



programme budgets

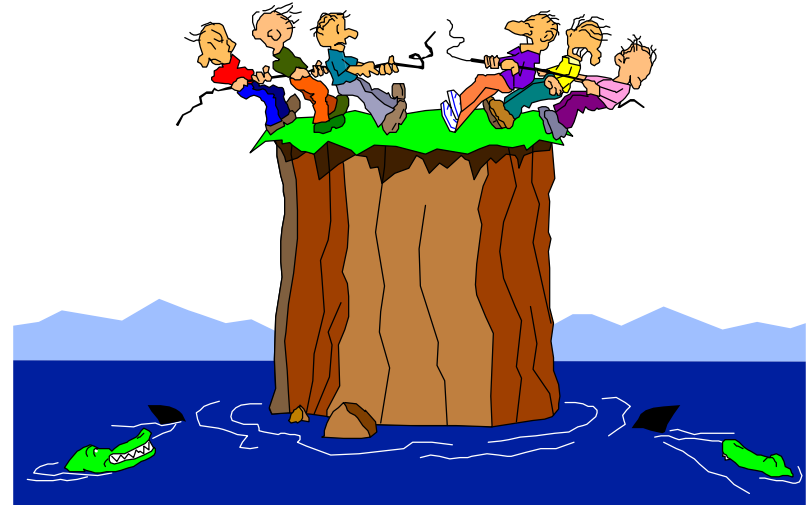
a better way to plan?

programmes...

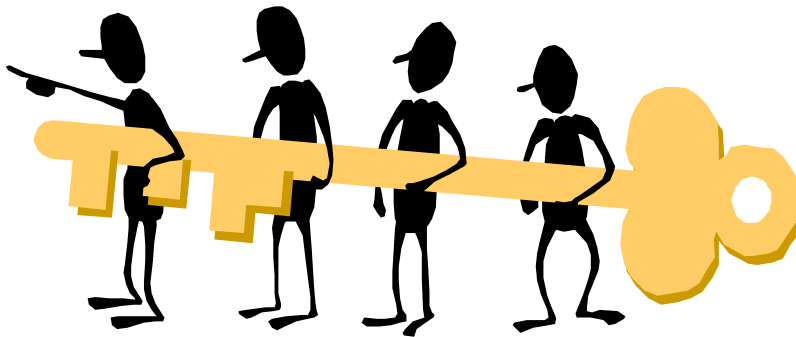
- what is a “programme”
- how does it work?
- who benefits?
- where do you start?

the tensions in healthcare planning

- involving clinicians
- crossing boundaries
- isolation
- evidence-based
- clinical governance
- separate resources



a programme addresses..



- a defined population
- a defined range of activities
- an agreed set of resources
- ❖ and aims at specified outcomes
- ❖ using health economic methodology



how does it work?

some conclusions from experience
in Newcastle and North Tyneside
*Priorities for investment - tackling
CHD*

what did we do?

the objectives were:

- to apply marginal change analysis to CHD
- to identify significant changes over 10 years
- to estimate impact on health and resources
- to select priorities for change
- to assess value of model and scope for application in other areas

some scenarios

gain in life-years

- inc. GP exercise ECGs
unit cost = £2345
- 10% inc. thrombolysis
unit cost = £5743

cost reduction of 1.2% (£190,000)

- 10% inc. aspirin and
beta blockers
- 70% angiographies as
day cases

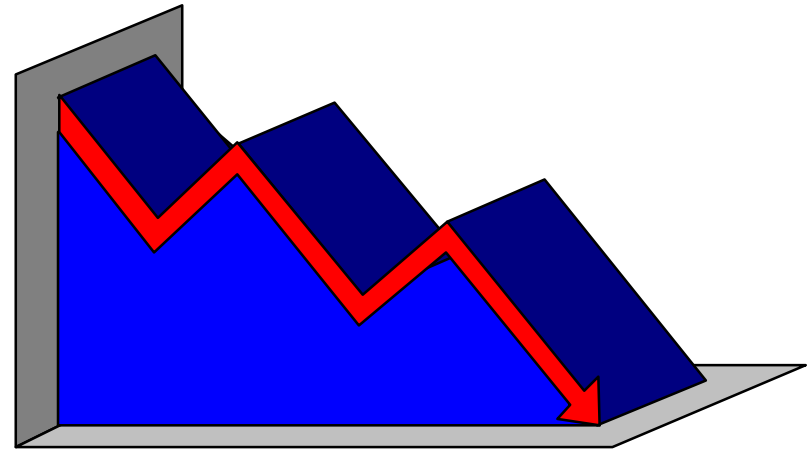
use of the model - was it clear?



- clinicians 2:1 **yes**
- commissioners - too theoretical
- HA members - praised for clarity/relevance
- local people - £ **yes**, health benefit **no**

use of the model- was it robust?

