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SECOND MEETING ON THE DEVELOPMENT OF HEALTH ECONOMICS LEARNING MODULES

Report on a WHO Meeting

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SCHERFIGSVEJ 8
DK-2100 COPENHAGEN Ø
DENMARK
TEL.: +45 39 17 17 17
TELEFAX: +45 39 17 18 18
TELEX: 12000
E-MAIL: POSTMASTER@WHO.DK
WEB SITE: HTTP://WWW.WHO.DK

1999

EUROPEAN HEALTH21 TARGET 18

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DEVELOPING HUMAN RESOURCES FOR HEALTH

By the year 2010, all Member States should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

Health economics and health policy experts met to review the work that had been accomplished in the development of health economics learning materials within the framework of target 18 of the *HEALTH21* policy: developing human resources for health. The objective of the initiative is to generate a set of modular learning materials by which the health economics approach can be disseminated to a broad audience There was consensus that, overall, the production of modules was proceeding well. It was agreed that the drafts of the current modules should be available by the beginning of September 1999, taking into account a common format and the suggestions of the meeting. After sequencing, packaging and preparing additional modules, the learning material would then be disseminated for pilot testing via the Internet. Publication of the revised modules would follow within a year.

Keywords

HEALTH ECONOMICS
TEACHING MATERIALS
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Purpose and background of the Meeting

Health for All widens the scope from health care economics to economics of health, and places special emphasis on health outcomes. The development of human resources in health economics includes not only professional health economists. Health care and other professionals and managers require an appreciation of health economics and skills to discern relevant health economics work of good quality. The activity is meant to stimulate education and training for different types of audience, skill level and duration.

The Meeting was intended to review, evaluate and conclude the work which took place during the initial meeting (30 September – 2 October, 1998, Lund, Sweden). During the first meeting an initial set of nine health economics learning modules, which had been specifically drafted for national courses for senior administrators and leaders of the economy, were reviewed and it was agreed that they formed an excellent basis for courses to stimulate education and training for different types of audiences and skill levels. The initial set of modules was extended to 20 by the addition of 11 new modules intended to bridge the gaps in the coverage of the current material and also to provide links with both the existing modules and learning materials available from other sources. Participants consisted of those who had been involved in the preparation of the draft modules, together with others having experience in public health training or health sector policy and management, who could give a disinterested critique of the work.

The Meeting was opened by Yannis Yfantopoulos on behalf of the host country and by Herbert Zöllner for WHO. Yannis Yfantopoulos was confirmed as Chairperson of the meeting and Herbert Zöllner as Secretary. Keith Barnard and Susanne Grosse-Tebbe were co-Rapporteurs.

Maintaining the *HEALTH21 – health for all* in the 21st century policy perspective

Herbert Zöllner drew attention to the background of the initiative to develop learning materials within the framework of health for all (HFA). He stressed the important contribution of health economics thinking and the application of its methods in the development of policies and intervention strategies and in the planning and management of services. The process of renewal of the HFA framework in Europe was now complete with the adoption by the WHO Regional Committee for Europe and subsequent publication of the policy document *HEALTH21 – health for all in the 21st century* (copies were distributed at the meeting). A study of its principal objectives and its underpinning values and principles confirms the significant contribution that health economics can make.

HEALTH21: Policy focus

- Health orientation, accountability
- Equity through solidarity
- People and life course
- Determinants of health
- Multisectoral strategies
- Outcome-oriented health sector
- Development and implementation based on evidence

The Meeting determined that there were a number of issues in an HFA/HEALTH21 perspective which needed particular attention. It was pointed out that some HFA themes such as equity, determinants of health, multisectoral action, PHC as central organizing concepts and evidence-based decision-making, should be considered as threads running more or less through the whole series of learning materials. Concern was expressed that some of those issues might be missed, or dealt with inadequately, simply because they were not linked to one module ("everybody's business is nobody's business"). A final review of the draft modules will be needed to ensure that these issues have been addressed appropriately and consistently across the whole set. A short presentation highlighted selected HFA-related issues that will need to be kept in mind.

Key HFA issues

- Emphasizing values (what is held to be good) and principles (what needs to happen or be in place to ensure that the values are given practical effect); the coherence of HFA values and principles (e.g. an inefficient intervention is an unethical and inequitable measure because it uses resources that could have been deployed equitably and effectively).
- Making the concept of responsibility operational: clarifying what is properly an individual responsibility (avoiding simplistic assumptions about what decisions individuals can/will make for themselves) and what requires collective action; deciding how the conditions can be created to enable individuals to take decisions/actions that could enhance their health (in particular how to develop the co-production concept).
- Clarifying the nature of outputs/outcomes; distinguishing between those that are directly health-related and those that have another beneficial effect, those that are visible and those that are invisible or intangible, and the intended and the unintended; and the implications for any subsequent action to be taken.
- Understanding the nature of costs (whether or not these can always be usefully given a monetary value), in particular the costs of any change (e.g. of introducing new technology, both high cost and high volume) and of inappropriate health care reform; and also on whose shoulders (which actors) costs fall.
- Emphasizing the crucial importance of knowledge for advocacy, refining the arguments to deploy in contacts with other sectors; and appreciating that actors in different sectors will have different logics which they bring to bear in assessing a situation facing the health sector.
- Understanding the nature of pressures on decision-makers and the costs of making or not making (postponing or avoiding) a decision.
- Clarifying the particular contribution of the insights and methods of economics in the pursuit of the HFA goal; what other skills from other disciplines (epidemiology, political science, sociology, research, etc.) are complementary; seeing the economic dimension in the context of the bigger picture.

