III JORNADAS de CONTROL y TRATAMIENTO DEL TABAQUISMO de la Región de MURCIA

"Economía y políticas de prevención del tabaquismo"

"Evaluación económica en Salud Pública:
el caso del tabaco"

Cartagena, 22 de Mayo 2014

Marta Trapero-Bertran PhD

Índice

- Introducción a la Evaluación Económica

- Características de las Eval Econ de Salud Pública

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INTRODUCCIÓN A LA EVALUACIÓN ECONÓMICA

Análisis comparativo de alternativas en términos de costes y consecuencias

Análisis comparativo de alternativas en términos de costes y consecuencias

Si uno piensa que trata solamente de los costes debería informarse acerca de la existencia del análisis coste-resultado

¿por qué? ¿

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racionalizar - equilibrar oferta i demanda

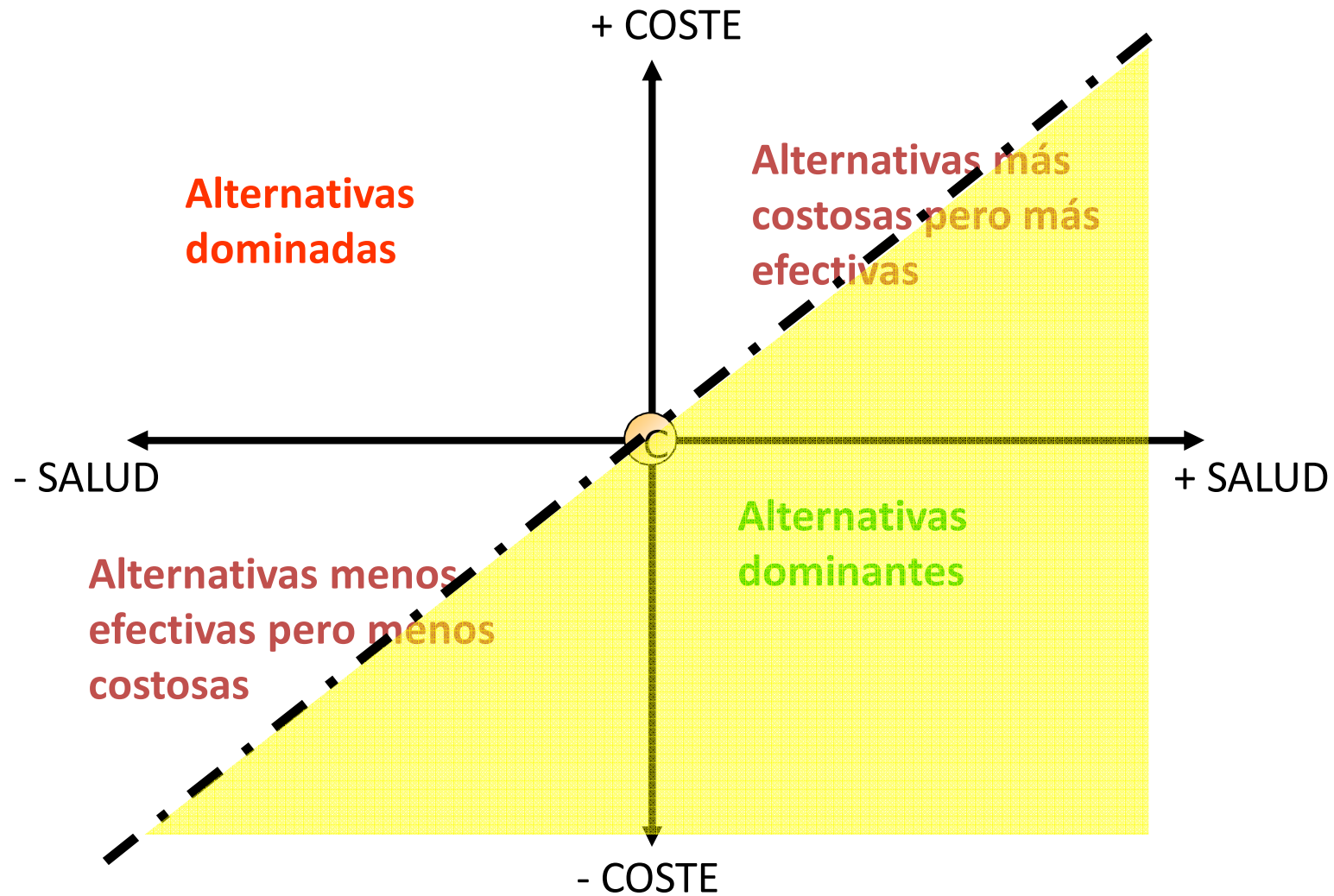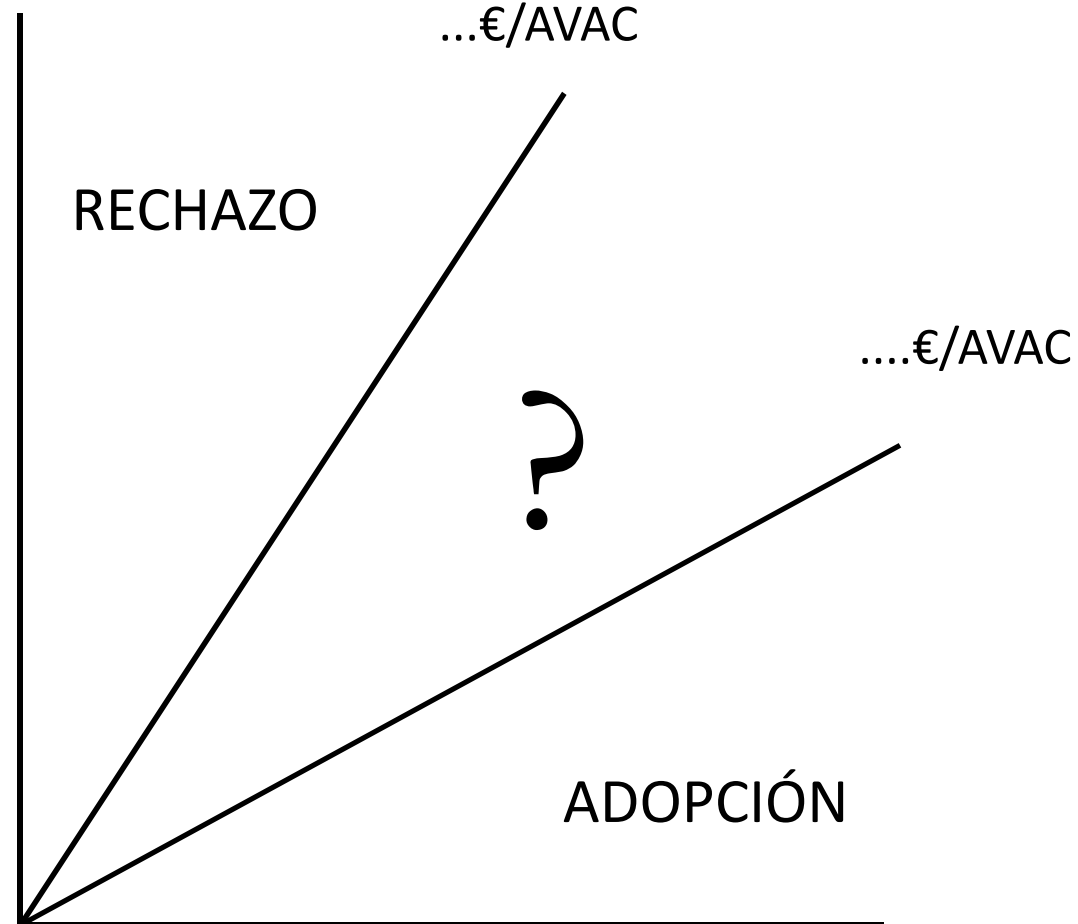| Formas alternativas	Formas formales
1. Listas de espera 2. Restricciones al acceso 3. Restricciones en el tiempo utilizado por un caso en particular	1. Precio (copago) 2. Priorización de necesidades clínicas(acceso prioritario para los pacientes mas graves) 3. Probabilidad de beneficio (edad o generación) 4. Coste-efectividad esperado(evaluación económica)

