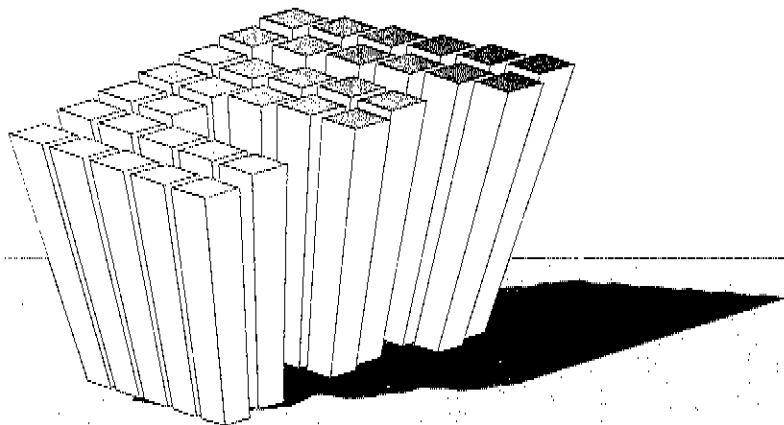


HEALTH ECONOMICS

**IDENTIFICATION OF NEEDS
IN HEALTH ECONOMICS
IN DEVELOPING COUNTRIES**



WHO TASK FORCE ON HEALTH ECONOMICS

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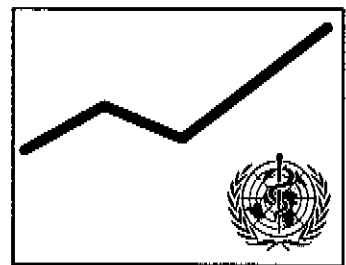
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**Identification of needs in health economics
in developing countries**

by

**Asamoah Baah
Ministry of Health
Ghana**



**WHO TASK FORCE ON
HEALTH ECONOMICS**

May 1995

Document of the WHO Task Force on Health Economics

Other documents in the «Task Force on Health Economics» series are :

- A bibliography of WHO literature.
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- A guide to selected WHO literature.
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FOREWORD

Building upon activities already undertaken in the area of health economics, the Director-General created a Task Force on Health Economics in November 1993 in order to enhance WHO's support to Member States.¹ Its goal is to further the use of health economics in the formulation and implementation of health policies, giving priority to countries in greatest need.

The Task Force aims not only to strengthen the technical content of WHO programmes so that they can better adapt the tools of health economics to country needs, but also to foster cooperation among development agencies in applying health economics at country level.

As a first step, the Task Force is preparing a series of documents in English and French to help meet the information needs of both those involved in the organization, planning and financing of the health sector and health professionals whose expertise may lie in other areas. A list of documents, which are distributed free of charge, appears before the contents page.

¹ Members of the Task Force are: J.-P. Jardel (Chairman), M. Jancloes (Vice-Chairman), G. Carrin (Secretary), S. Bertozzi, A.L. Creese, D.B. Evans, K. Janovsky, J.M. Kasonde, C.M. Kinnon, E. Lambo, P. Lowry, B. Sabri, C. Sakellarides, Than Sein, J.H. Perrot, L. Tijlffors, G. Velasquez, C. Vieira, A.E. Wasunna.



1. Introduction

The ill-wind of worldwide economic recession and indebtedness blowing through many countries has led to austerity measures and structural adjustments, resulting in a real decrease of governments budget in the health sector. At the same time, global acceptance of the goal of health for all by the year 2000 and the promotion of primary health care have created expectations for expanded services, easier access and improved coverage (1).

In addition to be asked to do more with less, health managers, in low-income countries in particular, are faced with the problem of lack of fit between the strategies of primary health care and the existing organizational structures and management support systems through which these strategies are to be implemented. Health managers therefore have to reconcile the conflicting demands of getting things done within existing - but often inappropriate and inadequate - systems and structures and changing those systems and structures so that they become better suited for implementing primary health care policies and strategies. There is also a tension between the quest for quick results and the slow and painful process of general capacity-building and infrastructure development (2).