Target groups for the learning materials

The Meeting re-affirmed that the primary end users (students) are intended to be professionals, policy-makers and managers in the health and other health-relevant sectors who need to be familiar with key economic concepts, insights and general methods, to be able to use them judiciously in certain circumstances, and to be able to understand and evaluate any advice they might receive from professional economists, i.e. to gain functional literacy in the field.

The overall assumption was that the students should be introduced to the broad view modules first, followed by those dealing with analytical methods and tools and finally those relating to policy or strategy and management. The modules are not being designed as self-standing self-learning materials, but for use by an instructor/facilitator who should adapt and build on the material provided, tailoring it to the experience and needs of a given (local) target group.

Comments on draft modules

Participants agreed that overall the production of the modules was proceeding well. This phase of the initiative should be completed by the end of the year. With the exception of Module 10 (introduction) and module 20 (primary health care (PHC)), work had now started on all modules. Modules 1–6 are in an advanced form and, with some fine-tuning to take into account comments made at this Meeting, will be ready for pilot testing. A further set of modules is quite well developed and should be useable after some further work. Lastly, the new modules whose themes were agreed at Lund were being reviewed for the first time.

The draft modules were presented and discussed in turn. Authors were invited to take note of the comments and suggestions of the group in finalizing their drafts. The points raised are noted below under the module to which they relate.

1. **The inter-relationship of health, health care, and the economy** (Stoddart)
   - Give advice on suitable examples in tutor's notes.
   - Bring out the dynamics of the economy: consider using scenarios to show different states of the economy.
   - Mention that there is also the *societal* view of the health care system (society is *not* a subset of the economy!).
   - Introduce *HEALTH21* material on multi-sectoral involvement; bring out the contribution of health to the economy in terms that can be used to present to other sectors.
   - Consider changing the term "economic performance" in Fig. 1.1 to "the economy".
2. **The differing viewpoints of health and economic ministries** (Stoddart)
   - The purpose of the module is to bring out the different logics of finance and health ministers: is it in this context significant whether the health care system is tax- or insurance-based?
   - Discuss the difficulty of quantification in the health sector and how the problem this creates in dealings with finance ministries could be handled.
   - Show how bargains are struck in sharing the cake (where, by whom, between public and private, etc.).
   - Cross-refer to broader view of *HEALTH21* outlined in Module 1.
3. **A view of health policy: health is everybody's business** (Stoddart)
   - The focus of the module is on *other* sectors and real settings; consider how to classify the examples that could be used by instructors/facilitators.

- Clarify the difference between multisectoral action (sectors providing health effects by own independent action) and intersectoral collaboration (working together) and introduce material on alliance-building and collaborating.
- Suggest how tools such as health impact assessment can be brought in, noting the differences in the situation of, say, mature market and transitional economies.
- Consider solely taking Fig. 3.2 for illustration.

4. **Re-allocation of resources for health: a conceptual framework** (Stoddart)

- Consider introducing the concept of allocation (the base-line pattern) before re-allocation and its implications, stressing it is not only finance; introduce also the tools for analysis.
- Need for practical examples of how it can be brought about in different systems; focus not only on Prince Edward Island, other examples could include joint win-win-situations for sectors.
- Clarify the future role of the *health ministry* in initiating/facilitating/negotiating re-allocations of resources; include specific reference to the conditions under which it is appropriate to re-allocate resources *to* and *away from* the health sector.

5. **Analytic framework for the economics of health care reform** (Stoddart)

- This is potentially a difficult module to use, more dependent on the skill of the facilitator/ instructor than some others. Make the guidance to the instructor as comprehensive and detailed as possible.
- Mention the complexity of achieving the accounting identity.
- Emphasize that what happens depends on how a given system works (the specific effects of a given change will not always be the same, there are no iron laws). There needs to be additional information on how incentives work and health is produced. Additional examples are desirable.
- Add a discussion on national health accounts as well as the concept/definition and measurement of price and quality to the accounting section. Note also problems with PPP.
- Link the module with Module 6, "Privatization of the health care systems", and differentiate the two modules in further detail.

