

key steps
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to delivery of a person
centred relapse service



4. Business planning and health economics

Health Economics

Health care budgets are limited, and demonstrating the economic impact of an intervention is particularly important for chronic illnesses that are relatively common, such as MS. Linking the costs of service inputs with outcomes is an essential method by which the cost-benefit of interventions can be demonstrated.

Economic evaluation involves comparing the costs and effectiveness of treatment or service options. It is essential to pre-define the economic perspective from which costs will be considered. This perspective can be that of the individual patient, the PCT, the hospital Trust, the NHS, or society as a whole. By identifying the perspective, three categories of cost may then be identified:

Box 11 Categories of costs

- (1) direct costs (those costs and savings arising from a treatment - for example staff time, hospital overheads, drug costs, patient transport etc)
- (2) productivity losses (the value of time lost in the workplace through illness)
- (3) intangible costs (the value of reduced quality of life arising from illness)

Most economic evaluations consider NHS and patient perspectives only, and are limited to direct costs. These perspectives and costs allow useful evaluations to be performed. But further information may be obtained when the impact of illness and its treatment on sick leave or unemployment (productivity losses) is analysed. Intangible costs can be measured by contingent valuation (such as time-trade off, or willingness to pay) or alternatively health-related quality of life methods. Although these latter costs are important, some argue that they are included in part in direct and productivity costs - and to include them involves a degree of 'double counting'. They are less frequently analysed in economic evaluation.

There are no validated, disease-specific instruments to measure economic inputs and outcomes in MS, although recent studies have successfully used a modified version of the Client Services Receipt Inventory to capture relevant costs from a variety of economic perspectives in MS. This instrument has recently been adapted to allow patient self-completion, and captures direct costs, productivity losses from the economic perspectives of patients, carers, social services, the NHS and to some extent society as a whole.

Business planning considerations

Primary and secondary care financial considerations

From a commissioner's perspective it is envisaged that an important impact for potential savings in MS could include high cost areas such as relapse management. Primary Care Trusts (PCTs) may choose to examine the number of patient cases to establish if they actually require hospitalisation, outpatient attendance or could be treated at home.

Primary and secondary care staff should work together to discuss and differentiate between specialised care (e.g. specialist nurse/ neurology assessment) and non-specialist care (intravenous drug administration). Secondary care providers should consider that provision of aspects of service delivery by primary care colleagues will free time to assess more new and complex referrals. Increased links between both services may also increase activity in other aspects of care delivery including appropriate diagnostic, disease modifying drugs, rehabilitation and palliative care services.

Potential benefits of a co-ordinated relapse service

Outpatient or at Home Service

Changes in service and patient outcomes as a result of prompt assessment, advice and treatment for example:

- Reduced inpatient stays
- Reduced hospital bed days
- Reduced time off work/education
- Reduction in requests for outpatient or GP consultation to resolve problems
- Reduced waiting times for, and availability of, urgent review appointments
- Improved concordance, documentation and risk management issues (e.g. specialist assessment, appropriate medication, MDT input, psychosocial support, early rehabilitation, referral for disease modifying drugs)
- Patient satisfaction, improved 'self efficacy' and empowerment promotion
- Quality of life indicators (e.g. prompt relief of pain)

Extra value advantages of Home Service (based on robust evidence)

- Cost neutral if not cheaper than hospital outpatient appointments
- Patients prefer home treatment
- Convenience of treatment
- Convenience of timing of treatment
- Comfortable setting
- Comfortable passing the time
- Calm and relaxed environment
- Treated in a comfortable position

National tariff

The great majority of hospital care is now funded under the national tariff, with fixed rates for outpatient, day case and inpatient care. There is a separate central adjustment for market forces factor (the local cost of staff, buildings etc). Neurology outpatient services are a current exclusion from the national tariff, and are therefore charged to PCTs on the basis of local Trust prices. The local prices for one London Trust offering specialist care have been used as an example.

Factor	Potential Cost
General hospital outpatient clinic visit	£91 (national tariff varies with specialty)
Routine Neurology new patient clinic visit (local price)	£143
Specialist Neurology new patient clinic visit (local price)	£590
Routine Neurology follow-up visit (local price)	£94
Specialist Neurology follow-up visit (local price)	£143
MS admission up to 2 days (coded under HRG A18)	£559 with additional charge of £193.00 per additional day (national tariff)

Relapse cost models

Specialist Hospital OPD and day case infusion model

OPD specialist relapse clinic Assessment	Day case in patient	Day case in patient	Day case in patient	Specialist follow-up	Total
£590	£559	£559	£559	£143	£2,530

OPD and Home Delivery model

OPD specialist relapse clinic Assessment	Community Delivery within PCT resources	Community Delivery within PCT resources	Community Delivery within PCT resources	Specialist follow-up	Total
£590				£143	£733.00

A financial case for an In reach / Out reach Specialist post

The lack of a central UK register of people with MS makes it difficult to ascertain exact numbers of people with MS living in any one primary care area. In the absence of exact data, assumptions regarding activity may be based on contemporary prevalence studies. Prevalence rates of 100-120 per 100,000 of the population are quoted in the MS NICE guidelines although some organisations believe this figure to be low. Use of prevalence data can help estimate the number of people living with MS in a local community.

For example in one London borough

- The population is approx 175, 000
- Assuming a prevalence of 1:1000 or 1:800 then the estimated number of people living with MS is 175-200

Based on the current tariff, the cost of treating an MS patient with intravenous (IV) steroids for three days in a specialist clinic relapse suite model is £2,530.

Example:

Assessment in specialist clinic and 3 days infusion suite = £2, 530

If a PCT had 10 patients requiring relapse management in specialist clinic in one year it would cost £25,300

PCTs will have many more than 10 people requiring relapse treatment

The establishment of an In Reach Outreach MS nurse post could facilitate treatment of relapse in the community as the post-holder could link into secondary care colleagues to access specialist assessment whilst working with district nursing colleagues, community matrons, intravenous therapy teams and GP's to provide treatment locally.

OPD relapse specialist clinic assessment £590, delivery in community, specialist follow up £143 = £733

10 patients requiring specialist assessment, drug delivery in the community and specialist follow-up in one year would cost £7,330

The establishment of such a post could realise further improvements in quality service delivery and cost savings as these figures represent only one component of MS management to which a CNS-MS would contribute.

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Key steps to delivery of a person centred relapse service.
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