Health economics, broadly defined as the application of the theories and techniques of economics to the health sector, is increasingly being seen as a mode of thought that can provide ideas for improvements into national health systems. Health policy making is essentially a political process. This paper outlines the **potential** uses of health economics analysis in decision-making in developing countries, with special focus on low-income countries, and provides an overview of approaches and mechanisms for strengthening capacity in management in general, and health economics in particular, at the country level. For obvious reasons, it does not cover the limitations of health economics.



2. Health policy decision-making in developing countries: key areas and context

At the risk of oversimplification, the key decisions or choices in health care at the national level in every country can be summarized as **intersectoral and macroeconomic issues; intrasectoral resource allocation and equity issues; financial planning; issues on economic perspectives on alternative financing and organization of health services; and the design of appropriate incentives** for providers and health managers (3).

2.1 Intersectoral and macroeconomic issues examine the impacts of macroeconomic changes on poverty, health and other socioeconomic measures of well-being; the impact of macroeconomic and monetary policies, structural adjustment programmes, policies and actions in agriculture, industry, energy and housing on health outcomes or performance; the magnitude and diversity of health consequences associated with economic development projects and activities; and the cost implications of these health consequences.

2.2 Intrasectoral resource allocation and equity issues are usually concerned with effective actions to reduce waste or to improve cost-effectiveness via a better mix of inputs and a better focus (health service- and population-wise) as well as more equitable distribution of these inputs and services.

2.3 Financial planning for the health sector (government and non-government) is usually concerned with the development of low-cost methods for assembling and analysing information on health finance; projection of the financial requirements (budgeting) imposed by national health policies and the assessment of the capacity of currently available revenue measures to meet these needs; provision of legitimate justification of the increasing expenses and costs of the health sector to government and the public.

2.4 Economic perspectives on alternative financing and organization of health services are usually related to different health financing modes and mechanisms; changes in sources of finance and payment mechanisms (government and non-government financing mechanisms such as user charges, insurance contributions by households and enterprises) as well as changing roles of consumers, purchasers and providers of health care.

2.5 The design of appropriate incentives is usually related to the establishment of incentives that promote individual and organizational behaviour in the direction of public health objectives, e.g. the design of adequate payment and remuneration structures that ensure more efficient and equitable use of resources and services by both users and providers, and the design of monetary and other career incentives that rewards merit and advances organizational goals.

In the context of low-income countries, these key areas of health policy decision-making have to be understood against the background of scarce resources, relatively **high level of uncertainty** (politically and economically), **loose organizational loyalty**, inadequate incentive schemes and increasing **donors' pressure**.

2.6 Scarce resources. The economy of most countries has seen a sharp decline throughout the 1980s. At the root of the problem are to be mentioned the economic slump of the industrialized world leading to a reduction in the world's demand for their export products (particularly agriculture's commodities and minerals), gross economic mismanagement (over-ambitious borrowing, abetted by unrestrained lending), and an increase in



payment obligations for amortization and interest on outstanding debt made especially acute by extremely high interest on floating rate debt since 1980. The problems of big debtors have been amply documented; the plight of smaller, poor borrowing countries is less well known. Most developing countries are showing signs of recovery but prospects of rapid growth are remote, given the recession in industrialized countries (4).

When faced with severe short difficulties of economic crisis management, it takes a «lot of resources» and energy to look ahead. Time horizons tend to be short, long-term planning is thrown to the wind. Considerations of survival dominate decision-making. Poverty is a persistent phenomenon in many developing countries. Individual health workers concern about personnel solvency overrides organizational priorities. Poverty increases «entrepreneurship» and causes individual civil servants to compete intensely for resources within an organization (5).

2.7 High level of uncertainty. Many developing countries face political uncertainty. Governments of most low-income countries tend to be fragile without an established firm agreement, custom or tradition on how power should be legitimately transferred. Because of this vulnerability, political considerations such as ensuring the survival of a regime, or preventing divisions along ethnic lines, may be more important than striving for economic rationality. Considerations of survival dominate decision-making (6).

Many low-income countries are economically also vulnerable; especially government revenue will be unpredictable, when it is heavily dependant on fluctuating commodity prices. This leads to seemingly irrational decisions such as across-the-board expenditure cuts, drawing limits and unnecessary expenditure controls for managers. There is great uncertainty about when budgets will be released, how much they will be worth, what capital projects will be approved and when. In addition, there is usually considerable uncertainty about the effects of health policies and the linkages between health and the general economy. This is in part due to lack of adequate data and subsequent analysis.