6. **Privatization in health care systems** (Stoddart)

- Need to clarify the concepts, e.g. distinguishing between a full-blown competitive market (as identified by Bob Evans' *Going for gold*) and a shift in the balance between public and non-public provision (which could be commercial or voluntary) and between privatization and de-regulation.
- Note that the underlying assumption in *Going for gold* is that a shift away from a public service creates a slippery slope that could end up destroying any prospects for equity and solidarity in health.
- Discuss problems arising, especially in countries of central and eastern Europe (CCEE), e.g. experience suggests that increased private financing works against solidarity. Outline the problems encountered in defining a basic package of care to be covered by public financing with supplementary private insurance to cover other services.

- Bring out the growing importance of a third sector (nongovernmental organizations (NGOs), etc.) that creates pluralism, provides low cost responsive services and does not undermine solidarity (contrast this effect with increased private finance). Note also that public must not be equated with central government.
- Think over examples in 6.1: consider removing or specify the period when these models were operative. Add some examples of successful privatization.

7. **Economic evaluation** (Drummond)

- Need for a stronger section to discuss problems and limitations of economic evaluations. Indicate uses and misuses of economic evaluations. Quote evidence showing that evaluation makes a difference in decision making. Emphasize the need for procedures and trained human resources to be in place.
- Mention that issues are not always defined and resolved easily, that a decision on definition of system boundaries, on what data to collect and their quality is needed. Stress that the assumptions used in analysis and interpretation of data are all crucial and need to be defined carefully.
- Outline that an evaluation can be prospective (option appraisal) or retrospective (for accountability), furthermore that an evaluation is dynamic and that judgements change as the world moves on. An economic evaluation made in one setting might not be applicable/valid to other settings.
- Need for an emphasis and *how to use guidance* on the concepts and methods of evaluation. Use of the excellent Fig. 7.1 needs clarifying as it is a counsel of perfection, an idea of how it ought to work. Significant prior technical knowledge is needed to understand the module, whereas the learning objective is to acquire functional literacy regarding issues of evaluation.
- Add reference to IUHPE report on the effectiveness of health promotion and to David Evans (WHO headquarters) on what is good cost-effectiveness.

8. **A framework of policy analysis** (Lavis)

- Need for guidance to facilitator that this module will probably work best with a mixed audience of participants with different backgrounds, experiences and responsibilities who can offer their distinctive perspectives to illuminate the issues. This will reveal the differences such as the way an issue is perceived at the centre of government (e.g. in the prime minister's office) and the view of the responsible functional ministry and the variety of influences and overt and covert factors that can shape the outcome (recognize the influences of the lobby groups, the media, etc.).
- Stress that the way the question in policy analysis is structured determines the range of feasible responses (the issues to be addressed are inherently messy, not clear-cut and pre-structured).
- The facilitator should stimulate discussion on how the process of policy analysis and development could be improved to support decision-making.
- Need to add *European* examples.
- Consider changing the descriptor "clinical" as a level of analysis ("operational" was tentatively suggested).

9. **Economic modelling and forecasting** (Leidl)

- Develop the content of page 1 further as it presents the most important part for a general audience.
- The primary purpose of the module must be to explain modelling and its uses (what/when/how, etc.) and especially how policy-makers can make use of modelling (including different types according to scale scope, etc.); also stress the limitations.
- A second purpose could be to make the students functionally literate in reading reports containing topics on economic modelling and forecasting.
- Stress the need for the facilitators/instructors to focus on the learning objectives.
- Since the focus is on uses, the technical content (examples) could be separated out into an annex.

10. **Introduction to modules** (Stoddart, with review by Gunnarsson)

- Take the finished versions of the other modules and the views and ideas expressed at this Meeting into account.
- Provide a *map* (schematic presentation) presenting an overview and indicating links between different component parts, a *commentary* emphasizing the coherence of the whole and how the components contribute to overall learning objectives and a *glossary* including the key terms.
- Recommend basic reference textbooks, CD-Roms, internet sites and practice reviews covering economics and health economics.
- Recommend a sequence in the use of the material, noting that for a number of modules there will be prerequisites, but also stressing that in general there will be no need to cover every module. Clarify the implications for an instructor making selective use of certain materials geared to the learning needs of a given local target group. Give advice either to summarize necessary prior knowledge in an opening section of a module's substantive content with appropriate referencing to the essential literature and to other modules, *or* to emphasize the prerequisites for each module, i.e. someone taking module z must already have taken modules x and y, or have satisfied their instructor that they were familiar with the content of those modules; the two suggestions are not mutually exclusive.
- Present the *underlying assumptions* in the production of the whole package: HFA/*HEALTH21* as the frame of reference, the types of learner (manager, etc.), the level of their need for awareness and skills and how these might vary between different groups. Stress that country circumstances will also influence how the material may be used.
- Add a table of contents.

