Public Health England

fuse The Centre for Translational Research in Public Health

Fuse Quarterly Research Meeting: Tuesday 27th January 2015: 12:30-16:00
Venue: Room 2.21 Research Beehive, Newcastle University, NE1 7RU

Managing the public health spend: the value of health economics for priority setting

Aims and Objectives

In light of fundamental changes to public health structures in recent years, commissioners face challenges for investment and disinvestment in times of austerity. In addition there is also a need to demonstrate transparency in decision-making in relation to local priorities for public health investment. These changes raise questions concerning the potential value of a health economics approach to priority setting and how best to apply the potential tools available.

This QRM will provide an overview of health economic principles which can be used to guide decision making. The programme will include a brief update on the changing public health landscape for commissioning. This will be followed by an introduction to economic approaches to managing scarcity and meeting need. An overview of health economic approaches to priority setting will be presented, and, in particular, the tools available.

In July 2013 a QRM was held on a two year project entitled 'Shifting the gravity of spending?' Priority-setting for local authority public health commissioners. The project is funded by the National Institute for Health Research School for Public Health Research (NIHR SPHR) and has explored methods for supporting public health commissioners in priority setting to improve population health and address health inequalities. Working closely with three local government case study sites across England, the project has assessed the feasibility and usefulness of priority-setting methods in relation to the ring-fenced public health budget as well as for public health investment across local authority departments. A practice partner, Mrs Marietta Evans, DPH North Tyneside, will share their experience of priority setting in practice, and reflect on how priority setting approaches can add value to public health decision making.

The afternoon will conclude with a panel question and answer session, involving all contributors to this QRM.

Who should attend?

The meeting is aimed at a wide academic, practice (working in any setting, including local authority, the NHS and government agencies) and voluntary sector audience, with an interest in the application of health economics in public health. Attendees will not require any prior knowledge of health economics to be able to benefit from the programme.

Outline Programme

12.30-13.00	Registration with refreshments
13.00-13.15	Welcome to the day and reflections on the public health landscape in 2015 *Professor David Hunter, Director of Health Policy and Management, Durham University and Deputy Director of Fuse*
13:15-14.00	**Health economics: the potential contribution to priority setting** • Basic Health economics principles that should not be contravened • Application of these principles in two contexts: 1. The conduct of economic evaluations of public health interventions 2. Frameworks for priority setting in which public health is competing with other options. *Professor Cam Donaldson, Yunus Centre for Social Business and Health, Glasgow Caledonian University*
14.00-14.45	**Making the case for Investing in Prevention** - economic evaluation applied to public health and health - intelligence tools to aid value for money decisions. *Dr Brian Ferguson, Director for Knowledge & Intelligence (England) Public Health England*
14.45-15.00	Refreshment Break
15.00-15.30	***Experience and Reflections of Priority Setting in Practice*** *Mrs Marietta Evans, Director of Public Health, North Tyneside Council*
15:30-16:00	Panel Question and Answer Session *An opportunity to ask questions of a panel of all our speakers and discuss issues from the day*

Booking your place

The event is free to attend, but you do need to book your place online by going to registration form. Please note places are limited and early booking is advised.

A map can be found on the Newcastle University website here:
http://www.ncl.ac.uk/about/visit/printablemaps/map-campus.htm
The venue is in Building No 25.
Nearest Metro Station: Haymarket, which is 5 minutes walking time from the venue via the pedestrianized Kings Walk

More about the "Shifting the Gravity.." project… The project is funded by the National Institute for Health Research (NIHR)'s School for Public Health Research. The research team is drawn from Fuse (Durham, Newcastle and Northumbria universities); the School of Health and Related Research, Sheffield University; London School of Hygiene and Tropical Medicine; and the Centre for Health Services Studies, University of Kent. The project is led by Professor David Hunter (Centre for Public Policy and Health, School of Medicine, Pharmacy and Health, Durham University). Further details are available on the project website project website

fuse Quarterly Research Meeting, Tuesday 27th January 2015

Health economics: the potential contribution to priority setting

Brighter futures begin with GCU

Cam Donaldson
Yunus Chair in Social Business & Health
Glasgow Caledonian University

Basic premise

- Resource scarcity is a global phenomenon
- We have to become smarter in managing scarcity, especially in a period of austerity and even disinvestment
- Integration, CCGs will not solve this basic problem

Principles and challenges: outline

- Statements from (integration) policy relating to potential for scarcity management:
    - what questions arise from these?
- How can we get there? Economic framework to address the questions:
    - two principles
    - five questions and 10 steps
- How has it worked to date and how does this fit with the world of public health?
    - focus on disinvestment
- Some questions for the future

Platitudes of service reform

- We are going to adopt a ‘balance of care’ model

Platitudes of service reform

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Question

“OK, what’s your process for deciding on the balance of care?”

Platitudes of service reform

- We are going to adopt a ‘balance of care’ model
- **It’s about effectiveness <u>and</u> efficiency**

Platitudes of service reform

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- It’s about effectiveness and efficiency

Question

“OK, what process for decision making results from these two concepts?”

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- **We are going to focus on outcomes and take an evidence-based approach**

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Question

“OK, what is the process into which an outcomes focus and staff engagement will be fed?”

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- We are going to involve front-line staff
- **We are going to examine how we are using resources and how can we use them differently?**

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Question

“Why then do we need to bring these bloody health economists down from that (potentially) rebellious part of the UK?”




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Question

“Have we decided on a process for doing this?”

Principles before practice: some definitions

- Opportunity cost:
  - Every time we use resources to meet one need, we give up the opportunity to use those resources to meet some other need
- The margin:
  - Technically, the extra cost/benefit associated with one more unit of production

“Marginal analysis”

- The “margin” is concerned with change
- Start with a given mix of services
- What are important are costs and benefits of changes in that mix
- If the mix of services can be changed to produce more benefit overall, this should be done

Screening for cancer of the colon

- Stool is tested for the presence of occult blood
- Proposal was for six sequential tests
- Neuhauser and Lewicki analysed the proposal, on the basis of:
    - a population of 10,000 of whom 72 have colonic cancer
    - each test detects 91.67 per cent of cases undetected by the previous test.

Screening for cancer of the colon

Cases detected and costs of screening with six sequential tests

No. of tests	No. of cases	Total costs ($)	Av. cost ($)
1	65.9469	77,511	1175
2	71.4424	107,690	1507
3	71.9003	130,199	1811
4	71.9385	148,116	2059
5	71.9417	163,141	2268
6	71.9420	176,331	2451

Screening for cancer of the colon

Incremental cases detected and incremental (and marginal) costs of screening with six sequential tests

No. of tests	Incremental cases detected	Incremental costs ($)	Marginal costs ($)
1	65.9469	77,511	1175
2	5.4956	30,179	5494
3	0.4580	22,509	49,150
4	0.0382	17,917	469,534
5	0.0032	15,024	4,724,695
6	0.0003	13,190	**47,107,214**

Implications of opportunity cost and marginal analysis

- to do more of some things, we have to take resources from elsewhere:
    - by doing the same things at less cost (technical efficiency)
    - by taking resources from an effective area of care because a new proposal (or proposals) is (are) more effective for the £s at stake (allocative efficiency)
- measure costs and benefits of care
- often about how much rather than whether
- economists don't have the answer to the meaning of life!

Programme budgeting and marginal analysis: what is it?

PBMA addresses priorities from the perspective of resources:

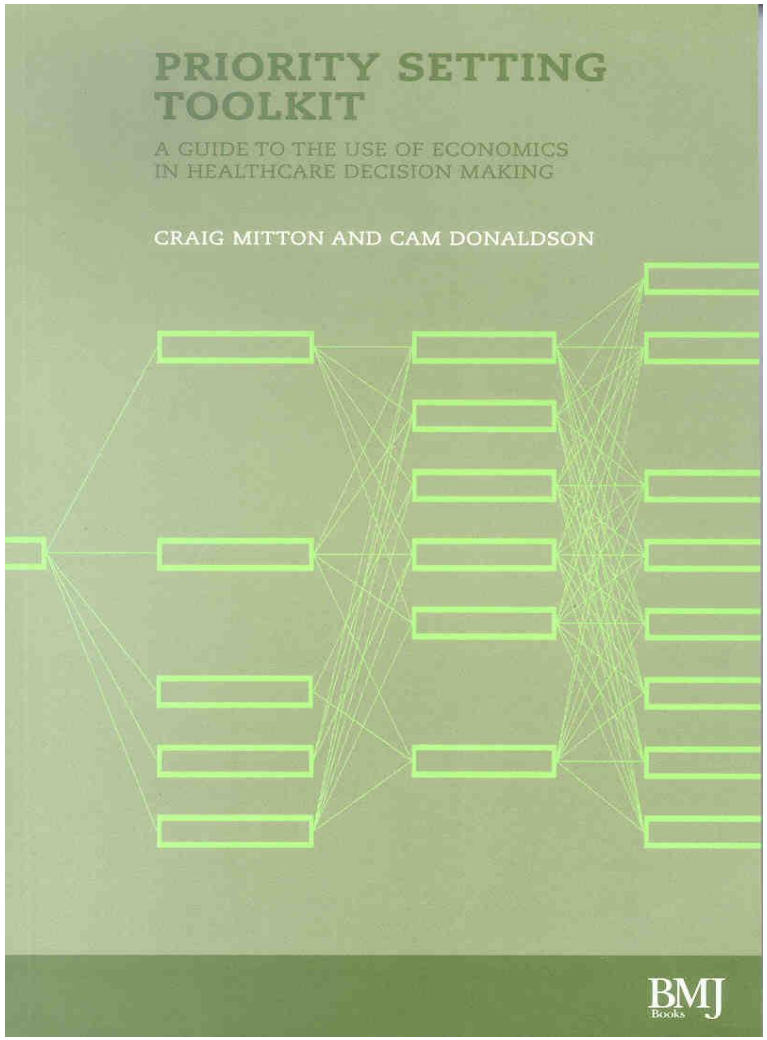
1. What resources are available in total?
2. In what ways are these resources currently spent?
3. What are the main candidates for more resources and what would be their effectiveness and cost?
4. Are there any areas of care which could be provided to the same level of effectiveness but with less resources, so releasing those resources to fund candidates from (3)?
5. Are there areas of care which, despite being effective, should have less resources because a proposal (or set of proposals) from 3. is (are) more effective (for £s spent)?

Questions 1 and 2 pertain to the *PROGRAMME BUDGET*

Questions 3-5 are addressed in *MARGINAL ANALYSIS*

Can be applied at 'micro' or 'macro' levels

Shameless promotion: Mitton and Donaldson (2004)



Project managing PBMA

1) Establish the organisational objectives
2) Ensure there is organisational 'readiness'
3) Establish an appropriate advisory panel structure
4) Ensure that implementation of results is feasible
5) Define the study question
6) Choose the most appropriate programme structure
7) Choose an appropriate level of detail for a programme budget
8) Use appropriate methods to identify options for investment and disinvestment
9) Identify, measure, and value costs and benefits of investments and disinvestments
10) Ensure that resource reallocation recommendations are valid and robust

Peacock S, Ruta D, Mitton C, Donaldson C, Bate A and Murtagh M. Using economics for pragmatic and ethical priority setting: two checklists for doctors and managers. *British Medical Journal* 2006; 332: 482-485.