2.8 Loose organizational loyalty. The concept of «a State» is a relatively alien concept in many developing countries. Individuals tend to have stronger loyalties to families, and to ethnic and social groups, than to organizations and their objectives. This blurs the notion of «public property»: government property is regarded as being for the benefit of officials and their kith and kin, and social groups (7).

Where public servants tend to be personalistic and lack an organizational ethos, and are not oriented to achieving organizational goals, organizations tend to be centralized and tightly controlled. Rules and regulations abound. Checking and counterchecking are felt to be necessary because of lack of organizational loyalty. Bureaucracy tends to be so little involved with consumer relations, and so much with itself (8). The «perks» provided by the system are important. Not invariably, arguments and negotiations over public vehicles, housing and equipment tend to be centred more about the convenience of the individual users rather than to the mission to which they were assigned.

2.9 Donors' pressure. Donors are increasingly playing a strategic role in policy formulation in developing countries, usually out of proportion with the resources they contribute. Their attractiveness to ministries of health lies in the provision of relatively safe resources - stable and not subjected to internal environmental shocks. Consequently, many ministries of health find it difficult to say no and tend to deal with more and more donors. This is time-and energy- consuming for the health managers who find themselves adopting a reactive rather than a proactive posture.



Each donor has its own objectives, which may conflict with those of the host-country and which are not always compatible with those of other donors. Donor officials are often under great pressure to spend money fast, considerations of efficiency being not always paramount. Obsession with fast disbursement coupled with the low absorptive capacity of most ministries of health lead to inefficient use of resources (9). Strict adherence to regulations leaves little room for efficiency considerations.



3. Challenge for health economics in developing countries

Under these rather difficult circumstances, what decision-makers in the health sector require are ideas, suggestions and tools that will help them take the right and the most appropriate decisions.

The health sector contains within it various groups with different values, and differing degrees of financial, organizational and professional autonomy. All these groups of interest cannot be expected to view present and future situations in the same way, and a conflict of interest and values, whether implicit or explicit, is only to be expected. The analysis of policy options through different lenses (and rationalities) is therefore crucial. The challenge for the 1990s is to ensure that the framework of decision-making allows dialogue among various kinds of rationality.

Health economics uses the tools and methods of modern economic analysis. Firstly, it seeks to quantify the resources used for health, the financing and organization of health care, the efficiency and equity with which resources are allocated and used for health purposes. Resources for health include resources from other health-related sectors such as agriculture and education. Secondly, health economics encompasses the analysis of the linkages between the economy as a whole and health.

Health economics thinking can, therefore, provide one part of the information (in addition to political, social, medical, and philosophical criteria) necessary to achieve truly informed decisions about using scarce resources (10). The use of many facets of economic analysis and its tools can identify areas of waste and inefficiencies, and map out options for better use of scarce resources. By generating more information on the economics of health, health economics can help reduce the uncertainty of the usefulness of health policy decisions and its effects. Exploiting this knowledge on linkages between health and the general economy can strengthen the hands of health officials in their dealings with the donors' community. Finally, by making use of the knowledge of individual and corporate behaviour, health economics can help design appropriate incentive schemes.

Tables 1 to 6 detail the common grounds between economics and health policy (11): column on the left identifies a number of «health policy issues» that are of pressing concern to developing countries, and column on the right («relevant corpus of economics») offers pointers to those parts of economic theory, concepts and techniques that can be used to analyse the various management issues identified.



4. Capacity-building in health economics in developing countries

In this context, capacity-building refers to what needs to be done to institutionalize and sustain the use of health economics in developing countries. The following three components are worth considering:

- . staff development,
- . systems and software development and,
- . institutions development.

4.1 Staff development

Basically, this refers to increasing awareness, knowledge and skills in health economics of people's skills at the country level who can and will use economic analysis to help address some of the problems of the health sector.

Health economists are scarce in developing countries. Every developing country has some very good economists, but they have, with very few exceptions, concentrated their work in academia, or in the economic rather than in the social sector. Developing countries have, as yet, produced only few health economists on their own. Insufficient levels and low-compensation levels make it difficult to attract and retain high-quality staff. There is also external brain-drain towards employment abroad.

