Keynote Presentation:
Introduction

Chair: John Cahill
CEO, McCann Healthcare Worldwide
Keynote Presentation:
The Value for Money of Behaviour Change

Dr Graham Lister
Visiting Professor, Health and Social Care London South Bank University (UK)
The Value for Money of Behaviour Change
Graham Lister NSMC

Why do we need to show VfM?

- Behaviour change is not an optional extra
  - A public relations gloss or just an NHS money saver
- We cannot afford the NHS without it
  - And we can’t ignore costs to families, employers or LAs

- Behaviour change is good value for society!
  - We have to demonstrate this to a wider public
  - In a clear and consistent way
  - Now!
Expensive and inconsistent: no consensus on
- Measures of costs, change or impacts
- How Value for Money should be measured
- What behaviour change achieves for health

Most evaluations are inconsistent because
- Each reinvents its approach and measures

But this only applies to large programmes
- Most local programmes are evaluated qualitatively
- An important basis for VfM but inconclusive
What it feels like

The NSMC Challenge

- National Advisory Board
  - Fiona Adshead, Julian Le Grand, Mike Kelly, Richard Little, Ian Basnett, Sunjai Gupta, Robert Anderson.
- Working team
  - Rowena Merritt, Graham Lister, Stephen Bell, Aiden Truss (NSMC) – Lesley Owen, Simon Ellis (NICE)
- To develop behaviour change VfM tools for
  - Smoking, Alcohol harm reduction, Obesity at schools, Breast Feeding and Cancer Screening
What it feels like

The NSMC VfM Programme

- Review Guidelines
  - What can we build on?
- Build consensus approach 50 experts and users
  - What works for you?
- NICE review of benchmark studies
  - Measures of behaviour change and their impacts?
- Estimate health and social impacts
  - Using WHO Burden of Disease and Benchmark studies
- Develop 5 Ready Reckoner tools
- Pilot and adjust tools for 10 users + 30 experts
What we found: Guidance

- Lots of Guidelines
  - NSMC, NICE, COI, CO, LGID, ACE...... 10 and rising
- Very similar guidance
  - Engage stakeholders and clarify objectives
  - Map the intended process and unintended outcomes
  - Establish baseline comparator
  - Estimate cost and impacts for all stakeholders
  - Examine extent and duration of changes in outcomes
  - Estimate the value of outcomes
  - Discount costs and outcomes
- But little practical help on the difficult steps

What it feels like
Practitioners don’t need guides they need help
- To defend programmes to PCTs, LAs and GPFH
- To show what behaviour change is worth
- And they want a VfM approach to VfM

Experts had expert views (all different)
- Most wanted cost/QALY before/after NHS and LA costs
- But wanted options for client/employer/social costs
- Some wanted Social Return on Investment
- To weight for disadvantage or not was debatable

What it feels like
What we found: NICE Review

- Few agreed indicators of behaviour change
  - We need common measures
- Costing of interventions is generally poor
  - Guidelines were provided
- There are measures of costs to the NHS
  - Could be based on NHS Programme Budgets
- But few measures of the health impacts
  - From benchmark studies or WHO Burden of Disease
- No consistent framework for social impacts
  - A pragmatic layered framework is needed

What it feels like
What we did: the value of change

- Using WHO data and/or benchmark studies
- For each behaviour we found estimates of:
  - Total impact on health (burden of disease)
  - Costs to NHS
  - Other costs such as care services and criminal justice
  - Plus impacts on Government, employers and clients
- We divided by the people at risk over 40 years
  - We used measures of behaviour for 1990
- Gives theoretical impacts per person
  - Modified by the extent and duration of change
- The value of achieving behaviour change indicator

What we did: Ready Reckoners

- Ready reckoners just do the maths
  - If you know the value of a behaviour change and
  - No of people achieving indicator (by age/ disadvantage)
  - At what cost to all stakeholders, you can
  - Project lifetime impacts (for a range of estimates)
  - And discount to current values
- This provides the basis for
  - Cost per QALY before and after NHS and LA savings
  - Deaths averted, Years of Life Saved, Odds Ratio, NNT
  - Lifetime savings to clients, employers, government
  - Weighting for disadvantage if you choose
  - Social Return on Investment
What it feels like

Example: Smoking
What next?