- clinicians - sensitivity analysis requested
- commissioners - better than nothing
- HA members - rely on experts
- local people - is it economic v medical?



use of the model - was it practical?

overall yes, but....

- clinicians - needs money and motivation
- commissioners - implement through programme
- HA members - other priorities not clear
- local people - safety, quality of life

value of the model

strengths

- matches pathways of care
- provides evidence-based framework
- clarifies options
- accepted by users and providers

weaknesses

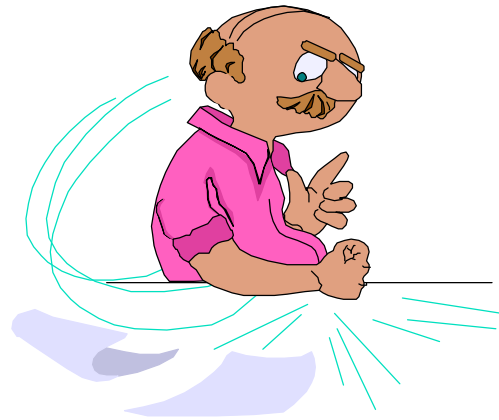
- health care data is incomplete
- expertise is scarce
- time consuming
- speed of advent of new technology

a clinician said..

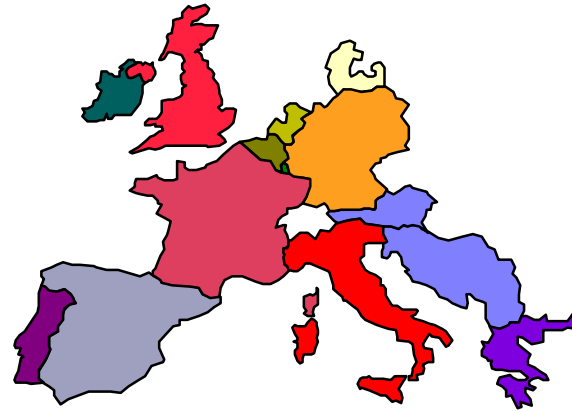
“the whole exercise has thrown my ideas about how I decide what to do with patients into **considerable confusion**. I thought that good studies with large endpoint differences with considerable absolute gains could generally be used to inform practice, given that treatment is not outrageously expensive.”

and another said..

“So where’s its value? If all this effort is going into evidence-based medicine, where’s its value if you can get the same thing by hunch medicine?”



applying this in Jersey - the diabetes programme



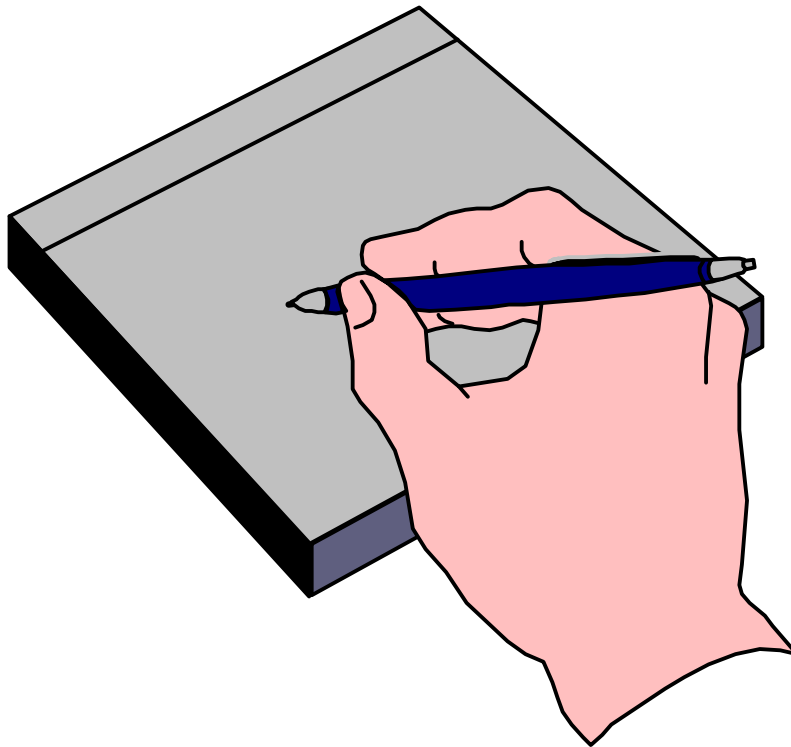
- under aegis of integrated health care group
- building on research carried out in 1999
- coordinated by public health department

what did we do?