Ministries of health have not until quite recently seen the need for health economics and applied research. Health economics is not included in the curricula of most schools of public health. There is a general disillusionment and a lack of interest for financial matters, a low level of financial awareness, and a general disdain among health workers for figures and calculations. The administrative culture of the public sector usually lacks appropriate incentives for the self-development of managers. Improvements in personal capacity are usually not recognized with increased responsibility or other rewards (12).

Staff development should therefore go beyond training to include the development of personnel systems and policies that can effectively guide career development, encourage better management and support performance review processes and link training to promotion opportunities (13).

Nevertheless, training is an important component of staff development. This should involve a whole host of people from different levels of the health sector and of different institutions, both public and private, such as senior policy-making staff in the ministries of health, of finance and economic planning, central planning commissions, middle level staff, key service providers, provincial and district health managers, hospital directors and other personnel involved in health services management, university lecturers, students of health professions and social science.

Different combinations of **training approaches** need to be used: **formal** training, **on-the-job** training, **action** training and **non-formal** training (14). Each of them has advantages and disadvantages and a different relevance (see Annex 1).



Training opportunities can also generally be classified into locations (15):

- (a) **in-country training:** provided within one's own country. In-country training can be further distinguished by whether it is provided by one's own organization or enterprise, or by an institute, a school, or an agency outside one's organization;
- (b) **overseas training:** traditional, and programmes provided to low-income participants overseas in industrialized countries, e.g. North America and Europe;
- (c) **third-country training:** provided outside one's country by an institute or a school in one's geographical region (regional institute).

Strengths and weaknesses of each of these training locations are listed in Annex 2.

Effective capacity-building requires in-country, as well as overseas and third-country training. Again, each of these has its strengths and weaknesses. The choice of utilizing one of the four training approaches mentioned above (formal, on-the-job, action, and non-formal), and encouraging health managers to participate in overseas, third-country, or in-country training, must be based fundamentally on the same assessment of the needs at national, organizational and individual levels.

4.2 Systems and software development

To promote and sustain the use of health economics, complementary subsystems that provide the foundations for the use of economic analysis must be developed and nurtured. Of particular importance are information and budget, accounting and auditing systems, the development of guidelines, protocols and standard operating procedures.

In most developing countries, existing information systems usually have large amounts of data concerning service activities. Some information about inputs such as personnel, vehicles, drugs and financial resources is also readily available. Much less attention is paid to the outcome and impact of these health service activities, and data related to the effects of these activities are usually limited.

Where data exist, they are either unreliable or incomplete. Where reasonable quality data exist, for example outpatient utilization, revenue generated, they are not used for decision-making. Skills to process and analyse massive data collected are in short supply. Information is rarely linked to activity data.

Budget data exist but are too often of poor quality, fragmented and incomplete and do not encompass all sources of income. Information on financing and resource allocation is held by public administrators, tends to be limited to that describing the public sector activity, frequently further confined to the ministry of health activity. Ministry of health administrators are generally poorly informed on the health-impacting financial allocations of the private sector, as well as on those of other ministries.

The budget process is fragmented between development and recurrent (or operating) budgets. In some countries, a central planning agency is responsible for the development budget whilst the recurrent budget is the responsibility of the ministry of finance. Each agency follows its own classification schemes and policies. No unified budget exists. This impedes expenditure planning and control.

Timely, accurate and reliable financial data are scarce. Multiple accounting systems exist in the ministry of finance, in central accounting offices, central banks and spending



agencies, and for the most part they are poorly coordinated. As a result, these agencies spend an enormous part of their time attempting to reconcile data among themselves. In planning budgets, spending agencies get only minimal fiscal and policy guidance from ministries of planning and finance. Rarely do they have as background information current and anticipated economic and fiscal trends: economic growth, inflation, balance of payments, estimated deficits, and debt financing policies.

The calendar for preparing the budget leaves little time for adequate analysis in the spending agencies. Justifications are thin, and few objective criteria are developed to assess the validity of budget requests. The focus tends to be on updating last year's budget (base-budget) and adjusting it for incremental changes and new activities. Monitoring the execution of budget is usually non-existent. Existing systems of expenditure control are unreliable, and the controls are excessive as well as ineffective. Estimates of external grants and loans are frequently unrealistic and do not take into consideration absorptive capacity (16).

