

Economic evaluation in social care: introduction

A photograph of a vast field of green crops, likely corn or wheat, under a sunset sky. The sun is low on the horizon, casting a warm orange glow over the scene. The field stretches towards the horizon, with some trees visible in the distance.

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**NIHR SSCR webinar
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- Why do we need economic evaluation?
- Design
- Costs
- Outcomes
- Trade-offs
- Examples
- Challenges



A photograph of a vast field of wheat under a sunset sky. The sun is a bright, glowing orb in the center of the horizon, casting a warm orange and yellow light across the scene. The wheat stalks in the foreground are in sharp focus, showing their green leaves and developing grain heads. In the background, a line of trees and a distant horizon are visible under a clear sky with a few wispy clouds. The overall mood is peaceful and contemplative.

**Why do we need
economic evaluation?**

The underlying problem is scarcity

- Almost all resources are almost always **scarce**.
- So we (= *society*) cannot meet every need, or agree to every request, or accommodate every preference.
- And so we (= *society*) must **choose** how to get the best out of our available resources.

Consequently ...

- ... any new policy idea or ‘intervention’ (service, treatment etc.) is looked at very carefully: Is it **effective**? Is it **affordable**? Does it **save money**? And is it **cost-effective**?
- Of course, these economic criteria are considered alongside other criteria too.

Where can economics be helpful?

- **Comparison** – between services, policies, localities or providers; maybe for monitoring (policy) or mutual learning
- **Commissioning** of services (e.g. by public sector bodies)
- **Individuals' own choices** – to find out what works
- **Provision** of services - to improve delivery or quality
- **Marketing of products** – to support manufacturers / sellers
- **System management** – by government, to understand how best to improve the performance of a health or other system
- **Guideline development** – e.g. health & social care through 'technology evidence' appraisal
- **Regulation / inspection** of services
- **Policy development (generally)** – to identify aspirations
- **Lobbying** – by interest groups / advocacy bodies

Note: Different uses will require different analyses

The core *economic evaluation* question

If the policy/practice question is:

‘Is this intervention effective?’

... then the economic question is:

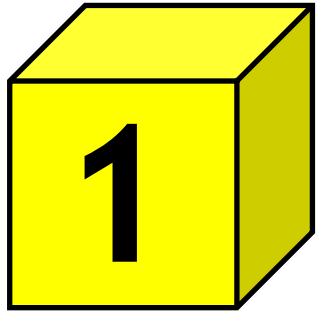
‘Is it worth it?’



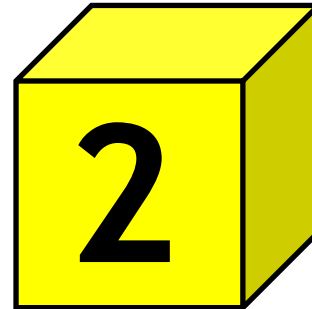
So ... we must define what we mean by ‘effective’ and ‘worth’ → i.e., we need to measure **outcomes** and **costs**.

Often the decision-maker faces difficult trade-offs between higher costs and better outcomes

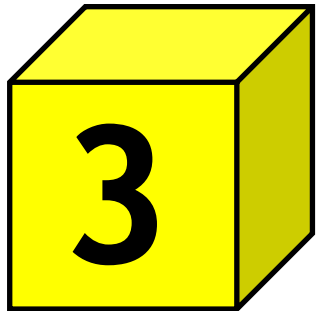
Building blocks for economic evaluation



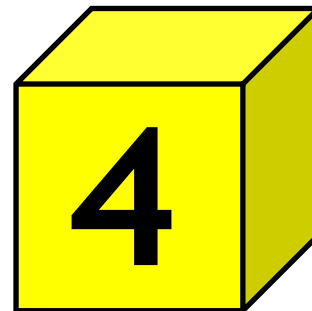
Design



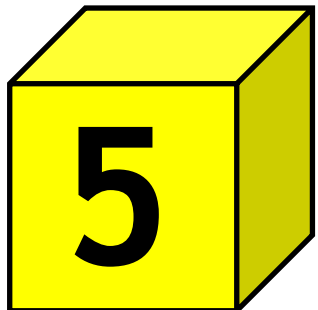
Costs



Outcomes



Trade-offs



Recommendations

Various types of economic evaluation ... and many different labels

Cost-effectiveness analysis

Cost-benefit

We will define these terms later, but they overlap (and unfortunately are used inconsistently).

Arguably, the label is not important so long as it is absolutely clear what is being measured and how

Short-term investment

A photograph of a vast field of wheat under a sunset sky. The sun is a bright, glowing orb in the center of the horizon, casting a warm orange and yellow light across the scene. The wheat stalks in the foreground are in sharp focus, showing their green leaves and developing grain heads. In the background, a line of trees and a distant town are visible against the horizon. The sky is a mix of soft orange, yellow, and pale blue, with a few wispy clouds and a faint contrail. The word "Design" is written in a bold, yellow, sans-serif font on the left side of the image, partially overlapping the wheat field.

Design

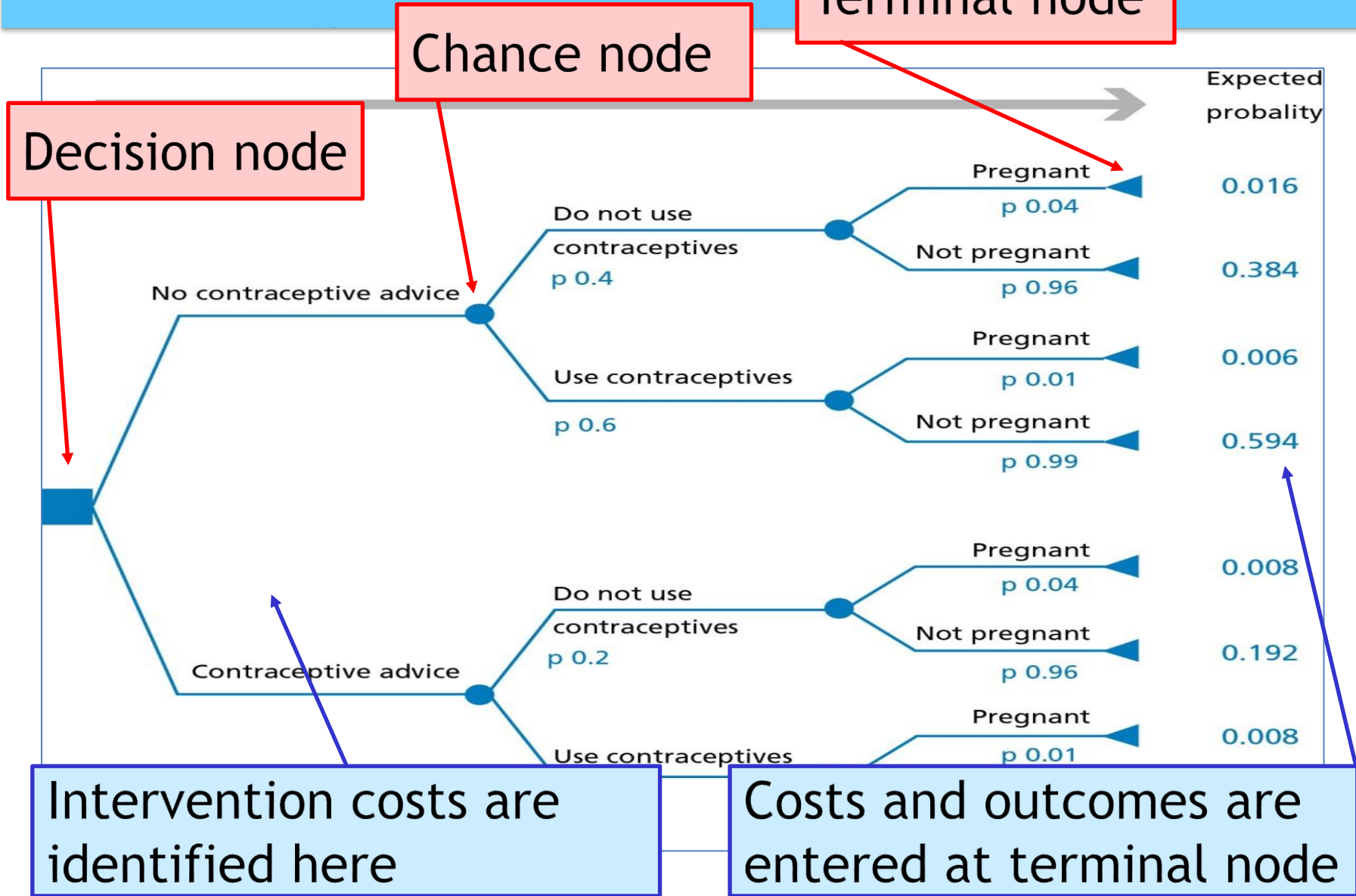
Evaluation designs - main approaches

- Simple **before-after calculations** (with no 'parallel' comparison group).