QJM Advance Access published June 8, 2010

Q J Med
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Commentary

QJM

Rational disinvestment

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From the [1]Yunus Centre for Social Business and Health, Institute for Applied Health Research, Glasgow Caledonian University, Glasgow, G4 0BA, UK, [2]Institute of Health and Society, Newcastle University, [3]School of Population and Public Health, Centre for Clinical Epidemiology and Evaluation, Vancouver Coastal Health Research Institute, University of British Columbia and [4]Department of Public health, Lewisham Primary Care Trust

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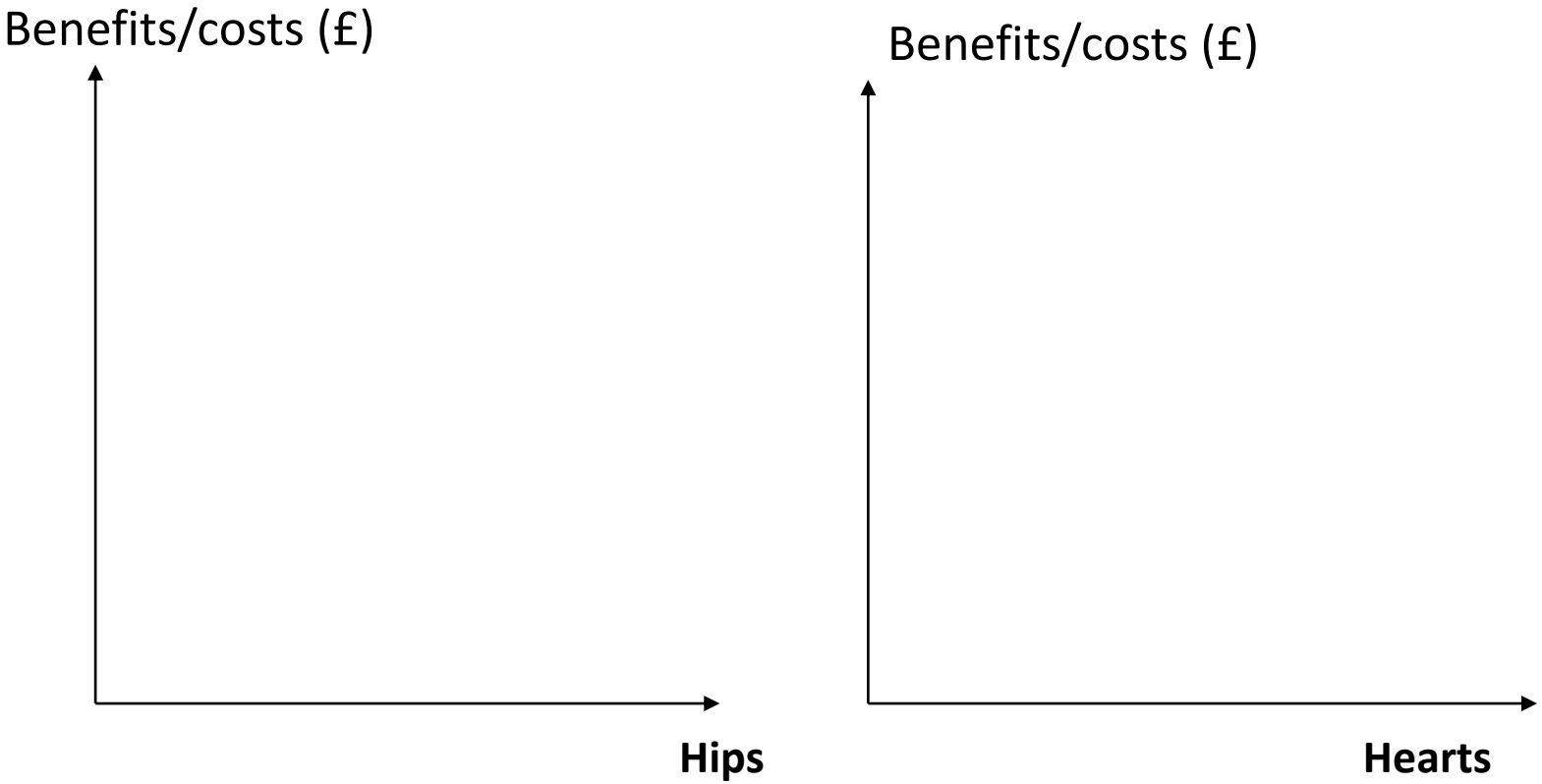
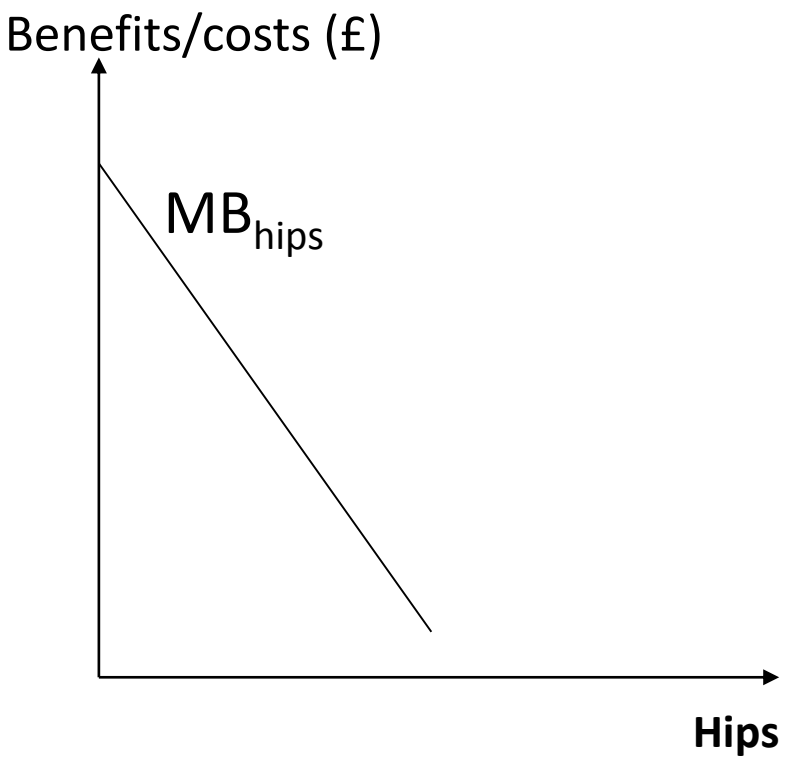
With potential budget claw backs of 20% to be found in UK health care in forthcoming years, the question arises as to how these might be achieved. Based on the long-standing economic principle of

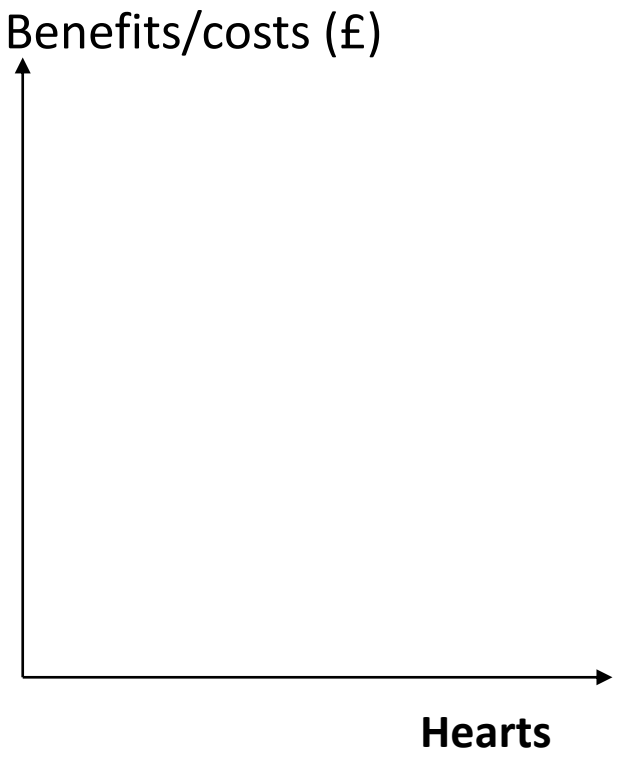
to refer to taking resources from areas of care that provide no added value, as though disinvestment will do no harm. Does anyone really believe that the scale of cuts required can be met by such

The PBMA theory

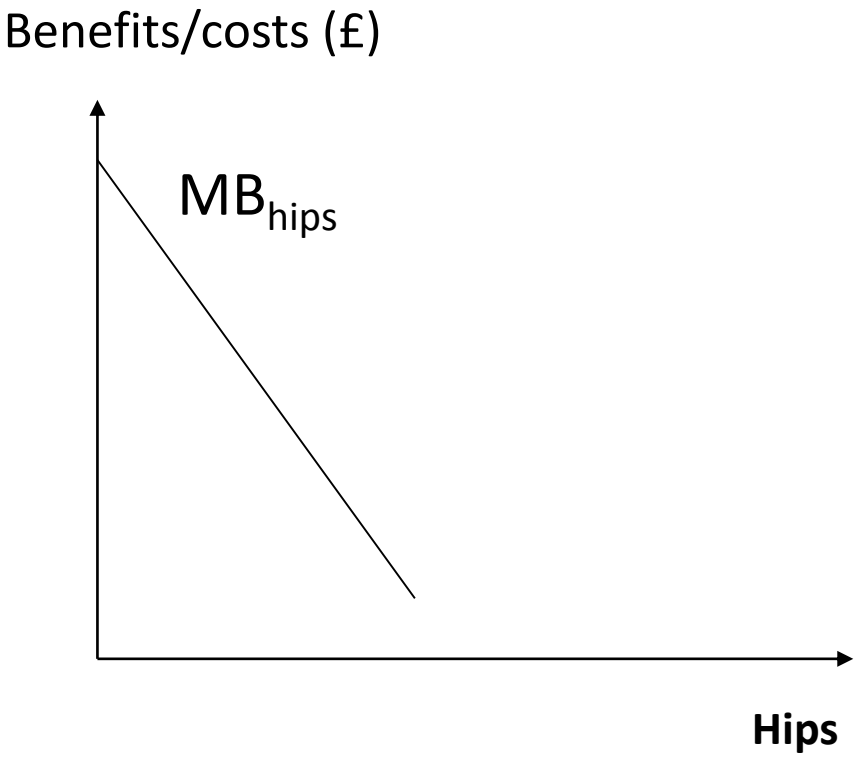


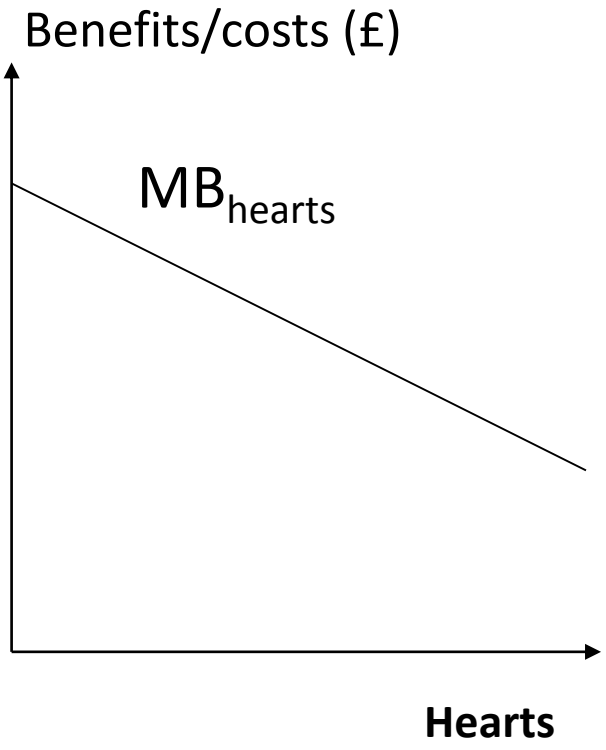
Treat those with most to gain first: benefits diminish for each additional patient treated