Capacity-building in health economics should therefore go *pari passu* with improving health information and financial management systems, the development of guidelines, protocols, and standard operating protocols. To be useful, guidelines, materials and tools must be robust enough to respond to country-specific needs. «Global» materials must be adapted rather than adopted wholesale. Not only do the administrative and organizational structures in low-income countries require modifications of imported tools, but the learner must modify the concepts and skills to the specific organizational situation in which the individual operates. Tools and guidelines must therefore be culture-specific, sector-specific and organization-specific.

4.3 Institutions development

To institutionalize and provide continuous impetus for the use of economic analysis, there must be institutional mechanisms specifically set in place for promoting the use of economic analysis. This could either take the form of task forces, working groups or both, at sectoral and at national level, or by the setting up of policy and planning units within the ministry of health and other major health-providing institutions, or of specifically set up institutions for policy analysis and strategic policy development. These institutions could also be involved in the training of health policy analysts, health economists at certificate, diploma, postgraduate and doctorate levels.

At the national level, major decisions affecting the health sector are usually taken without consulting this sector. It is hardly a forum at which policies of other sectors, which have an impact on health, are discussed. The setting up of committees, task forces, study circles, or management support groups, with the participation of planners, managers, and economists of various fields and professional background, can improve opportunities to learn from others' experience. This is particularly convenient to senior managers, for time constraints prohibit attendance at lengthy training sessions, and the «superman complex» inhibits executive managers from seeking assistance through training (17).

Most developing countries have planning units, but in most cases they are weak and not involved in the mainstream of decision-making. They are usually staffed by people with very little clout and influence. There are hardly people in them with adequate knowledge and skills in economic analysis. These units, with the exception of a few, tend to be involved in mundane activities. Seeking health economists in them or training health



planners, or better still, training staff from these units to incorporate health economics in planning, is critical.

A national institute for policy analysis can play a very strategic and advocacy role for the use of health economics. However, the location of the institute can be a delicate issue. A unit that is part of the government has the potential advantages of getting (a) favourable political and administrative support, better acceptance as part of public service in contrast with higher education linkages which are regarded with suspicion in some countries; (b) more readily access to information about the government and more opportunities for field work. The major disadvantage is the loss of control in the operation of the institute because of the government procedures and practices. Other disadvantages are higher turnover of staff and nepotism (18).

Locating the institute within a university can have many positive features: advantages related to the general atmosphere and ambience of the university, prestige, acceptability to students, research emphasis, library resources and more receptive climate to new ideas. Another option is a semi-autonomous institute. Normally, such an institute is viewed as more sensitive to client needs. Having the right to establish its own pay scale gives the institute the hiring edge over its public counterpart. The problems to be encountered include initial financing, difficulties in building an enviable reputation to attract clientele.

No single set of criteria exists for predicting an institution's success. However, there are some institutional arrangements that appear to be more effective than others. These include limited government controls, strong leadership, and a critical mass of talents sufficient enough to provide a scope for experimentation, innovation, and programmes and activities that require multidisciplinary groups (19).



5. Conclusions

In building capacity for the use of health economics, it is worth remembering that health economics is not an end in itself but a tool to improve health systems performance and a means to transform the health system so that primary health care can be implemented. Health policy decision-making is a highly political process. In the world of politics, there is no such thing as a single rationality. Different actors pursue their own differing rationalities. Health economics, which defines its rationality usually as economic efficiency, can help illuminate and enrich decision-making.

There is not one best approach to developing capacity in health economics in each country. It is contingent on a variety of factors and will be influenced by the context in which it is to be implemented. Entry points must therefore be chosen as a result of a tactical decision based on opportunity. An analysis of the social, political, economic and organizational forces is a critical initial step for any capacity-building intervention.

For practical and tactical purposes it may be advisable to start on a small scale to provide an opportunity to develop, test and document innovative strategies for addressing difficult operational and organizational problems. Staff training appears to be an attractive starting point. However, if appropriate structures and systems are not in place and functioning, staff development may not be all that is required, and training alone is insufficient.

Expansion of scope is usually required over time, both in response to demand, opportunity and changes in overall context to enhance the overall effectiveness of capacity-building. The planning for large-scale implementation requires a further careful analysis of new contextual factors which come into play.

