugs, carers say that they are able to save at least an extra hour a day as a result of the improvements in behaviour of people. We know that carers' health is improved when the person they are looking after is on the drug, because they are making less demands. These drugs cost £2.50 a day. Now why anybody can say that that cost for a progressive, ultimately fatal disease, for which we have no other treatments to help modify – and we're not talking about cures here, but we are talking about significant improvements in quality of life for people for six, twelve, eighteen months, sometimes a little longer. And that is going to be denied people.

NORTHAM: Faced with a wave of hostile reaction, NICE has put the future of Alzheimer's drugs into review. It says it's done its best to look at the impact on carers. A decision will be made shortly before Christmas and announced in January. The Chief Executive of NICE, Andrew Dillon, says he has currently no idea which way things will go. But in the end, value for money is what will count.

DILLON: Many of us, me included, have personal experience of the condition. We know exactly what it's like when it occurs, absolutely appreciate the fact that small improvements mean an enormous amount, but it's true for any disease or condition. What we have to be sure about is that enough patients get that improvement, given the cost of the drugs to the NHS, so that we can be certain that we're making the right recommendation for using the resources involved in the right way.

NORTHAM: If you decide that these drugs should be withdrawn, do you think you could get away with it, given that they have been available and people are now taking them, and there'll be a public outcry, won't there?

DILLON: The best I can do, the job I've got to do, the thing that matters to me most of all is that whatever judgement comes out of our independent advisory committees – and that word 'independent' is very important, by the way, because they're not influenced by anybody, they're influenced by what they see in the evidence and by reasoned argument put to them by people who have got an interest in the work they do. What I've got to be able to do is to lay out honestly the conclusion that I've reached, and to try and convince those who might differ in their interpretation of the evidence that we've got it right and that we're making the right recommendation on behalf of the NHS.

ACTUALITY IN HIGH HOLBORN

NORTHAM: This brightly-lit modern building on High Holborn in central London houses the headquarters of NICE. Inside, in the wide open-plan offices, officials tap away at their computers, assessing data on a range of drugs for the appraisal committees, which make the vital recommendations about which should be taken up and funded by the NHS. Outside the field of Alzheimer's, we've met no-one in making this programme who questions the high quality of these decisions - people call them the Gold Standard. But there is widespread concern over the length of time NICE takes to decide - typically 62 weeks of consultation and deliberation.

File on 4 commissioned a survey of GPs and cancer specialists in England from the research company Medix, asking what they think of the time NICE has taken over its appraisals. 59% of the GPs tell us it's too long. Only 4% say it's too short. Among the cancer specialists, comments express an even greater degree of concern.

READER IN STUDIO: NICE has lost public confidence already and is losing faith with the medical profession due to unacceptable delays.

NORTHAM: In all, 51 out of the 62 cancer specialists contacted say the decision process has taken too long. None says that it's too short.

READER IN STUDIO: In the time it takes for NICE to approve certain drugs, a significant number of patients who may benefit will be dead. Cancer patients do not have eighteen months to wait for a decision, especially when the clinical evidence of a significant benefit is indisputable.

NORTHAM: Last month, a prestigious Europe-wide study criticised the UK timetable for drug approval. It found that the Department of Health takes up to eighteen months before it even refers new drugs to NICE, where they take more than fourteen months to be appraised - a total of more than two and a half years. This puts the whole country down at the bottom of the EU in terms of getting new drugs to patients. The Professor of Cancer Medicine at Imperial College London, Karel Sikora, argues that such delays are critical for large numbers of patients.

SIKORA: One estimate looking at mortality data across Europe, that's cancer death data, suggests that about ten thousand people a year are still dying unnecessarily in Britain compared to comparable economies – France, Germany, Italy.

NORTHAM: You mean, if we had the same standard as the average in Western Europe, ten thousand people in Britain would live who are currently dying?

SIKORA: It would be something of that order.

NORTHAM: That's an extraordinary position for a doctor to be reporting.

SIKORA: I think it's been known for the last fifteen years that we've been behind. Corrective action has been taken. More money than ever is being spent on cancer. The trouble is, we know already that the surrogates of success – that is, the use and availability of new drugs for cancer, we're still lagging behind. So as Europe improves, we'll improve too, but we'll always be behind. And what we've got to try and do is really push right to the front.

