

5. RECOMMENDATIONS

5.1 Recommendations to member governments

Given the diverse nature of the countries in the Commonwealth it would be wrong to propose hard-and-fast rules for all. However, several general points have emerged from this review which could be considered to constitute guidance for health ministries. Obviously, such guidance may be ignored, either because it is inappropriate given local circumstances, or because it is already implicit in current policy.

The main points are as follows:

(i) In general, primary health care programmes can reach large numbers of people at a cost which is low relative to that of hospital-based care. Moreover, primary health care can act as the vehicle for interventions that are potentially effective in reducing morbidity and mortality. Thus, given that many PHC activities have been found to give good value for money when compared to other uses of health service resources, Ministries should continue to develop them.

(ii) Certain interventions, such as immunization and oral rehydration in developing countries, and screening for disease and community care programmes for the elderly or mentally ill in developed countries, have been shown to represent good value for money in many countries. However, in developing PHC activities several general principles should be observed if PHC is to be provided in the most cost-effective way. These are that the target population needs to be carefully selected, the timing and frequency of the intervention should be carefully considered and the least cost method of organising delivery of the service should be chosen. The overall principle should be that the marginal costs in further expansion of the PHC activity should not exceed the marginal benefits.

(iii) Economic evaluation in developing countries has concentrated on a few PHC activities (immunization, oral rehydration, family planning) neglecting vital areas such as health education and health promotion, appropriate treatment patterns and essential drugs. More economic evaluations should be encouraged in these areas.

(iv) A number of studies in both developing and developed countries have documented the potential for shifting interventions or care conventionally delivered in hospital to a primary care setting or to individual's homes. Such a shift has generally proved to be both feasible and cost-effective (e.g. tuberculosis treatment in developing countries, care of the mentally ill in developed countries). Countries should review their policies on the delivery of health care and identify services and interventions that could be shifted away from the hospital.

(v) In particular in developing countries further evaluation is required of the merits of the integrated and vertical organisation of particular interventions, and of fixed and mobile delivery strategies.

(vi) As a background to undertaking more economic analysis, Ministries should introduce a monitoring system for health service resource use, especially on PHC activities. This would improve the availability of information on the costs of PHC. Alternatively there should be more ad hoc cost analyses. Ideally cost analyses should be an integrated part of any programme evaluation.

(vii) Ministries' capacity to undertake, or to commission, economic analysis would be greatly enhanced if they developed their own capability for economic evaluations, for example, by having at least one person with economics training in the Ministry of Health.

(viii) Economic evaluation should be viewed predominantly as a way of thinking about choices in the provision of health and health services. Therefore, quite apart from undertaking studies of some major programmes, Ministries should try to incorporate economics concepts into health planning. One method was outlined in Section 4.2, where it was argued that a simple checklist of questions could be used to assess possible health developments.

(ix) In addition, Ministries should encourage the development of health economics expertise at selected universities or other suitable institutions. The development of multidisciplinary working, between clinicians, economists, epidemiologists and other health service researchers should be encouraged.

(x) Attention should be given to training in health economics, both for the planners and economics specialists themselves and for the policy makers who seek to use the results of economic analyses. Ideally policy makers should attend short workshops where they would learn how to interpret the results of economic evaluations. Planning and economics specialists will require longer courses, where the methodology of economic evaluation is fully explained and where there is the opportunity to undertake some practical project work.

(xi) Ministries should further ensure that teaching of economic evaluation is incorporated in the general management training of health personnel, including clinical practitioners.

(xii) Ministries should give more consideration to the managerial and organisational aspects of the adoption of PHC activities. For example, do the incentives and

disincentives in the primary health care field encourage the adoption of cost-effective practices and the efficient use of manpower? Are planning mechanisms in place to bring about compensating adjustments in secondary care facilities (e.g. closure of hospital beds that are no longer required) if the emphasis is on a shift towards primary care?

5.2 Recommendations to the Commonwealth Secretariat

The Commonwealth Secretariat could have an important role in furthering many of the objectives set out in section 5.1 above. In particular the following initiatives should be considered.

(i) Workshops could be mounted at the National and Regional level to educate those who may undertake economic evaluations and those who will use the results. Such workshops could focus on the evaluation of strategies to combat the major disease problems of each region and would be useful for those countries which could not justify the resources to mount their own workshops.

For example, the Commonwealth Secretariat could mount short one-week workshops for the users of evaluation results. These could concentrate on what to look for in a published study and the potential and problems of interpreting study results across different country settings.

Those who may undertake economic evaluations would benefit from a longer period of training of up to 3 months in duration. This should include extensive project work, some of which could take place back in their own countries. There may further be the possibility to link both training initiatives at the regional level. For example, policy makers and other evaluation users could review the project work undertaken by those attending the longer courses.

(ii) In order to develop further the technical expertise in economic evaluation in countries where it is currently lacking, attendance of individuals on larger and more advanced courses in health economics including economic evaluation, could be sponsored.

(iii) The Commonwealth Secretariat could give technical assistance to those countries wishing to develop local expertise in this field and to undertake economic evaluations of primary health care projects. For example, the Secretariat could facilitate the transfer of health personnel with economics skills between Commonwealth Countries.

(iv) The Commonwealth could assist in the dissemination of information relating to the economic aspects of health care, its planning and management.