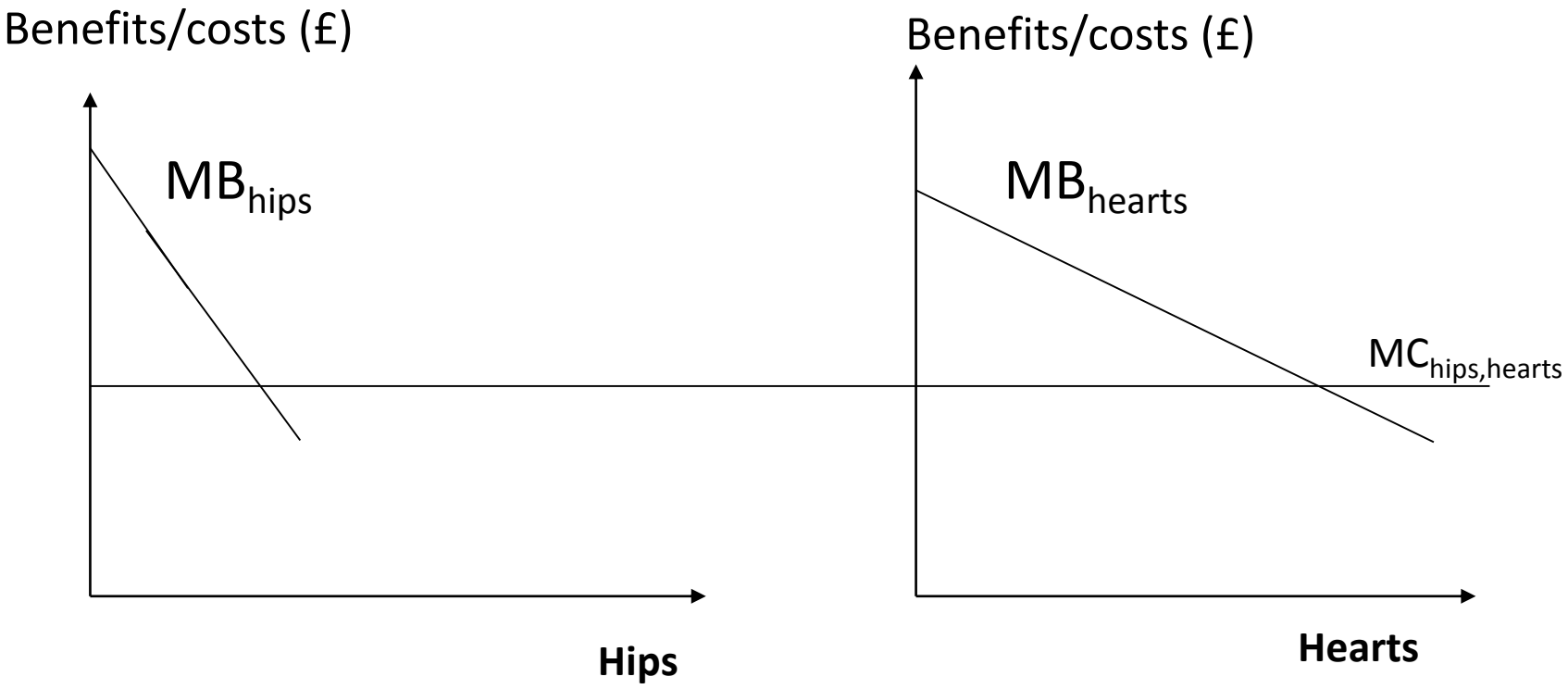


Same for hearts, but different slope

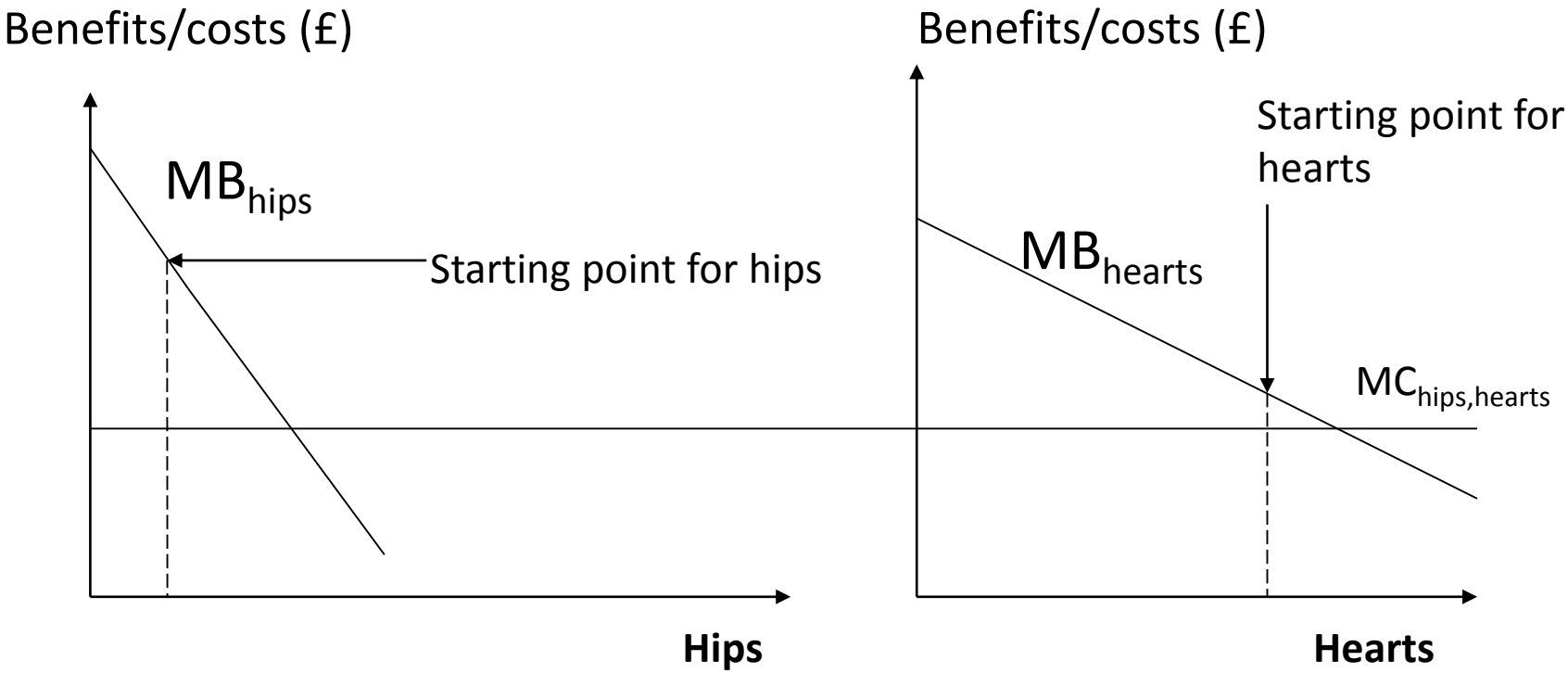




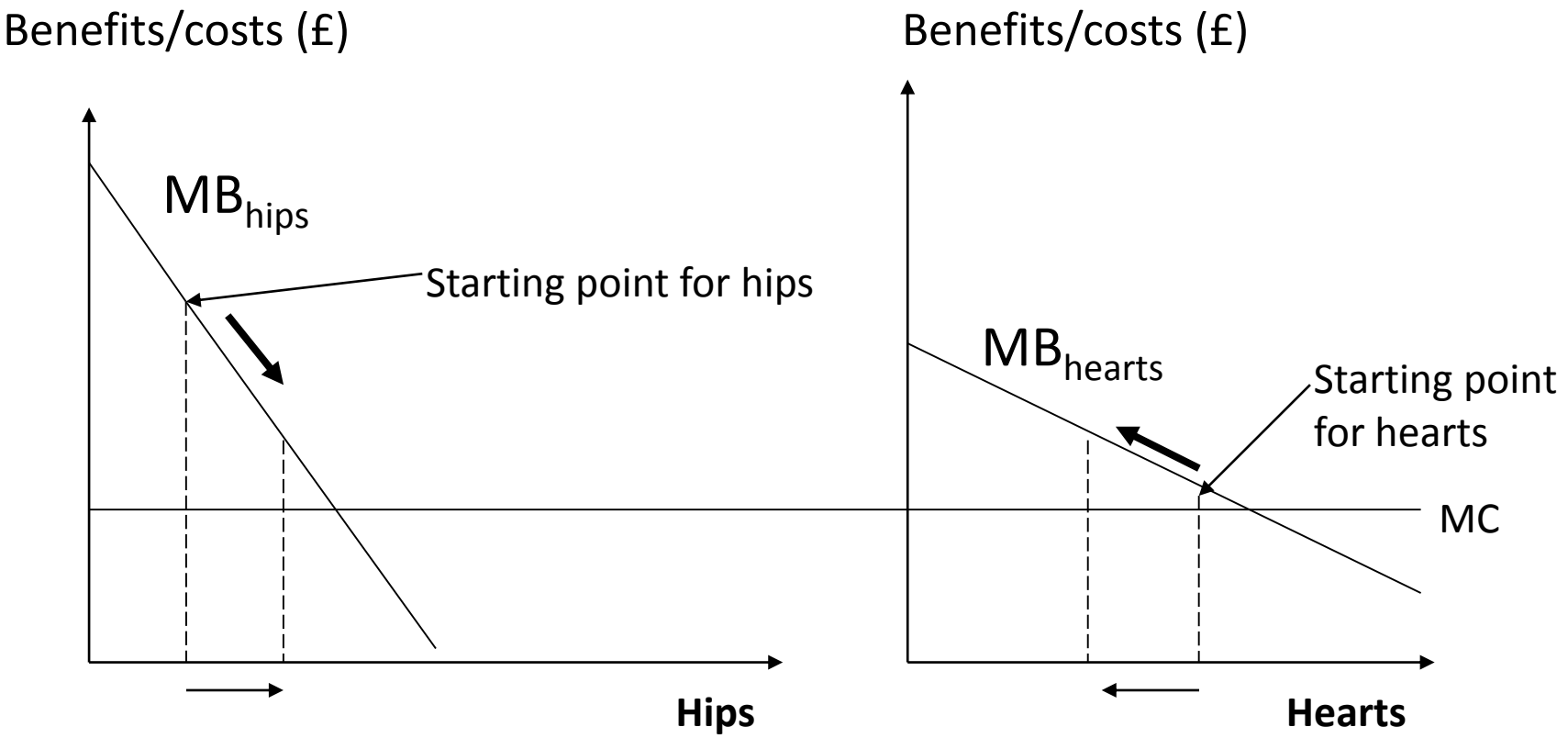
Equal marginal costs



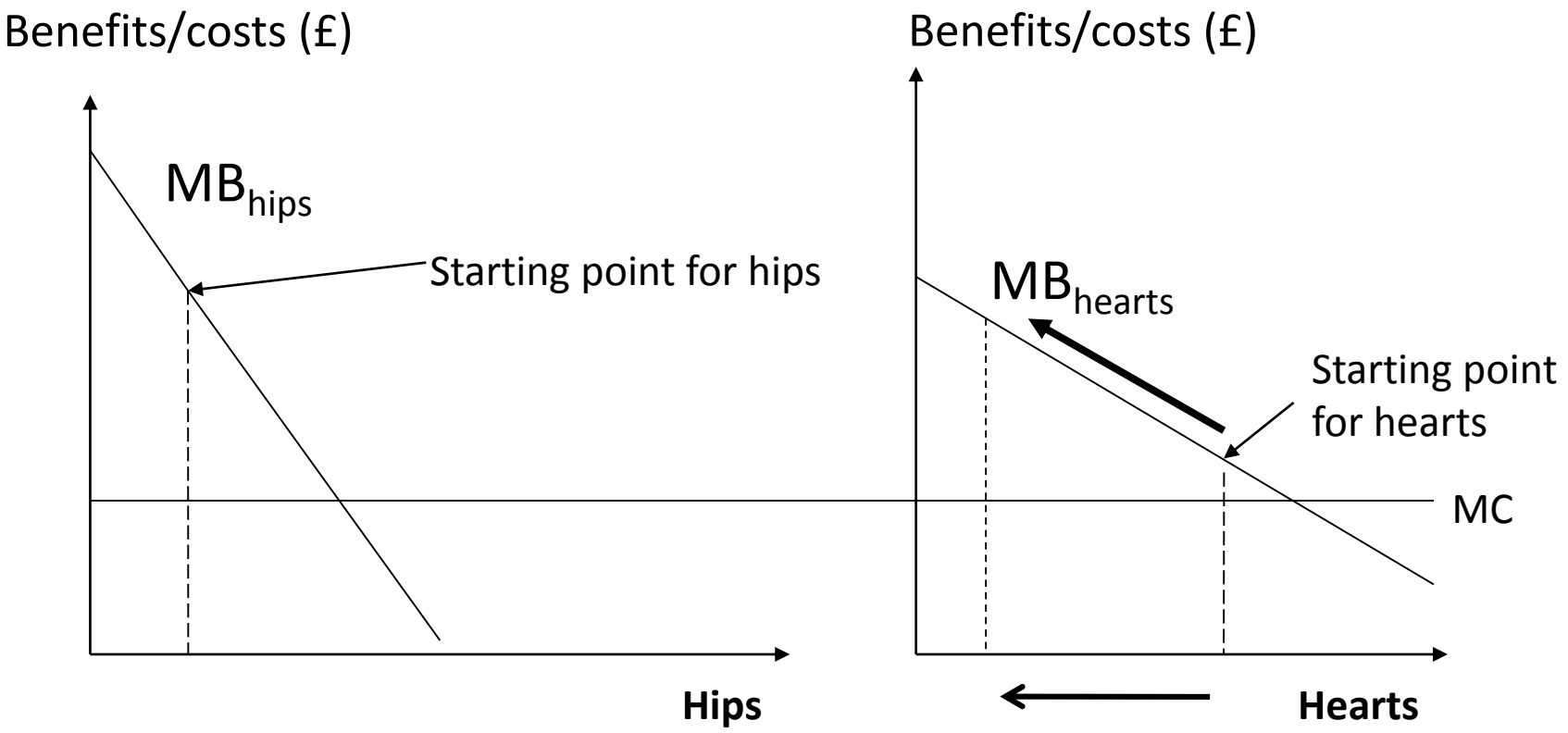
Where do we go from here?



Move resources from hearts to hibs, until ratios are equal



Rational disinvestment



Scale back hearts until MB/MC ratios are equal and then in proportion to MB/MC

Towards rational investment (and disinvestment)

Common resource allocation approaches

- history
- for disinvestment: across-the-board cuts

Rational investment (and disinvestment)

- elimination of waste and standard working
- substitution of:
    - less for more costly
    - later for now
- scale up on a greatest value basis, and scale back on a least value basis

Priority setting in total fundholding

- Nairn and Ardersier Total Fundholding Pilot Site within Highland Health Board
- Looked at chronic conditions using PBMA framework
- Combining current spending across admissions, outpatients, prescribing, consultations and tests with evidence on effective uses of resources to create more opportunities for local clinics

Scott A, Currie N and Donaldson C. *Family Practice* 1998; 15: 216-222.