11. **Relationship between HFA and health economics** (Lavis, with review by Gunnarsson)

- Consider retitling the module to read "Equity in Health".
- A teaching strategy for this module could be to move from a presentation of theories of justice to the implications of adopting equity (as opposed to other) criteria in policy-making to identifying major health inequities and the options for reducing them.
- Note that the foundation for this module should be a full exploration/exposition of the concept of equity (e.g. equity does not equate with equality, they are *not* synonyms;

dimensions of equality may be measured but equity implies a judgement, i.e. that which is widely felt or held to be fair); equity is both a process (its pursuit) and an end point. Note that in practice the object of policy will be to bring about a reduction in *inequity* (reducing *indefensible* differences between groups). Stress that equity criteria can be applied in judging options at macro and micro levels. Link contents of module to equity in the HFA/*HEALTH21* context (include reference to gender and inter-generational equity).

- Consider using one policy issue as a framework within which to exemplify all aspects of equity, for example health care incentives such as medical savings accounts rewarding health-promoting behaviour. Cross-refer to Module 15; this will need strong guidance from the tutor.
- Add a discussion of the Black/Whitehead/Acheson reviews of the evidence of inequalities.

12. **General introduction to health economics concepts** (Lavis & Stoddart)

- Consider retitling the module to read “Health Economics – Efficiency in Health Care Provision”.
- Stress the need to discuss both measurement problems (what outputs to measure and how) and judgement problems (values affect what is considered desirable).
- Indicate the problem of optimizing at lower level and, in direct consequence, *sub*-optimizing at a higher level. Mention the choice of incentives designed to influence behaviour and the actual behaviour responding to them. Note that efficiency should not be local but global.
- Emphasize the need to bring out intersectoral aspects and the cumulative effects of efficiency problems. Outline the distribution of costs and benefits in a proposed move to improve efficiency. Indicate the management of the implementation of a decision to improve efficiency in a given situation.
- Stress that in terms of macro-efficiency in the health care system, the key question for policy-makers is whether too much/too little is spent on this sector and how to present the case for a change to the general public.
- Mention managers’ need to decide on strategies to use overall resources more efficiently. Consider mentioning tools, incentives, trade-offs, etc.
- The challenges and problems policy-makers and managers face should be reflected in the exercises for the module.

13. **Economic and social determinants of health: “Health Capital”** (Majnoni d’Intignano, with review by experts to be determined)

- Consider structuring the module as follows: (a) the importance of socioeconomic determinants of health, (b) the differing approaches to health capital and health care utilization among societies and countries, and (c) industrially-induced epidemics.
- Add key messages and tutor’s notes.
- Health determinants include biological as well as economic, social and behavioural factors. The *HEALTH21* vision needs to be outlined at the beginning and a case made for action across sectors and settings.
- The text is intended to be the description of the existing situation, i.e. the beginning of the story – it reflects present policy *in practice*. Clarify to what extent this text is a case study

of *France* or it reflects commonly observed European phenomena: are the divergences in society and the behaviour patterns described universal?

- Clarify that *two* major issues are being addressed in the text: *first* an apparent health divide in the population between two groups where valuation of their own health and attitudes towards professional health services are very different, with consequences for their health behaviour including use of health care; *second*, the consequences of the marketing activities/strategies of certain industries in terms of the morbidity and mortality and disability of the targeted groups (so-called industrial epidemics).
- Define health and its measurement on the operational level. When taking gender differences into account, differing pictures can emerge. If physical health measured as morbidity/mortality is used as the indicator, women appear to enjoy better health; if social and physical health (however measured) is taken into account, contrary results are often observed (studies recording self-perception of health reveal apparently poorer health among women than men).
- Strengthen guidance to instructors on how to explore such key questions as why the divergences outlined in the text occur in society (what are the possible explanations and the evidence that supports them). Analyse whether those with poorer health status and those making less than rational use of health services should be seen as victims or culpable of wilful self-neglect. Explore the political consequences, e.g. resource allocation given the split in the population. Indicate the different types of system to be encouraged/developed to reflect the expectations and behaviour of the two groups.
- Give advice on policy to regulate/curb industries responsible for epidemics.
- Outline policies that would promote social cohesion and social capital growth and reduce health inequity.

14. **Individual versus collective behaviour and capital** (Lindgren & Bondar)

- Consider retitling this module to read “Social policy: Development of individual and collective capital”.
- Make a new draft replacing the copy that fell victim to computer virus.
- Stress that in social and economic planning the human being as such should always be at centre stage.
- Reconcile the proposed frame of reference of four levels producing health (individual, family, wider social network, and society at large) with the HFA/*HEALTH21* identification of the individual, organized settings (which include workplace, neighbourhood and the family household) and society (which includes the institutions which structure society and the public policies which are adopted). In both clusterings the levels imply different types of action.
- Add a definition of collective.
- Clarify the objectives of health production (and public policy investment in health), for example to promote individual welfare, to increase social stability.
- Recognize the conflict of investment in individual welfare versus collective social security.
- Highlight the problems arising at the different levels, for example conflicting preferences within a family, health consequences of family breakdown. Policies to reduce health inequities may be negated by policies to promote health because the greater response to

these by the already healthier can result in them becoming even more healthy than the rest of the population.