Designs with a 'parallel' comparison group include:

- **Randomised trial** – allocate people to interventions by chance
- **Quasi-experimental design** – allocate people to interventions in some other way
- **Observational study** – look at people in the groups to which they are already 'allocated' by services
- **Mathematical modelling** – simulate some parts of the evaluation using existing data

Decision tree: contraceptive advice



A photograph of a vast field of green wheat under a sunset sky. The sun is a bright orange orb in the center of the horizon, casting a warm glow over the scene. The wheat stalks are in the foreground, showing their developing grain heads. The background features a line of trees and a distant horizon under a clear sky with a few wispy clouds.

Costs

- A. Cost breadth
- B. Service utilisation
- C. Unit costs

Cost measurement: three stages

- A. Decide which *costs are relevant*
- B. Collect data on *service utilisation patterns* and similar activity indicators
- C. Attach *unit costs* to those indicators

A. Cost breadth depends on perspective

Health & social care system perspective

- Home care
- Inpatient services
- Outpatient, A&E
- Community health
- GP time
- Psychological therapy
- Social work inputs
- Residential care
- Etc.

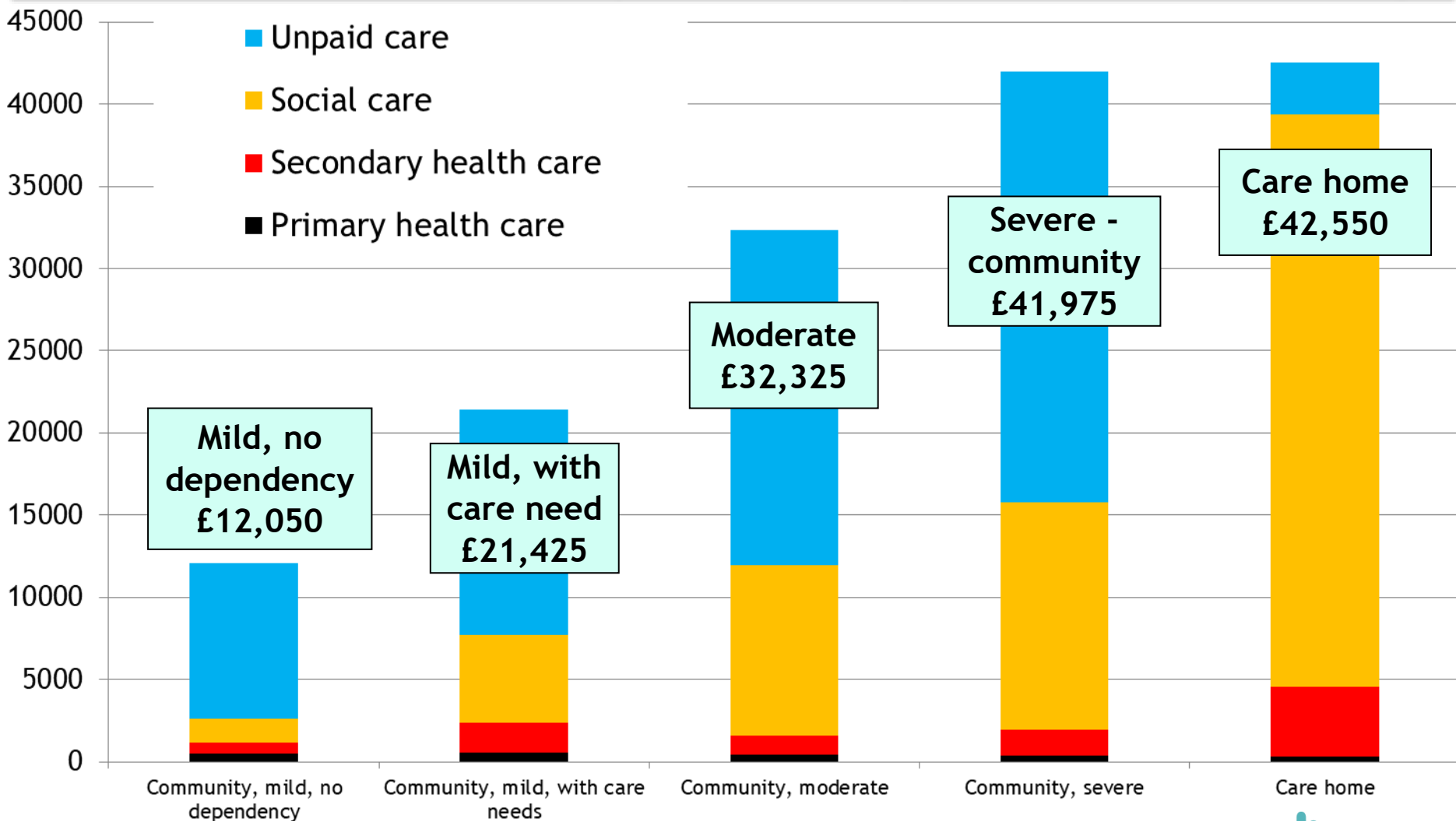
Public sector perspective

- Health & social care (*minus* user payments)
- Other public services
- Welfare benefits

Societal perspective

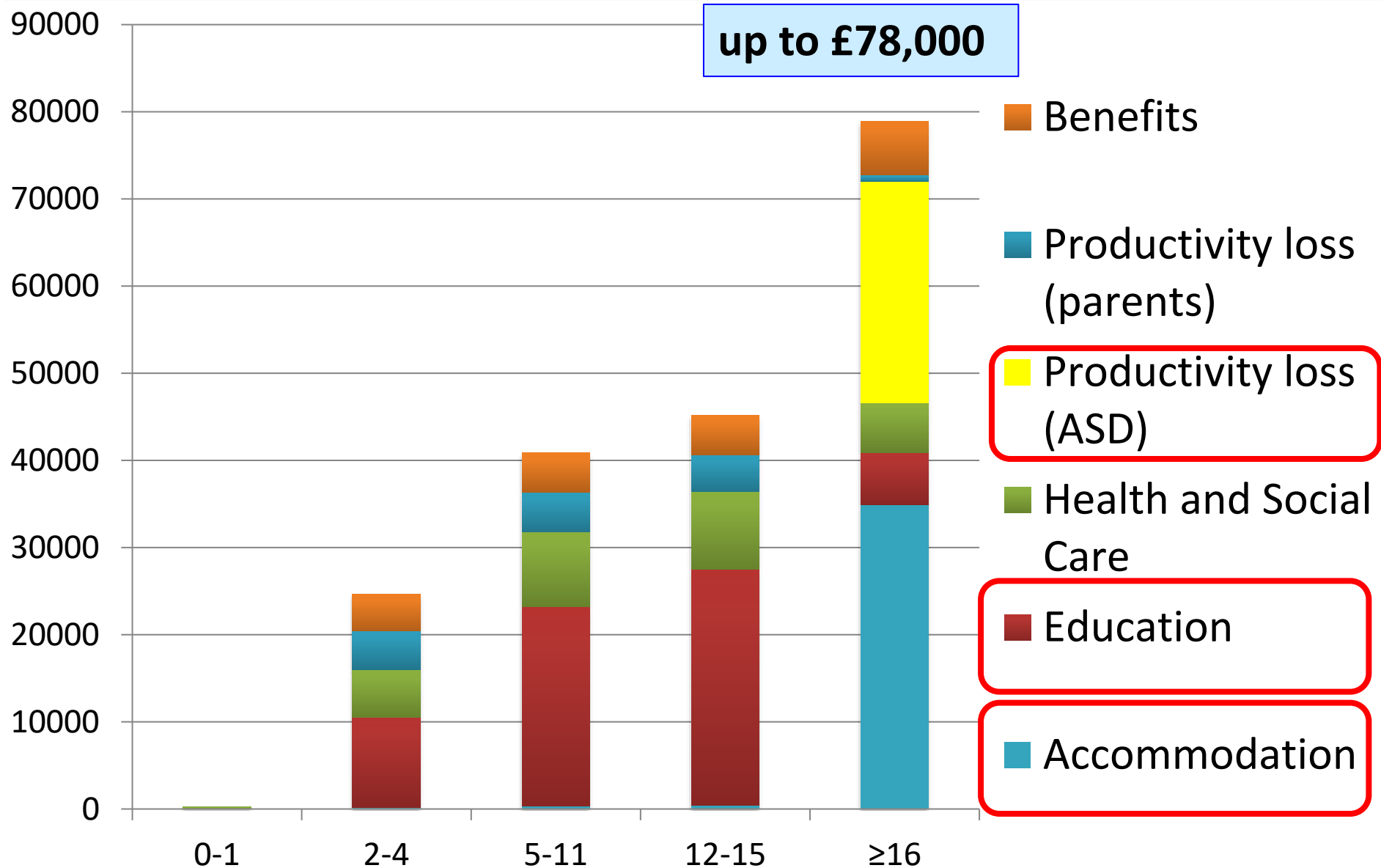
- All of the above... plus:
- User & family ('out-of-pocket') payments
- Lost productivity
- Cost of unpaid care

Example #1: Average annual cost for dementia care, by severity & care setting



Wittenberg et al *Int J Geriatric Psychiatry* 2019

Example #2: Annual cost per autistic adult *with* intellectual disabilities, Scotland (£)



B. Utilisation patterns

How many service 'units' does an individual utilise? E.g. how many therapy sessions, day centre attendances?