NORTHAM: When doctors talk like this, you're always accused of shroud-waving. Is that ten thousand figure reliable?

SIKORA: It comes from some very robust cancer registry data that's collected every three years from seventeen European countries. And although there are areas where it's difficult to make the direct comparison, it does seem that consistently for many of the common cancers, Britain lags behind the rest of Europe. So if we just got to the European average, we'd actually save ten thousand lives a year.

HAINY: I'm Marina Hainy and I am sixty-two years of age and I am suffering from liver cancer and I am desperately fighting to get the new drug, Avastin, that is apparently my only hope.

NORTHAM: Early this year, Marina Hainy learned that she had cancer of the lower bowel and was successfully operated on. But a scan found a secondary tumour on her liver, for which she's now having chemotherapy. The prognosis is not good. So Marina has done her own research and come across reports of a new drug – Avastin – which is specifically designed for patients with her condition. As matters stand without it, she says the advice she's had from a specialist is bleak.

HAINY: He said that he could do nothing unless the cancer was to shrink, which I have a small percentage chance of it happening if I went on chemotherapy, which I am now on, but it isn't working, because it has got slightly larger. The drugs that I'm on, the chemo I'm on at this precise moment, are not the ones I want. I want the new drug Avastin, which I'd heard about on the television, which shrinks the cancer. And then I was told if it was to shrink, I could have an op.

NORTHAM: And what do you know about the drug?

HAINY: It is the newest and most advanced way of treating liver cancer, because it starves the cancer and shrinks it.

NORTHAM: Avastin has been approved for use in Europe. But it hasn't yet been appraised for the NHS by NICE. It's currently under consideration and the NICE website says that it will be November next year before there's a decision. If it were suitable for her, this is time Marina can't spare. While NICE goes through its procedure of

NORTHAM cont: earlier than NICE. And, if it's approved, that should make the drug available to patients here on the NHS. The Consortium is a representative group of NHS doctors and officials and works differently from NICE. It doesn't gather data on new drugs independently, but has it submitted by manufacturers and then makes a judgment of cost-effectiveness. The Scottish system has worked up to now behind closed doors. But in his first broadcast interview, its chairman, Professor David Webb, stresses the importance of making decisions quickly in order to influence prescribing.

WEBB: The appraisal process, from the time a submission comes in to a decision going out to the NHS in Scotland, is around fourteen weeks.

NORTHAM: Fourteen weeks? Submission arriving, what, as the drug is licensed?

WEBB: It can arrive before the drug is launched, but more commonly a short time afterwards.

NORTHAM: This is a submission from the pharmaceutical company?

WEBB: Yes. And the reason we can undertake such a rapid appraisal is that we let the pharmaceutical industry do the work of preparing the submission for us.

NORTHAM: How much do you rely on their data and their analysis of the data about a drug?

WEBB: Well we allow them to provide those data and the analysis, then we have teams within house who look at the clinical trials, test the assumptions that have been made by the pharmaceutical company, and also look at the health economic data.

NORTHAM: Are you too dependent on the pharmaceutical companies?

WEBB: I don't believe so, and the data are transparent and clear. Where they're not, then we would question those and ask for further information and further analysis, and we believe that gives us a robust answer to the questions we're presented with.

NORTHAM: The effect of Scotland's speed is that some patients north of the border get access to drugs on the NHS long before some of their counterparts in England. And for them, this can seem a real lifeline.

NICAUDIE: I became aware of it with an unfathomable pain in the back without any justification. Whatever amount of paracetamol or any other painkiller I could take, there was no way of dealing with it, and that was what took me to the doctor.

NORTHAM: Jacques Nicaudie is 64 and his cancer is insidious – myeloma, which attacks his bone marrow, distorts his spine and wrecks his immune system. A year ago he was in a poor state, as the disease level in his blood was shooting up towards the danger zone. But fortunately for Jacques, he's lived in Scotland for the past forty years, and in October 2004, the Scottish Medicines Consortium announced that it had approved a new anti-myeloma drug called Velcade. Jacques was to be one of the first patients put on it.

NICAUDIE: I had been through everything. I had been on thalidomide, I had two transplants, and each of the treatments I had been offered at some point failed me, rather than me failing it. Therefore, when the Scottish Consortium for Medicine opened the gate, that consultant could actually begin to prescribe it, that was last October, that was a year ago, then that was welcome news.