- Briefly outline the measurement of health capital as well as health status.
- Introduce a discussion on whether the emphasis in public policy should be on: (a) reducing income inequalities (with the expectation that a reduction in inequities in health would follow), (b) mitigating health inequities by preferential resource allocation in the health sector to populations with poorer health and economic circumstances, or (c) other measures to improve social cohesion (with the expectation that this will lead to reduced economic and health inequities (John Lavis can supply references)).
- In the discussion of public policy bring out the arguments for and against government responsibility, i.e. collectivist and anti-collectivist positions[1] – who benefits in practice under different policies on public and private provisions? What are their consequences on individual behaviour? What is the influence of either the *medicalization* or the neglect of social problems?
- In discussing the roles of different stakeholders and the nature of their stakes, consider whether a government is more appropriately treated as one interest among other interests with its own stake or whether it is disinterestedly representing the whole society (can it be seen as both?).
- Include discussion of the emergence of the *third sector* (NGOs, cooperatives, voluntary sector, grassroots movements, etc.).
- Strengthen guidance to instructors on how to teach this module and include exercises.

15. **Appraisal of financing mechanisms for health services** (Kanavos, with review by experts to be determined)

- Consider changing the title to "Health policy: implications of financing systems".
- Clarify terms used and ensure consistency in use across modules (contributing to a *general glossary*): *financing* refers to raising revenue to be applied to health care; *resource allocation* refers to the mechanism for paying institutions (hospitals, etc.) and *remuneration* refers to the payment of individual providers in whatever form (fees and salaries). Definition of financing and funding should also be useful.
- Bring out key characteristic of types (e.g. progressive or regressive). Present advantages and disadvantages of different resource allocation and remuneration methods.
- Note that the choice of financing is linked to higher order government policy (including its ideological preference for the use of private or public sector agents) and explore whether there are any consequences of the financing method for the organization of health care. Explore the use and misuse of financing and insurance, the role of charges (income generation, use deterrence or cost shifting to user). Show that caution is needed in interpreting aggregate proportions of public and private finance (e.g. a 60:40 public/ private split may not in fact apply to any particular segment of the total system).
- Use *HEALTH21* as a point of reference in assessing different methods of financing, resource allocation and remuneration.

[1] See George, V. & Wilding, P. *Ideology and social welfare*. Routledge and Kegan Paul, 1985 (ISBN 0-415-05101-0).

- Introduce a discussion of the use of diagnosis-related groups and analogues in different systems' resource allocation mechanisms. Does the flow of money follow the patient, an institution or a service?
- Discuss the nature of economic risk implicit in different mechanisms, for example closed or open budgeting.
- Discuss the influence of culture (e.g. the tradition of patients giving gifts to health care professionals).
- Add a section on the management of implementation of a change.
- Strengthen guidance to instructors on how to teach this module.

16. **Managing health care reform: evaluation of options** (Mossialos & Kanavos)
    - Consider re-titling the module to "Health care system change" (like beauty, reform is only a reform in the eye of the beholder and instigator).
    - Give emphasis to key criteria/conditions to be satisfied in assessing proposals, e.g. public support, feasibility of implementation, sustainability. Use criteria derived from *HEALTH21* and also stakeholder analysis.
    - Emphasize the lack of political and managerial continuity, the difficulty of analysis and uncertain incidence of economic risks in societies with frequent changes on the governmental level; cross-refer to Module 17.
    - Explore the possible policy objectives of proposals (e.g. to contain the global cost of health care or to reduce public expenditure or to limit costs to the individual user).
    - Explore the capacity of institutions to cope with change (e.g. information systems in place, skills and experience of staff). Recognize the importance of benchmarks, objectives and regulations for evaluating change.
    - Develop a section on planning for change: include the role of *foresight,* i.e. what might be the consequences of anticipated developments (e.g. when all the findings of the human genome project become common knowledge). Mention the importance of analysis of the distribution of expected costs and benefits between stakeholders.
    - Use concrete examples and case-studies.
    - Strengthen guidance to instructors and cross-refer to other modules.

17. **Economies in transition** (Yfantopoulos with Zhuzzhanova)
    - Tutor's notes should give guidance on the selection of country examples suitable for specific student groups.
    - Consider structuring of this module: (a) what are the health issues specific to economies in transition; (b) analyse these issues using insights and analytical methods of health economics, drawing on research findings and pointing to gaps in our knowledge; (c) identify implications for evolution/change of policy and management of health care systems in these countries.
    - Explain what happened to trigger the discontinuity in CCEE and the newly independent states (NIS) and the consequences. Mention deregulation, etc. on the macro economic policy level in a new political environment and structure of institutions. Identify the impact on people's lives and their health (inflation, poverty, unemployment, deterioration

in health status and lower life expectancy) and the implications for social capital, the changes in the socioeconomic determinants of health. Stress the significance of the emergence of an underground economy.

