Teaching health economics

The first steps to getting doctors to pursue efficiency are to increase their awareness of what it means, why it matters, and how it can be pursued. Economics is about choice. Health economics is about choices which influence health and about making such choices efficiently. Efficiency means maximising benefit—in this context presumably the happiness, fulfilment, and satisfaction in living longer or more healthily—from whatever resources are available.

Yet this idea of efficiency seems to be spurned by doctors—in part because of a misunderstanding about what it entails but also in part because many doubt the practicalities of pursuing efficiency in health care when the outputs are so difficult to define, measure, and value.

Resources are inevitably finite in the National Health Service. That is an economic fact; it is only the extent to which they are limited that requires a political judgment. Every time a decision is made (consciously or otherwise) to devote £1 million to heart transplantation, geriatric care, or additional laboratory tests, benefits—health gains—are for-gone elsewhere. And by implication wherever the £1 million is deployed the benefits must be being judged to be in excess of £1 million.

Measuring the outputs—longer life, reduced morbidity, and so on—from health care is difficult; but it is no more than difficult. The *BMJ*, for example, recently published a paper showing how cost utility analysis could be used to rank different high technology procedures in terms of “costs per QALY” (quality adjusted life years).¹

Showing that efficiency matters and that it can be measured is not enough—and it is not all that health economics purports to offer. Persuading, cajoling, motivating actors on the health care stage to be efficient and to promote efficiency—the idea of incentives on the supply side—is now more widely recognised as important than at any time since the NHS was established.

In practice, however, not everyone supports the goal of efficiency: perhaps few genuinely understand it; some indeed may feel threatened by it and resent the idea of incentives, management budgeting, and performance indicators being used to try to alter well established (even if possibly inefficient) practices.

At a workshop in Birmingham for senior NHS staff the biggest hurdle to be overcome in getting economic appraisal used in the NHS was said to be lack of awareness of the need for efficiency and what it really means.² Jennett reported several reasons why clinicians were reluctant to accept economic appraisal: “Many were probably unaware of its existence; others misconstrued its nature and purpose or dubbed it as the management fashion of the year; and yet others held that it was no more than giving fancy labels to what was already being done.”³

Last year we circulated questionnaires to 28 medical schools in Britain and to several institutions concerned solely with postgraduate education. Respondents were asked to estimate the total amount of time devoted to health economics teaching in each course in which health economics was represented. Of the 26 schools from which information was available six had no undergraduate programme whatsoever in health economics; and about three quarters of those which did provide instruction devoted four hours or less of each student's entire undergraduate career to the subject. Furthermore, these figures are probably an overestimate as some

schools included health service financing in their health economics teaching.

Where health economics was taught at undergraduate level eight schools scheduled the teaching during the first two years of the undergraduate's programme, and 19 courses were provided in the third or later years. Five schools offered more than one course in each undergraduate programme. Nine schools were planning to increase their health economics teaching over the next two to three years.

The 13 postgraduate courses gave health economics a higher priority, in that all included the topic but only six included more than 20 hours of such teaching.

As three health economists it is difficult for us to argue for more training on economics in the medical curriculum without it appearing to be special pleading. Certainly we would suggest that the extent to which the General Medical Council's recommendation on teaching health economics is being carried out is at best limited.⁴ Assertions of “pressure on the curriculum” inhibiting the introduction of economics teaching in medical schools beg evidence about the opportunity cost of omitting such training of doctors—who will play such a vital part in resource allocation.

The respondents to our survey were agreed on the need for more teaching materials aimed specifically at medical students and indeed for health economists to be more prepared to offer their services for teaching in medical schools.

A shortage of suitable teachers was also highlighted as a problem. Yet it was only a minority of schools which had any plans to increase the amount of teaching over the next two or three years.

We find the position disappointing. It would not be so bad if, once qualified, doctors were coming forward for training in health economics, but they are not. We are not claiming that doctors should try to become experts in economics, but this is a topic on which a little learning is not a dangerous thing. Ignorance is.

We are grateful to all those who responded to our questionnaire and to Professor G S Kilpatrick, dean of clinical studies at the Welsh National School of Medicine, who lent support to the survey.

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