NORTHAM: Jacques had a full course of eight treatments with the drug over a period of months and kept a chart tracking the disease levels in his blood.

NICAUDIE: This graph here shows you November 2004, it had reached 19.2, as you can see, from March.

NORTHAM: It looks like a child's drawing of a mountain. Within weeks of starting treatment, the dramatic upward trend was reversed and came rushing down. For the past year, Jacques' wife Christine has found his health much improved.

CHRISTINE NICAUDIE: I was amazed by the effect it had on him, because he was very depressed last year at this time, and after a few weeks on the drug he was totally transformed. Not only was he much less tired, because myeloma makes you exhausted all the time, he was able to do things that he wasn't able to do before. He didn't fall asleep all the time, as he had been doing, and he had a much more optimistic outlook as well, and it's made our lives so much better. But we feel even now that the Velcade has stopped, we feel much more optimistic and we're hoping that the plateau will last.

NORTHAM: It's almost as if you're describing being given extra time.

CHRISTINE NICAUDIE: Well it is, it is giving a new lease of life, isn't it? Because I'm very well aware that he probably wouldn't be here today if he hadn't had the Velcade.

NORTHAM: But while this is good news for Jacques and Christine, other myeloma patients are less fortunate. The International Myeloma Foundation, which is based in Edinburgh, applauds the speed with which Scotland has adopted Velcade as a treatment. But the story in England is more patchy. NICE is not due to report on Velcade until some time after the middle of next year - more than eighteen months after the Scots. Some areas of England have moved to prescribe the drug even before NICE gives its guidance. But, according to the Foundation's Director Eric Low, many others still haven't.

LOW: NICE has not yet approved Velcade for use in myeloma, and this is causing real problems in terms of access in England. Where NICE guidance is not available for new drugs, the policy is that local PCTs can make a decision as to whether or not they see the drug as being appropriate or a priority in that area. So what happens – and for a whole range of different reasons – some PCTs agree that it should be funded and some PCTs say that it should not be funded, and this gets us into the ridiculous situation of postcode prescribing.

NORTHAM: Which is what NICE was set up to abolish?

LOW: Absolutely. So postcode prescribing hasn't gone away, it's just changed its identity.

NORTHAM: What proportion of patients in England who, in your view, need this drug, are actually able to get it on the NHS?

LOW: Less than half the patients who need the drug are getting the drug, due to the lack of NICE guidance and postcode prescribing. It's unfair, it's unjust and this situation needs to change immediately.

NORTHAM: Late last year, as Jacques Nicaudie was preparing to start his new drug treatment, another couple affected by myeloma, living hundreds of miles away in South West England, were desperately hoping to do the same.

MARRON: The situation was deteriorating rapidly. She had reached the stage when all the various chemotherapy treatments were no longer working. Her weight was down to five and a half stone. Her days were occupied by long periods of vomiting and pain and anguish, and it was quite clear from what was going on that what had previously been an eight and a half stone, very healthy lady was a skeleton. Our GP said to me, 'She will be very lucky to see Christmas.'

NORTHAM: Brian Marron's wife Patricia is 68, and he's watched her decline as myeloma has spread its effects. But Brian knows his way around the British establishment - for 26 years he was a senior official at the MOD. He'd heard about Velcade and decided to do whatever he could to ensure his wife got it, even though her hospital might have other ideas.

MARRON: I was told, 'We do not use Velcade. This PCT will not approve its use. We do not use it in this hospital.' And I said, 'Well, why not?' and they said, 'Well it is not part of our clinician's pharmaceutical drug list. We don't use it.' And I said, 'But it is being used elsewhere in the country. It's being used all over the world. Why not in Bath or Bristol?' And basically the message I got, reading between the

MARRON cont: lines, was it was too expensive. So I said, 'Well, okay, I will offer you £5,000 to buy the first infusion of the drug,' and they said no. And I said, 'I will offer you £10,000,' because I knew we had one bond in our life savings that I could redeem, and they said, 'That is not possible.' Now that was 5th October. All of a sudden, four weeks later, I receive a phone call, and I am told that a verbal protocol had now been put in place, which would allow me to fund the purchase of the drug.