Sources of this information?

- **User recall:** e.g. how many attendances in the past month?
Face-to-face, telephone, postal, web-based
- **Proxy recall:** information from family members or service staff
- **Diaries** completed prospectively by individuals / carers
- **Case files** for individual service users
- **Staff** consultation / visit records
- **Management information systems**
- **Billing systems**

These data are very easily and cheaply collected alongside outcome evidence

C. Unit costs - different options

- **Prices** or user charges – if we think market forces reflect social opportunity costs
- **Expenditure** by service providers (from accounts), divided by volume of provision or number of users
 - Previously calculated '**off-the-shelf**' unit costs – annual PSSRU volume for health & social care is 'priceless'
- **Opportunity costs** - the value of alternatives or opportunities missed (the benefit forgone by losing its best alternative use) ...
- ... especially important for *non-marketed inputs* such as (unpaid) carer time or volunteer activities

Note: The PECUNIA project will be reporting soon...

Example #3 What is the cost of unpaid care?

- ***Out-of-pocket payments*** – for travel, care assistance etc.
- ***Lost earnings*** (either carer-specific salary data; or average earnings; or National Minimum / Living Wage)
- ***Benefit payments*** (Carers' Allowance etc.)
- Impact on carer's own health – ***costs of health services***
- Value of time *not diverted* from employment; different methods (sometimes used in combination):
 - Opportunity cost
 - Replacement cost
 - Stated preference
 - Wellbeing



Outcomes

A. Effects ('natural' units)

B. Money

C. Utility

D. Wellbeing

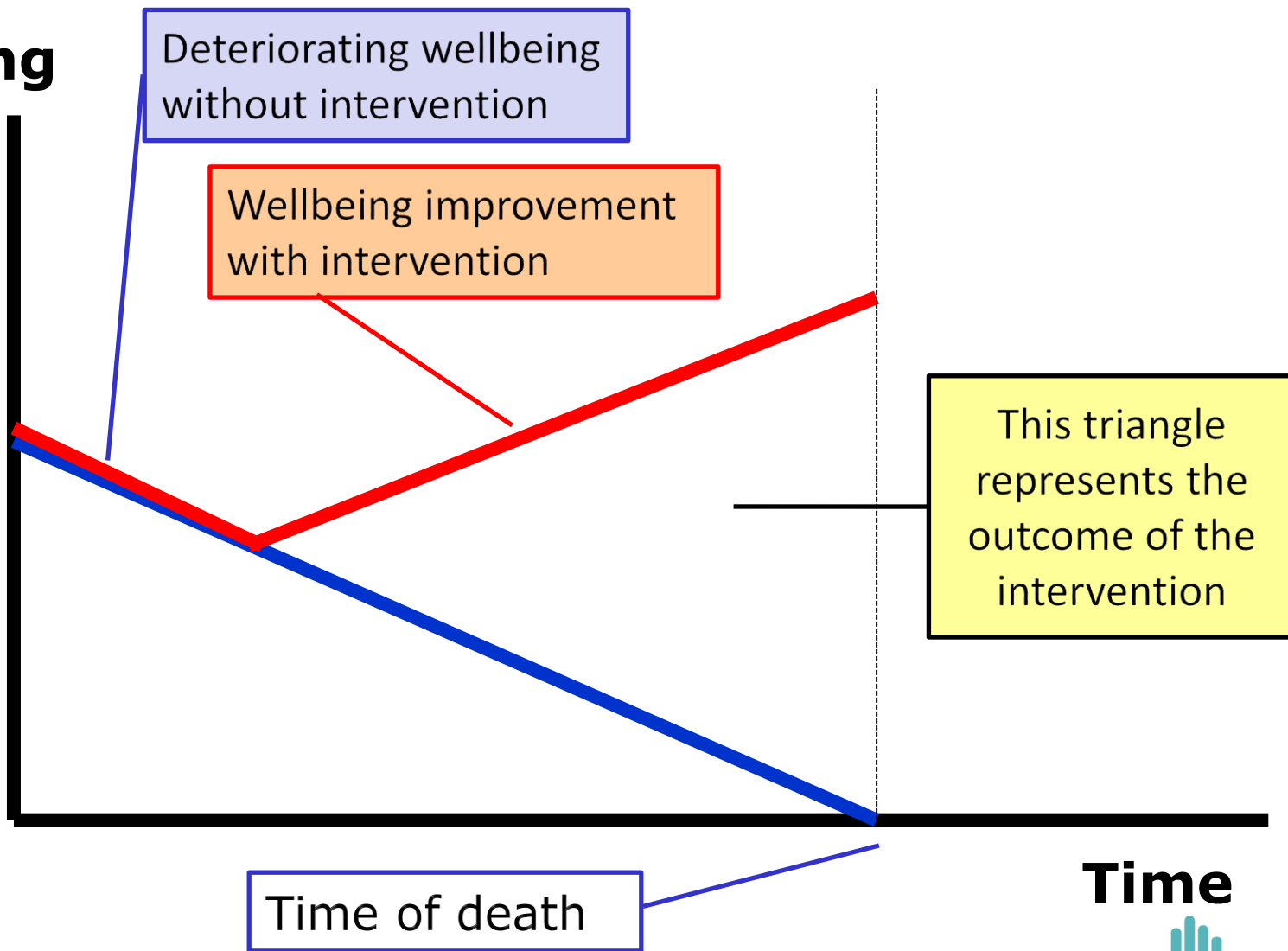
Outcomes: what should they look like ideally?

- a. directly link to the **service aims**
- b. involve **people with lived experience**
- c. capture **impacts on everyone** affected
- d. decide **who to ask** for the data
- e. be **quantitative** ... using robust measures (valid, reliable, sensitive etc.)
- f. supported by **qualitative** evidence to reflect individuals' experiences
- g. assess **change over time** ('before-after')
- h. assess change **in comparison** to an alternative
- i. allow **comparison across studies** or settings
- j. take account of **time preference** - discounting