Priority setting in total fundholding: views of a GP

- Clinical Decision = Purchasing Decision

  "Stress now mainly multi disciplinary teams and collaborative decisions. GPs are key players and buggeration factor if not corporate"

- GPs are well-placed to do this
  - "GP as family friend and trusted confidant with long term relationship essential for continuity of care walking financial and managerial tightrope with balancing individual care against locality/community good including value for money. Nobody else can do it!"
- Management and Finance must support and encourage GP responsibility for clinical decision
- The locality becomes the integrator for the clinical pattern/outcomes. This can be compared to current best locality outcomes and judged in value for money terms.
- PBMA says if you have a £100 you can only spend it once. Make best use of it. The best use is every patient knowing and having current best individual care plan. There will then be occasional trade offs but not many.

Who said this?

“If I had a plan, it would be simply to take the poorest and least organised hospital in London and, putting myself there, to see what I could do – not touching the Fund for years, until experience had shown how the Fund might best be available.”

A novel idea!

“If I had a plan, it would be simply to take the poorest and least organised hospital in London and, putting myself there, to see what I could do – not touching the Fund for years, until experience had shown how the Fund might best be available.”

Florence Nightingale (1857)

Important stages (and challenges)

- Define and agree decision criteria
- Criteria weighting:
    - e.g. health gain, equity, access, sustainability, fit with government strategy
- List of options for service growth and service reduction
- Process supported by business cases. These should show how each option meets the agreed decision criteria using supporting evidence and expert opinion
- Scoring options against criteria
- Scoring of options then allows for each option to be ranked according to weighted-benefit achieved for costs incurred
- This then can allow for resources to be released from the lower-ranking service reduction options to those ranked higher
- Rankings are merely the beginning of a conversation

Discussing using this in Health & Social Care Partnerships

Aims of project

- Pilot PBMA in three areas: Highland, Ayrshire & Arran, Perth & Kinross (Tayside)

- Aim of pilots
  - Establish how well PBMA can be used, to share learning with other sites and evaluate impact of PBMA
  - Can information needs be met?

- Focus on Highland pilot – working with two localities, Caithness (rural) and Inverness (urban).

Snapshot of what we have done

Workshops conducted prior to start of process:

- Outlining the key principles and stages of a PBMA process

Ten semi-structured interviews conducted prior to start of process:

- Addressing existing priority setting processes, issues and areas for improvement
- Elements in place (but nothing formal); need to broaden criteria (to reflect social care); varying views on role and quality of evidence; need staff and public buy-in; re-focus from acute

Have worked through various stages listed:

- Programme budget, yes, but still data gaps (linking data)
- Advisory panels formed: 11 (urban); 22 (rural)
- Determined (& weighted) criteria: access; equity; improved outcomes; effective practice; sustainable; culture & values
- Urban: developed business cases but focused on ‘care@home’
- Rural: struggling with disinvestments at moment
- Next: goes to board level for validation/approval; further interviews

Some concluding remarks

- Challenges abound:
  - Data linkage; involvement (GPs and public); finding evidence; time; organisational readiness, new ways of thinking?
- But:
  - Idea has been around for some while!
  - These procedures have been used here in Scotland and in "well over 150" health organisations worldwide
  - It can be used alongside other perspectives (e.g. ethics) and management activities (e.g. needs assessments, gap analyses)
- How, if at all, might this apply to you?
  - Let's discuss that!

Questions

- Does it resonate?
- Are you doing it (or some of it) already?
- What are the challenges?
- What are the alternatives?
- Does it provide other benefits?

Access

Facilitate access to health and social care services and informal support, as close as possible to where individuals are in need. Access by public transport and the local road network should be considered for those using the service and their families and/or carers. Access should be joined up, with the provision of easily accessible information and comprehensive advice for people, their families and carers to make informed decisions, promoting choice and control.

Equity

The level of care and/or support should ensure that people are treated with equity and fairness, promoting people's rights and supporting choice.

Improved outcomes

Improved outcomes for people will be achieved as a result of any changes made compared to existing practice and available services and support.

Effective practice

Establish pathways of care and support wherever possible across the services involved. There should be continuity of care and/or treatment and/or support designed to match the needs of the individuals and their carers i.e. right service, at the right time and place, provided by the right provider. Care and support should be delivered to the highest possible standards of quality and safety, with the person being at the centre of all decisions. Risks will be assessed, managed and minimised.

Sustainable

Any changes made should be able to adapt to the changing needs of the population over the longer term. Focus on effective partnership working to encourage and support personal responsibility for own health and well-being, anticipatory care and prevention. The aim is to focus on supporting recovery, re-ablement and rehabilitation alongside longer term interventions, where required.

Culture and values

The culture should continue to change and evolve to define a health and social care system based on co-production that is enabling and empowering to people. The cultural focus will be to enable people to get back to or remain in their home or community environment and that all care and support is personalised.

Criteria weighting

Instructions:

The criteria are weighted to show their relative importance compared to one another.

For each criterion agreed, we have 10 points to allocate.

As we have 6 criteria we have 60 points to allocate across all of the criteria. These points can be allocated as you feel is appropriate across all the criteria but they must sum to 60.

Example: If we have 6 criteria and you thought each should receive an equal weight, then your table would look like this.

Criteria	Weight
Criterion 1: Access	10
Criterion 2: Equity	10
Criterion 3: Improved outcomes	10
Criterion 4: Effective practice	10
Criterion 5: Sustainable	10
Criterion 6: Culture & values	10
Total	60

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Making the case for investing in prevention

Fuse event, Newcastle, 27th January 2015

Professor Brian Ferguson
Interim Director for Knowledge & Intelligence

Public Health England

A strong case

Public Health England

OECD work on health 2013-14

Obesity and the economics of prevention:

- At least one in two people is overweight or obese in more than half of OECD countries. Rates are projected to increase further. In some countries two out of three people will be obese within ten years.
- An obese person incurs 25% higher health care expenditures than a person of normal weight in any given year. Obesity is responsible for 1% to 3% of total health expenditures in most OECD countries. Obese people earn up to 18% less than non-obese people. Poorly educated women are two to three times more likely to be overweight than those with high levels of education.
- A comprehensive prevention strategy would avoid 155,000 deaths from chronic diseases in Japan each year, 75,000 in Italy, 70,000 in England, 55,000 in Mexico and 40,000 in Canada.

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CMO Report *'Our Children Deserve Better: Prevention Pays' (1)*

- **£4 trillion –** The approximate cost of a range of preventable health and social outcomes faced by children and young people over a 20-year period, according to research by Action for Children and the New Economics Foundation
- **6–10% –** The annual expected rate of return on investment to be achieved by investing in interventions early in life
- **6% –** The National Audit Office estimate of current government spending on early action, which it estimates has remained relatively static. The report concludes that 'a concerted shift away from reactive spending towards early action has the potential to result in better outcomes, reduce public spending over the long term and achieve greater value for money'

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CMO Report *'Our Children Deserve Better: Prevention Pays' (2)*

- Our analysis estimates the public sector annual costs of preterm birth to age 18 at £1.24 billion and total societal costs at £2.48 billion (including parental costs and lost productivity).
- Our analysis estimates the long-term costs of child obesity to be £588–686 million.
- Our analysis estimates the annual short-term costs of emotional, conduct and hyperkinetic disorders among children aged 5–15 to be £1.58 billion and the long-term costs to be £2.35 billion.
- A range of strongly evidence-based interventions, already recommended in National Institute for Health and Care Excellence (NICE) guidance, if implemented effectively and at scale could have a dramatic impact, improving children's lives while saving costs to the system.

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Diabetes

- Prevalence rising due to ageing population and obesity levels
- Identifying the undiagnosed population
- Good control (HbA1C etc) in primary care
- Getting people screened and achieving consistent screening rates across the country
- Avoiding hospital admissions:
  - lower limb amputations
  - sight loss
- Public Health Outcomes Framework Domain 4:
  - Proportion of Certificate of Visual Impairment registrations that are due to age related macular degeneration, glaucoma and diabetic retinopathy
- PbR system and perverse incentives

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If it was that easy……..

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So why haven't we done in it in the NHS?

- lack of incentives
  - using cost / QALY information to make what are essentially rationing decisions
- complexity of evidence
  - lack of specificity
  - confidence in economic modelling?
- requires culture change, which takes time
  - using evidence to make decisions
  - being able to take calculated risks
  - time horizons
- multiple (often conflicting) objectives
  - between sectors
  - efficiency / inequalities / equity

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A cautionary note on terminology

- Cost-effectiveness and efficiency are not the same as cost-cutting / cost savings
- Investing in prevention makes economic sense
- But will it release cash in the short term?
- Implementing interventions that are deemed cost-effective within NICE cost/QALY thresholds will not necessarily save money
  - most of the public health interventions that have been analysed are highly cost-effective
  - still a need to prioritise
- Wider approach (cost-benefit) recognising return on investment techniques is to be welcomed

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To what extent is public health ‘different’?

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Review

Methods for assessing the cost-effectiveness of public health interventions: Key challenges and recommendations

Helen Weatherly[a,*], Michael Drummond[a], Karl Claxton[a,b], Richard Cookson[c], Brian Ferguson[d], Christine Godfrey[e], Nigel Rice[a], Mark Sculpher[a], Amanda Sowden[f]

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[e] *Department of Health Sciences, University of York, United Kingdom*
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Four main methodological challenges

- Attribution of effects
  - also raises questions around the nature and strength of evidence required in public health interventions
- Measuring and valuing outcomes
  - can the QALY capture everything?
  - aggregating health and non-health outcomes
- Identifying intersectoral effects and consequences
  - expenditure in one sector reducing costs in another sector
- Incorporating equity considerations
  - distribution of benefits (eg QALYs) across population sub-groups
  - health (and income) inequalities

Lesley Owen[1], Antony Morgan[1], Alastair Fischer[1,2], Simon Ellis[1], Andrew Hoy[1], Michael P. Kelly[1]

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ABSTRACT

Background The need to make best use of limited resources in the English National Health Service is now greater than ever. This paper contributes to this endeavour by synthesizing data from cost-effectiveness evidence produced to support the development of public health guidance at the National Institute of Health and Clinical Excellence (NICE). No comprehensive list of cost-effectiveness estimates for public health interventions has previously been published in England.

Methods Cost-effectiveness estimates using English cost data were collected and analysed from 21 (of 26) economic analyses underpinning public health guidance published by NICE between 2006 and 2010.

Results Two hundred base-case cost-effectiveness estimates were analysed, 15% were cost saving (i.e. the intervention was more effective and cheaper than comparator). Eighty-five per cent were cost-effective at a threshold of £20 000 per quality-adjusted life year and 89% at the higher threshold of £30 000. A further 5.5% were above £30 000 and 5.5% of the interventions were dominated (i.e. the intervention was more costly and less effective than comparator).

Conclusions The majority of public health interventions assessed are highly cost-effective. The next challenge is to provide commissioners with a framework that allows information from economic analyses to be combined with other criteria that supports making better investment decisions at a local level.