NORTHAM: After the first three cycles of treatment, the effect on Mrs Marron was as positive as for Jacques Nicaudie in Scotland. Her blood tests showed the same remarkable improvement. So much so that the hospital agreed to fund the rest of her treatment itself. It said the reason the couple had to dip into their life savings to get treatment started was that the drug hadn't gone through the approval process at NICE. In a statement this month the hospital Trust told File on 4:

READER IN STUDIO: The Trust's intention had always been to carefully consider the options available to Mrs Marron and to provide her with the best possible treatment and care.

NORTHAM: Concern that some patients in England don't receive new drugs on the NHS as early as their counterparts in Scotland has persuaded the national information service, CancerBACUP, that there is a systemic problem in drug approval which puts large numbers of patients at a serious disadvantage, at a time when cancer research is producing a number of early treatments which can save lives. Joanne Rule, the charity's Chief Executive, argues that delay means patients can be put at risk.

RULE: We are now talking about treatments for early cancer that will make a difference to survival rates. So we are now talking about cancer treatments that you would be desperate for your mum, your daughter, your sister to get, and that's a big difference. We've looked at those treatments, we are a patient organisation, and yes, I'm now saying that some of these treatments actually are about life or death.

NORTHAM: What do you make, then, of the gap that exists between what patients in Scotland get and what patients in England get?

RULE: I think increasingly the gap between the two countries is shocking, unacceptable. The only reason that it kind of goes on is that nobody knows about it. If people in England knew that in Scotland cancer treatments had been approved this summer, that NICE wasn't going to look at until next year, they would be appalled.

NORTHAM: Those running the Scottish system argue that patients north of the border get the best of both worlds - the speed of the Scots, later followed by the rigorous independence of NICE as a backup. The Scottish Medicines Consortium, though, does have its critics. Its decisions have been called not just quick, but quick and dirty. The Chairman, Professor David Webb is happy with the first adjective - but not the second.

WEBB: I've heard the statement, but I certainly don't accept that. I think we are reliable and robust in our analysis.

NORTHAM: So you don't accept the criticism that in pursuing speed in decision-making, you may be sacrificing the quality of some decisions?

WEBB: I don't believe we're sacrificing quality, but I do accept that a late approach may bring more to the table and may allow some refinement of that decision.

NORTHAM: Is your position really that Scotland needs both? A quick decision from you and the more measured, fully informed appraisal over time that would come from NICE in London?

WEBB: I think I'd absolutely accept that position, I think not just for Scotland, but for the UK and for many other countries in Europe. That sort of rapid and late appraisal scheme works in a very complementary fashion.

NORTHAM: You have both in Scotland at the moment. England only has NICE.

WEBB: We have the benefits of accepting NICE guidance for late appraisal. There's nothing equivalent in England.

NORTHAM: Should there be?

WEBB: I think there's every grounds for doing that now, yes. We've, I think, almost eliminated postcode prescribing in Scotland, but clearly that still exists across the border, and I think it would be helpful if we were all acting in very much the same manner.

NORTHAM: But at NICE, the Chief Executive, Andrew Dillon, is dismissive of comparisons between Scotland and England, maintaining that the two systems have different remits. The Scots evaluate a wide range of new drugs, about seventy a year, including many which are dealt with at local level in England. Only the most important fifteen or so a year get the full rigour of appraisal by NICE.

DILLON: What NICE does isn't to deal with the routine drugs, which the Scottish Medicine Consortium does quite competently, as a hospital drug and therapeutics committee would do quite competently. But to select from the annual group of new drugs that are introduced, the really significant, important drugs, the one that offer significant potential additional benefits to patients, ones that have the potential for driving very substantial extra costs into the healthcare systems, those are the ones that need the careful, considered NICE appraisal.

NORTHAM: But the reality is that patients and doctors in Scotland have access to drugs much earlier than patients and doctors uniformly do in England, and the reason is that the Scottish Medicines Consortium gives them the best of both worlds. That's still not going to happen in England.

DILLON: You're not in a position to say that, because you don't have the data, I don't have the data. We simply don't know whether or not England has been disadvantaged by not having a national system, because all those local systems are still in operation for the drugs that NICE doesn't look at.

NORTHAM: But we do know, because there are patients – like patients we’ve met, a patient in Scotland who was prescribed Velcade a year ago and a comparable patient in England who couldn’t get it and had to fund the treatment themselves. We do know that there are these gaps between England and Scotland.

DILLON: Do we know that every patient in Scotland who needs Velcade gets it? I don’t know. I don’t think you have the data either.

