Investing in prevention in work on infectious diseases – making the economic case for prevention

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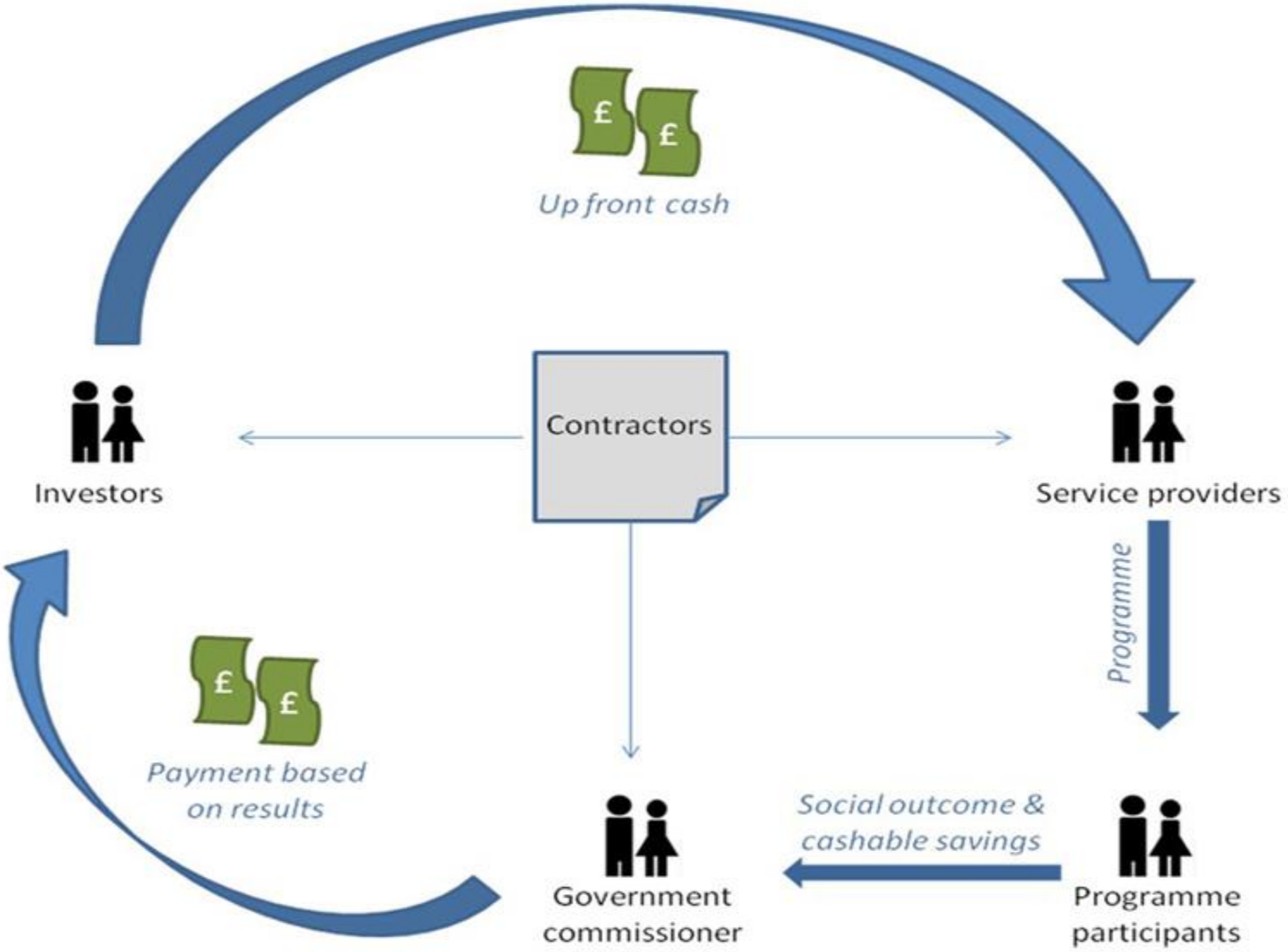
What we are going to talk about today

- What we did – new migrant screening package
- How we built a business case in this scenario
- The challenges we faced
- What we learnt / what we might do differently
- Any questions from you?