Ratio Coste-Efectividad Incremental (RCEI)

$$RCEI = \frac{C_B - C_A}{E_B - E_A}$$

Plano coste-efectividad

CARACTERÍSTICAS DE LAS EVAL ECON DE SALUD PÚBLICA

Rasgos intervenciones Salud Pública

- Evaluación de intervenciones aisladas pueden fallar en capturar los efectos que pueden suceder en intervenciones múltiples
- El impacto de los programas de salud pública NO es a corto plazo
- Las medidas monetarias son hasta ahora las medidas homogéneas más comunes para captar el impacto de este tipo de programas. El uso del AVAC debe ser más estudiado en esta área.
- Perspectiva social (costes y beneficios sociales)- externalidades

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EJEMPLOS DE EVAL ECON DE TABACO

Expert Opinion

A cost-effectiveness model of smoking cessation based on a randomised controlled trial of varenicline versus placebo in patients with chronic obstructive pulmonary disease

Kevin Lock, Koo Wilson, Daniel Murphy[†] & Juan Antonio Riesco

[†]Heron Evidence Development, Butterfield Technology and Business Park, Stopsley, Luton, UK

Objectives: Smoking is an important risk factor in chronic obstructive pulmonary disease (COPD). A recent clinical trial demonstrated the efficacy of varenicline versus placebo as an aid to smoking cessation in patients with COPD. This study examines the cost-effectiveness of varenicline from the perspective of the healthcare systems of Spain (base case), the UK, France, Germany, Greece and Italy.