- Join the VfM movement:
  - At [http://thensmc.com/resources/vfm](http://thensmc.com/resources/vfm); you need to register and log-in to be able to use the tool
  - Watch out for 4 more tools by June

- Public Health England to provide direction
  - With NICE, PH Observatories, NHS Evidence, QIPP, DPHs

- NSMC to support behaviour change
  - Develop training, networking and support
  - Build and improve tools as knowledge develops

What will it feel like?
Questions

Please wait for the microphone and state your name and organisation before asking your question
Keynote Presentation: Japanese social marketingsuccess: Improving both cancer screening and ROI

Akio Yonekura
Marketing Director, Cancer Scan Co Ltd
$\text{cancer screening rate} = 3 \times \frac{1}{2}$ time ROI

\text{ROI 2 times}
death: 12,000+
missing: 14,000+
$100M+ donation
and prayers from all over the world

thank you
issue

issue: cancer
no.1 cause of death in Japan since 1981

medical expenditure 5 times since 1980
solution

\[ \frac{1}{3} \]
of all cancer deaths can be prevented by cancer screening

solution: cancer screening
Goal: **50% by 2012**

1981 Cancer became the leading cause of death
1984 Comprehensive 10-year Strategy for Cancer Control
2007 Cancer Control Act
   Basic Plan to Promote Cancer Control Program
   -> officially set screening goal: **50% by 2012**

MH aggressively increased **budget**

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Source: MHLW Budget Report '09, Statistics and Information Department, Minister’s Secretariat, Ministry of Health, Labour and Welfare
Pink Ribbon Campaign got active

Pink Ribbon Campaign

cities followed

How to make an appointment
(send a postcard. Call to ask questions.)
**Awareness followed**

- **Japan MHLW budget on cancer control**
- **Awareness: benefit of cancer screening by mammography**

Source: NTT Resonant Co., Ltd, "Awareness survey for 20,000 women about breast cancer '05, '06, '07, '08, '09"

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**Action didn’t follow**

- **Awareness: benefit of cancer screening by mammography**
- **Breast cancer screening rate**

Source: National Livelihood Survey, Statistics and Information Department, Minister’s Secretariat, Ministry of Health, Labour and Welfare
how can we improve cancer screening with cost-efficiency?

Cancer Scan’s way
Deliver the right message to the right target with the right media.

0. Landscape Analysis

1. WHO
- Select target w/ equity in mind
- Develop hypothesis on target's motivations/ barriers, utilizing behavior science (TTM, TPB, IBM, etc.)
- Conduct qualitative/ quantitative research to understand target's "insight"

2. WHAT
- Develop executions and deliver them to the target
- Select media/ com. channel based on target's insight and evidence (e.g. CDC comm. guide)

3. HOW
- Develop com. strategy (concept) based on target's "insight"
- Utilize message framing theory when necessary

P&G marketing + scientific evidence
Trial Intervention in Tokyo
- breast cancer -

Trial Intervention Outline

- Goal: Achieve 50% breast cancer screening rate

- Project duration: Jul ’09 ~ Mar ’10 (after the city sent out 1st invitation)

- Team consisting of:
  Tokyo state govern. officials, City officials, Japan National Cancer Center Prof. and Cancer Scan

- City population: approx. 174,500
  (women over 40: approx. 47,500)

- Breast cancer screening rate: approx. 30 ~ 40%
**WHO**: target understanding

1. **WHO**
   - who is the target?
   - what is her insight?

2. **WHAT**
   - Landscape Analysis

3. **HOW**

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1. **Quantitative Research** (n=8,000, age 51-59)

City + Cancer Scan Resident sent out questionnaires approx. 40% replied
WHO: target understanding

1. Quantitative Research (n=8,000, age 51-59)

- Prejudice
- Taker
- Non-taker

WHO: target understanding

1. Quantitative Research (n=8,000, age 51-59)

- Reality
- Taker
- Non-taker

Pre-contemplation Stage
Contemplation Stage
Preparation/Action Stage
Maintenance Stage

15% barrier
17% barrier
26% barrier
42% barrier
WHO: target understanding

2. Qualitative Research (n=20, age 51-59)

Segment C (15%)
"I am just fine. Don’t worry."
"I know breast cancer is a big thing these days. But it’s not my issue. I am very healthy. I haven’t been hospitalized or anything. I’ll consider screening when I become unhealthy."

Contemp. (17%)
"I am so scared…"
"I’ve heard of the importance of screening and probably I’d better go, right? But what if cancer is detected? What am I gonna do? I am so scared."

