

EXECUTIVE SUMMARY

1. Given that health care budgets in all countries are increasingly stretched in the face of competing demands, there is a pressing need for evidence on the cost and benefits of health care programmes. The objective of this project was to review the evidence on the costs, effects and benefits of key primary health care (PHC) projects, to analyse and to interpret the results of such projects, to report on the policy implications for ministries of health and to suggest further work that the Commonwealth Secretariat could undertake in this area.
2. The survey has included both existing published literature and data solicited from Commonwealth countries by use of a questionnaire. It has been found that formal economic evaluations have been undertaken of primary health care activities in more than one third of the Commonwealth countries.
3. In the first section of the report, the topic of interest is defined (Section 1.2) as economic evaluations of the delivery, in or near people's homes, of one or more of the eight essential elements of PHC identified in the Alma Ata Declaration. These eight elements are: education concerning prevailing health problems; promotion of proper nutrition; provision of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

4. Also in the first section of the report, the basic forms of economic evaluation are defined (Section 1.3). These have the common feature that some combination of the inputs to a health programme are compared with some combination of the outputs. In cost-effectiveness analysis the outputs of the programme are measured in the most convenient natural units (e.g. deaths averted); in cost-benefit analysis the outputs are valued in money terms so that they can be directly compared with the inputs (costs). Because of the difficulties of measuring health improvements in money terms, yet recognising the need for policy makers to make comparisons across a wide range of health programmes, analysts have developed methods of assessing outputs in such terms as healthy days of life gained and quality-adjusted life-years (QALYs) gained.

5. In Section 2 of the report, existing evaluations of PHC activities in Commonwealth countries are reviewed. In the developing countries the main topics addressed have been the control of communicable diseases, programmes to provide adequate nutrition, family planning and immunization services, and choices in the methods of delivering PHC, such as fixed versus mobile clinics. In the developed countries the main topics addressed have been maternal and child health (especially screening programmes for neonates and the unborn), immunization, prevention of locally endemic diseases (again primarily through screening) and appropriate treatment in the community for the elderly, mentally ill and mentally handicapped.

6. Several major methodological issues arising from the review of the existing studies are highlighted in Section 2.2. These include the importance of adopting a broad (societal) perspective when undertaking economic evaluations, the importance of good evidence on programme effectiveness as an input to economic studies, the importance of estimating the marginal costs of

expansions or contractions in programmes (since it is these that are relevant to most decisions) and the importance of considering objectives other than economic efficiency, such as equity or fairness in service provision. (A checklist of questions for assessing the quality of a published study is given in Table 2.2.)

7. Another key issue arising from the review of the existing studies is the potential for, and dangers of, making international comparisons (Section 2.3). This is important because some countries may not have the expertise or time to undertake their own empirical work, and will have to rely on results obtained elsewhere. The two major points to consider are the legitimacy of any price and exchange rate conversions made in order to compare studies from different countries and the range of factors that could cause the cost or effectiveness of interventions to vary from one location to another. These factors include the local availability and cost of the resources required, population density, geographical factors influencing access to services, the likely level of co-operation from health care workers and the local population, the type of existing provision and whether it can be easily adapted to accommodate the new programme at low marginal cost.

The existence of these factors means that further analysis is usually required to interpret study results obtained elsewhere for one's own purposes, although often the differences in the relative cost-effectiveness of alternative health care programmes are so large that rough estimates of their likely value for money can be obtained from the international literature.

8. In Section 3 of the report, four key PHC projects/programmes are discussed in more detail. These have been selected both because of their intrinsic merit and

because they reflect the different needs and concerns of various Commonwealth regions. The projects are: integrated health care and nutrition in India; the expanded programme of immunization in the Gambia; control of schistosomiasis in St. Lucia; and screening for disease in the developed Commonwealth. The main purpose of the four examples is to show how economic evaluation can be applied in practice, the major methodological pitfalls that should be avoided and the usefulness of the evaluation results to those planning and organising PHC activities.

9. In Section 4 a number of policy issues arising from the application of economic evaluation to PHC activities are discussed. First, should PHC programmes continue to have high priority for development? In the context of developing countries it is argued (in Section 4.1.1) that the per capita cost of effective PHC is affordable if one recognises that both public and private funds can be drawn upon, or if some of the household resources at present used to purchase private health care can be tapped. Also, there is now fairly good evidence that certain PHC activities, particularly immunization and oral rehydration, do represent good value for money when compared to hospital-based programmes.

A similar picture emerges in the developed Commonwealth (Section 4.1.2). A major conclusion of the review is that PHC does provide a feasible and more cost-effective alternative to secondary care for a number of diseases and conditions. This is true for primary prevention of some diseases by vaccination, secondary prevention through screening for disease and for community-oriented services in the long-term care field (for the elderly, mentally ill and mentally handicapped).

However, further attention needs to be paid to whether PHC services are being delivered in the most efficient way. In the developing countries there need to be more evaluations of options in choice of target group(s), choice of the public or private sector for the delivery of supplies such as essential drugs and contraceptives, choice of the mix of PHC activities, choice of delivery strategy (e.g. integrated versus non-integrated, and static versus mobile) and choice of place of intervention (health centre versus the person's own home). The methods described in this report can be, and have been, used to evaluate these choices.

In the developed countries there are similar options to be evaluated, such as the location for long-term care (e.g. the person's own home versus residential care) in relation to the patient's dependency level, or the guidelines given (by age group, sex or previous family history of disease) for screening for disease. In addition, in the developed countries attention needs to be paid to the incentives and disincentives given to health care professionals by the way PHC is financed and organised, in order to ascertain whether these lead to efficient delivery of PHC.

10. A second policy issue arising from the report, discussed in section 4.2 and 4.3, is that of how best to commission, conduct and use economic evaluations of health care programmes. It is concluded that it is important for ministries of health to develop their own expertise in this field so that they can better interpret the results of evaluations carried out elsewhere, commission good quality work and also carry out evaluations in-house. As well as developing expertise in-house, it is clear that ministries in some countries have used other institutions (such as universities) to great effect and this should also be encouraged.

11. The recommendations, which are given in Section 5, echo the major points made here. In addition, recommendations are made for more training both for policy makers and for those who will undertake economic evaluations, so that the other aims outlined above can be fulfilled.