Methods: A Markov model was developed to determine the cost-effectiveness of varenicline as an aid to smoking cessation, compared to a placebo, in a COPD population. Cost-effectiveness was determined by the incremental cost per quality-adjusted life year (QALY) gained.

Results: In the Spanish base case varenicline had an incremental cost of €1021/person for an average of 0.24 life years (0.17 QALYs), gained over the lifetime of a cohort of COPD patients, resulting in an incremental cost-effectiveness ratio (ICER) of €5,566. In the other European countries, the ICER varied between €4,519 (UK) and €10,167 (Italy). Probabilistic sensitivity analysis suggested varenicline had a high probability (>95%) of being cost-effective at a threshold of €30,000/QALY.

Conclusions: Varenicline is expected to be a cost-effective aid to smoking cessation in COPD patients in all of the countries studied.

Effect of smoke-free legislation on perinatal and child health: a systematic review and meta-analysis

Jasper V Been, Ulugbek B Nurmatov, Bianca Cox, Tim S Nawrot, Constant P van Schayck, Aziz Sheikh

Summary

Background Smoke-free legislation has the potential to reduce the substantive disease burden associated with second-hand smoke exposure, particularly in children. We investigated the effect of smoke-free legislation on perinatal and child health.

Methods We searched 14 online databases from January, 1975 to May, 2013, with no language restrictions, for published studies, and the WHO International Clinical Trials Registry Platform for unpublished studies. Citations and reference lists of articles of interest were screened and an international expert panel was contacted to identify additional studies. We included studies undertaken with designs approved by the Cochrane Effective Practice and Organisation of Care that reported associations between smoking bans in workplaces, public places, or both, and one or more predefined early-life health indicator. The primary outcomes were preterm birth, low birthweight, and hospital attendances for asthma. Effect estimates were pooled with random-effects meta-analysis. This study is registered with PROSPERO, number CRD42013003522.

Findings We identified 11 eligible studies (published 2008–13), involving more than 2·5 million births and 247 168 asthma exacerbations. All studies used interrupted time-series designs. Five North American studies described local bans and six European studies described national bans. Risk of bias was high for one study, moderate for six studies, and low for four studies. Smoke-free legislation was associated with reductions in preterm birth (four studies, 1 366 862 individuals; –10·4% [95% CI –18·8 to –2·0]; p=0·016) and hospital attendances for asthma (three studies, 225 753 events: –10·1% [95% CI –15·2 to –5·0]; p=0·0001). No significant effect on low birthweight was identified (six studies, >1·9 million individuals: –1·7% [95% CI –5·1 to 1·6]; p=0·31).

Interpretation Smoke-free legislation is associated with substantial reductions in preterm births and hospital attendance for asthma. Together with the health benefits in adults, this study provides strong support for WHO recommendations to create smoke-free environments.

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and Primary Care (CAPHRI),
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(J V Been); Centre for
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How effective and cost-effective was the national mass media smoking cessation campaign 'Stoptober'?

Jamie Brown [a,*], Daniel Kotz [a,b], Susan Michie [c,d], John Stapleton [e],
Matthew Walmsley [f], Robert West [a,d]

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ARTICLE INFO

ABSTRACT

Background: A national smoking cessation campaign based on behaviour change theory and operating through both traditional and new media was launched across England during late 2012 ('Stoptober'). In addition to attempting to start a movement in which smokers would quit at the same time in response to a positive mass quitting trigger, the campaign set smokers the goal of being smoke-free for October and embodied other psychological principles in a range of tools and communications.

Methods: Data on quit attempts were obtained from 31,566 past-year smokers during nationally representative household surveys conducted monthly between 2007 and 2012. The effectiveness of the campaign was assessed by the increase in national quit attempt rate in October relative to other months in 2012 vs. 2007–2011.

Results: Relative to other months in the year, more people tried to quit in October in 2012 compared with 2007–2011 (OR = 1.79, 95%CI = 1.20–2.68). In 2012 there was an approximately 50% increase in quitting during October compared with other months of the same year (9.6% vs. 6.6%; OR = 1.50, 95%CI = 1.05–2.15), whereas in 2007–2011 the rate in October was non-significantly less than in other months of the same period (6.4% vs. 7.5%; OR = 0.84, 95%CI = 0.70–1.00). Stoptober is estimated to have generated an additional 350,000 quit attempts and saved 10,400 discounted life years (DLY) at less than £415 per DLY in the modal age group.