What were we trying to do

- Build a business case for social investment in a new migrant screening package in primary care
- Reduce inequity of GP offer
- Support new migrants wider needs
- Encourage registration in primary care
- ……All with aim of *earlier diagnosis and treatment leading to better life chances*

Context of social investment



Context of return on investment

- Wrong Pocket Problems in ROI
- ROI Tools have gained some popularity
  - Add value when no economic specialist in house
  - Vulnerable to errors of interpretation

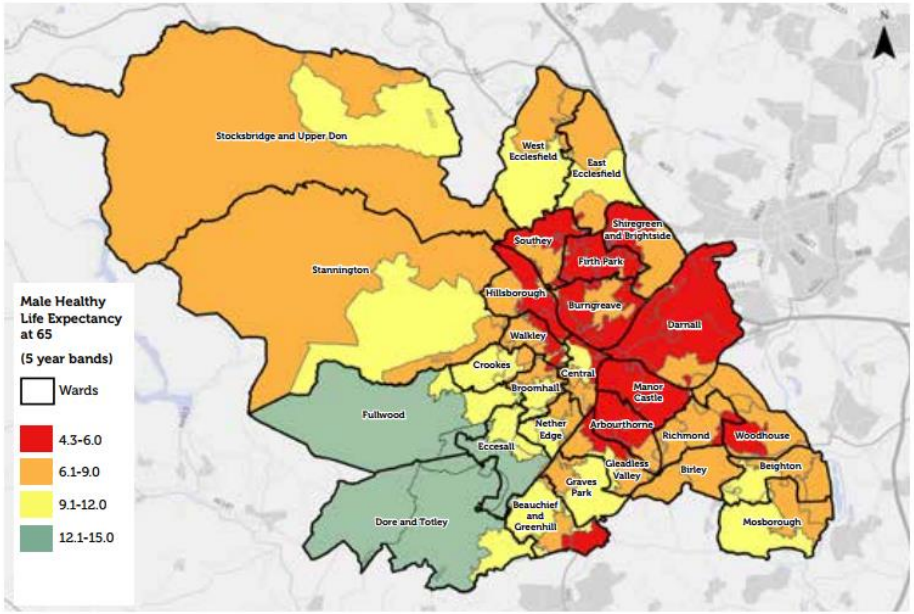
- Narrow view of how they should be implemented – “cost saving” or bust…..
  - Frames the discussion in negative terms from the outset.

Infectious disease

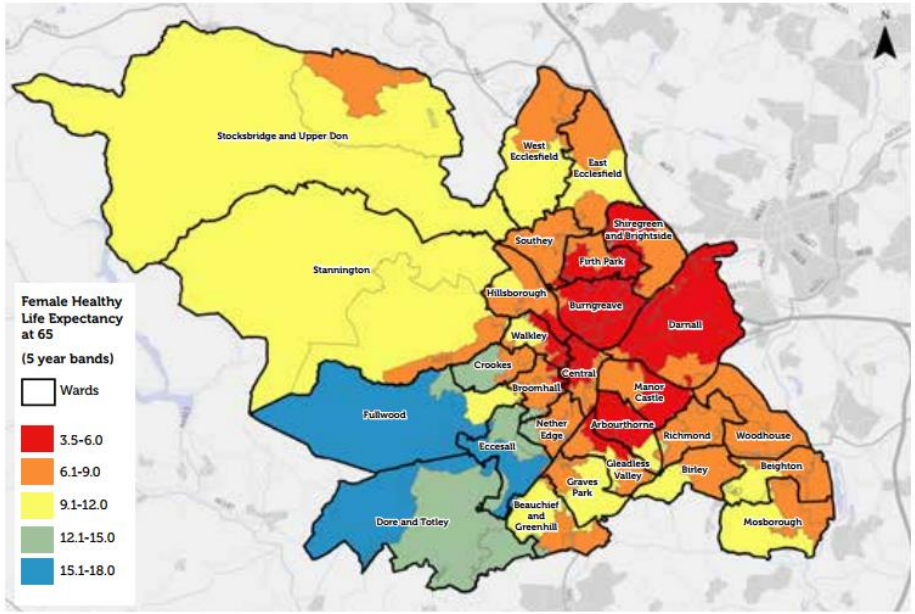
- Infectious diseases (TB, HIV, Hepatitis B) affects individuals, families and communities life chances – ability to get on with work, school, life in new country
- Currently have inconsistent screening for higher risk populations (new migrants) in primary care
- Our most vulnerable populations are disproportionately affected by infectious diseases (PHE 2018 Health Profile for England)
- Success in managing infectious diseases is about what doesn't happen (transmission)– therefore it can be difficult to measure