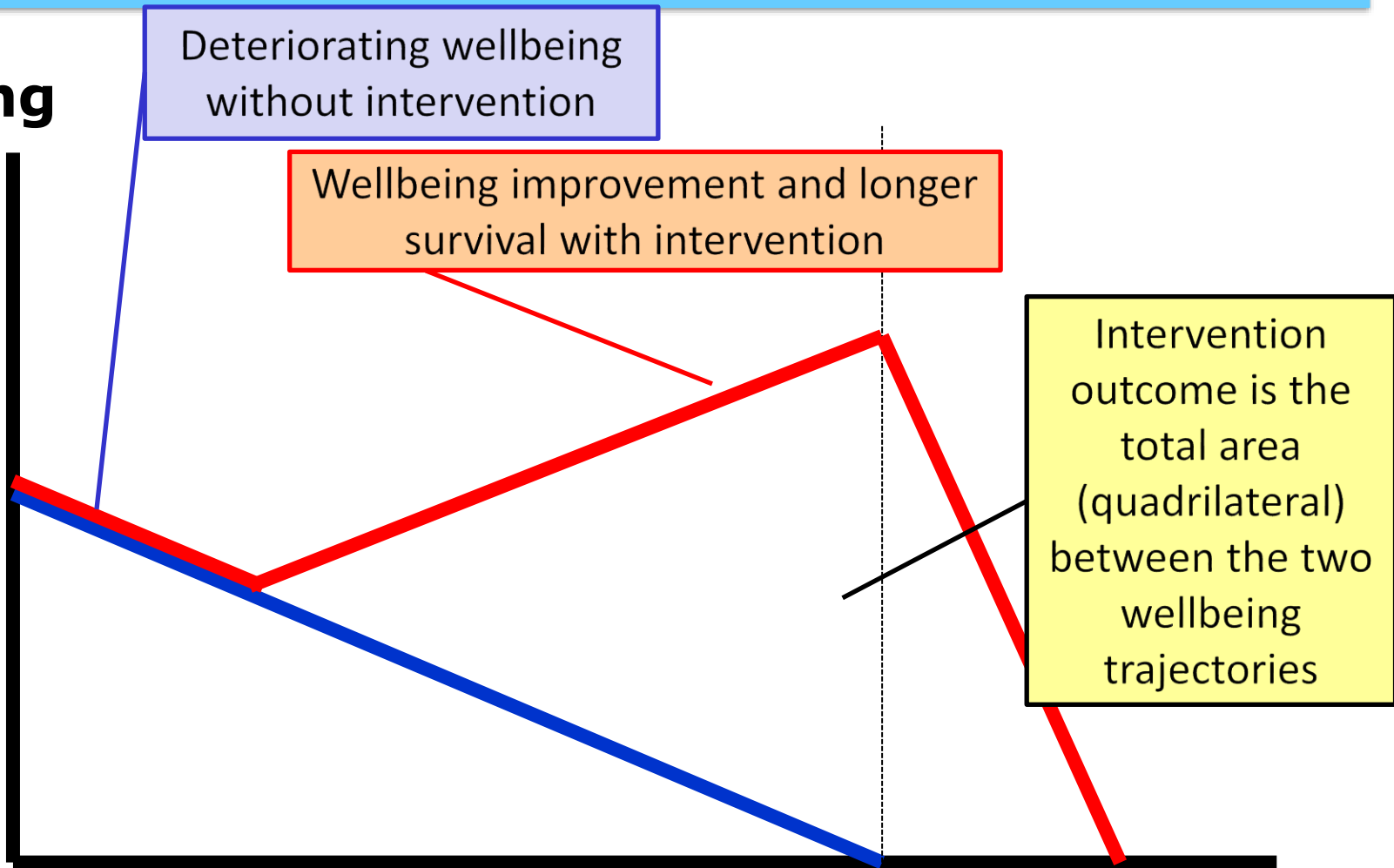
Measuring outcomes - 1

Wellbeing



Measuring outcomes - 2

Wellbeing



Deteriorating wellbeing without intervention

Wellbeing improvement and longer survival with intervention

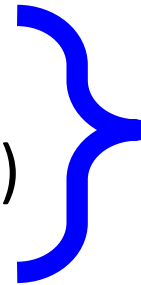
Intervention outcome is the total area (quadrilateral) between the two wellbeing trajectories

Time of death

Time

Different outcome measures are needed for different priority-setting tasks

- A. **Effects** in ‘natural’ units
- B. **Money**
- C. **Utility** (QALYs in healthcare)
- D. **Wellbeing** (high-level)



**Generic
outcome
measures**

Effect measures are the most ‘natural’ or ‘intuitive’ – linked directly to service or policy aims.

But:

- Different effect measures might go in different directions, so which indicator should ‘dominate’?
- Many decisions span more than one topic / need / context: do we need more generic measure?

A. Outcomes measured in terms of 'effects' are context-specific (e.g. health & social care)

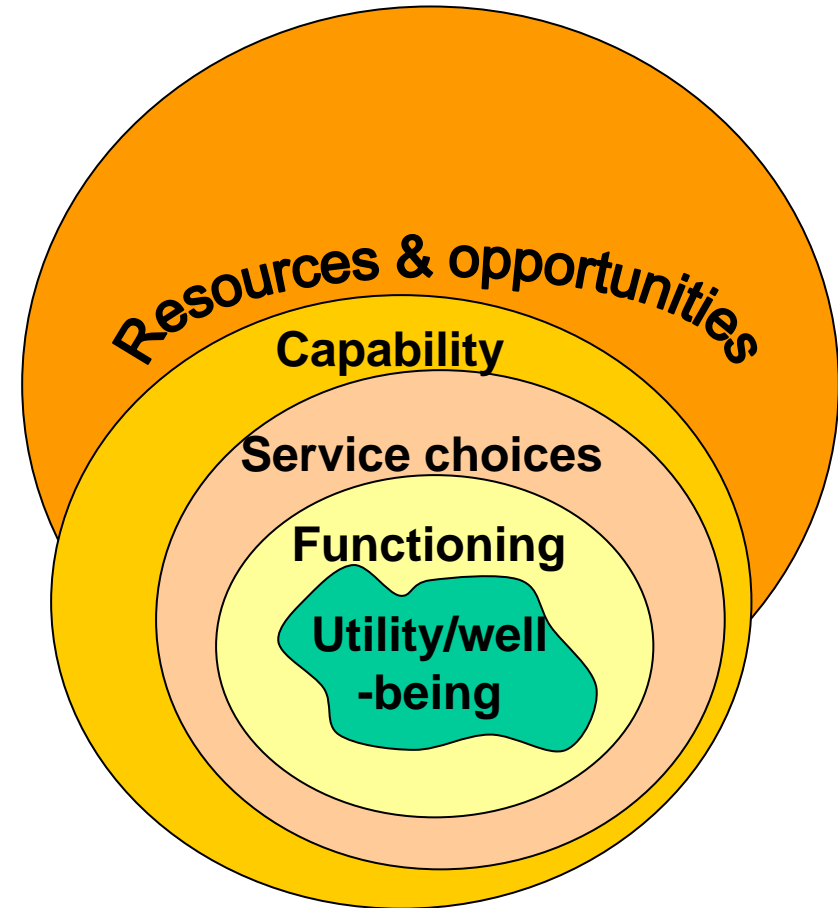
- Symptoms of illness
- Extent of disability
- Needs (met, unmet)
- Social functioning
- Independence
- Self-care abilities
- Employment & leisure activities
- Behavioural characteristics
- Quality of life (need or condition-specific)

- Choice & control
- Family well-being
- Carer 'impact'
- Societal perceptions

Generic indicators (health)

- Health-related quality of life (= 'health') eg SF36
- Quality-adjusted life years (QALYs)
- Disability-adjusted life years (DALYs)

- Personal cleanliness and comfort
- Food and drink
- Safety
- Clean and comfortable accommodation
- Social participation and involvement
- Control over daily living
- Occupation
- Dignity



B. Outcomes measured in terms of money

- **What expenditure is saved?** ... But we need to go much further than just measuring cost savings.
- **Stated preference** – Just ask people! But do people answer honestly, or can they do so accurately?
- **Revealed preference** – Observe how people make decisions already, and infer the value implicitly attached.
- **Compensation settlements** through litigation – Unreliable
- **Market value** of (some?) outcomes; e.g., productivity gains from higher employment rate

But note: Money is worth (in wellbeing terms) different amounts to different people (e.g., it varies with an individual's income)

C. Outcomes measured in terms of utility

- Utility - a generic measure combining quality and quantity of life; widely used in health services research



Jeremy Bentham



John Stuart Mill



William Stanley
Jevons

C. Outcomes measured in terms of utility

- Utility - a generic measure combining quality and quantity of life; widely used in health services research
- Combine dimensions of health-related QOL using **societal weights**
- **QALYs (quality-adjusted life years)** combine years of (extra) life with quality of life
- QALY range: 0 (*death*) to 1 (*perfect health*)
- **Evaluation question**: How many **additional QALYs** are generated by treatment / care (relative to a comparator)?
- Most frequently used QALY-generating tool *in health economics* is **EQ-5D**

Tools for measuring utility

Generic health-related quality of life: EQ-5D

- Consists of 5 attributes: Mobility, Self-care, Usual activity, Pain/discomfort, Anxiety/depression
- And (now) 5 possible levels: 1=bad, 2=rather bad, 3=satisfying, 4=good, 5=very good
- Combining attributes with levels gives 3125 possible health states, plus 'unconscious and 'dead'
- Preferences between health states obtained from large samples (using time trade-off or other techniques)

Condition-specific utility measures; examples:

- DEMQOL for dementia (see later class)
- ReQol for mental health

ASCOT:

- Can generate **social care-specific** QALYs

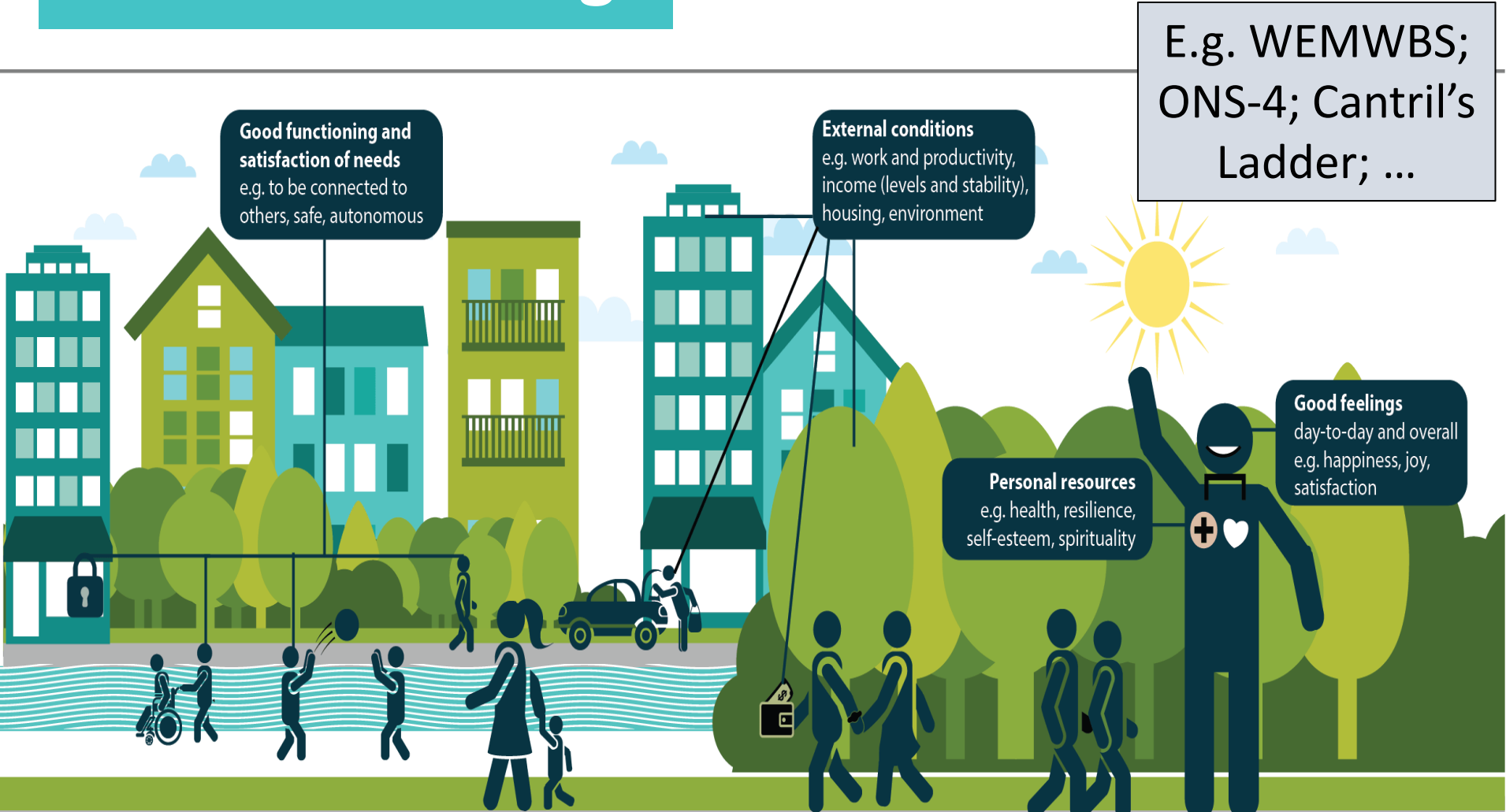
D. Outcomes measured in terms of wellbeing

Wellbeing (especially hedonic) as the most generic way to reflect outcomes

What Works Centre for Wellbeing

What is wellbeing?

E.g. WEMWBS;
ONS-4; Cantril's
Ladder; ...





Trade-offs

The core *economic evaluation* question

If the policy/practice question is:

‘Is this intervention effective?’

... then the economic question is:

‘Is it worth it?’



So ... we must define what we mean by ‘effective’ and ‘worth’ → i.e., we need to measure **outcomes** and **costs**.

Often the decision-maker faces difficult trade-offs between higher costs and better outcomes

Economic evaluation: dominance

If one intervention is *more effective* and simultaneously *less costly* than its comparator, then it is said to **dominate**.

The recommendation to the decision-maker - at least on these *resource efficiency grounds* - is straightforward.

Trade-offs: Is it worth it? (#1)

If an intervention is more effective but also more costly, then calculate the cost per unit gain in outcome (effectiveness). So . **Is it worth it?**

Trade-offs: Is it worth it? (#2)

If an intervention is more effective but also more costly ... then what does it cost to achieve the outcome gain? And ... **Is it worth it?**

Health economists usually calculate the **incremental cost-effectiveness ratio (ICER)**:

$$\text{ICER} = \frac{(C_2 - C_1)}{(E_2 - E_1)}$$

where C = cost; E = effectiveness;
1 and 2 are different services
or interventions or policies

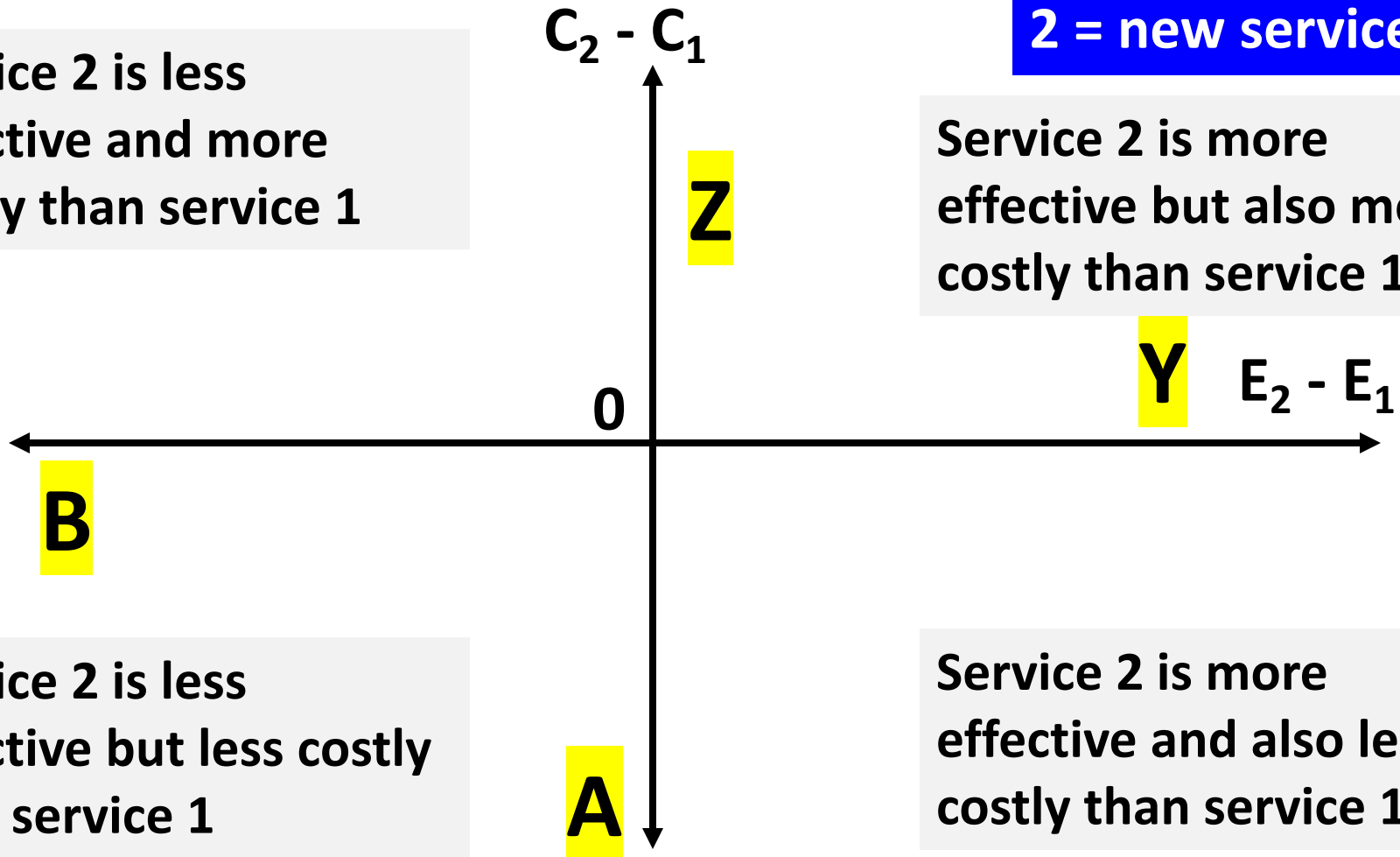
= the cost of achieving one additional unit (an incremental improvement) of outcome

Possible results from a cost-effectiveness analysis

C = costs
E = effects
1 = old service
2 = new service

Service 2 is less effective and more costly than service 1

Service 2 is more effective but also more costly than service 1



Service 2 is less effective but less costly than service 1

Service 2 is more effective and also less costly than service 1

Trade-offs: Is it worth it? (#3)

How to reach a decision?