To ensure institutionalization and sustainability, there must be a sense of ownership by the country involved. The recommended approach should be participatory, flexible and pragmatic. Indeed, the failure of some programmes of capacity-building has been ascribed to the adoption of a normative approach which does not take into account what managers themselves feel is both possible and desirable.

Whilst it is easy to link capacity-building with improved management competence and performance, it is not so easy to substantiate causal links with changes in utilization or health status. The need for achieving quick and quantifiable results should not override that of institutionalization and sustainability.



ANNEX 1
COMPARED TRAINING APPROACHES

Elements	Formal training approach	On-the-job training approach	Action training approach	Non-formal training approach
What is the general orientation of this approach?	Expert learning that focuses on one subject area (e.g. budgeting) or a set of interrelated subjects (e.g. effective supervisory practices).	Organization-specific task orientation, one-to-one relationship between senior managers and "trainees" focusing on improved individual job performance.	Focuses exclusively on training to solve a "live" organizational problem or opportunity utilizing the resources of an intact work group or unit; all substantive material focuses on the problem at hand (problem-centred).	Peer learning self-renewal and improvement focus conducted in a mutually supporting learning community with individuals from different organizations and projects.
What are the objectives of this approach?	To transmit knowledge, concepts and techniques to groups of people with the ultimate goal being individual improvement.	To acquire organizationally relevant and job-specific skills through person-to-person training.	Organization development through successful project implementation; knowledge and use of problem-solving procedures; individual and group improvement of performance; learning how to learn.	Maintenance of a learning community that, in addition to social and affiliation activities, provides an environment where individuals can learn from each other and learn from accepted "authorities" in specific areas.
How is content/curricula decided? How are needs assessed?	Decided by sponsoring agency; teacher-centred learning; needs assessed by sponsoring agency.	Teacher-centred learning; needs assessed by boss/senior manager.	Joint needs assessment with decision-makers and the working group training emerges from research (data collection and problem analysis) regarding organizational performance, and the training intervention then leads to further evaluation, assessment and follow-up.	Content focuses on internally generated insights and indigenous knowledge; curricula/format determined by needs of learners, problem-centred.
Trainer/learner role?	Trainer is expert authority who imparts wisdom; learner-dependent relationship, passive to semi-active learning.	Boss as expert authority, coach, reinforcer and role model.	Trainer joins the work team or project as a resource.	Each member is simultaneously a trainer and a trainee.



Elements	Formal training approach	On-the-job training approach	Action training approach	Non-formal training approach
Strengths?	<p>Economy of "method" - "one" teaching "many" maintains uniformity in training substance; most easy to evaluate/most measurable; speeds up learning/more information in a shorter period of time; avoids errors of trial-and-error method.</p>	<p>Low monetary outlay; keeps training closely related to the job; more effective in changing behaviour than outside training interventions; flexible enough to be adjusted to different learning rates; more complex skills can be learned over longer period of time; reinforces learning from formal training.</p>	<p>Integrates formal training sessions and informal coaching with on-the-job problem solving; fosters self-direction by the group and builds group coherence and commitments to objectives; creates learning opportunity for host-country trainers; emphasizes maximum participation in learning process; directly imparts individual managerial capacities and organizational performance; concepts and skills taught are directly related to needs or problems or opportunities identified.</p>	<p>Common interests and unique learning needs serve as basis for initiation and continuation, reliance on local resources/low cost; emphasis of knowledge acquisition and informal exchange issues addressed have immediate relevance to most, if not all, participants; means of enhancing managerial capacities at highest levels; emphasizes learning from organizational experiences.</p>
Weaknesses?	<p>Difficult to transfer classroom learning to behavioural change on job; transfer and learning dependent on (1) inclination of learner; (2) bosses' style; (3) climate; (4) need to use it on the job. Training takes place away from immediate supervisor or project officer; dependent on knowledge and biases of trainer; can be expensive in time and money to customize to make culturally specific and relevant.</p>	<p>Too slow in view of urgency - learning by doing and trial and error - may take time; dependent on ability of senior manager to train subordinates; lack of high-caliber senior managers in some organizations; success dependent on rapport between senior and junior managers; doesn't address future educational and development needs of younger managers.</p>	<p>Long-term commitment of time, money, personnel; group orientation in individually oriented societies; instability of external environment in many least developed countries (LDCs); doesn't address future educational and development needs of younger managers.</p>	<p>Contrary to incentive and reward patterns in many LDCs; no formal authority pressing for behavioural change/no guarantee of success can reinforce existing systems and practices; groups must be homogeneous or group learning can be dominated by persons with rank; success dependent on rapport among participants.</p>
Most effective for which levels and types of management?	<p>Most effective for junior and middle-level managers; senior management seldom attends formal training.</p>	<p>Especially junior and middle-level managers; not effective at senior or pre-entry level.</p>	<p>Project management, middle management.</p>	<p>Senior level, top management.</p>



