A survey and scoping exercise to investigate health economics training in the ECSA health community: Opportunities for supporting health economics capacity in the region

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Executive Summary

This report presents the findings of health economics training assessment in the ECSA-Health community region. Data were collected through a survey and a scoping exercise. The findings show that only two out of nine countries in the ECSA-Health Community region do not offer any form of health economics training. Despite the majority of countries offering any form of health economics courses, member states felt that the current courses do not meet the expectation of many participants and there is no institution providing formal comprehensive postgraduate training in health economics in the ECSA-Health Community region. The findings also show that there is a high demand for health economics from policy-makers/decision-makers and researchers/analysts in the ECSA-Health Community region. However, efforts to increase health economics capacity is hindered by inadequate financial and technical capacity of training/research institutions, weak coordination between researchers and policy-makers on one hand and between national and international researchers and development partners on the other hand. As a way forward, national training/research institutions need to strengthen their technical capacity in provision of health economics courses, while member states need to support these national institutions with the needed financial resources and also create appropriate structures and career paths for the upcoming health economists in public institutions. Development partners need to support international training/research institutions with financial resources that could be used to help build health economics technical capacities and also provide direct financial support to member states for research and health economics analyses in the ECSA-Health Community region.

1 Introduction

Absolute inadequacy of financial resources in health systems has been found to be a major constraint in improving health systems performance in many low- and middle-income countries (LIMICs), especially in sub-Saharan (SSA). However, there is also a realization that relative inadequacy—inefficiencies and inequities—in the allocation and utilization of these limited resources, i.e., a realization of the dangers of not spending well given limited resources hence not able to maximize user benefits, greatly contributes to health systems poor performance, especially in SSA. The field of health economics has developed a large body of evidence-based methods for improving health resource allocation and utilization. For example, the design of health benefit packages using cost-effectiveness of interventions, design of resource allocation formulas, assessment of technical efficiency using Data Envelopment Analysis, among others. These evidence-based methods in health economics have motivated the ECSA-Health Community member states (eSwatini, Kenya, Lesotho, Malawi, Mauritius, Tanzania, Uganda, Zambia and Zimbabwe) to support health economics capacity building initiatives such as the creation of Thanzi La Onse (TLO) (Health of All) Health Economics Community of Practice (COP) in the ECSA-Health Community region with technical and financial support from TLO research programme managed by the University of York (for more details on the ECSA-Health Community member states, see appendix 1). However, currently very little information is available on the existing health economics capacities in this region.

2 Aims and Objectives

This assessment was undertaken with the following specific objectives:

1. as part of TLO's capability building objectives, the need to establish a 'baseline' of health economics training provision in the ECSA-Health Community region to help guide efforts in delivering short courses and inputting towards national level MSc curricula etc.; and
2. responding to a request from the TLO-ECSA-Health Economics COP, which requested TLO support in informing its capability building agenda.

3 Methods

The assessment used two main approaches to collect the data: First, a survey of ECSA-Health Community members including joint ECSA-TLO Health Economics COP in which information on: i) existing training materials and provision available to ECSA-Health Community members; ii) the needs and demand for health economics training in the ECSA-Health Community; iii) the existing health economics capacity in the ECSA-Health Community; iv) the general content/focus of these courses; v) the types of individuals who access these

courses (students, technical analysts, researchers, policy-makers etc.); vi) gaps in training provision; and vii) challenges encountered in health economics capacity building efforts were obtained. This was done through the use of a questionnaire (Appendix 8.2) sent via email (google survey) to all members of the ECSA-Health Community Health Economics COP and some well-known health economists in some ECSA-Health Community member states.

Second, a scoping exercise of: i) health economics courses and materials available and accessed in the ECSA-Health Community region; ii) the general content/ focus of these courses; iii) the types of individuals who access these courses (students, technical analysts, researchers, policy-makers etc.); and iv) gaps in training provision. This was done through internet search using google search engine of different universities websites in the ECSA-Health Community region such as "university of Nairobi", "Makerere University", etc. and using some key search words such as "health economics", "capacity building in health economics", and "health economics capacity in Africa", "strengthening research capacity in low- and middle-income countries", "strengthening research capacity in sub-Saharan Africa" etc. To verify some of the information obtained in the survey and in the scoping exercise, key informant interviews with well-known health economists in the ECSA-Health Community region were conducted via telephone.