Sheffield: A Tale of Two Cities

Males

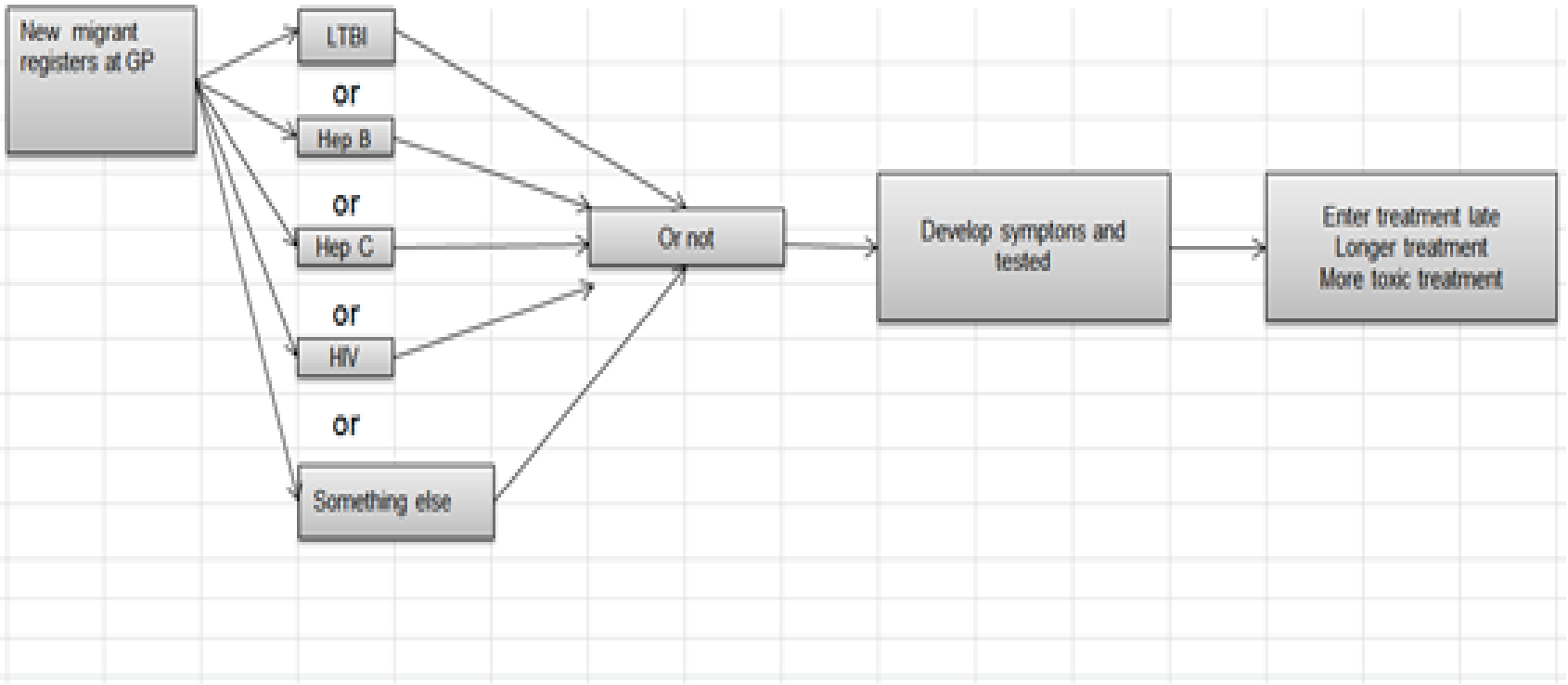


Females

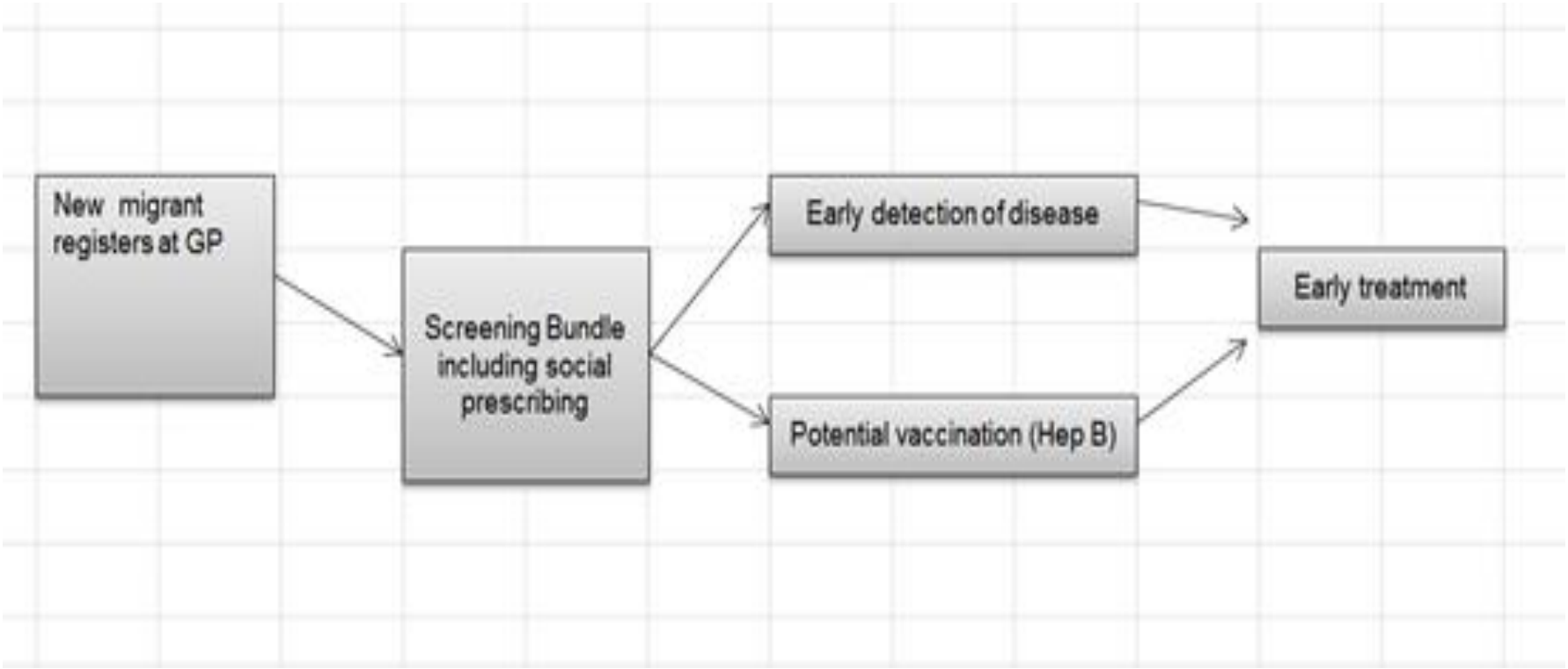


Core city	*Natural change*	*Internal migration*	*International migration*
Birmingham	*8,111*	*-4,529*	*6,411*
Bristol, City of	*3,023*	*1,302*	*2,489*
Leeds	*3,598*	*541*	*3,509*
Liverpool	*1,469*	*425*	*3,738*
Manchester	*4,459*	*-956*	*6,567*
Newcastle upon Tyne	*611*	*-485*	*2,920*
Nottingham	*1,761*	*-897*	*3,827*
Sheffield	*1,566*	*-706*	*5,157*

