Life as a Fellow: Professor Anne Mills, Professor of Health Economics and Policy, London School of Hygiene and Tropical Medicine

Ministry of Health Malawi, 1973–75

Health Economics and the ODI Fellowship Scheme: some unexpected synergies

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I have ODI to thank for offering the opportunity to enter a profession where demand has exceeded supply throughout my career. When I was interviewed in 1973, I was asked in what area of economics I might like to work. I expressed a preference for the social sector, having parents who both worked in education, and was offered the post of economist in the Ministry of Health in Malawi. Although I did not know it at the time, I was one of only a handful of economists working in health in developing countries, and in the UK and US, the sub-discipline of health economics had really only begun to develop in the late 1960s.

When I returned from Malawi, I spent a few years researching the UK NHS, but found the health economics issues of the developing world far more challenging. I joined the London School of Hygiene and Tropical Medicine when it was expanding its social science capacity – with the financial support of the then Overseas Development Administration. I have stayed there ever since, partly because the LSHTM is such a flexible institution that one can constantly redefine one's job over time. I was fortunate in 1990 to receive a research programme grant from DFID, to develop research on the efficiency and equity of health systems in developing countries. We are now nearing the end of the third phase of that programme. The programme mode of research funding has enabled us to build up a large volume of applied research on the economics of health, and to do that in close collaboration with governments and academic institutions in developing countries.

The experience of 30 years' work in health economics gives me the opportunity to look back over the development in the sub-discipline, and to reflect on changes. While health economics is generally regarded to have developed from the late 1960s, some perennial themes have much earlier roots. The importance of identifying the most appropriate role of the state in health was noted by Sir William Petty in 1676, when he commented that 'it is not in the interests of the State to leave Phisitians and Patients (as now) to their own shifts' (Petty 1676). New Public Management influences have challenged the assumptions of a strong state role in health care, but this still remains one of the most controversial issues within health economics. Another perennial theme is that of the impact of ill health on economic development. One of my favourite historical accounts is that of the impact of malaria in India:

> 'The autumn of 1908 in the Punjab was characterised by an epidemic of extraordinary severity. The effects of this epidemic were first prominently brought before the public by a sudden disorganisation of the train services due to 'fever' amongst the employees at the large railway station, Lahore…. At Amritsar….almost the entire population was prostrated and the ordinary business of the city disrupted. For many weeks labour…was unprocurable and even food vendors ceased to carry on their trade' (Christophers 1911).

The recent SARS epidemic demonstrates the continued ability of disease to disrupt economic activity.

Notwithstanding these continuing themes, there have been distinct trends over time in the emphases of health economics. In the 1970s, there was increasing involvement of economists in Ministries of Health – a trend which my appointment in Malawi illustrates. Areas of concern were primarily micro-economic, concerning issues of resource allocation both to and within the health sector. Health economists concentrated on studies of cost and cost-effectiveness, with cost-effectiveness analysis in particular being seen as a key tool for improving the efficiency of health services; and on improving

economic data for decision making, especially on health sector financing and expenditure. In retrospect this can be seen as a pioneering age, when health economists were striving to get their ideas and techniques accepted as a legitimate component of health sector decision-making.

The 1980s can be crudely categorised as the era of health care financing. Arguments over the merits of user fees and insurance dominated the literature, and encouraged the expansion of work on demand functions, in contrast to the previous focus on the supply side. Economists, especially those in the World Bank, were perceived to be driving health sector policy, and debates became increasingly ideological. The development of research on household expenditure choices, ability to pay, and coping strategies was stimulated by concern that demand analyses took as given the desirability of patterns of private spending on health.

In the 1990s and more recently, the field of health economics has greatly expanded, drawing on the broader economics discipline, especially in the areas of institutional and industrial economics, to inform health system design. Much greater attention has been paid to issues of incentives, payment mechanisms, and alternative organisational models. On the service delivery side, much more attention is being paid to private markets and how they might be influenced to contribute to public health goals. For example, 60% of Tanzanians with malaria symptoms currently purchase drugs from shops compared with only a third who visit government health centres for treatment. We are gradually learning how these retail markets work, and how their quality of treatment can be improved. The question of the relationship between health and economic development has received new attention, with the Commission on Macroeconomics and Health, of which I was a member, arguing that the influence of health on economic growth has been greatly underestimated, and that health should receive much higher priority in public expenditure (WHO 2001).

This brings me to the role of ODI. While I am sure that economists were supplied to Ministries of Health because of their perceived need for health economics expertise, the Scheme has had important spin-offs in knowledge generation and the development of health economics. My own research programme has recruited heavily amongst ex ODIs, and I currently have 4 working with me, with 3 others who have joined us for periods in the past. Other ex-health ODIs have also stayed working in health, in other universities, WHO and bilateral aid agencies.

A number of important contributions to the development of health economics have been made by ex-ODIs. Mike Mills (MOH Botswana 1976-8) was one of the first economists to develop methods for systematic surveys of health finance and expenditure. The research and publications of Lucy Gilson (MOH Swaziland 1983-5) in the late 1980s were key in challenging the World Bank's pro-user fee stance, and are some of the most widely quoted of studies on user fees; more recently she has explored the relationship between economic analysis and policy making and implementation. Andrew Green (MOH Swaziland 1976-8) has also focused on improving public decision making, publishing one of the most widely used textbooks on health planning. Sara Bennett (MOH Lesotho 1987-9) has provided valuable and much referenced evidence on the pros and cons of community-based health insurance. Ex-ODI Fellows in WHO, such as Katherine Floyd (MOH Guyana 1993-5) and Ulla Kou (now Griffiths) (MOH Guyana 1995-7) have been involved in valuable work on the economics of TB and HIV interventions and vaccines. My own work with colleagues has created a body of important knowledge on the value of contracting out heath services to the private sector, and economic aspects of malaria control. Most recently, Kara Hanson (MOH Swaziland 1988-90) and Catherine Goodman (MOH Lesotho 1994-6), who work in the LSHTM economics of malaria group, have broken new ground in exploring how private markets operate for health products such as drugs and mosquito nets and insecticides, what tools are available to influence both demand and supply, and how well they work.

The ODI experience has undoubtedly shaped the nature of the research that ex ODI Fellows are engaged in, and the way in which the sub-discipline of health economics as applied to low income countries has developed at least within the UK context. An ODI Fellowship provides invaluable knowledge of civil service decision making, the realities of service delivery, and the big issues facing policy-makers. Ex ODI Fellows tend to share a prime concern to influence policy and practice, and hence to tackle topics that are of great concern to policy-makers where applied research can have an impact on decision making. In this sense, policy imperatives rather than theory drive the research. ODI Fellows also have an insiders' knowledge of the weaknesses of routine data, encouraging a bias towards primary data collection rather than secondary data analysis. Early exposure to the complexities of policy development and implementation appears to stimulate an interest in the process of policy making, and a concern for how best to present and communicate research in order to influence the policy-making process, and improve decision-making. So the ODI scheme can pride itself not only on

providing useful pairs of hands to developing country agencies, but also on helping to influence the development of health economics as applied to low income country settings.

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