Elements	Formal training approach	On-the-job training approach	Action training approach	Non-formal training approach
<p>Conditions for effective use.</p>	<p>Requires effective design: (1) diversity and mix of methods; (2) action oriented; (3) effective sequencing of methods and content modules. Trainer must possess wide repertoire of learning tools and materials; back-home support - boss, peers and consistent with organizational norms; accurate needs assessment done; topic seen as relevant to learner.</p>	<p>Boss needs managerial style that facilitates counterpart learning; high caliber senior managers; clearly defined expectations; positive learning climate; junior and middle-level managers must have appropriate level of basic education to meet increased job requirements; long training time-frame.</p>	<p>Felt need for change; flexible training design; stability and continuity in supportive external environment; long-term commitment of resources; highly skilled trainers (diagnostic and process skills); trainer as "expert" credibility; minimal personnel turnover; use with other strategies (e.g. formal).</p>	<p>Homogeneous interest groups, similar managerial levels or ranks; primary input should be from outside experts; learning content and focus must be selected by group participants; use with other strategies.</p>



STRENGTHS AND WEAKNESSES OF DIFFERENT TRAINING LOCATIONS

	Strengths	Weaknesses
In-country training	Allows for the combination of any of the four available training approaches; all three programme designs are potentially available: packages, custom tailored, and distance learning; both relevance and specific custom tailoring of curriculum are possible; training can be conducted in office or immediate work environment; per capita, and potentially overall training cost are reduced compared to overseas and third-country training; can tap local resources for training.	Reliance on local resources which may not be available; curriculum content can be narrow and mechanistic, building job skills without the mind broadening effect; specialized and advanced training may be difficult to provide.
Overseas training	Can be a major catalyst of change, has strong mind-broadening effects; an important vehicle for acquiring special skills, including skills in a foreign language; enhances upward mobility and provides prestige and cross-cultural experience.	Course content may be irrelevant; is expensive; studying abroad involves opportunity cost; individuals participating in overseas training for extended periods often become part of a consumer-oriented culture, and assimilation back can be difficult; chances of brain-drain are higher.
Third-country training	A range of comparative experiences can be provided; provides mind broadening; per capita reduced compared to overseas training.	Similar to overseas training, but maybe of a lesser degree.



Table 1. Intersectoral and macroeconomic issues

Health policy issues	Key questions	Relevant corpus of economics
Health and economic development	1. What constitutes health and health improvement?	Identification and measurement of health and illness/disease; basic needs measures. Macroeconomic models of economic development, determinants of growth. Human capital theory, investment and consumption elements of health expenditure, household production functions for health, ill-health and productivity of labour.
Health and health care as a determinant and consequence of socioeconomic development	2. What are the determinants of health care improvement?	
	3. How does it and health services affect production and the economy?	

Table 2. Financial planning

Health policy issues	Key questions	Relevant corpus of economics
Cost containment and cost efficiency (Financial management)	1. How is the budget divided, who controls it, and how is the control exercised? 2. Can economies be effected in the procurement and distribution of resources? 3. What is "appropriate technology"?	Budgetary systems and accountability (cost centres, cost units); inventory management. Determinants of supplier behaviour (local, national, multinational). Shadow pricing and social opportunity costs.