Conclusions: Designing a national public health campaign with a clear behavioural target (making a serious quit attempt) using key psychological principles can yield substantial behaviour change and public health impact.

Effectiveness and cost-effectiveness of computer and other electronic aids for smoking cessation: a systematic review and network meta-analysis

Y-F Chen, J Madan, N Welton, I Yahaya,
P Aveyard, L Bauld, D Wang, A Fry-Smith
and MR Munafò

An economic evaluation based on a randomized placebo-controlled trial of varenicline in smokers with cardiovascular disease: results for Belgium, Spain, Portugal, and Italy

Koo Wilson[1], Robert Hettle[2], Sophie Marbaix[3], Silvia Diaz Cerezo[4], Monica Ines[5], Laura Santoni[6], Lieven Annemans[7], Jacques Prignot[8] and Esteban Lopez de Sa[9]

Abstract

Background: An estimated 17.2% of patients continue to smoke following diagnosis of cardiovascular disease (CVD). To reduce the risk of further morbidity or mortality in cardiovascular patients, smoking cessation has been shown to reduce the risk of mortality by 36% and myocardial infarction by 32%. The objective of this study was to evaluate the long-term health and economic consequences of smoking cessation in patients with CVD.

Design and methods: Results of a randomized clinical trial comparing varenicline plus counselling vs. placebo plus counselling were extrapolated using a Markov model to simulate the lifetime costs and health consequences of smoking cessation in patients with stable CVD. For the base case, we considered a payer's perspective including direct costs attributed to the healthcare provider, measuring cumulative life years (LY) and quality adjusted life (QALY) years as outcome measures. Secondary analyses were conducted from a societal perspective, evaluating lost productivity due to premature mortality. Sensitivity and subgroup analyses were also undertaken. Results were analysed for Belgium, Spain, Portugal, and Italy.

Results: Varenicline plus counselling was associated with a gain in LY and QALY across all countries; relative to placebo plus counselling. From a payer's perspective, incremental cost effectiveness ratios were €6120 (Belgium), €5151 (Spain), €5357 (Portugal), and €5433 (Italy) per QALY gained. From a societal perspective, varenicline in addition to counselling was less costly than placebo and counselling in all cases. Sensitivity analyses showed little sensitivity in outcomes to model assumptions or uncertainty in model parameters.

Conclusions: Varenicline in addition to counselling is cost-effective compared to placebo and counselling in smokers with CVD.

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ANTECEDENTES EQUIPT (EUROPEAN-STUDY ON QUANTIFYING UTILITY OF INVESTMENT IN PROTECTION FROM TOBACCO)

Evidencia internacional sugiere que estrategias coordinadas de control del tabaquismo, implementadas a nivel subnacional, podrían reducir la prevalencia de fumar

¿Como justificar mejor la inversión en programas de control del tabaco en contextos económicos con grandes presiones?

Objetivo

Desarrollar una herramienta que ayude a los que toman las decisiones, a nivel local y subnacional, entre el rigor académico y la práctica local

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Research Programme

Building the Economic Case for Tobacco Control

About the research programme

Research funding

Consultancy

Applied economic evaluations

The measurement and valuation of health outcomes

The economics of public health

Measuring the impact of health and medical research

Building the Economic Case for Tobacco Control

What does this toolkit do?

This toolkit allows you to estimate the economic impact of tobacco on services in your local and sub-national area. By using the drop down menus on the Inputs page, you can select your area of interest and the toolkit will automatically estimate the smoking and ex-smoking populations based on up-to-date statistics. This population composition is used to model the impact of smoking on relevant endpoints, taking into account short-, medium- and long-term events.

How are costs and outcomes modelled?

The model predicts changes in health and non-health impacts in response to reduction of smoking prevalence, which is moderated through natural background quitting behaviour, an increase in local cessation support and by establishing a sub-national tobacco control programme. At a local level, the model allows you to allocate a proportion of your smoking population to one or several interventions, with reduced prevalence resulting from their relative effectiveness over and above the natural background quit rates. The inclusion of a sub-national programme in your area further increases this background rate. Outputs are presented to allow you to compare the economic impacts of the different scenarios.

Who developed this toolkit?

The Health Economics Research Group (HERG) at Brunel University developed this work in partnership with London Health Observatory and Queen's Medical Centre, University of Nottingham, and South West Public Health Observatory. This work was funded by Tobacco Free Futures, Fresh Smoke Free North East and Smoke Free South West.

Has this tool been subject to piloting?

The Model Structure has been developed and tested with stakeholders and commissioners.

Are there any other documents I need to read to be able to use this toolkit at its full potential?