- Show decision-makers the cost-effectiveness findings; **leave them to choose** their preferred option.
- Ask decision-makers to be *explicit* about their **willingness to pay** for the improvement in outcomes.
- Set a **threshold**, rigidly or as a guide. E.g. NICE in England & Wales uses **cost per QALY** to compare across disorders / diseases: current guide (whose relevance is however disputed) is £20,000 per QALY.
- **Note**: Thresholds of this kind are merely guides, and NICE often recommends interventions that don't appear to be cost-effective by reference to the threshold.

Main types of (*health*) economic evaluation

	Outcome measures	Strengths and limitations
Cost-minimisation analysis	None – outcomes assumed equivalent across interventions	Limited use unless outcome evidence is convincing
Cost-effectiveness analysis (CEA)	Single ('primary') outcome such as symptoms <u>or</u> independence	Limited by focus on single outcome, but any recommendations will be unambiguous
Cost-consequences analysis (CCA)	Multiple outcomes such as symptoms <u>and</u> independence <u>and</u> QOL	Can capture all outcomes. Not always easy to form recommendations if outcomes point in different directions.
Cost-utility analysis (CUA)	Generic, utility-based measure such as QALY or DALY	Useful for strategic decision-making in health sector. QALY/DALY measures too generic? Miss nuances of mental illness
Cost-benefit analysis (CBA)	Monetary values of outcomes, plus any savings in budgets	Useful for strategic decision-making across <u>all</u> sectors. But difficult to monetize MH outcomes
Wellbeing economic evaluation	Subjective (probably hedonic) wellbeing	Useful for strategic decision-making across policy sectors. But does generic indicator miss the nuances of MH?

A photograph of a cornfield at sunset. The sun is a bright orange circle in the sky, casting a warm glow over the field. The corn plants are in the foreground, and the field extends to the horizon. The sky is a mix of orange and blue.

Examples

A. Carer support (START)

B. NICE guideline: older people with learning disabilities

C. Services for homeless adults

D. Hearing dogs

Example A: Carer support (START)

- **Research question:** Is a structured programme of support (START) for family carers of people with dementia effective and cost-effective?
- **Design:** RCT comparing START with carer support as usual; 260 carers; analyses at 8, 24 and 72 months.
- **Cost measurement:** Health & social care services (carer; then carer + person with dementia); no unpaid care costs
- **Outcomes:** **Carer** mental health (*Hospital Anxiety and Depression Scale - HADS*), 'burden' (Zarit), coping, health status, QALYs. **Person with dementia** severity of dementia, neuropsychiatric symptoms, quality of life, mortality, care home admission

Evaluation of START: RCT conducted over 72m

Long-term clinical and cost-effectiveness of psychological intervention for family carers of people with dementia: a single-blind, randomised, controlled trial



Gill Livingston, Julie Barber, Penny Rapaport, Martin Knapp, Mark Griffin, Derek King, Renee Romeo, Debbie Livingston, Cath Mummery, Zuzana Walker, Juanita Hoe



Summary
Background Two frequently developed effectiveness (long-term psychological in

BMJ

BMJ 2013;347:f6276 doi: 10.1136/bmj.f6276 (Published 25 October 2013)

Page

RESEARCH

Methods We did services and one dementia who had dementia. We ran independent clin supervised psych symptoms (Hos effectiveness (the carers with data

Clinical effectiveness of a manual based coping strategy programme (START, STRategies for Relative) in promoting the mental health of carers of family members with dementia: a randomised controlled trial

OPEN ACCESS

Gill Livingston *professor of older people*
Penny Rapaport *principal clinical psych*
Griffin *lecturer in medical statistics*², Der
Cath Mummery *consultant neurologist, h*
*of the elderly*¹, Juanita Hoe *senior clinic*
*lecturer*¹, Claudia Cooper *clinical senio*

BMJ

BMJ 2013;347:f6342 doi: 10.1136/bmj.f6342 (Published 25

Cost effectiveness of a programme in promoting carers of people with dementia (for Relatives) study): a randomised controlled trial

OPEN ACCESS

Martin Knapp *professor of social policy; professor of health economics*^{1,2}, Derek King *research fellow*¹, Renee Romeo *lecturer in health economics*², Barbara Schehl *visiting student*¹, Julie Barber *lecturer in medical statistics*³, Mark Griffin *lecturer*¹, Penny Rapaport *principal clinical psychologist*², Debbie Livingston *trial manager*⁵, Cath Mummery *consultant neurologist*⁶, Zuzana Walker *reader*

Individual programme of 8 sessions over 8-14 weeks. Delivered by psychology graduates + manual. Carers helped to:

- understand behaviours of person they support
- manage behaviour
- change unhelpful thoughts
- promote acceptance
- improve communication
- plan for the future
- relax
- engage in meaningful, enjoyable activities.

Livingston et al *BMJ* 2013

Knapp et al *BMJ* 2013

Livingston et al *Lanc Psy* 2014

Livingston et al *BJPsych* 2019

English adaptation of *Coping with Caregiving Programme* in USA

START: effectiveness and cost-effectiveness

Carer health & quality of life

- Mental health improvements at 8m, 24m and 72m
- QALY gains at 8m and 24m (not assessed at 72m)

Person with dementia health & quality of life

- No differences in health or QOL at 24m (not assessed at 72m)

Costs of health & social care services

- Increased carer healthcare costs at 8m (*not sig*)
- Reduced total health & social care costs at 24m (*not sig*)
- No cost difference from 25m to 72m ($p=0.07$)

Cost-effectiveness

- £118 per 1-point change on HADS-total; £6000 per QALY at 8m
- START *dominates* usual care: better outcomes, lower(?) costs

Livingston et al *BMJ* 2013; Knapp et al *BMJ* 2013; Livingston et al *Lanc Psych* 2014; Livingston et al *BJPsych* 2019

START: recommendations

- **Better mental health for carers:** “At 2-year follow-up, carers in control group were ***seven times more likely*** to have clinically significant depression than in START intervention group.”
- By 6-year point, it was ***five times more likely***
- **QALY gains too** – this helps in dialogue with HTA bodies.
- People with dementia were **no better or worse in health/QOL**
- Probable **delay to care home admission**, but sample size too small by 6-year follow-up
- By 6 years, **cost** per individual in START group is only a third of cost in the usual support group (not significant because of small sample)
- **NICE** recommendation

NICE social care guidelines

NICE Collaborating Centre for Social Care (NCCSC)

NCCSC Home

Guidance topics

Guidance topic resources






Quick guides

Webinars

Quality standard resources


Guideline topics

The NICE Collaborating Centre for Social Care developed 11 social care guidelines using NICE's methods and processes. They are available on the NICE website:

- Care and support of people growing older with learning disabilities 
- Child abuse and neglect 
- Decision making and mental capacity 
- Home care: delivering personal care and practical support to older people living in their own homes 
- Intermediate care including reablement 

Our new paper ... out soon!

Bauer A, Tinelli M, Weatherly H, ... Knapp M (2021) Value for money in social care: The role of economic evidence in the guideline development process of the NICE in England. *Journal of Long Term Care* – forthcoming.

- Transition from children's to adults' services for young people using health or social care services 

The work of the NCCSC has now been successfully completed, but SCIE has been commissioned by NICE to continue supporting the implementation of social care guidance. Find out more about NICE social care guidance.



