Yorkshire Cancer Research

Changes to the NICE regulations: cost-effectiveness threshold

Proposal 1

Give ministers a limited power of direction to set the core cost-effectiveness threshold that NICE uses in the development of guidance, including technology appraisal and highly specialised technology evaluation recommendations.

Do you agree or disagree that a ministerial power of direction, as outlined under proposal 1 above, should be limited to the NICE standard cost-effectiveness threshold?

- Agree
- **Neither agree nor disagree**
- Disagree
- Don't know

Please explain your answer. (Optional, maximum 200 words)

In December 2025, it was confirmed that NICE will apply new cost-effectiveness thresholds of £25,000 -£35,000 per quality-adjusted life year (QALY), an increase of 25% on the current thresholds. The threshold had not changed since 1999, and many charities and organisations had been calling for it to be updated in line with inflation to enable more innovative medicines to be available on the NHS and bolster UK life sciences. An increase to the cost effectiveness threshold could therefore enable more patients to access innovative, new treatment options and Yorkshire Cancer Research welcomes this announcement.

However, it is critical that any further decisions to change the standard NICE cost-effectiveness threshold are evidence-based and not informed by industry or international pressures. Yorkshire Cancer Research therefore disagrees with the proposed change and recommends that powers should remain with NICE as independent, apolitical experts.

It is important that, with the NICE cost-effectiveness threshold increase that has been agreed as part of the UK-US pharmaceutical deal, the NHS is supported to cover the additional costs of new medicines approved under the new threshold. Without the necessary funding, new medicines may be approved at the expense of other NHS services which deliver significant benefits to patients.

Do you agree or disagree that the power to direct NICE about the standard cost-effectiveness threshold should apply to all NICE guidance that makes recommendations on health spending? This includes technology appraisal and highly specialised technology evaluation recommendations.

- Agree
- Neither agree nor disagree
- **Disagree**

- Don’t know

Please explain your answer. (Optional, maximum 200 words)

NICE plays an important role in developing evidence based and independent standards that help ensure NHS resources are used effectively. Its assessments of cost effectiveness are grounded in rigorous methodology, transparent appraisal processes and broad expert input. This independence is essential to maintaining neutrality in how decisions about access to treatments are made.

Decisions about the appropriate thresholds for cost effectiveness have significant implications for patient access, long-term system sustainability and the broader distribution of limited health resources. It is therefore critical that such decisions are informed by robust evidence, health economic expertise and established methodological standards. Bringing all health spending recommendation powers under direct ministerial direction could risk undermining the independence of this process.

Proposal 2

Remove the requirement for NICE to consult on methods changes where these result from a ministerial direction.

Do you agree or disagree that NICE should not be required to consult on any proposed changes to its procedures that are necessary as a result of a ministerial direction on cost-effectiveness thresholds?

- Agree
- Neither agree nor disagree
- **Disagree**
- Don’t know

Please explain your answer. (Optional, maximum 200 words)

A fundamental element of NICE’s independence lies in their broad consultation with clinicians, academics, industry, patient groups and other subject-matter experts. This enables NICE to rigorously test the evidence base, challenge methodological assumptions, and ensure its procedures lead to fair, consistent and high-quality recommendations.

Removing the requirement for consultation when changes are made as a result of a ministerial direction risks weakening this foundation. Even if the underlying change is externally mandated, the implementation of that change still requires careful scrutiny to identify unintended consequences.

Consultation provides a critical check on potential biases and helps maintain NICE’s neutrality by ensuring decisions are informed by a broad range of expert perspectives rather than solely by governmental direction. Without this safeguard, there is a risk that cost-effectiveness thresholds could be adjusted to meet short-term political priorities rather than evidence-based need. For example, thresholds could be raised to support approval of a high-profile treatment under public pressure, benefiting one group but generating substantial downstream costs for the wider NHS. This could ultimately undermine equitable resource

allocation, affect the care available to other patients and leave future governments constrained by decisions driven by political rather than independent, evidence-led judgment.

Additional comments

If there are any further comments you would like to make in relation to the proposed regulatory changes set out within this consultation, please include them here. (Optional, maximum 300 words)

Both proposals carry risks for widening regional health inequalities.

The first proposal to move health-spending decision making into Ministerial powers has the potential to undermine the independence of the process. By placing these decisions under political control, choices may be influenced by industry or international interests rather than clinical evidence or population health needs. This could result in changes to the NICE threshold being driven by political priorities at a time when the NHS lacks the funding and capacity to absorb such changes. For example, the recent uplift in the threshold associated with the UK–US trade discussions was not introduced as part of a planned, evidence-based strategy to improve NHS services. This could leave the NHS funding expensive medicines without any additional resource. Such a scenario would disproportionately affect regions that operate with tighter budgets or higher levels of illness, such as parts of the North of England and deprived areas. These providers may need to divert a larger proportion of existing expenditure to cover new medicines, widening gaps between well-resourced and under-resourced areas.

The second proposal, to remove the requirement for consultation when changes stem from ministerial direction, further undermines independent scrutiny. Even when Ministers initiate changes, broad consultation is critical to understanding their practical impact across different health systems and geographies. Without this process, government may overlook how variations in infrastructure affect local capacity to implement new treatments. For example, Yorkshire has only three major treatment centres and relies heavily on district general hospitals, whereas other regions have a greater concentration of specialist centres. A rapid increase in the NICE threshold could therefore disadvantage areas like Yorkshire, which may struggle to adopt new technologies at the required pace. Inclusive consultation would help identify such risks early and support equitable planning.