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Trapero-Bertran M, Pokhrel S, Trueman P. An economic model of tobacco control version 1. Tobacco Free Futures, Fresh Smoke Free North East & Smokefree South West. December 2011.

http://www.brunel.ac.uk/about/acad/herg/research/tobacco

Building the Economic Case for Tobacco Control   x

Introduction | Model Structure | Inputs | Disclaimer |

BUILDING THE ECONOMIC CASE FOR TOBACCO CONTROL
A TOOLKIT TO ESTIMATE ECONOMIC IMPACT OF TOBACCO

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The following citation is recommended:

Trapero-Bertran M, Pokhrel S, Trueman P. An economic model of tobacco control version 1.
Tobacco Free Futures, Fresh Smoke Free North East & Smoke Free South West. January 2011.

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Please acknowledge the source in all oral and written communications.

[View Model Structure >]   [**Go to INPUTS >>**]   [Read Disclaimer >>>]

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Research Programme

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Has this tool been subject to piloting?

The Model Structure has been developed and tested with stakeholders and commissioners.

Are there any other documents I need to read to be able to use this toolkit at its full potential?

Details as to how to use this model and technical data are available as downloads. Always refer to accompanying Report, Technical Annexes and User Guide, where appropriate, if you need any clarification. Also, read the Disclaimer information before you use this model.

How do I install the toolkit on my PC?

This site contains the most up-to-date toolkit- so make sure you download this version. The toolkit is packaged in a zip folder. Click on the 'Download' link and save it to a location on your PC. You must unzip/extract this folder before the first use. Some operating systems allow you to open the file directly from the zipped folder without having to extract/unzip it – this is not recommended here. If you attempt this, an error message will show up and the toolkit will not function properly.

How do I get the password to unlock the locked fields?

Some fields (eg tobacco control interventions without behavioural support) have been locked as most of the intended users are not expected to make any changes in the inputs screen (see accompanying User Guide). If you see a padlock next to a field, this means the field is pre-populated and locked. However, if you are an advanced user and would like to unlock these fields to input your own parameters, please email subhash.pokhrel@brunel.ac.uk to request the password.

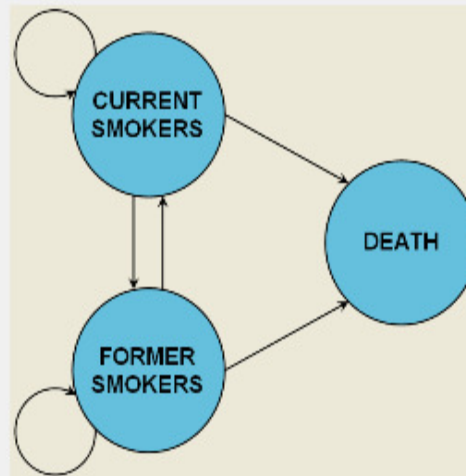### Who do I contact if I need to provide my feedback on the toolkit?

This toolkit may be subject to continuous improvement. Please email subhash.pokhrel@brunel.ac.uk if you encounter any problem or detect any inconsistency.

Download

- Toolkit (zip)
- User guide
- Background Report
- Technical Report

- Download ALL (zip)

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Introduction | Model Structure | Inputs | Disclaimer

Diagrammatic representation of the Markov Model

This is an adapted version of the model developed by Flack et al. (2007).
A cohort of smokers in the chosen location is followed up over two years (for short-term outcomes), over 10 years (for medium-term outcomes) and over their lifetime (for long-term outcomes) in a yearly cycle.

In each cycle:
   - Smokers could either remain smokers, quit (become former smokers) or die.
   - Former smokers could either remain former smokers, relapse (become smokers) or die.

In each cycle, smokers and former smokers have a chance of getting five conditions:
   - Lung cancer;
   - Coronary heart disease;
   - Chronic obstructive pulmonary diseases;
   - Myocardial infarction;
   - Stroke.
The possibility of multiple conditions was excluded.

< View Introduction   **Go to INPUTS >**   Read Disclaimer >>

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Modelled Results for City of London

Area of interest: City of London   *Smoking prevalence:* 5,50%   *Average wage:* £12,90
Population: 11   *Smoking population:* 594   *Average days absence:* 1,63

Scenario 1: No Local Services, No Programme	**Scenario 2:** Local Services, No Programme	**Scenario 3:** Local Services + Programme