NICE GUIDANCE 

Get SCIELine ebulletin & access all resources. Free MySCIE account

REGISTER

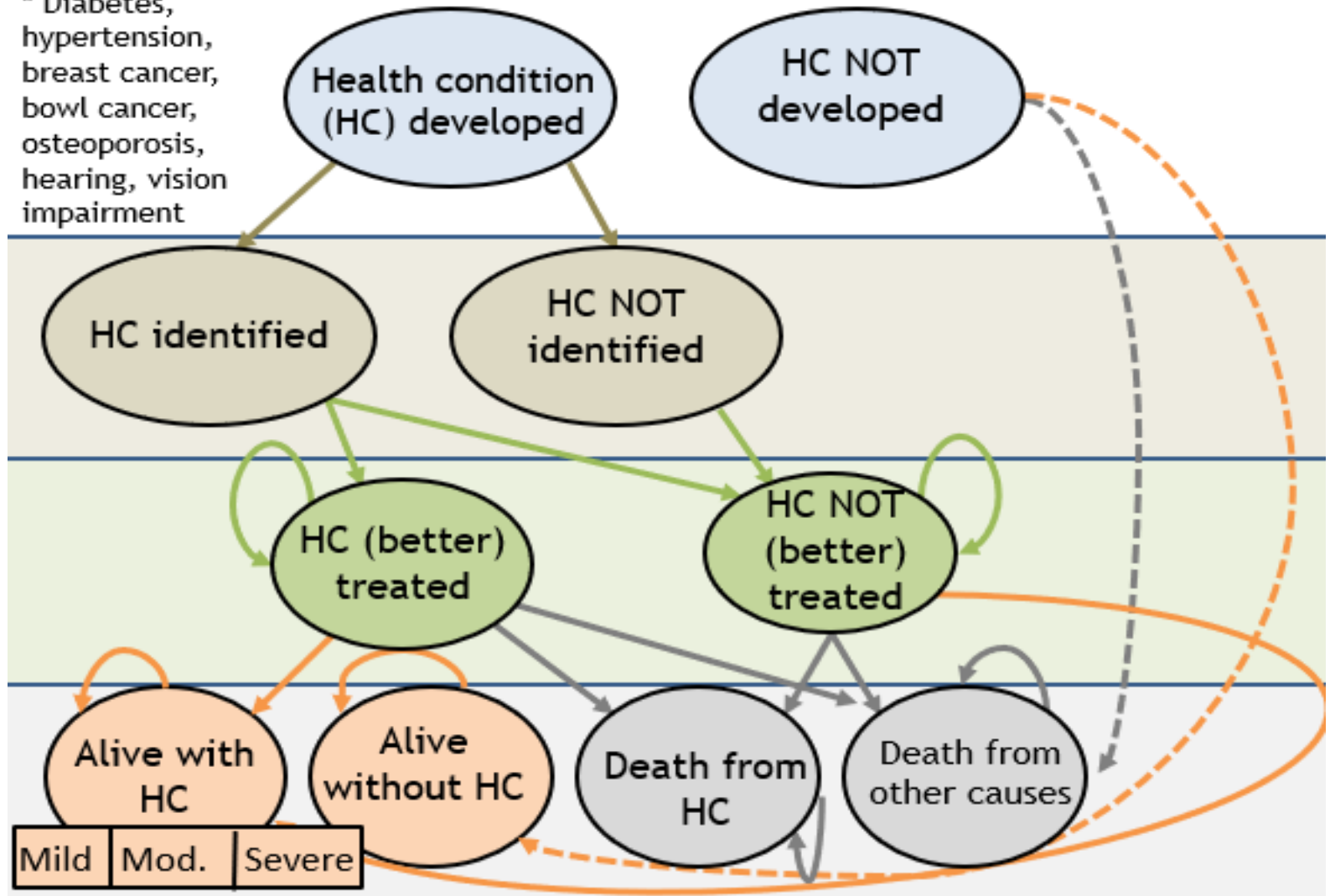
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Example B: Improving access to health care: health checks for older people with learning disabilities

- **Research question:** What is the acceptability, effectiveness and cost-effectiveness of interventions or approaches to improve access and referral to health, social care and housing support services for older people with learning disabilities?
 - **Are annual health checks cost-effective for this population?**
- **Design:** Decision-analytic Markov modelling; cost-utility
- **Cost measurement:** NHS and Personal Social Services
- **Outcome measurement:** Health-related quality of life (measured in QALYs)

Improving access to health care: health checks for older people with learning disabilities

* Diabetes, hypertension, breast cancer, bowel cancer, osteoporosis, hearing, vision impairment



Improving access to health care: health checks for older people with learning disabilities

Difference (Δ): AHC vs standard care	Δ Costs (excluding costs of AHC)	Δ Costs (including costs of AHC)	Δ Quality-adjusted life years (QALYs)	Δ Cost / Δ QALYs (excluding costs of AHC)	Δ Cost/ Δ QALYs (including costs of AHC)
Mean	£120	£4,911	0.0719	£1,670	£89,200
95% confidence interval	£105.80 to £341.30	£4,897 to £5,133	0.0695 to 0.113	£1,482 to £4,704	£86,252 to £136,769

Improving access to health care: health checks for older people with learning disabilities

According to NICE criteria, annual health checks are **not cost-effective** for this population

- Dilemma between economic and **ethical** arguments (partly due to knowledge gaps and methodological challenges)
- Disinvestment would lead to even greater **inequality and inequity** (with economic implications)
- Investment in **training and collaborative care** to ensure that universal systems support early identification and treatment
- More research needed on **(cost-)effective ways to support early identification and treatment** of long-term health conditions

Example C: hospital discharge services for homeless adults

- **Research question:** Is specialist homeless hospital discharge (HHD) care effective and cost-effective?
- **Design:** Observational study (1-year follow-up) comparing HHD vs. care as usual
 - 17 HHD services (3882 participants) in England
 - *plus* in-depth analyses of three sites (354 participants)
- **Cost measurement:** Service delivery costs (NHS and social care) + economic consequences for other public services
- **Outcomes:** Hospital bed-days avoided and QALYs

June 2021: 'First Look' summary of final report (led by Michelle Cornes, KCL). NIHR Journals Library

Hospital discharge services for homeless adults: the interventions

- **The 17 HHD services were grouped and compared as follow:**
 - **Comparison 1:** ‘Clinically-led’ services with those that were ‘housing-led’ (*vs. control*).
 - **Comparison 2:** Those that provided access to ‘step-down’ intermediate care with those that did not (*vs. control*).
- **Control (standard care)** - defined as one visit by the homelessness health nurse before discharge, during which individuals received an information leaflet describing local services.
- **Plus three in-depth case studies:**
 1. Clinically-led services *with no* step-down intermediate care
 2. Clinically-led services *with* step-down intermediate care
 3. Housing-led

Hospital discharge services for homeless adults: economic evaluation results

- Specialist homeless hospital discharge (HHD) care is more effective and cost-effective than standard care.
- **Clinically-led** increases costs for the NHS but improves access to elective (planned follow-up) care.
- **Housing-led** support schemes are as effective as clinically-led and cheaper (cost-saving).
- Hospital discharge schemes with **step-down intermediate care** are more cost-effective than those without.
- **In depth analyses**: **Clinically-led with step-down intermediate care** and **housing-led** are more cost-effective and cost-saving compared with **clinically-led with no step-down intermediate care** (NHS and the wider public sector).

