Improving the value from health spending
The case of mental health

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EPA 2018: 26th European Congress of Psychiatry

Forum: Person centered mental health care: outcomes that matter to patients and their carers

(3 April 2018)
Faculty Disclosure

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<tr>
<th>X</th>
<th>No, nothing to disclose</th>
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Yes, please specify:

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<th>Consulting/Advisory Board</th>
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Value for Money in Health Spending, benefits for whom?

- Improving patient outcomes should not simply be seen as a matter for health policy.

- Better health can make a very important contribution to economic and social goals through longer working lives, greater productivity, reduced disability claims, better educational outcomes, and reduced social exclusion.

- An example: The **Value of Treatment (VoT) Project** is a timely and ground-breaking initiative of the European Brain Council (EBC) in collaboration with the LSE and other partner institutions.
Value of Treatment: Bridging the Treatment Gaps for Brain Disorders with person centred care

• **Framework:** “how better healthcare practice in brain disorders can improve the lives of European citizens and have a positive socio-economic impact”

• **The project goals:**
  • To develop case studies demonstrating (i) health gains and (ii) socio-economic impacts resulting from best health interventions;
  • To perform a robust analysis to support the research framework with empirics;
  • To make policy recommendations grounded in relevant and solid scientific knowledge.
Value of Treatment: Bridging the Treatment Gaps for Brain Disorders with person centred care

Hundreds of EBC experts across Europe/overseas

Australia

WHO
Value of Treatment: Bridging the Treatment Gaps for Brain Disorders with person centred care

• **Nine case studies**: Alzheimer’s Disease, Epilepsy, Headache, Multiple Sclerosis, Normal-pressure hydrocephalus (NPH), Parkinson’s disease, Restless Legs Syndrome, Schizophrenia, Stroke across EU settings

• **Aim**: to identify treatment gaps, propose solutions and measure their socioeconomics impact

• **Methods**: patient journey analysis and economic evaluation
Aim & approach of economic case studies

• To produce economic evidence on the value of treatment of brain disorders to inform decision-making (at potentially many levels).

• No new primary data collection

• New analyses of evidence in previously published studies and administrative datasets; with inputs from a wide range of experts over many months
What do we mean by ‘economic case’?

• We need to compare **2+ interventions** (= policies, strategies, services, treatments etc.)

• Those interventions need to be **effective**

• We look at as **wide a range of costs and outcomes** as possible, and for the **longest time periods** possible

• Is the intervention **cost-saving**?

• If not, is it nevertheless **cost-effective** (i.e. seen as ‘worth it’)?
Methods – Economic modelling

- **Types**: decision analytic models; simulation Markov models
- **Interventions**: Chosen by expert groups to represent ‘better/best treatment/care’
- **Baseline scenarios**: where treatment/care as usual represents a ‘gap’; e.g., delayed diagnosis, poor adherence etc.
- **Timeframe**: short 1-2 years, medium 3-5 years, long term (>5 years).
- **Perspectives**: health & social care system, or whole public sector, or whole society.
- **Health outcomes** (when included): varied ... sometimes included Quality-adjusted life years (QALYs) gained, healthy life years (HLYs) gained, lives saved.
- **Discount rate**: 3.5% applied if needed.
Methods – depend on data available...

- **Approach #1 (‘best scenario’)** - Where there was a recently completed economic evaluation in European settings already available from the literature.

- **Approach #2** - Where there was a *previous* economic evaluation in one European setting or outside Europe (if considered relevant).

- **Approach #3** - Only effectiveness evidence available - no economic evaluations. We explored economic case with experts using reported findings in the literature.

