Overcoming low delivery of IBAs in primary care:
Results from the ODHIN project

Colin Angus
Sheffield Alcohol Research Group
Optimising Delivery of Healthcare Interventions

• 4 year EU-funded research project across 9 countries

• Aim to improve delivery of healthcare interventions through better understanding how better to translate the results of scientific research into clinical practice

• IBA used as case study of well evidenced but under-implemented intervention
Is IBA cost-effective?

• Is IBA under-implemented because it is effective but not cost-effective?
• Systematic review of published cost-effectiveness studies shows a consistent finding that they are cost-effective
• Some evidence that cost-effectiveness may vary between countries
• So we modelled cost-effectiveness across every EU country…
The ODHIN trial

• Cluster-randomised controlled trial in 120 primary care practices across 5 countries (incl. England)
• Practices randomised to either control, training and support (TS), financial reimbursement (FR), or patient referral to eBI tool (alone and in combination)
• Compared impact on screening, screen positive and intervention delivery rates at baseline, implementation and follow-up
## Baseline IBA delivery

<table>
<thead>
<tr>
<th>Country</th>
<th>Screening rate</th>
<th>Screen positive rate</th>
<th>Brief Intervention rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catalonia</td>
<td>6.8%</td>
<td>5.0%</td>
<td>48.3%</td>
</tr>
<tr>
<td>England</td>
<td>4.6%</td>
<td>48.9%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>5.3%</td>
<td>44.4%</td>
<td>70.4%</td>
</tr>
<tr>
<td>Poland</td>
<td>2.0%</td>
<td>41.2%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Sweden</td>
<td>10.6%</td>
<td>29.4%</td>
<td>74.0%</td>
</tr>
</tbody>
</table>
Effectiveness results (1)

- TS+FR
- FR
- TS+FR+eBI
- TS
- FR+eBI
- TS+eBI
- eBI
- Control

Baseline vs Implementation

Screening rate

0% 2% 4% 6% 8% 10% 12%
Effectiveness results (2)

- Screening rates showed greatest changes as a result of intervention – increased for all strategies.
- Screen positive rates decreased slightly for almost all strategies, suggesting additional screens may be being delivered to ‘wrong’ patients.
- Intervention delivery rates increased for all strategies, with largest increase (+25%) in TS+FR group.
- Overall TS+FR clearly the most effective strategy, followed by FR alone.
Cost-effectiveness results

• All strategies estimated to be cost-saving and health improving in England versus control

• TS+FR most cost-effective option, costing £110m in reimbursements and IBA delivery costs over 10 years, but leading to £250m of savings to NHS, while saving 33,000 QALYs

• Cost profile is ‘front loaded’ with substantial investment required in early years leading to large gains in the longer-term
Cost-effectiveness results (2)

The graph shows the relationship between incremental cost vs. control (£m) and incremental QALYs gained vs. control (1,000s). The data points represent different interventions, such as TS+eBI, eBI, TS, FR+eBI, TS+FR+eBI, TS+FR, FR, and TS. The green line represents the trend, while the red dashed line indicates a potential threshold.
Conclusions from the trial

• Financial incentives are an effective and cost-effective means to increase IBA delivery

• The addition of training and support to incentives increases effectiveness for little marginal cost

• Increasing IBA delivery rates is cost-saving and health improving and TS+FR is a cost-effective method to achieve this

• For reference, incentives in trial were £4.80/screen, £20/BI, capped at £1,800/practice over 12 week trial period
Thanks for listening

Any questions/comments?

The ODHIN project was funded by the EU framework 7 Programme, contract no. 259268
Questions for discussion

1. Should we advocate for financial incentives (and training and support) for IBAs in primary care?

2. How should you set up financial incentives?
   - What do you incentivise?
   - How much should they be?
   - How should delivery be monitored?