- Note the difficulties with the reliability of data, for example the difference between the aggregated data of the former Soviet Union versus data from 15 single NIS.
- Note that different countries are at different levels of transition from centrally planned to market economies. The economies in transition do not form a homogenous group, nor do the different countries enter into the process of change from a homogenous position.
- Although the common feature in health care is a change in financing from state budget to insurance with user charges, no two countries have developed the same system: the Czech Republic, Hungary, Poland et al. have all had different experiences. Explore the nature of the forces driving changes (are any reasoned choices being made?) and the observed consequences of different measures adopted.
- Identify and analyse specific health economics issues: privatization, deregulation, change of ownership of institutions, new modes of remuneration, etc.. Mention the impact of external forces, WHO, the World Bank, etc.
- Compare CCEE and western countries' recent experience in changing their health care systems. What lessons can be drawn?
- Add guidance material for instructors on learning objectives and key messages, together with exercises, readings (including literature on transition economies). See also World Bank material.
- Country comparisons should suit the audience.
- Cross-refer to material that is already covered in other modules.
- Cite papers by Klein & Marmor on how bad ideas travel rapidly and link to CCEE experience.

18. **Health administration and management** (Wyn Owen & Selby Smith, with Gunnarsson to advise and review)

- Consider aligning the organizational/managerial levels with the policy levels used in Module 8 (possible to adopt the same terminology?) and clarify the difference in responsibility and required competence between, say, policy advisers, planners and operational managers.
- The implication of HFA/*HEALTH21* is that the successful manager must have a full awareness of where his/her unit fits into the whole intersectoral *health* system. Consider referencing the literature on complexity and on soft systems thinking, for example the work of Peter Checkland.[2]
- Explore how managers survive, especially those with multiple accountabilities (e.g. need to satisfy the community and a corporate hierarchy). Explain the need for balance between generalist and specialist managers. What is the manager's time horizon (essentially short term?) and attitude to and responsibility for innovation (given the specific nature and constraints of the sector)? Stress the importance of managers keeping up to date with the literature to identify innovative trends and practise evidence-based

[2] Checkland, P.B. *In: Reorienting health services*. Plenum, 1984 (ISBN 0-306-41481-3), and Checkland, P.B. *System thinking, systems practice.* Wiley, 1981.

management. Point out the possibilities at the policy level of what can be done to create political and organizational environments that support good management.

- Note Keeling's distinction between *administration* (ensuring that rules and regulations are followed), *management* (harnessing and using resources for a purpose) and *diplomacy* (persuading others to use their resources for a purpose you have identified). Tthe latter is especially relevant to interagency and intersectoral action.[3]
- Refer to the contrasting schools of management thought – Lindblom's muddling through versus the rational comprehensive planners (e.g. WHO's earlier concept of managerial process for national health development).
- Guidance to instructors should identify examples/case studies to suit the audience, i.e. they should highlight the issues affecting that audience.
- Consider shortening the Welsh case-study and draw on other contexts also.

19. **Development and diffusion of health technology** (Drummond & Lindgren with Bondar)

- Start with the *HEALTH21* concept of quality development and its stress on health outcome.
- Focus on pharmaceuticals and medical equipment after presenting the larger picture of health technology (including software, hardware, skill-ware, institution- and organization-ware, procedures).
- Emphasize increasing costs of new technology (so that evaluations before and in use become more important than ever). Discuss the ethics of introducing new technology. Raise such questions as what kind of innovations are justified on what grounds, whether new technology necessarily presents better technology?
- Explore possible policy dilemma for governments: industrial policy (fostering national industrial development, attracting inward investment, etc.) versus health policy (containing growth of unnecessary new technology, promotion of generic rather than "me too" pharmaceuticals). Explain the role of regulation, the role of the World Trade Organization and the difficulty of economies in transition in complying with the regulations/guidelines of western markets.
- Explore why the economics of research and development and economics of health care are different (overlaps, trade-offs, etc.).
- Distinguish between the *theory* of innovation/competition/regulation (see also harmonization of clinical trial practice) and the *reality* of countries' command and control strategies for research and development. Discuss the implications for stimulation and diffusion of innovation.
- Consider the consequences of industries' effective marketing technology for the medical profession – e.g. *in extremis* diversion of budgets to expensive innovations at the expense of purchasing essential drugs. Mention studies on the appropriate use and cost-effectiveness of drugs and equipment.
- Outline specific issues of orphan and homoeopathic drugs.
- Consider potential for collaboration between countries in technology assessment.

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[3] Keeling, D. *Management in government*. London, George Allen & Unwin, 1972.

- Strengthen guidance to instructors on how to teach this module. Reflect whether the exercise included in the draft represents the most useful for the proposed target groups.