Keywords economics, public health, research

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The NHS has a strong role to play in prevention

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Working with the NHS

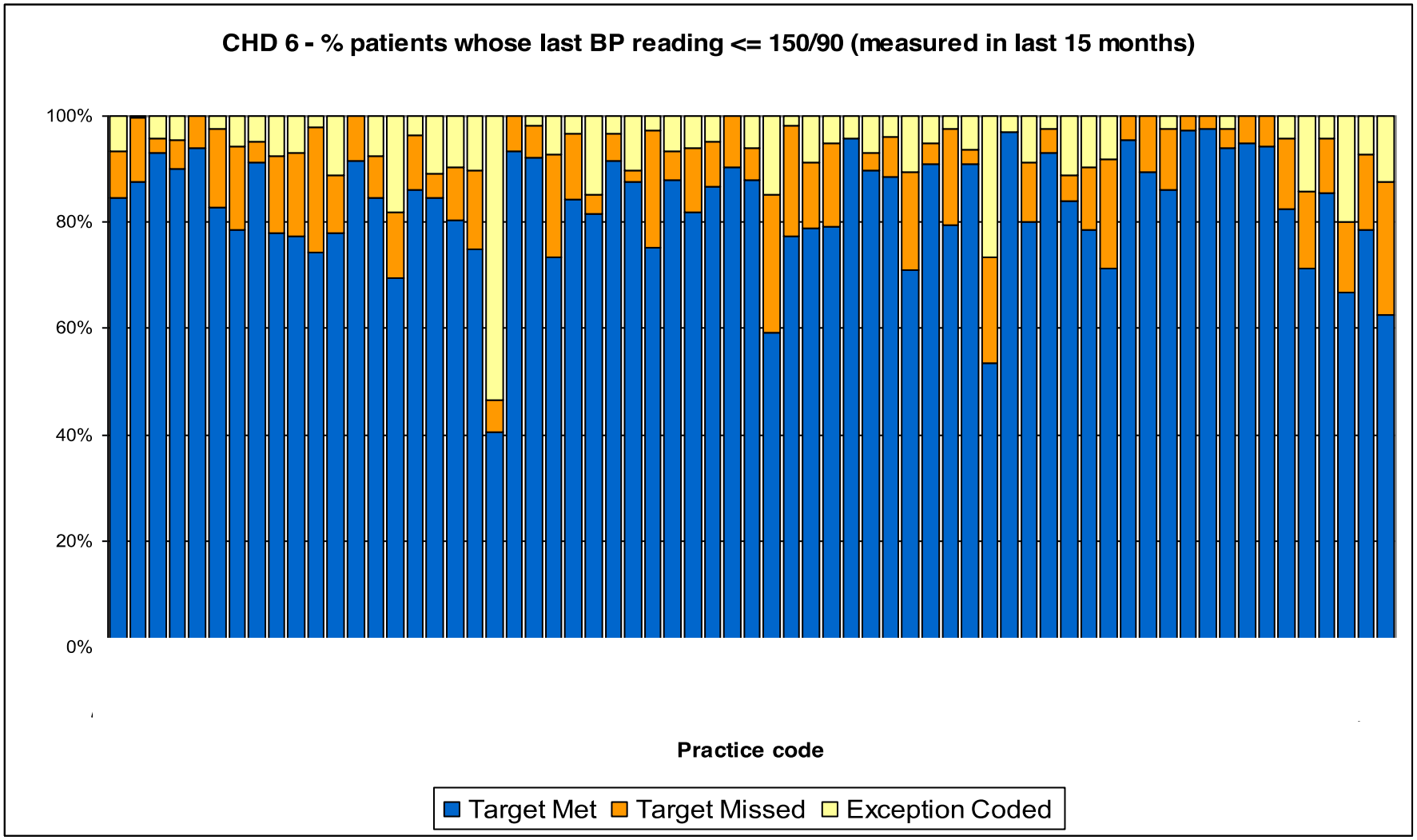
- Investing in primary prevention
  - tackling obesity, alcohol and the wider determinants

- Systematic, at scale secondary prevention
  - tackling unwarranted variation
  - doing what we know works

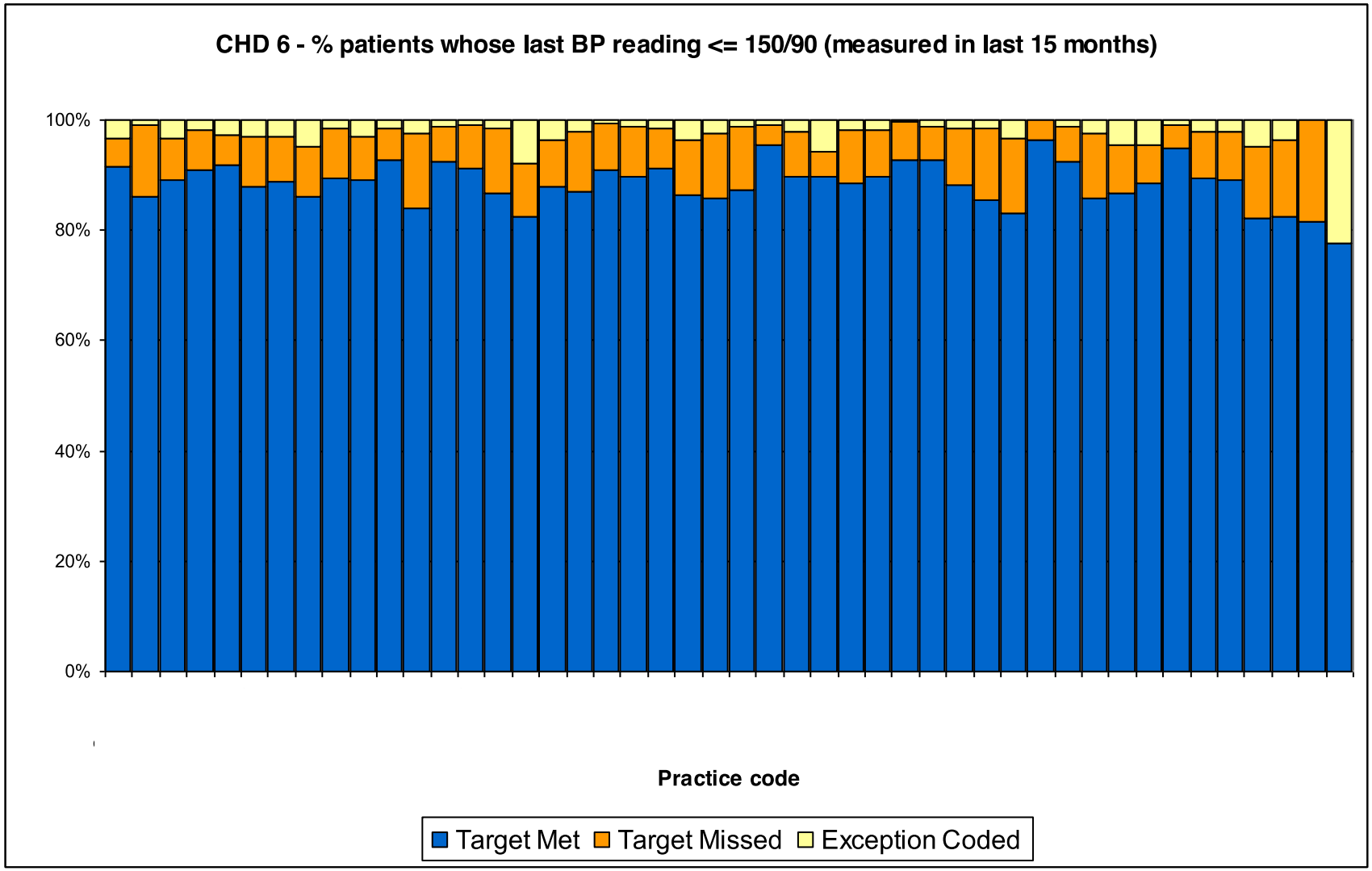
- ‘Investing’ in prevention does not always need money: it needs energy to be focused in the right areas

- Next 2 slides courtesy of Chris Bentley who led the National health Inequalities Support Team……

An Unsystematic PCT



A High Performance PCT



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So what is needed?

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Knowledge & intelligence skills

- knowledge management expertise to:
  - synthesise data and evidence to create timely health intelligence
- business cases for public health investment (identifying value gained from resources invested)
- a ‘common currency’ for assessing impact of health & well-being
- identifying the impact of cost-effective interventions on health inequalities
- more focus on quality and outcomes data
- presenting intelligence effectively to different audiences
- knowledge transfer skills to make a difference to care / service delivery

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The right supporting environment

- alignment of incentives
  - conflict between ‘Payment by Results’ in the hospital sector while we encourage more preventative care to keep people out of hospital
  - health and social care working together (avoiding cost-shifting)
- realistic time horizons
  - recognising the need for short-term changes without losing focus on longer-term wider determinants
- real public engagement in debates about prioritisation
  - “It is disappointing that so few boards identified public engagement as a priority, and there is no evidence of boards being creative in reaching out to local communities through, for example, social media” (King’s Fund report on H&WBs, Oct ‘13)
- permission to be bold about (dis)investment decisions

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Identifying cost-effective interventions

- In areas where ROI tools have been developed by NICE:
- Identify cost-effective interventions that can be implemented at different levels of the system, e.g.
  - at national level
  - brief interventions in primary care
  - making use of local authority powers
- Identify barriers to implementation (draw upon SPHR ‘shifting the gravity of spending’ project)
- Identify incentives and levers available to help local implementation
- Training people to use tools to help local systems to interpret and prioritise

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Example: NICE guidance on alcohol-use disorders (preventing harmful drinking)

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The wider effects of alcohol misuse

"Alcohol causes long-term ill-health, but even a single binge can end in hospital: in Britain, for example, such admissions doubled in 2003-10. It is not only drunks who suffer from their excess. Booze contributes to a third of all deaths on Europe's roads each year and stokes abuse and violence. It features in almost all public-order offences in Ireland; up to 80% of Australian police work is alcohol- and drug-related; across the European Union, it is linked to 65% of domestic violence and 40% of murders. When lower output and higher social costs are taken into account, alcohol costs Europe and America hundreds of billions a year, up to 1.5% of GDP by some estimates."

The Economist 21st December 2013

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NICE guidance (2010)

- Combination of population and individual approaches required
- Evidence suggests that policy change likely to be more cost-effective than actions taken by local health professionals
- Structured recommendations for policy:
  - price
  - availability
  - marketing

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Pricing

- Current excise duty varies for different alcoholic products
- Duty does not necessarily relate directly to the amount of alcohol in the product
- Increases in duty may or may not follow through to increases in price if producers or retailers absorb the cost
- Australian study – Sharma *et al*. (2014):
  - estimated effect on alcohol consumption from implementing MUP vs a uniform volumetric tax (i.e. tax according to alcohol content)
  - both MUP and uniform volumetrix tax have potential to reduce heavy consumption without adversely affecting light and moderate consumers
  - MUP offers potential to achieve greater reductions in heavy consumption, and at a lower annual cost to consumers

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Availability (NICE policy recommendations)

- Consider revising legislation on licensing to ensure that:
  - protection of the public's health is one of its objectives (as in Scotland)
  - health bodies are responsible bodies (Licensing Act 2003 – includes police, child protection services and trading standards)
  - licensing departments can take into account the links between availability and alcohol-related harm when considering applications
  - immediate sanctions can be imposed on premises in breach of their licence (following review proceedings)
- Consider reducing personal import allowances to support the introduction of a minimum price per unit of alcohol

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Alcohol example - summary

- Action needed at all levels of the system (including individual responsibility)
- Scope to consider national policy changes – though the economics of this is complex and under debate
- Local government has some levers at its disposal
- Some NHS interventions are cost-effective
- Need to consider costs, benefits and risks beyond the health and care sectors
- Tools and resources to identify scale of problems locally (e.g. local authority alcohol profiles)

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Some wider tools to help at system level:

SPOT
Commissioning for Value
ROI work with NICE

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Spend & Outcome Tool (SPOT) for Local Government

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Spend & Outcome Tool (SPOT)

- Has been produced for several years now for the NHS (previously at PCT, now CCG, level)
- Essential starting point to know where to look further at areas of (e.g.) high spend / poor outcome
- Could we develop a similar tool for local government?
- We all know that transport, education and housing contribute to health and wellbeing – can we start to look at those using a common framework?
- And look at the NHS-facing information alongside the local government information – single conversation within Health & Wellbeing Boards