4 Findings

The survey of ECSA-Health Community member states had a high response rate—all member states responded to the survey and the scoping exercise also yielded a lot of useful information. The findings of this assessment are presented according to specific themes as follows:

3.1 Training provision in ECSA-Health Community

The findings of this assessment show that only two countries (Lesotho and Mauritius) in the ECSA-Health Community region do not provide any form of health economics training at domestic institutions. In the rest of the ECSA-Health Community member states, the status of health economics training capacity is presented in Table 1. It can be clearly seen that the majority of economists, medical or public health undergraduates, postgraduates or some policy-makers are exposed to health economics modules embedded in either an undergraduate or masters course in economics, medicine or public health or short-courses in health economics in the ECSA-Health Community region. It is also clear that there is no institution in the ECSA-Health Community region that offers formal comprehensive postgraduate Masters or PhD training in health economics.

Table 1. Training provision in the ECSA-Health Community Region

Country	Institution	Health economics training embedded in:			
		Masters course	Bachelors course	Short-courses	Additional information
Eswatini	Department of Agricultural Economics and Management, Faculty of Agriculture, Luyengo campus	x			MA agriculture economics covering: basic concepts and practical issues faced by decision makers at all levels of the health care system in allocating scarce resources so that the choices they make maximize health benefits to the population
Kenya	University of Nairobi, School of Economics	x			MA Economics and MA Economic Policy Management courses
	University of Nairobi, Department of Community Health	x	x		Bachelor of Medicine and Master of Public Health covering: Basic Concepts of Health Economics, Demand and Supply, Cost and Production of Health Services, Market and Health Care, Economic Evaluation, Health Care Financing, Health Policy and Health Sector Organization
	University of Nairobi, Health Economics Unit			x	Targeting middle level managers, technical analysts, decision-makers, and policy-makers
Malawi	University of Malawi, Chancellor College, Department of Economics		x		Bachelor of Social Science (economics) final year students covering: Basic Concepts of Health Economics, Demand and Supply, Cost and Production of Health Services, Market and Health Care, Economic Evaluation, Health Care Financing, Health Policy and Health Sector Organization
	University of Malawi, College of Medicine, Department of Health Systems	x	x		Bachelors and masters students in medicine, public health and global health covering: economics, health and health economics; demand and supply of health care; market failure and health, organization of healthcare and health financing; rationing in healthcare; ethics, equity and economics; provider incentives; and economic evaluation in health care
Tanzania	University of Dar es Salaam, College of Social Science	x			MA Economics covering: Demand and Supply of Health Care, Markets and Market Failure in Health and Health Care, Health Insurance, Moral Hazard and Adverse selection, Basic Principles of Epidemiology, Health and Development, Health Systems and Financing, Health Policy and Reforms, Economic Evaluation of Health Interventions

Uganda	Uganda Martyrs University, Department of Health Sciences	x			MSc. Health Services Management course
	Makerere University, Institute of Public Health	x			a part-time MSc Economics course
Zambia	University of Zambia, Department of Economics	x	x	x	BA Economics and MSc. Economics covering: Production of Health, Demand for Health, Supply of health, Health Insurance, Economic Evaluation of Health Programmes, Basic Epidemiology, Health Financing, and Health Policy. Short-courses targeting middle level managers, technical analysts, decision-makers, and policy-makers covering National Health Accounts (NHA), health insurance, costing of health services etc.
Zimbabwe	University of Zimbabwe	X			MSc Clinical Epidemiology
	Bindura University	X			MSc. Economics covering: Contemporary issues in Health Economics, Health Management, Health Financing, Health Policy and Planning, Epidemiology, and Health Promotion
	Africa University		X		Bachelor of Health Services Management