20. **Primary health care** (Authors to be decided)
    - Begin with *HEALTH21*'s broad concept of primary health care.
    - Evaluate PHC activities as a strategy for achieving savings, having regard for increasing substitutions (as a result of, for example, technology developments), assuming transfer of resources from secondary and tertiary care, and seeing the individual as a co-producer rather than a user or passive recipient of services.
    - Discuss the differing needs for health care over the life-span. Outline that the changes taking place in health potential (physical, psychological and social health) have strong implications for the consequent need for care and support over the life-span. Stress the links with the determinants of health and the health actions in the health community.
    - Indicate the specific aspects of long-term care.
    - Include a discussion on the strategies for care of the elderly. Point out demographic trends, future patterns of morbidity (see also age-related illnesses) and disability and the need for health and social services. Recognize the critique of the compression of morbidity hypothesis. Mention alternative policy assumptions (e.g. based on different expectations about the health status of the elderly and available technology) and their resource and management implications. Make the link with equity issues, e.g. the how and who of paying for services for the elderly (cost-sharing or cost-shifting between agencies, intergenerational solidarity and equity).

Proposals for additional material

The set of modules needs to have full regard for HFA/*HEALTH21* objectives, values and principles (see above). This means there is potential for expansion of the material, and hence the number of modules to be developed. Nevertheless, participants felt that any significant increase in the number of modules above the present 20 could make the total product unwieldy for instructors and students. The sense of the Meeting was that, as far as possible, gaps in the present material should be filled by additions to existing modules. It will only be appropriate to commission new modules if material identified as essential cannot for some good reason (e.g. an overload of content) be incorporated into one of the present modules.

In discussion the following three issues were identified as possibilities for inclusion or elaboration as new modules (see below).

1 **Health protection and promotion**
- Economics of health promotion (note was taken of work by Miriam Wiley, Dublin).
- Economics of environment and health (note was taken of papers prepared for the WHO Third Ministerial Conference on Environment and Health, London 16–18 June 1999, and learning materials prepared by the Regional Office for environmental health professionals).
- Health implications of the globalization of the economy and European regional integration (see also Planning and management of resources below).

2 **Planning and management of resources**

- Trends in national health care expenditure (alternative approaches to estimation and comparison, e.g. OECD and LSE).
- International trends in health care expenditure and changing financial patterns.
- Critique of alternative methods of health care financing (e.g. alternative insurance systems).
- Planning for human resources in health care.
- Implications of the globalization of the health market. Evolution of EU policy: interpretation of Art. 152 and other provisions of the Amsterdam Treaty, and the subsidiarity principle (note was taken of the Nuffield Trust Conference on Globalization and Health, Oxford, June 1999).

3 **Argumentation and advocacy in support of health policy developmen**t

- Acquisition and use of information (need for and sources of information, including research and development results).
- Economics of information management and technologies.
- Role of values and assumptions in public policy formulation (e.g. responding to evidence of market failure or giving effect to a shared belief in collective ownership of assets and action in health protection and promotion and provision of care).
- Planning (alternative approaches, e.g. forecasts based on extrapolation, futures scenarios – note Martha Garrett's handbook on futures methods commissioned by WHO headquarters). Forecast of medicine and health care in the 21st century.
- Managers' need for skills in advocacy in effective communication and information dissemination.
- Economics of coalition-building, effective bargaining and negotiation.

Next steps

Finalization of modules

Authors agreed to finalize their modules (to make them ready for pilot testing) and forward them to Herbert Zöllner by the beginning of September 1999, taking account of the common format (see below), the key HFA issues (outlined at the beginning of this report) and the need to cover the additional themes listed above.

Establishing a common format for the modules

Each module should have in similar form the following essential features.

- Guidance for the facilitator/instructor highlighting the main features of the material and issues likely to arise in using it.
- Key learning objectives/messages to be absorbed and used by the end user.
- Cross-references to other modules.

- The learning materials (i.e. the substantive technical content)
  - relevant economic (and other) theory;
  - relevant experience and case studies where appropriate;
  - implications of theory and experience for practice (guidance on how to do it will be expected from the target groups of learners);
  - reference to relevant *HEALTH21* and other material by WHO and other intergovernmental organizations (World Bank, European Union, etc.).
- Questions for discussions/exercises/group or individual tasks.
- A list of references, which should distinguish between basic reading for the module and supplementary or further reading.

The Meeting noted that the early modules in the series, which are the most developed, have these features. Attention was also drawn to the format of the World Bank's modules (information on which had been included in the papers for the meeting) which could be regarded as exemplary, although the WHO modules will be less detailed.

Packaging the learning materials

Once all the modules have been developed to the point where they are ready for testing they will need to be sequenced and packaged as a coherent whole. On the basis of the draft modules, Module 10 will be prepared and circulated to the group for feedback and any necessary revision.

A further step would be the production of a cover note, setting out the scope of the material and how it can be used.