- aim: to assess costs of type 2 diabetes in Europe
- cases defined as diagnosis aged 30+
- retrospective (1998)
- data from primary care & hospital
- random sample from register



data items



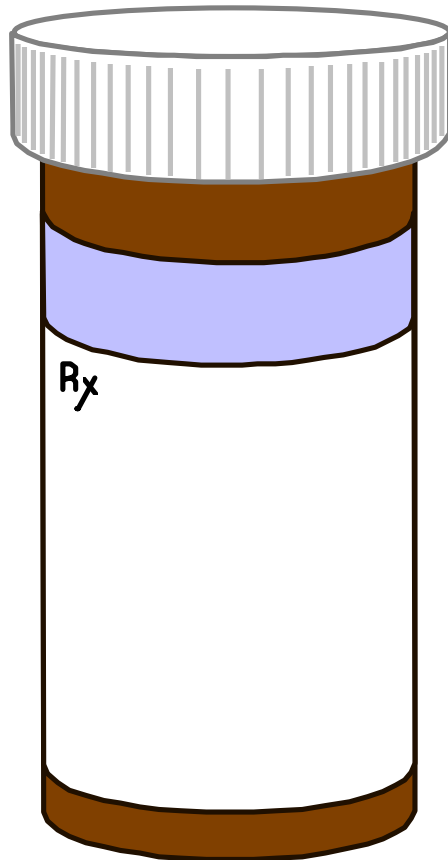
- demographics
- complications
- investigations
- attendances
- admissions
- medication

UK demographics (1)

- Total sample sizes:
 - UK = 762
 - Jersey = 231
 - Europe = 7000
- Gender split
 - male 60%
 - female 40%
- mean age 63.3 years



UK demographics (2)



- mean BMI 29.9
 - mean time since diagnosis = 7.87 years
- primary treatment type**
- ⇒ diet & exercise **17.8%**
 - ⇒ oral drugs only **59.6%**
 - ⇒ insulin alone or combined **22.6%**

risk factors

Risk factor	Jersey prevalence rate %	UK prevalence rate %
smoking	21.0	18.6
obesity	33.9	39.9
hypertension	49.6	47.7
hyperlipidemia	42.0	32.2

complications - prevalence rates as %

complication	A	B	J
retinopathy	21.9	14.0	19.6
micro- albuminuria	15.4	3.4	16.5
cataract	13.1	6.8	15.2
depression	20.8	8.7	8.9

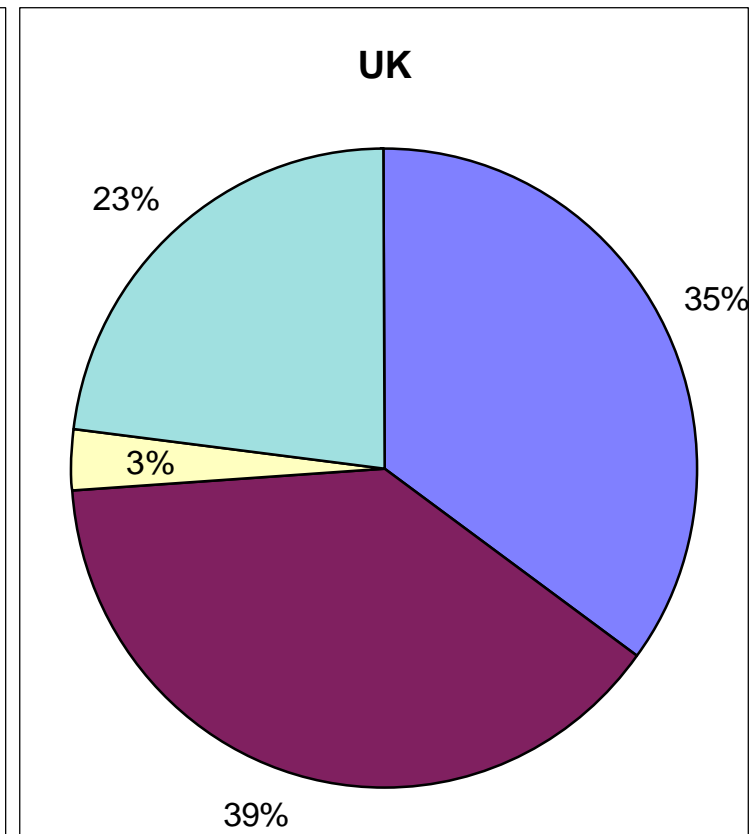
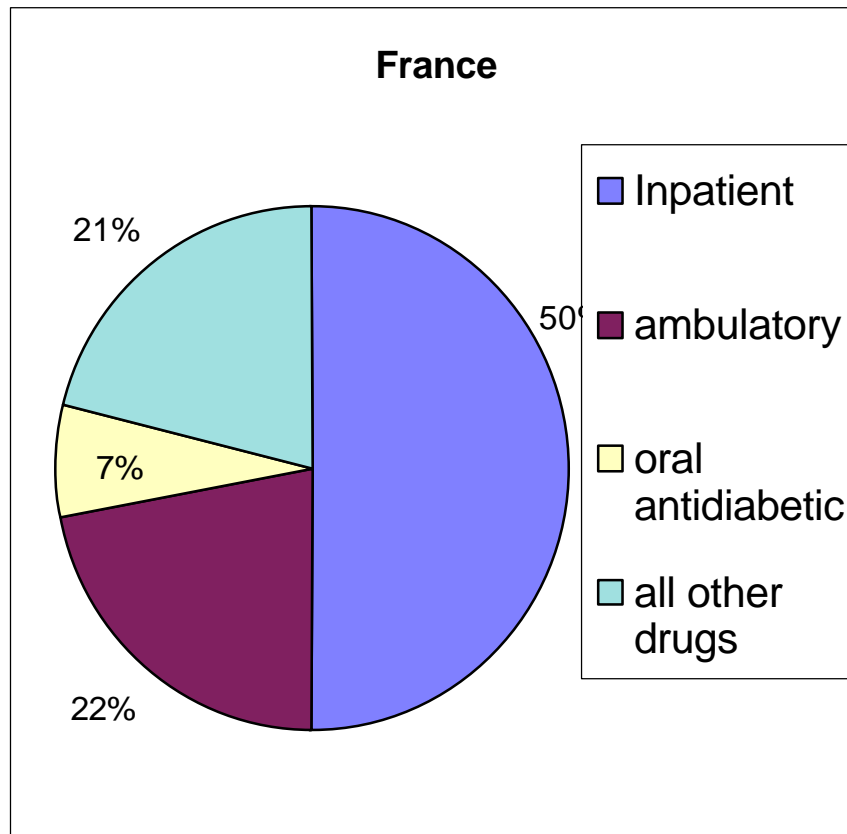
complication events - rates as %