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Sta cy

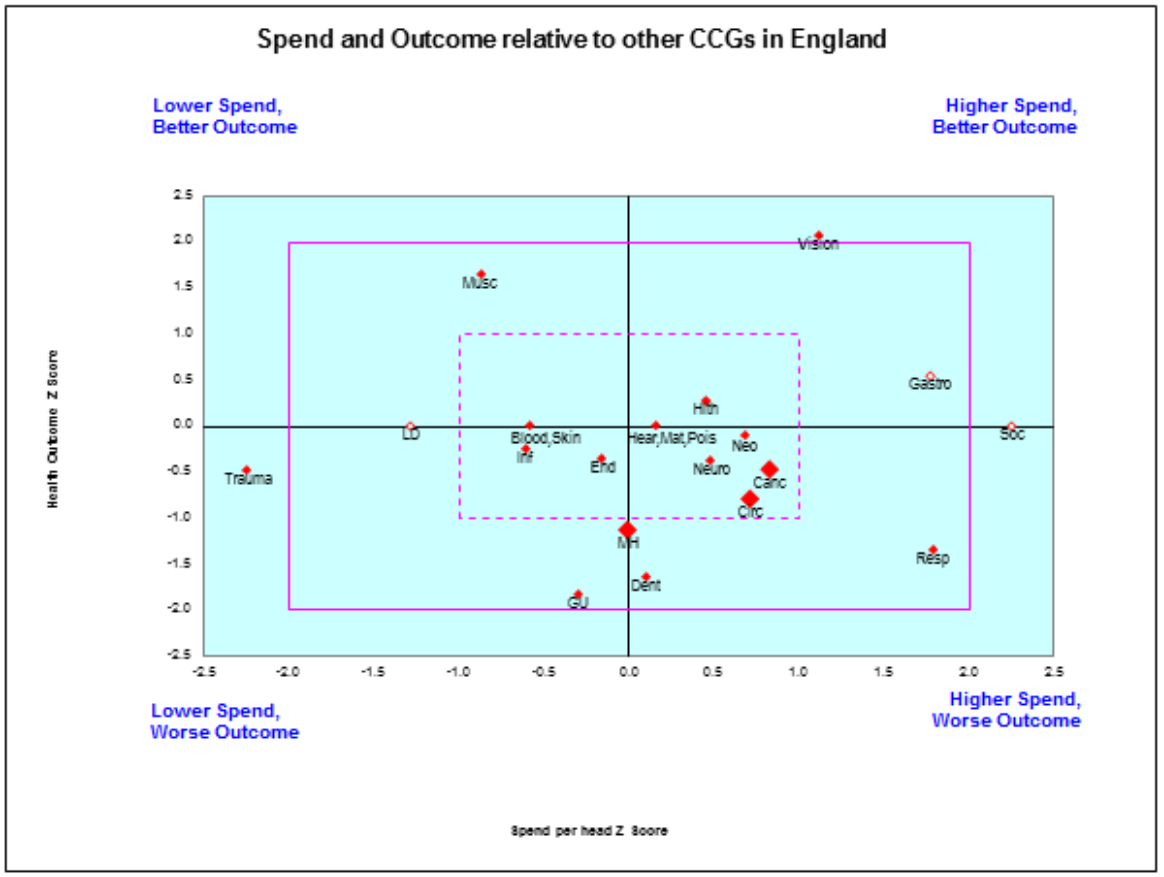
YHPHO YORKSHIRE & HUMBER PUBLIC HEALTH OBSERVATORY

RightCare

NHS Commissioning Board A special health authority

NHS North East Lincolnshire CCG 2010/11

Spend and Outcome relative to other CCGs in England



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Background

- The Spend and Outcome Tool (SPOT) gives local authorities in England an overview of spend and outcomes across key areas of business including public health and its sub-programmes
- The tool helps local areas to understand the overall relationship between spend and outcomes, by identifying areas of significant variance which are likely to require more in-depth analysis
- SPOT includes a large number of measures of spend and outcome from several different frameworks
- Spend data has been gathered from the Department of Communities and Local Government (DCLG) for top-tier local authorities
- A number of different benchmarking groups are used to provide a range of peer comparisons
- To adjust for non-optimal distributions of the underlying data, values are modified through a transformation and z-scoring process

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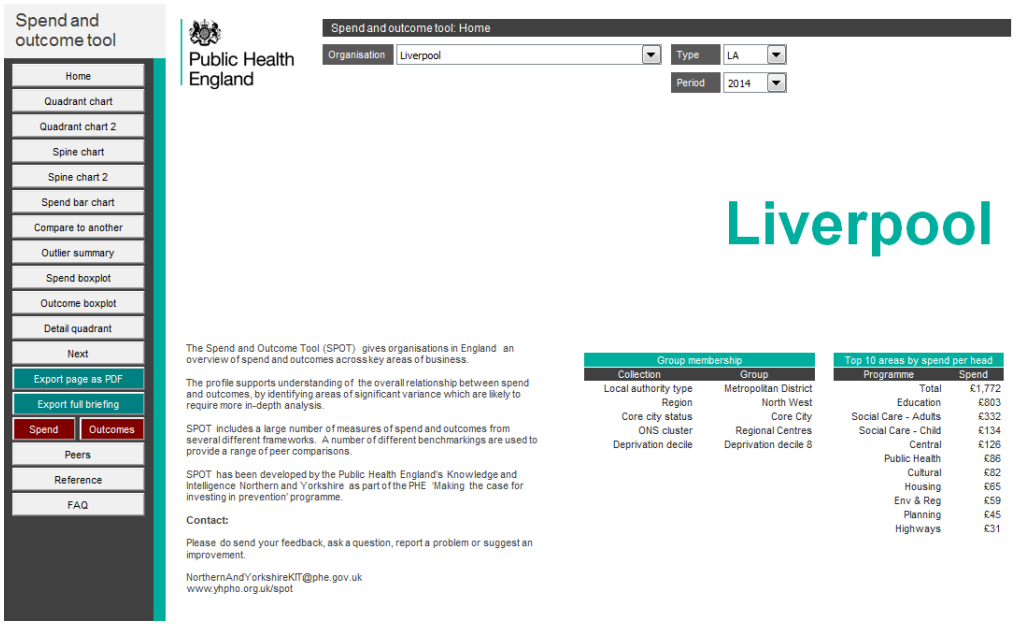
Home Screen

- On the left, there is a vertical menu which contains your main navigation controls.
- At the top is a dropdown menu that contains a list of available organisations.
- Future versions will have the ability to change the time period to switch between Local Authority and CCG geographies.



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Programme Quadrant Chart

- Shows how all programme budgets in your chosen organisation perform against the respective national averages, using modified z-scores plotted on axes.
- Spend plotted on the horizontal, outcome on the vertical.
- Can be viewed with weighted analysis (multiple outcome measures) or unweighted (single relevant outcome measures).

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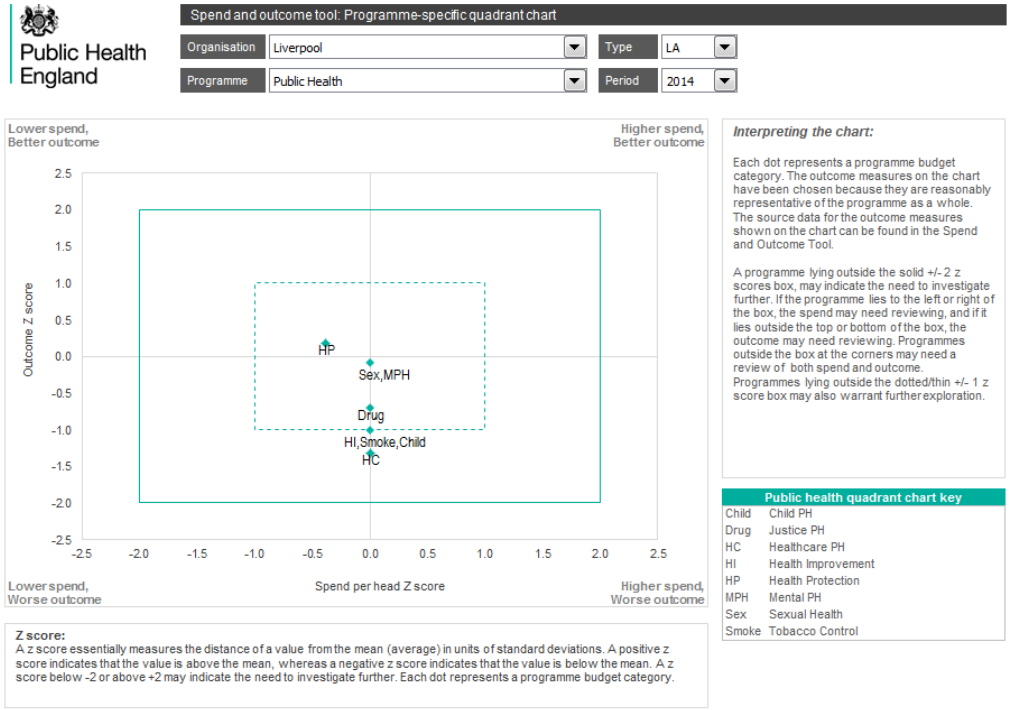
Sub-programme Quadrant Chart

- SPOT can also display quadrant charts for the contributory sub-programmes.
- In this example, sub-programmes in Public Health are displayed.
- From here, you can assess how your chosen programme's constituent parts perform against national comparators using the same method.



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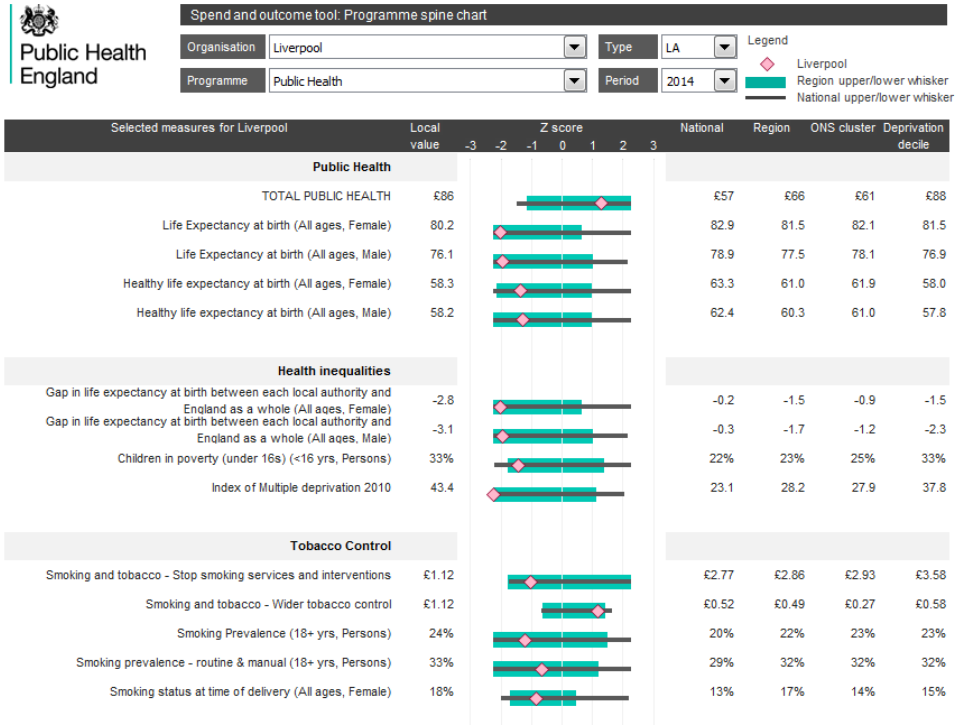
Spine Charts

- SPOT provides dynamic spine charts for both high-level programme budgets and Public Health's specific programme budget.
- These spines cover expenditure and associated outcomes.
- In these spine charts, the diamond represents the LA value, the black whisker represents range of scores nationally and the green bar represents the range of scores within the geographical region.



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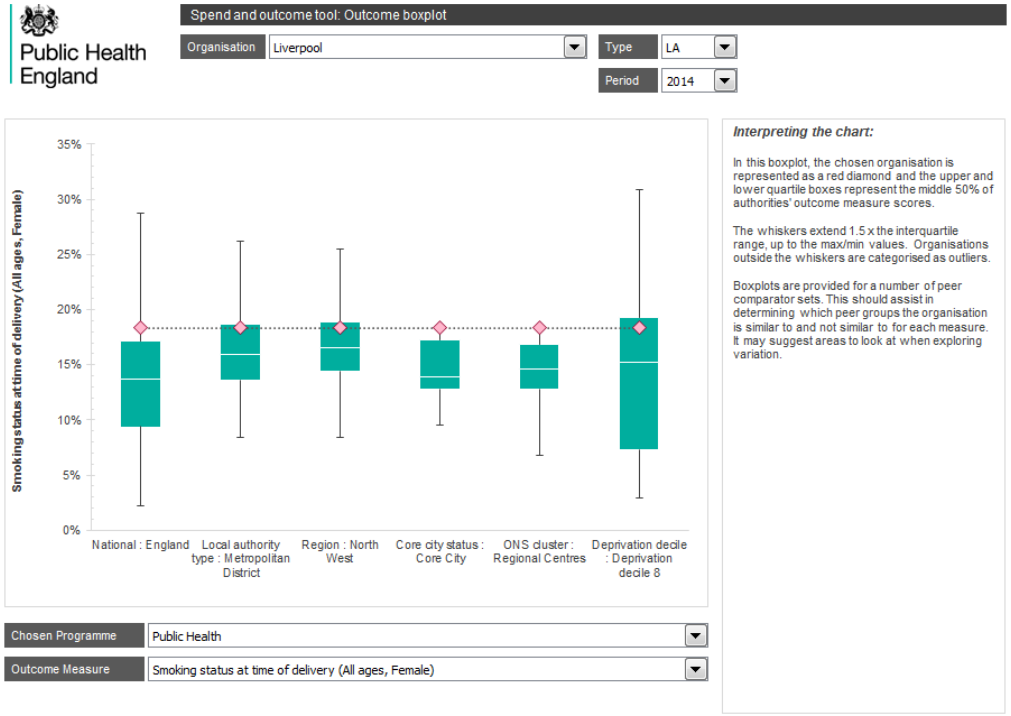
Boxplots

- The boxplots are non-parametric displays of the actual (raw) data behind both outcome and spend.
- The chosen organisation is denoted by the red diamond.
- Boxplots are provided for a number of peer comparator sets, suggesting areas to look at when exploring variation.
- On the spend boxplot, sub-programme expenditure can also be displayed.