Table 3. Intra-sectoral resource allocation and equity issues

Health policy issues	Key questions	Relevant corpus of economics
(a) Physical resources and cost	<ol style="list-style-type: none"> 1. What determines the behaviour of organizations and health agencies? 2. How and why will costs vary with changes in the scale, location, type of medical and health services (and facilities) provided? 3. What mix of services will produce specific services. 	<p>Production functions and substitutability between inputs. Estimation of short- and long-term curves, average and marginal costs, private and social costs. Determinants of hospital and health centre cost variations (case-mix, quality factors); economies of scale.</p>
(b) Human resources for health : their availability, motivation and remuneration	<ol style="list-style-type: none"> 1. What determines the supply and demand for each type of human resource? 2. What do forms of remuneration and other determinants, absenteeism, retention, affect geographical distribution? 3. What are the productivities of various types of health workers in relation to their training costs and rates of pay? 	<p>Labour markets and the demand for the supply of health workers. Marginal productivity theory. Factors influencing supply elasticities: impact of income levels and financial incentives, leisure preferences; private practice; the brain-drain.</p>
(c) Equity and social justice Provision of the right services in the right places to the right people at the right time	<ol style="list-style-type: none"> 1. How best can resources be matched to the populations need, morality and morbidity patterns, demands and utilization? 2. What impact do different health care systems have upon eligibility, access, take-up and benefits received by target groups in the population? 3. What are the barriers, if any, to the provision of an equitable (fair) health service? 	<p>Optimum welfare criteria and the concept of the social welfare function. Inequalities and equities in health care definitions and measurement issues. Effect of socioeconomic variables and physical access on utilization patterns</p>



Table 4. Intersectoral resource allocation

Health policy issues	Preliminary questions	Relevant corpus of economics
<p>Demand analysis ;</p> <p>The demand and need for health and health services</p>	<ol style="list-style-type: none"> 1. What determines the demand (or absence of demand) for specific health services, and for traditional healers, herbalists, and practitioners? 2. What factors determine the providers response to an individual demand for health care, including factors such as availability of referral facilities? 3. How do health payment systems (e.g. charges pre-payment systems methods) affect the demand and utilization of health services? 	<p>Theories of household, individual and supplier-induced behaviour; generation and interpretation of demand schedules; determinants of demand, price, income, and cross-elasticities, time costs.</p>
<p>Project Evaluation</p> <p>Desirability and implications of reducing, expanding, or redeploying existing services, or introducing new activities</p>	<ol style="list-style-type: none"> 1. Does the service do any good or have any discernible effect on health ? For whom ? 2. What are the relative efficiencies (merits and demerits of alternative health activities ? 3. What are the distributional consequences of health activities (who incurs cost, who receives benefits ?) 	<p>Budgetary systems and accountability (cost centres, cost units); inventory management. Determinants of supplier behaviour (local, national, multinational). Shadow pricing and social opportunity costs.</p>



Table 5. Economic perspectives on alternative financing and organization of health services

Health policy issues	Key questions	Relevant corpus of economics
Finance of the health sector Income aspects of health care and health-related activities	<ol style="list-style-type: none">1. What are the sources of health financing ?2. What types and quantity of resources are being utilized to finance the health sector ?3. What do alternative financing methods achieve both in terms of yield and incidence (burden) ?	Social accounting systems and public finance; revenue generation and tax incidence, self-financing, insurance and pre-payment mechanisms, ability and willingness-to-pay concepts.
Organization and delivery systems Structure of health care and health-related activities	<ol style="list-style-type: none">1. What are the economic characteristics of health care and health-related activities?2. What is the relevance of these characteristics for the pursuit of health through market and non-market mechanisms ?3. How do different health care systems handle their organization and distribution decisions ?	Welfare theory and market failure: rationality, consumer sovereignty, income and wealth issues, indivisibilities, externalities, public goods, and merit goods.



Table 6. Incentive packages

Health policy issues	Preliminary questions	Relevant corpus of economics
<p>Individual and corporate objectives and motives underpinning behaviour of agencies</p> <p>Organizational behaviour, health system analysis</p>	<ol style="list-style-type: none"> 1. Who makes resource allocation decisions to and within the health sector, and what are their objectives ? 2. What is the feasibility of reconciling the conflicting goals, values and interests of the various groups and individuals involved in the health sector ? 3. What types of controls or incentives (monetary or otherwise) can be introduced to encourage efficient behaviour ? 	<p>Managerial and behaviour theories of government, not-for-profit, profit and voluntary organizations. Notions of efficiency and the role of inducements (rewards and penalties), game theory.</p>



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