3.2 Training needs in ECSA-Health Community

The majority of member states (6/9) felt that the health economics courses currently being provided in their domestic institutions did not fully meet the expectations of the participants. Several important areas were felt to be missing such as design of health benefit packages, development of resource allocation measures e.g. resource allocation formulas, provider payments mechanisms for essential health services e.g. services included in health benefit packages so as to ensure alignment between health benefit package and payment mechanisms at implementation level, cost analysis, cost effectiveness analysis, measurements of health and models of health and development/poverty; health planning, links between fiscal space, public financial management and payment mechanisms, performance-based financing, economics of non-communicable diseases, simulation-based cost-effectiveness analysis among others. In all ECSA-Health Community member states, comprehensive post graduate health economics training needs are sought outside the ECSA-Health Community region: in Africa—University of Cape Town—and in Europe.

3.3 Training demand: policy and decision-makers in ECSA-Health Community

All member states in the ECSA-Health Community region indicated that there was a high demand for health economics in their countries from policy and decision-makers. For example in Malawi, both Government and Non-governmental policy and decision makers tend to seek consultants (working in the universities, International non-governmental organizations, donor organizations or government itself) input in health economics analyses to inform decision making, however, it was noted that there is over-reliance on international health economics experts as evidenced by studies commissioned by the Ministry of Health to generate evidence that would inform health financing options especially with regard to health insurance in 2015. In Zambia, for a long time, the ministry of health has consistently sought expertise from the University of Zambia on health economics related matters such as National Health Accounts (NHA), Social Health Insurance, costing, development of a health financing strategy, among others. However, there was also a feeling from some member states (4/9) that health economics advice is not well appreciated and hence intermittently demanded by policy-makers in situations where the majority of top leadership in ministries of health have biomedical expertise and experience.

3.4 Training demand: researchers and analysts in ECSA-Health Community

All member states in the ECSA-Health Community region indicated that there was a high demand for health economics in their countries from researchers/analysts. Several examples were given: 1) research or analyses for decision making in the health sector such

as evaluation of health services, program formulation or reforms and these processes almost always include an economist or a team of economists to provide direction on issues of economic decision making ranging from resource allocation to expenditure analyses; 2) increased health policy analyses and desire to make choices in a resource constrained environment so as to meet demands from policy-makers; 3) researchers engaged in policy analysis and development thus requiring evidence to inform policy recommendations, hence need for analytical skills e.g. skills in health financing; and 4) few health economists available in some countries in ECSA-Health Community region in light of new developments in health economics such as the design of health benefit package using cost effectiveness approach which would need a lot of health economists to provide technical support for its design and implementation, among others.

3.5 Current health economics capacity existing in ECSA-Health Community

Table 2 shows the distribution of health economists in the ECSA-Health Community region by country and within country by institution in 2019.

Table 2. Distribution of Health Economists by Country and Institution in the ECSA Health Community, 2019

	Institution							
Country	**Public Sector (Ministry of Health)**	**Domestic Universities**	**Other domestic research institutes**	**International University/ Research institutes in the country**	**Donor/ Development Partner**	**National/ International NGO**	**Other**	**Total**
Eswatini	0	2	0	2	0	0		4
Kenya	6	10	2	3	4	1		26
Lesotho	0	0	0	0	1	1		2
Malawi	3	5	0	2	1	3		14
Mauritius	1	0	0	0	1	0		2
Tanzania	2	5	6	0	2	5		20
Uganda	0	6	4	1	2	0	4	17
Zambia	4	5	2	0	2	3		16
Zimbabwe	2	5	1	0	1	3	2	14

From Table 2, it can be clearly seen that Kenya has the highest number of health economists (26) in the ECSA-Health Community Region, seconded by Tanzania (20) with Uganda (17) and Zambia (16), coming third and fourth, respectively. The concentration of most health economists' capacity in each country by institution appears to be in domestic universities. For example, in Kenya, Malawi and Zambia, most health economics capacity is housed in domestic universities, while in Tanzania, it is in other domestic research institutes (Table 2).