Prep/ Action (26%)
"Not so sure where to start"
"I know the severity of breast cancer and importance of screening, and know I need to go now. But I am not so sure where to start. Sorry, I’m lazy."
WHAT: message development

1. WHO

0. Landscape Analysis

2. WHAT

what is the right message based on her insight?

3. HOW

Segment C (15%)

"I am just fine. Don't worry."

"I am so scared..."

"Not so sure where to start."

Contemp. (17%)

Prep/ Action (26%)

Brest cancer is everyone's issue of life or death.

Don’t worry too much about breast cancer & screening.

A-to-Z of how to take screening in your city
**HOW**: execution development

- **WHAT**
- **WHO**
- **HOW**

**0. Landscape Analysis**

**1. WHO**

**2. WHAT**

**3. HOW**

**Execution Development**

What is the right execution and media to deliver it?

**Brutal Information Environment**

Internet and cell phone penetration accelerated in Japan


99.2% of information is not received
HOW: execution development

CDC Community Guide 2008:
Evidence on effectiveness of intervention methods

<table>
<thead>
<tr>
<th>Intervention Methods</th>
<th>Breast Cancer Scr. (MM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call System by provider 1)</td>
<td>😊</td>
</tr>
<tr>
<td>Small Media 2)</td>
<td>😊</td>
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<tr>
<td>Incentive (alone)</td>
<td>-</td>
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<tr>
<td>Mass Media Campaign (alone)</td>
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<tr>
<td>Mass Education</td>
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<tr>
<td>1-on-1 Education</td>
<td>😊</td>
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<tr>
<td>Monetary Burden Reduction</td>
<td>😊</td>
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</tbody>
</table>

1) call system to remind of cancer screening dates, etc.
2) broacher to explain cancer/screening (importance, how to take it, etc.)

HOW: execution development

2nd most trustable info source

HOW: execution development

send customized leaflets (invitation)

City + Cancer Scan

Prep/Action

Contemp.

Prep/Action

Contemp.

Residents

HOW: execution development

Prep/Action (26%)

"Not so sure where to start"

A-to-Z of how to take screening in your city

1. Susceptibility
2. Severity
3. Benefit

How to make an appointment
Benifit: You can cure breast cancer!
Let's go to MM!

Removing a barrier: This is how screening goes.

Don't worry too much about breast cancer & screening.

“I am so scared...”

Contemp. (17%)

Brest cancer is everyone’s issue of life or death.

“I am just fine. Don't worry.”

Segment C (15%)
$S, \text{ when/ where to take it,}$

**Screening method**

**How to make an appointment**

(send a postcard.
Call to ask questions.)

HOW: execution

City + Cancer Scan

questionnaire

Residents
**HOW:** execution

City + CancerScan

Residents

Prep/ Action

Contemp.

Result: amazing

0. Landscape Analysis

1. WHO

2. WHAT

3. HOW

Control group

Pre-contemp.

send leaflets
Result: screening rate tripled

P2Y Non-taker (Female, 51-59) N=1,859

Intervention w/ customized message
N = 1,394
Screening rate: 19.9%

Control w/ city’s message
N = 465
Screening rate: 5.8%
A: N=206 (7.3%) B: N=129 (4.7%) C: N=130 (4.6%)

OR = 2.3, P < .001
OR = 3.8, P < .001
OR = 5.7, P < .001

Result: $/screen-taker halved

P2Y Non-taker (Female, 51-59) N=1,859

Intervention w/ customized message
N = 1,394
Screening rate: 19.9%

Control w/ city’s message
N = 465
Screening rate: 5.8%

Cost to bring 1 person to breast cancer screening

$193/ person

1/2 times

$355/ person
Deliver the right message to the right target with the right media.
Total (in 3 years)
Intervened: 57,508
screening taker: 4,731
$149.64/behavior
thank you

Questions

Please wait for the microphone and state your name and organisation before asking your question
Keynote Presentation:
M is for Marketing; M is for Movement

Prof Gerard Hastings OBE
Founder/Director “Institute for Social Marketing and Centre for Tobacco Control Research at Stirling and Open University (UK)
Questions

Please wait for the microphone and state your name and organisation before asking your question.
Refreshments and Exhibition (Exhibition Hall)
Addressing the major behavioural challenges of our time

ENGAGE! EMPOWER! INSPIRE!

The 2nd World Non-Profit & Social Marketing Conference

11-12 April 2011 Citywest Hotel, Dublin, Ireland