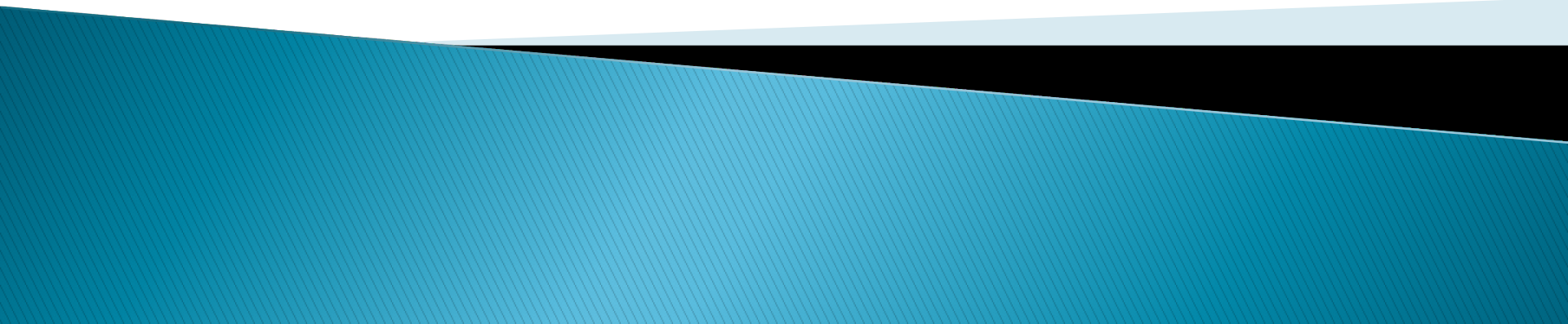


Alexander Foss

Added value



Value

- ▶ Reducing costs

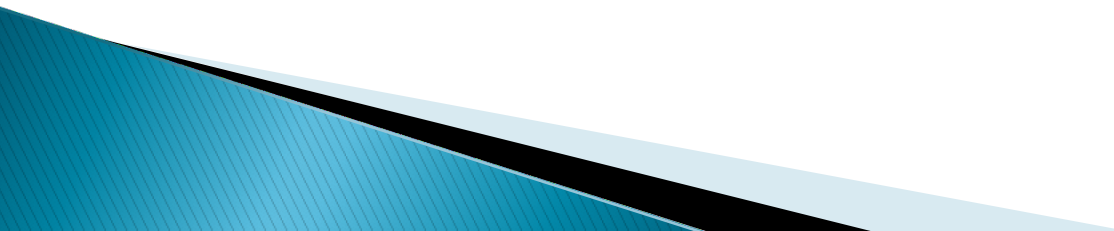
- Often short term costs – even if long term costs could be predicted to rise

- ▶ Improving quality

- Increasing capacity/reducing waiting times
- Investment
- Training and education of workforce

- ▶ Gaining information

Value

- ▶ Reducing costs
 - ▶ Improving quality
 - Increasing capacity/reducing waiting times
 - Investment
 - Training and continuing medical education
 - ▶ Gaining information
- 

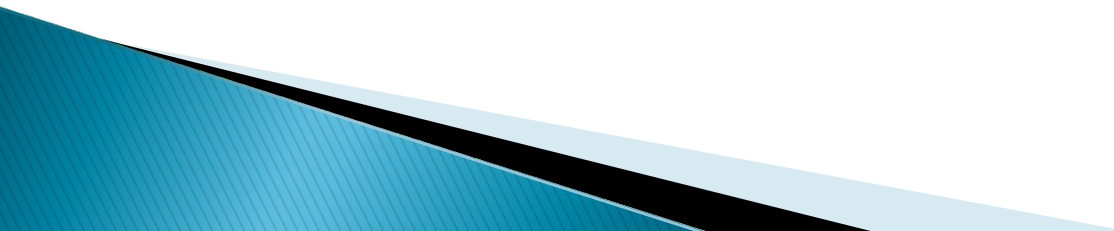
Information as Value

Evidence based medicine


The Pharmaceutical industry:-

- ▶ Commissioning bias
 - ▶ Study Design
 - ▶ Publication bias
 - ▶ Changing epidemiology
 - ▶ Medicalization
- Commissions most of the trials
 - Good industrial practice to have a marketing executive on the trial management group
 - Responsible for publishing and still only about half of trials registered ended up published
 - Sales team will endeavour to maximise the group of patients who may benefit

Commissioning a service as a Trial

- ▶ Major barriers to health care delivery
 - Cost
 - Frequency of visit is a major cost
 - How much would you pay to know bimonthly is as good as monthly?
 - Particularly if information was shared between all CCGs?
 - ▶ Improve standards
 - Have to meet specified standards.
 - Hawthorne effect. Performance improves when observed!
 - ▶ Real World population (not selective)
 - ▶ Reduce risk if using “unconventional options”
- 