Short Term Outcomes | Medium Term Outcomes | Long Term Outcomes

SHORT TERM OUTCOMES (next 2 years)		View MEDIUM TERM Outcomes >

	Scenario 1	Scenario 2	Scenario 3	Scenario 2 Savings	Scenario 3 Savings
PRIMARY CARE	**£135.962**	**£133.417**	**£128.938**	**£2.546**	**£7.024**
GP consultations	£51.199	£50.240	£48.554	£959	£2.645
Practice nurse consultations	£4.861	£4.770	£4.610	£91	£251
Outpatient attendances	£46.881	£46.003	£44.459	£878	£2.422
Prescriptions	£33.021	£32.403	£31.315	£618	£1.706
SECONDARY CARE	**£108.966**	**£108.197**	**£106.812**	**£769**	**£2.153**
Cancer admissions	£55.304	£54.920	£54.223	£384	£1.081
CVD admissions	£16.216	£16.001	£15.617	£215	£599
Respiratory admissions	£27.741	£27.685	£27.586	£55	£155
Other admissions	£9.705	£9.591	£9.386	£114	£319
TOTAL NHS COSTS:	**£244.928**	**£241.613**	**£235.750**	**£3.315**	**£9.177**
PASSIVE SMOKING	**£94.042**	**£92.287**	**£89.175**	**£1.755**	**£4.867**
Adults exposed	£18.308	£17.966	£17.361	£342	£947
Children exposed	£75.734	£74.321	£71.813	£1.413	£3.921
SMOKING POOL					
Quitters	22	33	58		
New smokers	45	44	42		
PRODUCTIVITY LOSSES					
Days lost	£90.330	£88.645	£85.654	£1.686	£4.676

(To view your outcomes in greater detail, click 'Export Data')

< Amend INPUTS	Export Data	Close

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Home > The NICE Tobacco Return on Investment Tool

Into practice

Benefits of implementation

NICE implementation programme

Commissioning guides supporting clinical service redesign

Implementation tools

Forward planner

'How to' guides

Horizon scanning

Assessment tools

Clinical audit

Costing tools

Electronic clinical audit tools

Information resources and templates

Learning resources

Service planning

Slide sets

Thematic guidance support

Help implement NICE guidance

Education

The NICE Tobacco Return on Investment Tool

• About the tool

• Supporting documents

• Regional workshops

• Implementation support tools

• User feedback

• Download the tool and accompanying support materials

• Disclaimer

About the Tobacco Return on Investment Tool

The Tobacco Return on Investment Tool has been developed to help decision making in tobacco control at local and sub-national levels.

The tool evaluates a portfolio of tobacco control interventions and models the economic returns that can be expected in different payback timescales. Different interventions, including pharmacotherapies and support and advice, can be mixed and matched to see which intervention portfolio or package provides the best 'value for money', compared with 'no-services' or any other specified package.

Produced for NICE by the Health Economics Research Group (HERG) at Brunel University, the tool is to support commissioners and policy makers, in local authorities and the NHS, in their investment decisions. Select an area of interest using drop down menus, and the tool will automatically estimate the smoking and ex-smoking populations based on up-to-date statistics. This population composition is used to model the impact of smoking on relevant endpoints, taking into account short-, medium- and long-term events.

The tool builds on previous work including work undertaken by HERG on behlaf of Tobacco Free Futures, Fresh Smoke Free North East and Smoke Free South West.

The tool is accompanied by a package of support materials, including a user guide and technical report, and can be downloaded using the links below.

This site contains the most up-to-date tool, so please ensure that you are using the latest version. The most recent version is **version 1**- check this page regularly to ensure the tool you have downloaded is up to date.

Supporting documents

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Pokhrel, S., Owen, L., Lester-George, A., Coyle, K., Coyle D., Trapero-Bertran M. Tobacco Control Return on Investment Tool. 2012. London: National Institute for Health and Clinical Excellence.

http://www.nice.org.uk/usingguidance/implementationtools/returnoninvesment/TobaccoROITool.jsp

EQUIPT (EUROPEAN-STUDY ON QUANTIFYING UTILITY OF INVESTMENT IN PROTECTION FROM TOBACCO)

Cuantificar la utilidad de la inversión en la protección del tabaco en los países europeos para promover las decisiones basadas en la evidencia y contribuir a la armonización de tomar decisiones de financiación utilizando herramientas que informen la toma de decisiones

http://equipt.ensp.org/

EQUIPT
European-study on Quantifying Utility of Investment in Protection from Tobacco

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EQUIPT is a **comparative effectiveness research (CER) project in tobacco control**, funded by the European Commission's Seventh Framework Programme (FP7).

EQUIPT brings together expertise from multiple disciplines and aims to provide policy makers and wider stakeholders with bespoke information about the economic and wider returns that investing in evidence-based tobacco control including smoking cessation agendas can generate.

Led by Health Economics Research Group (HERG) at Brunel University, London, EQUIPT is a partnership of 11 consortium members from 7 member states – Belgium, Croatia, Germany, Hungary, the Netherlands, Spain and the UK.