Hospital discharge services for homeless adults: recommendations

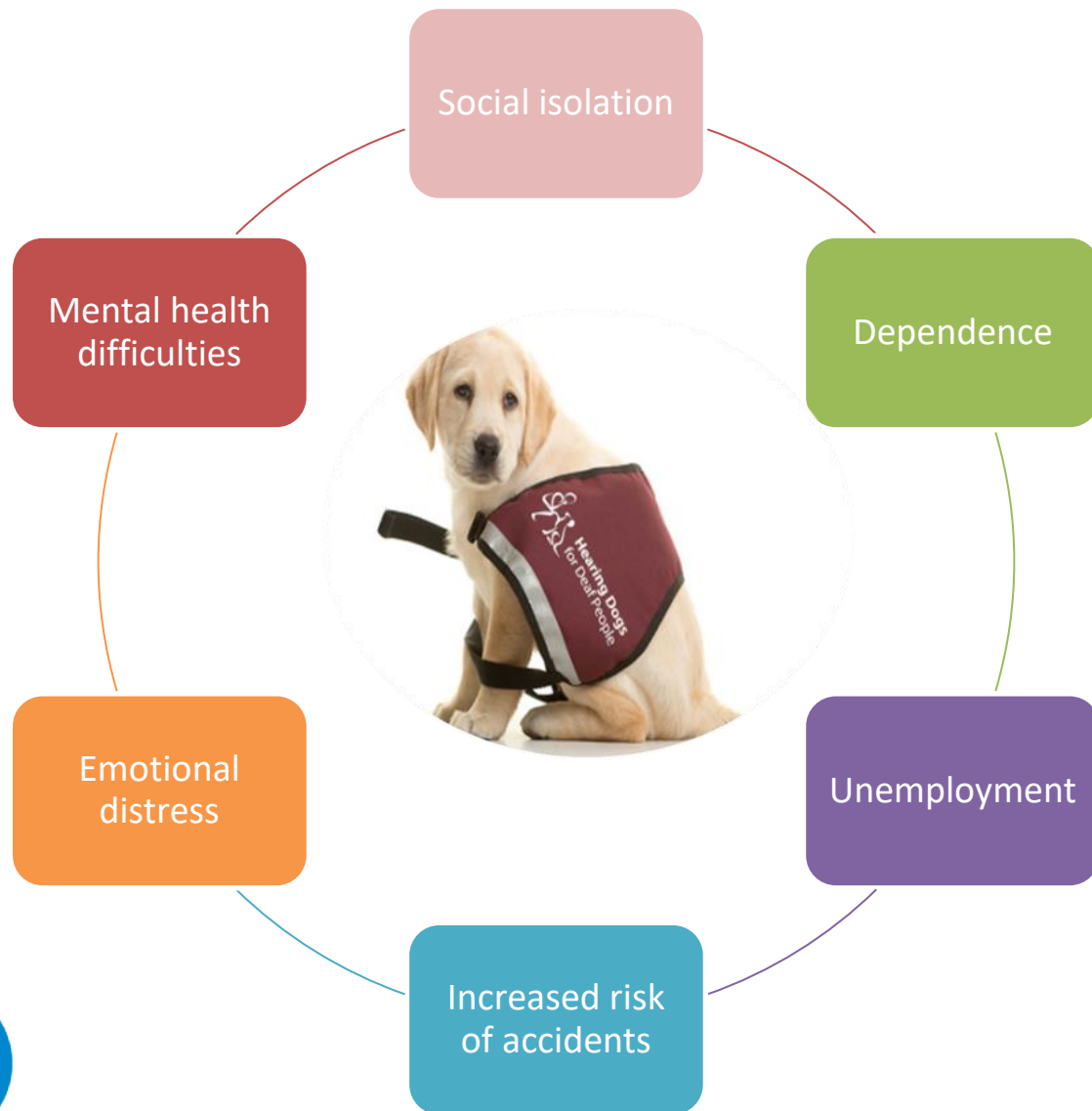
- Scale-up **clinically-led** homeless hospital discharge services to increase access to planned follow-up care.
- (Cheaper) **housing-led** schemes are more successful than originally anticipated (NHS and the wider public sector).
- Economic findings used to inform:
 - [Road map toolkit](#) to guide future intervention development.
 - **NICE guidance** in integrated health and social care for people experiencing homelessness (underway).
 - **DHSC-led reorganisation of homeless services in England** (underway).

Example D: Hearing Dogs (PEDRO)

- **Research question:** For people with severe and profound hearing loss, is a Hearing Dog (HD) effective and cost-effective? <https://www.hearingdogs.org.uk/>
- **Design:** RCT comparing use of a HD with no HD. Use of a waiting-list design; 165 people with hearing loss randomised; analyses at baseline and at 6 months.
- **Cost measurement:** Cost of a HD, social care and health care services
- **Outcomes:** Health care QALYs & social care QALYs.



PEDRO: intervention & rationale



PEDRO: effectiveness & cost-effectiveness

Outcomes: Health care QALY gains & social care QALY gains at 6 mths with a HD (not sig).

Costs of health and social care services: If cost of HD is borne by the charity (rather than public sector), health & social care costs are lower for HD arm (not sig).

If cost of HD is borne by the public sector, costs in the HD arm are higher (sig).

Cost-effectiveness:

- If costs of provision are borne by the public sector, HD do not appear to be value for money.
- If public sector does not fund HD (or partial), HD dominates usual care (better outcomes, lower costs)

PEDRO: recommendations

- HD appear to benefit recipients across a number of life domains, at least in the short-term.
- Within the current funding model (costs entirely borne by the charity), HD are cost-effective from the public sector perspective.
- Whilst it would not be cost-effective to fully fund the provision of HD by the public sector, a partial contribution could be explored.



Stuttard et al JMIR Research Protocols 2020; Stuttard et al *Trials* 2021 (*accepted subject to necessary revisions*)

A photograph of a vast field of wheat under a sunset sky. The sun is a bright orange orb in the center of the horizon, casting a warm glow over the scene. The wheat stalks in the foreground are in sharp focus, showing their green leaves and developing grain heads. The background shows a line of trees and a distant horizon under a sky with a few wispy clouds and a faint contrail. The word "Challenges" is written in a bold, yellow, sans-serif font across the middle of the image.

Challenges

Challenges of turning economic evidence into better policy or practice

1. No evidence?
2. Worth it but unaffordable?
3. Real savings?
4. Silos?
5. How long can we wait?
6. Transmission?
7. Does it work for everyone?
8. Is it fair?



SPECIAL ARTICLE

Economics and mental health: the current scenario

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Economics and mental health are intertwined. Apart from the accumulating evidence of the large economic impacts of mental ill health, and the increasing emphasis on economic data to support their decisions, how we consider how economic evaluation (including cost effectiveness analysis, cost utility analysis and related techniques) can contribute evidence to inform the development of mental health policy, strategy, and identify some consequences of the treatment or care level that are of relevance to service providers and funding bodies. We provide an update and reflection on economic evidence relating to mental health using a lifespan perspective, analysing costs and outcomes to shed light on a range of pressing issues. The past 20 years have witnessed a rapid growth in mental health economics, but major knowledge gaps remain. Across the lifespan, clearer evidence exists in the areas of perinatal depression identification plus treatment; risk reduction of mental health problems in childhood and adolescence; and up treatment, particularly psychostimulants, for depression; community-based early interventions and employment support for psychosis; and cognitive stimulation and multi-component care interventions for dementia. From this discussion, we pull out the main challenges that are faced when trying to take evidence from research and translating it into policy or practice recommendations, and from there to actual implementation in terms of better treatment and care.

Key words: Economic evaluation, cost-effectiveness, cost-benefit, cost-utility, return on investment, mental health policy, depression, psychosis, dementia

(*World Psychiatry* 2020;19:3-14)

Mental health economics has developed rapidly over recent decades. From an earlier 'age of innocence', with apparently little recognition of resource scarcity by the research community, to a phase of 'unbridled criticism', which rejected economics as having any legitimate role to play in evaluating treatment and care, the field has moved on noticeably¹.

There was perhaps an era of 'undiscriminating utilization', characterized by methodological imprecision, poor quality data made (in some countries at least) towards a more constructive development of questions and more robust answers. In terms of numbers, the cumulative total of reports on economic evaluation of mental health care and treatment has grown from approximately 100 in 1989 to over 4,000 in 2019.

Changes in mental health economics are far greater than suggested simply by these numbers. Developments are shown, for example, by research focus and journal interest moving beyond discussing discussion of findings from cost-effectiveness and other economic evaluations. There are also

many developments in this area of study². As well as improved empirical techniques, health economic evaluators are showing greater readiness to explore inequalities. Another notable development has been inclusion of different outcomes, such as life year (QALY) measures. Most importantly, recent years have seen the findings from economic evaluations having greater impact, and there are now burgeoning opportunities for applying change in many countries.

These developments warrant a review and reflection on mental health economics. Despite encouraging progress, large evidence gaps still exist regarding the economic case for many areas of mental health treatment and care, with evidence also unevenly distributed globally and transferred sluggishly across health care, social care, and other implicated systems. In this overview, we provide an overview of current

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Make it available in a form that supports decision making

Improve understanding of economic evaluation through training and learning materials

Identify adult social care interventions where new economic evidence might be generated

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Final words

- Why would a decision maker **NOT** want to know the economic consequences of a potential or actual decision?
- So ... why would a researcher conducting an evaluation **NOT** want to include an economic component?
- Economic evaluation is **easy to understand ...**
- ... and usually **straightforward to undertake ...**
- ... although a lot depends on study design and any issues encountered with the data.
- **Please give it a try!**



A photograph of a cornfield at sunset. The sun is a bright, glowing orb in the center of the sky, casting a warm orange and yellow light across the scene. The corn plants in the foreground are green and appear to be in the tasseling stage. The background shows a line of trees and a distant horizon under a clear sky with a few wispy clouds.

Disclaimer

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