- **Approach #4** - Where evidence of effectiveness was limited we agreed with experts on specific patient case studies to explore treatment gaps.
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• **Approach #4 -** Where evidence of effectiveness was limited we agreed with experts on specific patient case studies to explore treatment gaps

Schizophrenia. For **UK** we updated model parameters with fresh evidence so that they reflected what could be expected in Europe today, at today’s prices. For **Czech Republic** we adapted UK model and set it fully in CR context.
## Schizophrenia: one example

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Low prevalence (0.8% to 1.5%), heterogeneous, highly distressing disorder, with potentially devastating long-term consequences. Challenges include recognising schizophrenia early enough, and keeping people in treatment.</th>
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<tbody>
<tr>
<td>Question</td>
<td>What is the economic case for early detection / early intervention programmes in UK (where EI is already available) and Czech Republic (where it is not, but could potentially be developed)?</td>
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| Findings  | **UK**: In short term (1-2 years), EI more costly than usual care but from year 3 onwards it generates cost savings - due to reduced inpatient care costs, improved employment and crime costs (€20-€32 million savings annually)  
**CR**: Costs of care as usual could be reduced by 25% if only indicated prevention services were adopted, 33% if only EI services were adopted, and 40% if both. Potential annual savings of up to €18.3 million  
In both UK and CR there is strong potential to be cost-saving. |
# From the patient journey …

**Gaps addressed in economic terms**

<table>
<thead>
<tr>
<th>Gaps</th>
<th>Schizophrenia</th>
<th>Alzheimer’s Disease</th>
<th>Headache</th>
<th>Stroke</th>
<th>Parkinson’s Disease</th>
<th>Epilepsy</th>
<th>Multiple Sclerosis</th>
<th>Restless Legs Syndrome</th>
<th>Normal Pressure Hydrocephalus</th>
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<td><strong>Prevention</strong></td>
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<td><strong>Screening</strong></td>
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<td>Missed detection</td>
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<td><strong>Diagnosis/treatment</strong></td>
<td>Late intervention</td>
<td>Late intervention; inadequate treatment</td>
<td>Lack of structured headache services &amp; education</td>
<td>No access to impatient stroke unit</td>
<td>Late treatment; inadequate treatment for advanced PD; poor adherence</td>
<td>Inadequate treatment &amp; care</td>
<td>Delays in treatment</td>
<td>Inadequate treatment (&amp; socio-economic impact)</td>
<td>Delayed &amp; inadequate treatment</td>
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<td><strong>Follow-up</strong></td>
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From the patient journey …

Gaps addressed in economic terms

- Impact of modifiable lifestyle factors
- Missed detection
- Late intervention; inadequate treatment
- Lack of structured headache services & education
- No access to impatient stroke unit
- Late treatment; inadequate treatment for advanced PD; poor adherence
- Inadequate treatment & care
- Delays in treatment
- Inadequate treatment (& socio-economic impact)
- Delayed & inadequate treatment
- Lack of rehabilitation

(Case studies)
## Closing the treatment gaps ...

### Prevention

- Lifestyle factors prevention
  - COST-EFFECTIVE

### Screening

- Early detection
  - COST-SAVING/COST-EFFECTIVE

### Diagnosis/treatment

- Early intervention
  - COST-SAVING/COST-EFFECTIVE
- Early & adequate treatment
  - COST-EFFECTIVE
- Early intervention/adequate treatment
  - COST-EFFECTIVE
- Structured headache services and education
  - COST-EFFECTIVE
- Inpatient stroke unit
  - COST-EFFECTIVE
- Early/timely treatment
  - COST-EFFECTIVE
- Adequate treatment for advanced PD
  - COST-EFFECTIVE
- Adherence to drug treatment
  - COST-EFFECTIVE
- Early in treatment
  - COST-EFFECTIVE
- Adequate treatment
  - COST-EFFECTIVE
- Early & adequate treatment
  - COST-EFFECTIVE

### Follow-up

- In hospital rehabilitation
  - COST-EFFECTIVE
Conclusions

• Closing treatment gaps is widely beneficial – for patients, families, providers, payers, policy-makers.

• The VoT project looked at prevention, early detection, diagnosis & early intervention, better adherence to treatment, access to appropriate treatment.

• Economic arguments need to be seen alongside other essential elements in shared decision-making, especially patient, family and public involvement – and that has been central to the whole VoT approach.
Acknowledgments

- **EBC team**: Vinciane Quoidbach, Giovanni Esposito, Fred Destrebecq, Stephanie Kramer
- **EBC executive board**: Drs Nutt, Boyer, Di Luca, Oertel
- **EBC academic partners**: Nick Guldemond
- **Working group leaders**: Drs Dodel, Gaebel, Kalviainen, Kehler, Mitsikostas, Sorensen, Trenkwalder, Vanhooren, Visser
- **All working group members**