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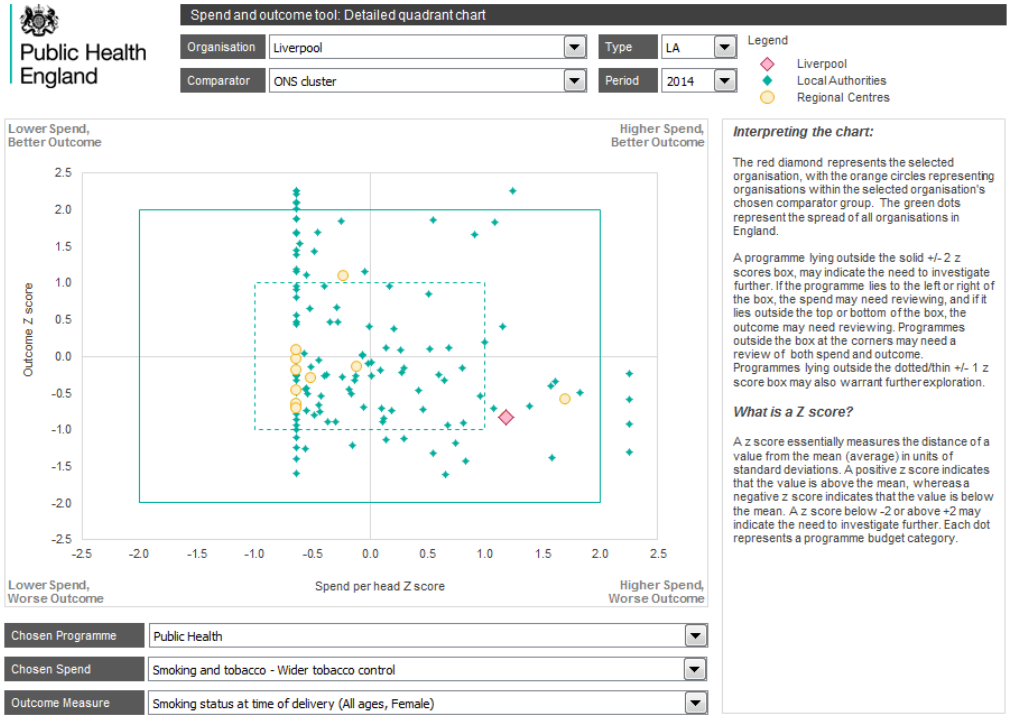
Customised Detail Quadrants

- Users can drill down into specific programmes and sub-programmes, and create quadrant analyses on-the-fly by assigning relevant outcomes.
- In this example, Public Health's expenditure on wider tobacco control is being compared against maternal smoking prevalence, with its ONS cluster comparators highlighted.



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Other Features

- For your convenience, SPOT will also output a list of all measures – both spend and outcomes – where it considers the chosen organisation as an outlier, or where there is insufficient data to make that judgement
- All outputs can be customised and are exportable as PDFs
- Full access to raw and processed data for end-user analysis
- Public Health spine chart has been updated to incorporate all the PHOF measures that local authorities might choose as options for the Health Premium
- *Latest:*
  - *releasing version with CCG and LA data in same tool*
  - *updating with outturn spend data for 2013-14*

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Availability

- SPOT is available online as both an interactive Excel tool and organisation-level PDF briefings
- The PDF profiles are a good place to start your exploration of the SPOT tool
- 10-minute video taking users through main outputs of the tool
- SPOT resources can be found at: www.yhpho.org.uk/spot
- It has been tested on Excel 2007-2013 in both Windows 7 and Windows 8 environments. It will not run on Mac. Linux installations running Excel under WINE cannot be guaranteed to run correctly.

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Help needed

- We piloted with NICE's Local Government Reference Group and a range of individuals and partners
- Initial feedback very good
- Data will improve with use
- We want to improve the outcome measures in the non-public health programmes – have we got the right indicators and can we add others?

All feedback welcome to:

brian.ferguson@phe.gov.uk or sue.baughan@phe.gov.uk

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RightCare

NHS England

NHS Barking and Dagenham CCG

Commissioning for Value insight pack

October 2013

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England Gateway ref: 00525

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Commissioning for Value packs

A partnership programme of work

Insight packs produced in October 2013 for every CCG

Look at spend, drivers of spend and quality and quality for the top 10 (by value) programme budget categories

Highlight opportunities for primary and secondary preventative measures

http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

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Focus packs for cardiovascular disease

Focus packs for cardiovascular available from National Cardiovascular Intelligence Network (NCVIN):

http://www.yhpho.org.uk/default.aspx?RID=199884

CCG level packs which show opportunities for improving quality and efficiency along the CVD pathway

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Commissioning for Value – coming soon

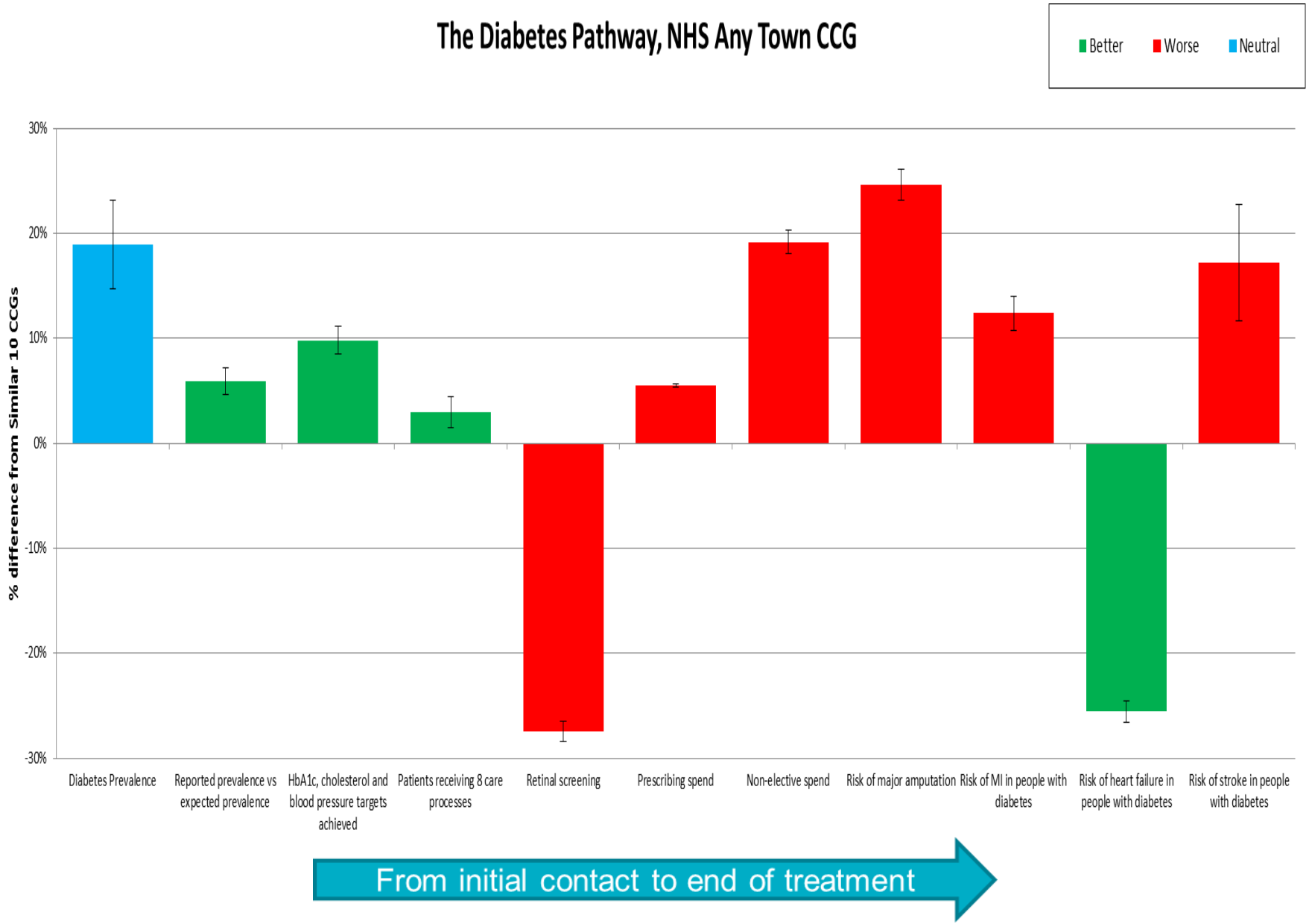
Following on from the Insight packs (October 2013) each CCG will receive a ‘pathway on a page’ for every programme which offered an opportunity for improvement – November 2014

Integrated care pack – February 2015:

- Top 2% of admissions
- Focus on the patient not the condition
- Complex patients with multiple admissions for multiple conditions
- Focus also on mental health and children’s pathways

Compendium atlas of variation – March 2015

The Diabetes Pathway, NHS Any Town CCG



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Return on Investment (ROI) work

Jointly with NICE and other partners

Focusing on NICE's initial ROI tools in tobacco control, alcohol and physical activity

Developing training and the concept of 'super users' in PHE's distributed Knowledge & Intelligence Teams (KITs)

- piloted in Northern and Yorkshire
- currently creating a network of super-users across the KITs

Currently commissioning a short-term piece of work aimed at summarising ROI measures and cost-effectiveness evidence in selected priority areas (supporting five of PHE's main priority areas)

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And finally…. (published March 2014)

Project CPB 6: investing in prevention
Approaches to prioritisation in local authorities and the NHS

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Summary

- Identifying health and well-being outcomes across areas of local government expenditure
- The time horizon dilemma
- Getting incentives right and aligning them across different parts of the system
- NHS and public health system working together on the investing in prevention agenda
- Signposting and help to use existing health intelligence tools
- Linking baseline analysis to cost-effective interventions
- Identifying the costs, benefits and risks of *disinvestment* as well as ROI
- Do we need a QALY equivalent for local government?

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Thank you for your attention

Quarterly Research Meeting – Summary Report

Managing the public health spend:
the value of health economics for priority setting
Tuesday 27th January 2015 – 12:30-16:00

Research Beehive, Newcastle University

Introduction

This report summarises the keynote speaker's presentations and the concluding panel discussion session at the January Quarterly Research Meeting held on the topic of "NHS Health Checks: making inequalities better or worse. This summary report is to be read in conjunction with the slide sets used for two of the presentations, also on the Fuse website. The slides are cross-referenced in the summary account, below.

Health Economics: the potential contribution to priority setting: Cam Donaldson, Yunus Chair in Social Business & Health, Glasgow Caledonian University

Professor Donaldson began the presentation by indicating that the management of scarcity is a basic premise for health economics, and that even in a situation of abundance this will still apply. Integration of organisations will not of itself solve resource scarcity issues, (see slide 2, and also slide 3 for an outline of the whole presentation.) Health care reform is something which is always under discussion and phrases are used which really need to be explored and tested to establish what process is implied behind the statement. Slides 4-14 build up the picture, as follows:

The statement	The economist's question
We are going to adopt a balance of care model It's going to be about effectiveness and efficiency	OK, what process of decision making results from these two concepts?
We are going to focus on outcomes and take an evidence based approach We are going to involve front line staff	OK, what is the process into which an outcomes focus and staff engagement will be fed?
We are going to examine how we are using resources and how we can use them differently	Music to the health economist's ears…..But why then do we need health economists in the first place? …and… Have we decided on a process for doing this?

Continuous reform, which has been a feature of the NHS creates new entities which always have resource scarcity issues.

Two principles were defined – opportunity cost (the loss of resources which could be used for one purpose when used for another) and the margin (the extra cost/benefit associated with one more unit of production), see Slide 15. This can also apply to reductions in production. In essence, the central issue is about making a change, if the change is beneficial, is should be done (expanded on in Slide 16, headed, "Marginal analysis"). An example of screening for cancer of the colon was used. In the USA in the 1970s, six levels of tests were set up designed to find cases of colon cancer. The results were reported in the New England Journal of Medicine. As each of the six tests is used additional cases are found until a clinical ideal is reached, but at the same time the cost of the tests is progressively increasing, (see Slide 17 for the outline of the tests and Slide 18 for the costs compared with the number of cases found). At first glance this looks like a good buy, including and up to the sixth level of testing (see Slide 18) but when the additional cases detected at each level are highlighted, the additional value of later tests in the series starts to look like very poor value because of the few cases identified (see Slide 19). When a finding like this emerges it raises the question of whether funds might be better spent elsewhere on either a different cancer or maybe another condition – and the implications of this are described in Slide 20.