EQUIPT is built around **five synergistic themes**:

WP1 →	WP2 →	WP3 →	WP4 →	WP5
Understanding Context	Tool co-creation	Evidence Transfer	Policy Proposals	Communication

NEWS

October 21, 2013
Tool to measure the effect of smoking interventions wins €2 million EU funding // A Brunel University-led project to develop a decision-support tool comparing the cost of anti-smoking interventions with savings to the local economy and the wider

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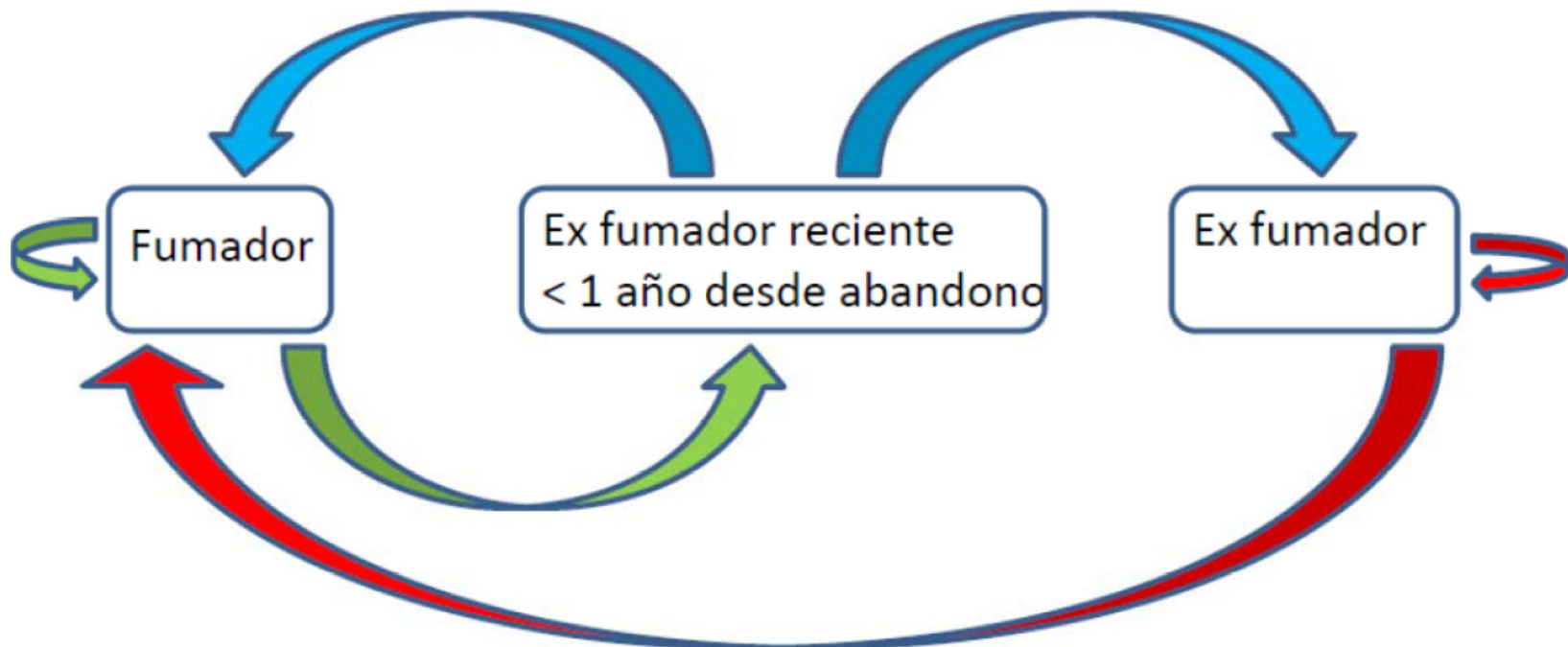| Activity	Tasks
Comparative assessment of contexts in which tobacco sits in sample countries	1. Desk reviews of literature 2. Survey data analysis 3. Collection of parameters
Needs assessment to inform how differential contexts demand most appropriate approach to ROI tool development and usage of the tool	1. Stakeholder interviews 2. Stakeholders consensus meetings
Development of core components and country-specific components (local models) of the ROI tool	1. Economic modelling 2. Quality checks and validation 3. User-interface development
Comparative effectiveness research (CER), based on local ROI models, to identify key determinants of policy decisions	1. Within and cross-country analysis of outputs from local model 2. Identification of causes of variability
Drawing policy recommendations	1. Contextualisation of research findings
Testing of transferable policy recommendations	1. Collection of additional data from out-of-sample countries

HERRAMIENTA PARA MURCIA (SIMDFRM)