CHALLENGES

- ▶ Not a standard approach
 - ▶ Embedded into routine practice
 - Can not compromise capacity
 - ▶ Protocol agreement from clinicians
 - Treatment decisions left to clinicians discretion
 - Discharge criteria not specified
 - ▶ Minimise data collection
 - Involving clinicians not normally engaged in research
 - No impact on service capacity
- 

HOSTILE ENVIRONMENT

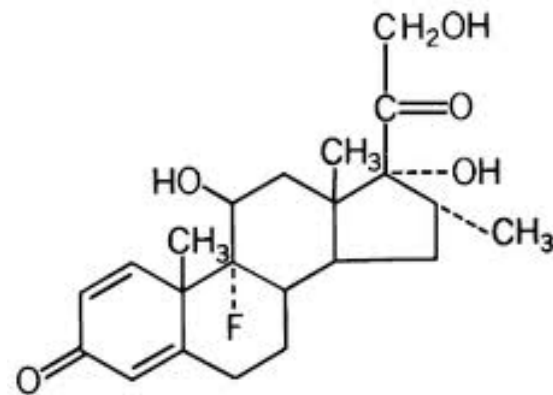
- ▶ Information costs money and NHS continually under cost pressure
- ▶ Industry has control of evidence based medicine.
 - “Is academic medicine for sale?” M Angell N Eng J Med 2000;342:1516
- ▶ I am running a trial that was funded by PCTs – Not given portfolio status as PCTs were not an approved funder and so not eligible for network support
- ▶ Any inspection going and we were inspected
 - People do not like being inspected

REGULATION AND INSPECTION

- ▶ We were twice inspected by the MHRA (twice more than is usual)
 - When does audit become a witch hunt?
- ▶ Controversial
- ▶ Easy to inspect

OZURDEX

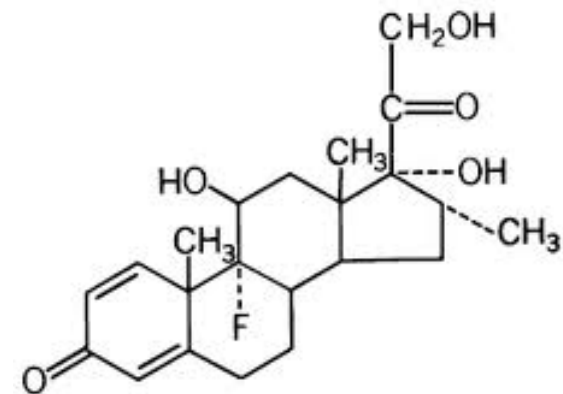
- ▶ 11 Authors
- ▶ 765 Collaborators
- ▶ 833 implants used
- ▶ 426 sham implants



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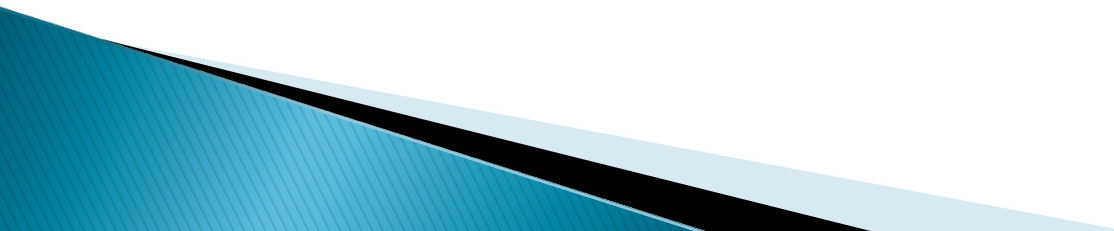
OZURDEX



OZURDEX

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Lack of Incentives

- ▶ Doctors need CPD points but study leave budgets have been slashed.
 - ▶ Much of CME is provided by the pharmaceutical industry who will fund trips to major meetings abroad (e.g. the American Academy).
 - ▶ My prescribing costs are around £300,000. A change in my prescribing pattern of 1% equates to £3000.
- 

IMPROVING STANDARDS

- ▶ In trials, things get checked.
- ▶ Clear that some people's understanding of visual acuity measurement could be improved
- ▶ Set a test for Doctors. Doctors do not understand logarithms which is a problem for logMAR visions. LogMAR stands for logarithm of minimum angle of resolution.
- ▶ This is a particular problem for visions outside the range of logMAR 0.0 to 1.0 (Snellen equivalent of 6/6 and 6/60).



COMPLIANCE

- ▶ Failure to follow protocol has to be reported
- ▶ Monitoring

CONCLUSION

- ▶ For high cost drugs, room to fund a clinical trial from the drug savings.
 - ▶ Answers questions of direct relevance to commissioners
 - ▶ On a real world population
 - ▶ Drives standards up
 - ▶ Ensure compliance with protocols
 - ▶ Is exceptionally difficult to do
 - ▶ No incentives to encourage this approach
- 