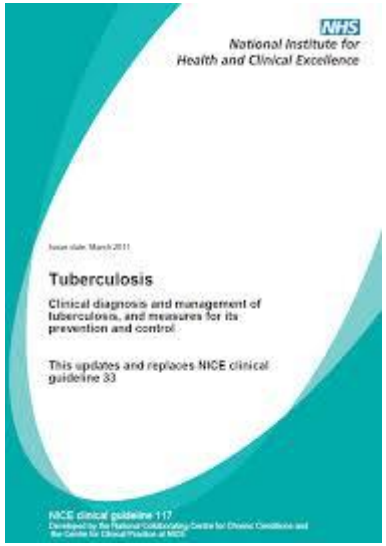
Current Provision



Our proposal

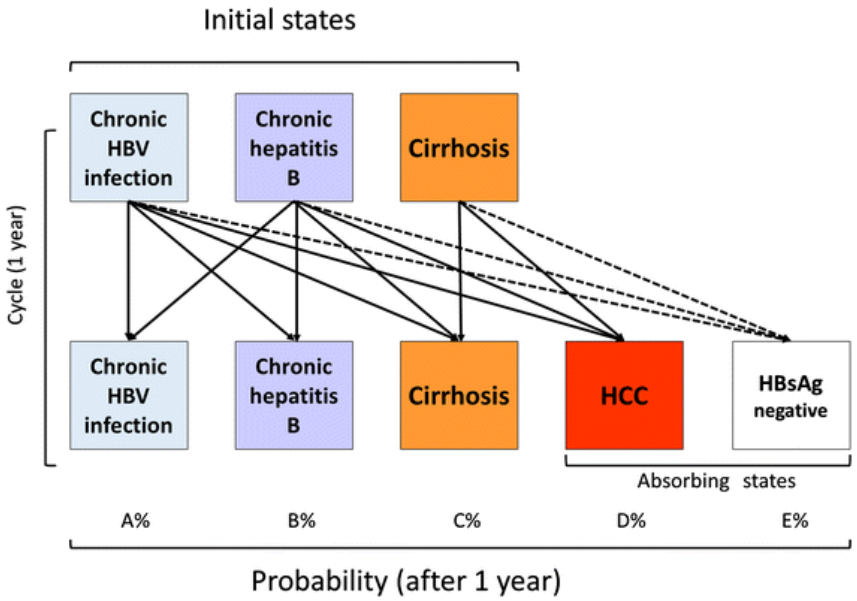


Modelling



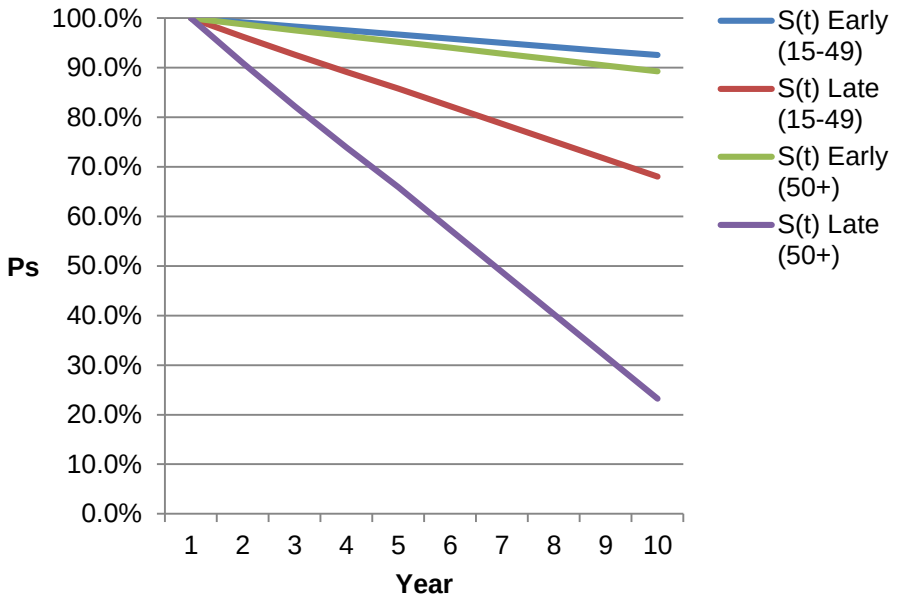
Costing Template from NICE NG33

LSHTM CEA of HBV case finding



Zah V, Toumi M**. Economic and health implications from earlier detection of HIV infection in the United Kingdom**.

HIV AIDS (Auckl). 2016;8:67-74. Published 2016 Mar 15**.**



Modelling

- Over 5 years, likely to be cost effective
- Not likely to be “cash saving”. Not viable for Social Investment Bond.
  - Case Finding
  - Natural history
  - Discounting
  - Treatment costs
    - HIV therapy is life-long
    - MDR TB drugs – wider savings too?

What went well

- People saw this as a “good thing”
- Recognition of value/issue by primary care in particular
- Recognition of potential health inequality impact
- Modelling -
    - technical successes
    - evidence communication
    - transparency
- Positive decision in principle from life chances fund

What went not so well

- Calculating wider return
  - Challenge of quantifying wider (economic) benefits
  - Challenge of identifying outcomes WTP
- Engagement of partners
  - Some partners did not have capacity to provide financial information
  - Some commissioners were less engaged
  - Tension in colleagues who have financial responsibility in their organisation and role in programmes which may impinge on internal finances
- Wider context – data governance is prohibitive to evaluating registration

What happened in the end

- Conclusion was that work would be cost effective but not cost saving
- Has not gone forward for social investment and life chances fund
- Partners expressed appetite for taking component parts forwards eg promoting registration in primary care, improving consistency of offer
- BUT…ultimately not top of the ‘to do’ list

Learning and observations

- Public Sector Reform – how do we tackle the fact that return is in a different place from investment?
- What about all the things commissioners ‘blindly’ pay for that haven’t been through this process?
- Disinvestment is key to investment when there is no new money
- Block contracts and ‘tariff mindset’ doesn’t encourage providers to work on prevention
- hesitancy to explore more innovative finance – political preference for public services provided by public funds

What would help make the case

1. Quantifying and monetising the gain from changed life trajectories and investments. Big R research – extending the QALY project etc.
2. Belief and narrative vs evidence –needs decision makers to consider value of existing programs with same level of rigour
   - Trade offs!!!
3. Integrated commissioning and budget/risk sharing
4. Political preferences for investment vs evidence-based decision making