Proyecto **SimdfRM**

- Proyecto **Sim**ulación de intermenciones para **d**ejar de **f**umar en la **R**egión de **M**urcia
- Apoyo financiero desde la Consejería de Sanidad de la CARM
  - Equipo investigador:
    - Grupo de I+D en Economía, Políticas Públicas y Salud de la UPCT
    - Marta Trapero Bertran
- Modelo epidemiológico-económico que proyecta la evolución de una cohorte poblacional en función de su estatus con respecto al tabaco y su estado de salud y predice resultados de utilización de servicios sanitarios, y CVRS en un horizonte temporal largo, con diversos indicadores del coste efectividad / beneficio de la intervención

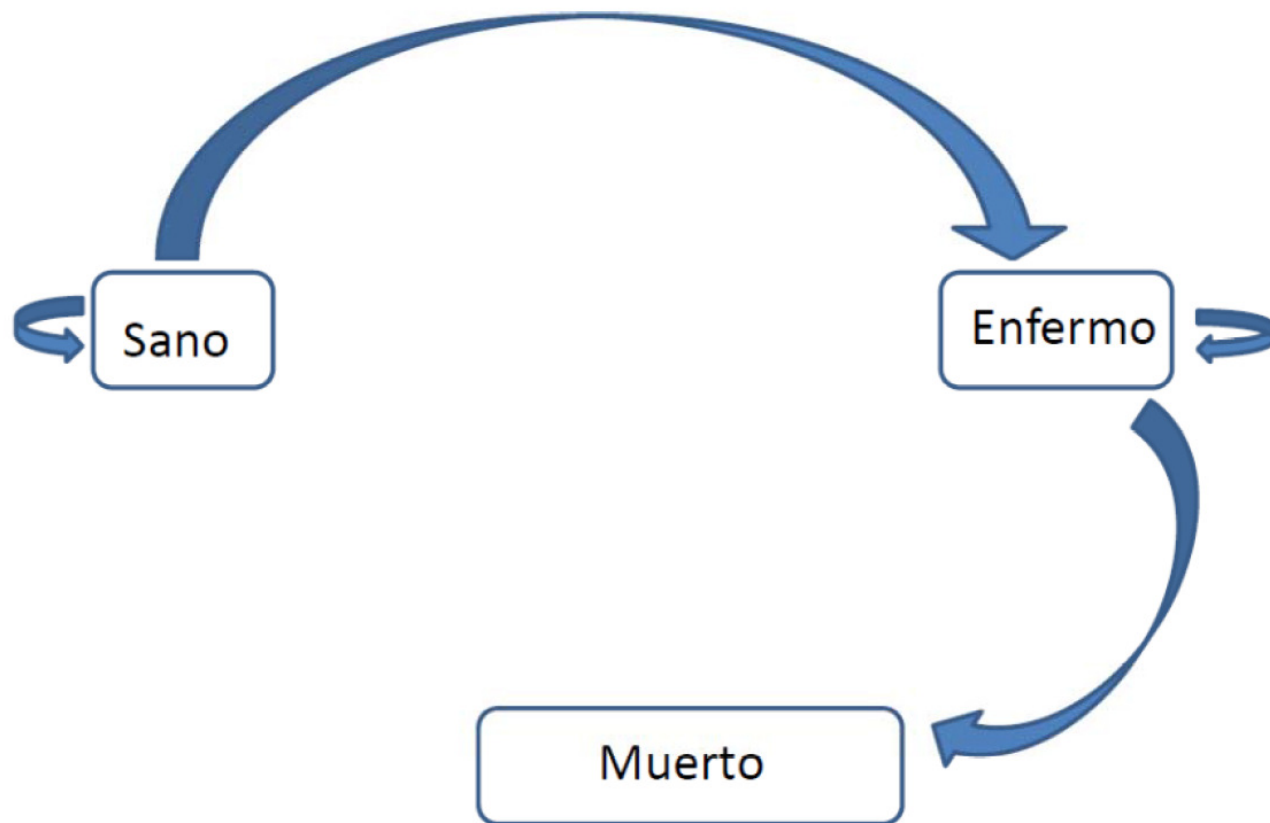*"Entre todos se puede..."*

Esquema del modelo

1) Intervenciones que incentivan dejar de fumar: fiscalidad, restricciones al consumo, campañas de información

2) Intervenciones que evitan la recaída a corto plazo: tratamientos farmacológicos y conductuales

3) Intervenciones que evitan la recaída a largo plazo: 1) y 2)

Esquema del modelo

Enfermedades: EPOC, Ictus, Cáncer de Pulmón, Enfermedad Coronaria y Asma

Ningún modelo es perfecto....

Pero aporta transparencia a la toma de decisiones