Testing and marketing the modules

The authors agreed to test the current material with their own students and to ask for their feedback. The intention is that the available material will be disseminated end 1999/beginning 2000 via the Internet. The purpose is to make the modules available to a broader group of potential instructors/facilitators. The e-mail addresses of authors will be given so that feedback can be sent directly to them. A flyer could be produced for wide distribution announcing and inviting use of the material. New case studies and references contributed by instructors/ facilitators will be especially useful.

Prior to full publication on theWeb or in hard copy, it will be necessary to ensure that the material has been used with a variety of end users in different operating environments and the material refined in the light of the feedback received. Consideration will also need to be given to whether the modules should be published in additional languages.

Annex 1

PROGRAMME

Thursday, 6 May

18.00 – 21.00	*Registration*

Friday, 7 May

08.30 – 09.00	*Registration*
09.00 – 09.30	Introduction and welcome
09.30 – 12.30	Review and finalization of modules 1–9
14.00 – 18.00	Review of new modules 10–19

Saturday, 8 May

09.00 – 10.30	Need for additional modules – the wider HEALTH21 challenge
11.00 – 12.00	Steps for completing the learning modules
12.30 – 14.30	Testing, dissemination and marketing
14.30 – 15.30	Conclusions

Annex 2

PARTICIPANTS

Temporary Advisers

Dr Eva Bondar Coordinator, Soros Foundation Project on Health Research in Economics 5, Gellerdhegy Utce H-1016 Budapest Hungary	Tel.: +36 12702001 Fax.: +36 11208423 e-mail: Bondar_Eva@s16.kibernet.hu
Dr Panos Kanavos LSE Health London School of Economics and Political Science Houghton Street London WC2A 2AE United Kingdom	Tel.: +44 171 9556802 Fax.: +44 171 9556803 e-mail: p.g.kanavos@lse.ac.uk
Dr Mihaly Kökény Chairman, Health and Social Affairs Committee The Hungarian Parliament Szechenyi rkp. 19 H-1055 Budapest Hungary	Tel..: +36 1 2685101 Fax.: +36 1 2685969 e-mail: mihaly.kokeny@mszp.parlament.hu
Dr John N. Lavis Assistant Professor Centre for Health Economics and Policy Analysis Department of Clinical Epidemiology McMaster University Health Science Centre, Room 3H27 1200 Main St. West Hamilton, ON, Canada	Tel.: +1 905 525 9140 Fax.: +1 905 546 5211 e-mail: lavisj@fhs.csu.mcmaster.ca
Professor Björn Lindgren Department of Community Medicine, Health Economics and Biostatistics Malmö University Medical Research Centre Carl Gustafs väg 33 S-205 02 Malmö Sweden	Tel.: +46 40 33 19 69 Fax.: +46 40 33 62 15 e-mail: Inger.Lindgren@smi.mas.lu.se
Professor Béatrice Majnoni d'Intignano Faculté de sciences économiques et de gestion Université de Paris XII 12 rue Debelleyme F-75003 Paris-Créteil France	Tel.: +33 1 4277 1633 Fax.: +33 1 4325 2450

Dr Elias Mossialos
Senior Research Fellow, Director
London School of Economics and Political Science
– LSE Health
Houghton Street
London WC2A 2AE
United Kingdom

Tel.: +44 1719557564
Fax.: +44 171 9556803
e-mail: e.mossialos@lse.ac.uk

Professor Chris Selby Smith
Faculty of Business and Economics
Department of Management
Monash University
Clayton Campus
Clayton, Victoria 3168
Australia

Tel.: +613 9905 5412
Fax.: +613 9905 5434
e-mail: Chris.SelbySmith@BusEco.monash.edu.au

Professor J.N. Yfantopoulos *(Chairperson)*
Professor of Health Economics and Social Policy
University of Athens
Sahtouri 12 Str.
152 32 Halandri – Athens
Greece

Tel.: +301 6840212
Fax.: +301 684 0212
e-mail: YFA@otenet.gr

Dr Naila Zhuzzhanova
Health Policy and Management Department
Kazakhstan School of Public Health
Utepov 19A
480060 Almaty
Kazahkstan

Tel: +7 3272 491 766
Fax.: +7 3272 491 766
e-mail: mkk@ksph.almaty.kz

WHO Regional Office for Europe

8 Scherfigsvej, DK-2100 Copenhagen Ø
Tel.: +45 39 171717, Fax.: +45 39 171818

Mr Keith Barnard *(Co-Rapporteur)*

Tel./Fax: +46 31 147101
e-mail: barnard@tripnet.se

Ms Joy Bartrup
Assistant

Tel.: +45 39 171539
e-mail: job@who.dk

Ms Susanne Grosse-Tebbe *(Co-Rapporteur*

Tel.: +45 39 171399
e-mail: sgt@who.dk

Dr Herbert Zöllner *(Secretary)*

Tel.: +45 39 171347
e-mail: hzt@who.dk