NORTHAM: But charities which run patient helplines report that Scotland does have swifter access to new drugs than England. And our survey of doctors in England shows strong support for the speed of the Scottish system. 83% of the GPs say that such rapid decision-making is important, and so do 60 of the 62 cancer specialists. In May this year, as campaigners grew increasingly concerned over the time taken in drug decision-making, NICE delayed still further the appraisal of some new cancer drugs. It blamed this on a £3.5 million funding cut. As a result it had to abolish one of its appraisal committees, causing the backlog of drugs to grow even longer. Then, after widespread publicity over the breast cancer drug, Herceptin, the Department of Health this month announced a new fast-track for some treatments through NICE. This seemed a sudden reversal. Particularly since many of the drugs now in the fast-track are the very ones that were to be further delayed only six months ago. But Andrew Dillon, NICE’s Chief Executive, sees no contradiction in the policy. The outcome of those new funding arrangements was that you cut the number of appraisal committees from three to two, you announced that a number of drugs, which were already in your backlog, were going to be further delayed, and now all of a sudden you’ve got a fast-track system in which some of those same drugs are to be rushed through. It doesn’t look very well-planned. It looks more like a muddle, doesn’t it?

DILLON: It may look like a muddle, but when you’re in the business of running an organisation, anybody who’s in the business of running an organisation knows they have to respond to often rapidly changing circumstances. By introducing the short process, we can make more out of the money that we’ve got available.

NORTHAM: Do you get extra money to run this fast track, or are you having to take that by squeezing further the drugs timetable for those that aren't being fast-tracked?

DILLON: With the resources that we've got available this year, and the resources that the Department of Health have indicated that we're going to get next year and beyond, we've got enough money to run both the short process and the current process.

NORTHAM: And will this mean, as you squeeze elsewhere, that some other drugs will be further delayed because they're not in the fast track?

DILLON: People who run organisations know that you can look all the time at how money is used, and you can move it around, you can continue to operate good quality services with different levels of resources.

NORTHAM: That's neither yes nor no. Are you going to delay some other drugs further?

DILLON: No, we're not delaying any of our programmes. What we're doing is making better use of the money than we have in the past, and that's allowed us to free up resources to operate the new programme.

NORTHAM: So to be absolutely clear about this, no other drugs, no drugs that aren't in the fast track, are going to be further delayed because you've squeezed money in order to create the fast track?

DILLON: No.

NORTHAM: NICE's fast track is to consider an initial fourteen drugs, thirteen of them for cancer. First results will appear in June next year. The aim is to take something like eight months out of the normal appraisal process of fourteen months. But news of developments from cancer researchers may mean further pressure is on the way. One leading drug laboratory has told File on 4 that its plan is to flood the system with new targeted medicines, which will force their way up the political agenda. Andrew Dillon is

NORTHAM cont: confident that once the fast-track gets going, NICE will be able to cope. But Professor Karel Sikora is less optimistic. He sees potential for further strain on an already over-stretched system.

SIKORA: It'll go some way, there's no doubt that fast-tracking is better than the current slow track. However, there's only a few drugs listed to be fast-tracked, and there's a huge deluge coming now, probably forty drugs over the next five years to the marketplace.

NORTHAM: Just in cancer?

SIKORA: Just for cancer. The current situation was eminently predictable in 2001, and yet here we are in 2005 and we have this problem. The future is going to be much much greater pressure and much greater understanding by patients who are empowered with far more information than they were even five years ago.

NORTHAM: So when the Chief Executive of NICE says that over time the fast track will solve the problem of a backlog of drugs, are you that optimistic?

SIKORA: No. The fast track is a step in the right direction, but it's not really fast enough.

NORTHAM: So NICE is still going to have a backlog, is it?

SIKORA: I believe they won't catch up with the backlog and there will be delays consistently, as we have had over the last five years, over the next five years with new compounds coming to the marketplace, unless we get a radical new solution to the problem.

NORTHAM: We wanted to ask the government about the system of decision-making for NHS drugs - why some patients in Scotland benefit from new drugs much earlier than some of their counterparts in England, and why the government cut funding to NICE six months ago, causing further delay for drugs which have now suddenly been put into the fast-track. No Minister was available for interview. And it's the government itself which has turned the recent furore over Herceptin into a testing time for NICE. The Secretary