Event	UK prev	UK inc	J prev	J inc
foot ulcer	5.7	2.9	8.0	4.9
photocoag	11.6	3.6	9.8	4.0
MI	13.6	1.2	9.4	0
stroke	6.3	1.1	4.0	1.3

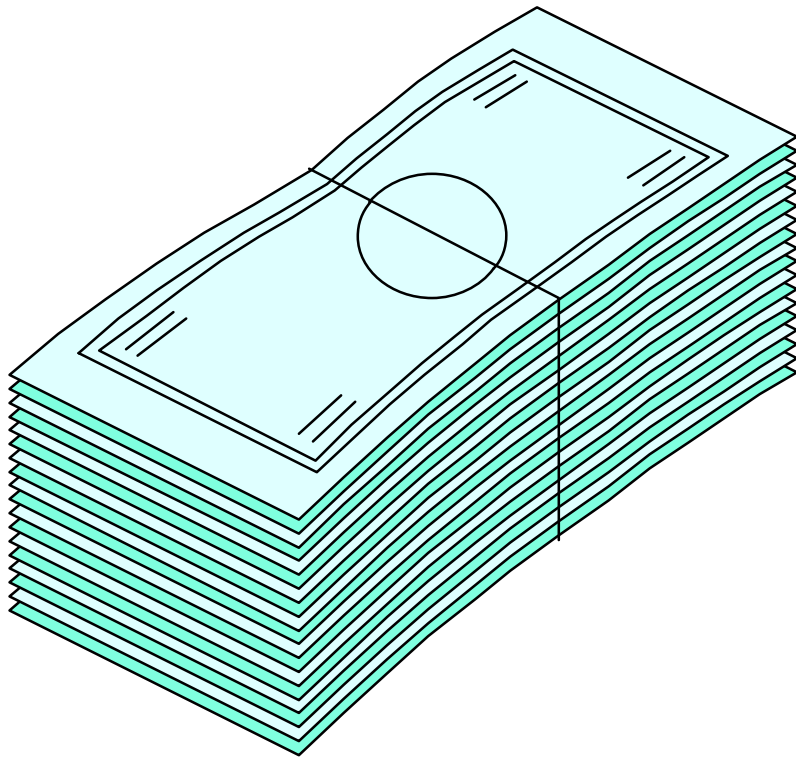
clinical management - % patients by level of control

indicator	UK good	UK border	J good	J border
glucose	7.6	25.2	9.9	34.2
HbA1c	24.1	44.7	47.1	69.1
HDL	43.7	76.7	48.2	87.8
diastolic	94.9	94.9	86.1	94.2

overall costs by main resource category



overall costs per patient (£) by type of complication



■ None	864
■ macrovascular	2124
■ microvascular	1339
■ both macro-& microvascular	2277

some conclusions

- diabetes care costs are 3.3% of all healthcare costs
- complication rates are major indicator of resource use, but actual rates require validation
- clinical management can be improved



What now?



- clinical management : baseline established - plan regular audits
- costs : prospective study to include indirect costs
- collaboration : use “programme” approach to deliver cost-effective integrated care