Programme Budgeting and Marginal Analysis (PBMA) is a technique for working through questions connected with matching resources to need, so that as much need as possible is met. The process can be described in five questions as set out on Slide 21, which also states that PBMA can be used at macro and micro level. A useful publication (entitled "Priority setting toolkit") to assist with the process was published by Mitton and Donaldson (2004) and the cover is this is shown in Slide 22. Project management of PBMA involves ten steps as listed in Slide 23 and was also described in a BMJ article "Rational Disinvestment" shown in Slide 24. The remainder of the presentation considered an example through a series of diagrams, summarised in the next paragraph.

Two programmes were posited, one for hearts and one for hips. Two charts represent these treatment programmes where the X axis is the number of cases treated and the Y axis is the benefit and cost of the treatments, see Slide 25. The aim would be to treat those patients with most to gain first, and as a result a downward slope emerges on the charts for hearts and hips, going down as patients with less to gain from the procedure are treated, see Slides 26 and 27. In the example the marginal costs is assumed to be the same, represented by a horizontal line cutting through the slope or curve as it is known technically, see Slide 28. After putting in the marginal costs line a smaller gap arises on the chart for hearts, when compared with hips and the idea would be to transfer the financial allocation from hearts to hips until the ratios were equal, see Slides 29-31. This same way of thinking can be used in disinvestment, as opposed to investment used in the hearts and hips example. Slide 32 contrasts common resource allocation approaches (based either on historical allocations or 'across-the-board' cuts) with a rational investment or disinvestment method, which offers an alternative. A real example was described which dated back to the days of total fundholding for the purchase of health care by GP practices. In the example shown the fundholder approached the health economics unit in Aberdeen University to help develop a process for resource allocation, see Slide 33. The views of a GP involved in the project are encapsulated in Slide 34 and Professor Donaldson brought out the multi-disciplinary dimension to the decision taking process. Back in 1857, Florence Nightingale espoused

views that would have made her a supporter of PBMA in the modern era, see Slides 35 and 36.

The stages involved in a PBMA process are listed on Slide 37. The comment was made that these appear to be onerous because "they are not what managers do as a rule". However, on closer inspection it may be that some of the stages, like, for example identifying options and ranking them may already have been tackled through day to day business. Ranking is an important foundational activity, but it can only be the start of a conversation, which might need to be conducted across a partnership. Slide 38 sets out the aims of a PBMA pilot in three areas in Scotland. Slide 39 gives a snapshot view of work done and contrasts initial findings between rural and urban areas, for example concerning the number of panels set up and the impact of governance different processes on pace and scope. The topic that the pilots were trying to address concerned care for older people. Slide 40 draws together some conclusions, and, when addressing these Professor Donaldson stressed that there were lots of challenges, but that the procedures have nonetheless used in 150+ organisations worldwide. The issue was the extent to which the audience felt that they applied to their situation. A number of questions were posed in the concluding slide, 41.

Discussion following Professor Donaldson's presentation

The discussion immediately following the above presentation drew out these main points:

- Relative to health and social care, health economics has not been widely applied in public health. This may be due to the broad scope of public health and also that it is still fairly new as a discipline to local government.
- The availability of relevant data to the issue being considered for PBMA can be significant. Behind this is a more philosophical issue about how comfortable the parties are with, for example, a lack of data.
- Embedding a health economist with an organisation was discussed. This can be useful in encouraging participation from the host organisation. Starting with simpler processes to get people involved can be a good beginning. An audience member described this as being "fast and frugal".
- There was a short debate about why PBMA had not 'taken off'. It was noted that PBMA was responsive to incentives, when record resources were being put into the NHS there was relatively little interest, but once scarcity set in there was an upsurge of interest in PBMA.
- There was a discussion on values and theoretical principles and the alignment between these two.

Making the case for Investing in Prevention: Professor Brian Ferguson, Interim Director for Knowledge & Intelligence (England) Public Health England (PHE)

Professor Ferguson began his presentation by stating that he had been asked to lead on health economics across PHE, and described this as "exciting but daunting". The strengths of health economics were in 'framing and shaping' problems, and being a decision-making aid although not providing all the answers. In his experience the biggest ask from local government was for help from health economists. There is scope for action on health issues outside the envelope of the public health grant. Some examples:

- Obesity – the wider costs to the economy of obesity were illustrated. The Chief Medical Officer's report on children highlighted significant potential return on investment form interventions in the early years (see Slides 3, 4 and 5)
- Diabetes prevention is a 'very live' issue and there are considerable benefits to be gained. An unintended incentive is evident in the payments to hospitals for (eg) lower limb amputations, when in fact prevention to ensure that such operations are not needed should be the priority (see Slide 6)
- There were large increases in health funding in the 2000s but this did not lead to a big shift of work to primary and community care despite there being a real need to move genuinely to prevention.

Why haven't these changes happened? The standard answer is that it is to do with culture and this is critical. As NHS Chief Executives generally have just two years in post, there is no incentive to make long term decisions, for example, about childhood obesity. The tools exist but it has never been easy politically to make the right decision. Initiatives like QIPP (Quality, Innovation, Productivity and Prevention) in effect became cost-cutting activities, (see Slide 8)

Four main methodological challenges were identified:

- Attributing effects
- Can QALY's capture everything?
- Identifying inter-sectoral effects and consequences – and considering how to respond to these especially when the sector that benefits is separate from the sector originating the measure.
- Incorporating equity considerations, for example, where QALYs are distributed unequally

See Slide 12 for an expansion of the above points.

An intervention may be cost-effective but that doesn't negate the need for prioritisation across interventions. Another issue is the monetary threshold for cost-effectiveness in public health, for example should this be the same as the NICE threshold of around £20,000 cost per QALY?

The NHS also has a role in prevention, not just PHE. Professor Ferguson referred to the work undertaken under the leadership of Professor Chris Bentley who looked at the importance of systematically scaling up interventions across the board, such as blood pressure measurements across the entire (then) primary care trust as opposed to being done patchily by a few practitioners, (see examples in Slides 16 and 17 of different performance in two PCTs). The right environment to be able to take and implement these kind of decisions needs to be in place (see Slide 20). Public engagement is one of the biggest challenges and this is an area where local government has a potential advantage given its local democratic accountability. In fact the public do understand the need for difficult prioritisation decisions. PHE is now using return on investment (ROI) tools developed by NICE, to identify cost-effective interventions that can be used at different levels. The scope for action is considerable in areas such as alcohol (see Slide 23), where NICE guidance has highlighted the need for national action (eg on pricing and availability) in

conjunction with the use of local Licensing Act powers and brief interventions in the NHS (see Slides 24-26).

The SPOT (Spend and Outcome Tool) was mentioned (see Slide 30). This was developed for the NHS but has potential too in local government, because it is a simple tool comparing level of spend with the value of the outcome. The tool leads to the creation of charts that can provide a visual outcome and comparative information that enables comparisons to be made with equivalent, peer authorities. It puts Clinical Commissioning Group (CCG) and local authority information in one place, to compare, for example, ICD data and area of local government spend (examples of charts are shown in Slides 31, and 33-38). The SPOT tools for both NHS and local government are publicly available on the legacy YHPHO website prior to migration to the '.gov.uk' site in due course (see Slide 40).

Another useful information source are the "Commissioning for Value" packs produced for each CCG in 2013, with some subsequent work focusing on themes such as CVD (see Slides 42 onwards). One useful diagram was a (clinical) pathway on a page that showed a set of relevant measures for each pathway (see Slide 46).

In the concluding part of his presentation, Professor Ferguson returned to the topic of ROI (see Slide 47). Operating this approach is not easy to do technically, so 'super users' are being trained, who have real in-depth knowledge and competence. Work is underway to summarise cost-effectiveness / ROI information in five of PHE's priority areas: alcohol, smoking, dementia, early years and obesity. Professor Ferguson also highlighted a PHE publication in March 2014 entitled, "Approaches to prioritisation in local government and the NHS" (cover page shown on Slide 48). It is important to have a common language to identify outcomes and it would be good to have that common language spread across the NHS and local government, to work on the investing in prevention agenda. Professor Ferguson concluded with the question whether we need the equivalent of a QALY for local government? (see Slide 49 for concluding summary points)

Experience and Reflections of Priority Setting in Practice: Mrs Marietta Evans, Director of Public Health, North Tyneside Council

Mrs Evans began her talk by reminding the audience that she was Director of Public Health (DPH) for the area of North Tyneside, not the Council alone. The move of Public Health as a function from the NHS to local authorities presented an opportunity as there was the potential for a wider focus on inequalities and wider determinants of health. However, the new statutory responsibilities for public health within local government did not always protect funding. A lot of time had had to be invested in developing working relationships with Councillors, officers and individuals critical within the organisation in terms of their influence. Another change had come about following the demise of Local Area Agreements (LAAs). When LAAs were in place, there was a lot of scrutiny and performance management within local authorities, which had now diminished and one consequence was that a lack of targets can take out levers for discussion and change. The emphasis now was much more on service improvement and efficiencies. .

When Public Health first moved into the local authority it was clear that the allocation of the budget needed reviewing because of historically low expenditure by the NHS and inherited contracts. During the Autumn of 2012 as a result of seeing information about the "Shifting the Gravity of Spending" Fuse project, contact was made with the research team on behalf of the Health & Well-being Board. A major workshop followed led by Luke Vale *[title to add]* on health economics tools. As a result of the ensuing discussion, it was decided to use a matrix based on the Portsmouth score card. Essentially, the Board wanted a basic tool, because historical allocations were inadequate to the task, especially in relation to low spending in some areas, such as mental health. Several months of work followed, working on a draft framework and weighting. Over this period there were personnel changes which had to be accommodated. This led to a final workshop at the end of the process. This included a revisiting of criteria and challenge to those on the day, which was a useful process. The framework was tested on some services, and it became clear that it was most useful if applied by people who really knew the service in question well.

One conclusion emerging was that there was a need to prioritise the whole budget not just a service or services. Another key factor has been the provision of sufficient evidence for outcomes. Some results have been seen, in terms of investment in public health on a wider base, for example, remodelling sport and leisure funding to move from attracting people to buy membership for sports centres to working on inequalities in the uptake of physical activity.

Panel Discussion
The following issues were raised and debated:

Inter-sectoral benefits: A debate took place about the complexities of dealing with a situation where the benefits of action in one area, for example, housing would actually be felt elsewhere, such as health, for example if there was a successful intervention reducing falls. It was noted that it would be important to pre-empt the arguments, to get commissioners like Clinical Commissioning Groups on board and exploit joint funding. The point was made that benefits to social care could be brought out and would be significant to Councils. Profiles published by PHE were referred to as a good source of evidence. The Director of Public Health for Wigan had used the SPOT tool for fuel poverty work. Net present value was suggested as a useful common currency understood in local government. Integrated budgets would be useful so that one conversation could take place rather than multiple discussions.

Can PBMA be done without health economists? It was suggested that technical support would be needed, especially as local government has very small teams. It was suggested that outside help was a good mechanism for keeping people on board with the process. Whilst public health specialists received training in economics, managers and other clinicians did not, which indicated that training for a wider group would be helpful. A comment was made that Clinical Networks work with an academic base and that this model could be replicated as a model for health economics too. Chief Executives need to be informed, defining outcomes is a good start and implementation is actually the key, not getting the evidence as such.

NICE threshold for QALYs (quality adjusted life years): The monetary threshold for QALYs (ie; the value per QALY) was discussed, noting the anomalies caused by having a separate cancer drugs fund, albeit that the latter is very important politically because of the profile of cancer. The discussion reinforced the importance of having a systematic approach to prioritisation at a local level.

Who really influences public engagement? Health & Well Being Boards were a new construct around which to frame public engagement. Some GPs continue to focus on treatment rather than prevention and prevention has to move more comprehensively into primary care. Whilst the climate is one of a provider driven budget, it had been a good thing that the local authorities have reviewed the whole of their public health budget. Diabetes will act as a 'test case' for the move towards greater self-care. One factor to be cognisant of is that whilst there is a rhetoric around prevention, communities actually have a different idea of what the health issues are, and that's the starting point. Community development suffered a dip but is now recovering and helping people to help themselves. The public do understand the concept of rationing but politicians shy away from it.

The NHS is good, but unfortunately inequalities are getting worse and the example was given of the position in Glasgow in 2010 where there was a 28 year difference in life expectancy in different parts of the city. Yunus (whose name graces the chair held by Professor Donaldson) pioneered micro loans to enable people to prosper and really improve their economic position. Social vulnerability can be tackled without mentioning health but helps build up health nonetheless.

A year ahead – the Panel were asked about what they would like to see a year ahead. Answers included:

- Research on asset based approaches influencing the public discourse
- A greater shift away from NHS services, for example to sustained tenancies
- An increase in the emphasis on public health stemming from the support for public health measures demonstrated by the current NHS Chief Executive in a recent lecture organised by the Centre for Public Policy and Health, Durham University
- Provision of the facts on cost benefit analyses to the Treasury leading to action rather than a continual request for more research

AR – FINAL as at 24th February 2015