Almost all member states (8/9) indicated that increasing the number and skills of health economists would improve the ways in which health care is financed and organized, leading to better health in their countries. For example, one responded mentioned the importance of health economics in health reforms so as to achieve universal health coverage:

"Our government has prioritized health and wants to reform it for better efficiency so that it could achieve universal health coverage and as such, this requires good advice and guidance based on sound health economics training".

Another respondent underscored the importance of health economics in aiding programme design, implementation and evaluation and stated:

"Even in all other health disciplines that currently do not directly apply health economics concepts, they would begin to use health economics as a basis for organizing programming, execution and evaluation of their interventions; thus improving the overall approach and use of the limited resources of the entire health system"

While another respondent underscored the need for increasing health economists working in the public health sector and stated that

"*We require health economists employed in the Ministry of Health other than general economists",*

Another respondent expressed the dilemma that the current few health economists sometimes face in some ECSA-Health Community member states:

" There are a few health economists already trained at masters (and PhD) level in this country but opportunities to practice are notoriously rare. As a result, most end up in other economics careers".

3.6 Factors affecting demand and supply of health economics in ECSA-Health Community

The majority of member states (8/9) cited inadequate technical (both quantities and training skills) and financial capacity to offer comprehensive health economics courses in their countries and inadequate experienced health economists to undertake research and policy analyses as affecting the supply of health economics in their countries. However, one member state respondent mentioned lack of time, software, and structure of the postgraduate programme to which health economics is embedded as it does not accommodate more content because students have to take other courses in other departments. From the demand-side, some member states (4/9) indicated that sometimes there is low appreciation of health economist's role in overall health policy analyses and development in an environment where the majority of the top leadership in the public health sector—ministries of health—have biomedical expertise and experience. In such situations,

for example, the role of health economists has been reduced to mere annual government budgeting and physical infrastructure planning.

5 Discussion

The results of this assessment show that the majority of member states (7/9) in the ECSA-Health Community offer any form of health economics training embedded in either undergraduate or postgraduate courses. This is a huge increase compared with the findings of a similar earlier assessment that found that there were few institutions that were offering any health economics courses in the whole of Africa and ECSA-Health Community in particular (McIntyre and Wayling, 2008). However, despite the majority of member states offering any form of health economics courses, member states felt that the current courses do not meet the expectation of many participants; and similar to the findings of McIntyre and Wayling (2008), there is no institution providing formal comprehensive postgraduate training in health economics in the ECSA-Health Community region—the only institution offering comprehensive post graduate health economics in English outside the ECSA-Health Community region in Africa still remains the University of Cape Town.

In addition, the results show that there has been a huge increase in the number of health economists working in ECSA-Health Community members states compared with the findings of a similar assessment by McIntyre and Wayling (2008). McIntyre and Wayling (2008) found that in 2005, Kenya had only seven health economists compared with 26 found in this assessment, Uganda had 10 compared with 17 found in this assessment, Zambia had three compared with 16 found in this assessment, and Malawi had two compared with 14 found in this assessment. This increase could partly be attributed to increased realization of the importance of health economics in health planning, policy analysis, implementation, monitoring and evaluation by policy-makers, donor organizations and the would-be health economists; and increased financial support for scholarships by development partners.

The findings further show that there is a huge demand for health economics from policy-makers/decion-makers and researchers/analysts in the ECSA-Health Community region. This finding is similar to the findings of an earlier similar assessment by McIntyre and Wayling (2008). The results also show that efforts to increase health economics capacity is hindered by inadequate financial and technical capacity of training/research institutions, inadequate effective demand from policy-makers, weak coordination between researchers and policy-makers on one hand and between national and international researchers and development partners on the other hand.

In a similar earlier assessment, McIntyre and Wayling (2008) also found similar factors as affecting the growth of health economics capacity in Africa as follows: 1) the need for health economics had not been translated into effective demand as evidenced by low funding by national governments in health economics analyses and research—this situation is still true

for the ECSA-Health Community region—all member states indicated lack of domestic financial resources for health economics research and analyses in this assessment; 2) concentration of health economics demand among international organizations—much as this situation appears to have improved in the ECSA-Health Community region—but it still remains a reality as the majority of demand for health economics research/analyses and funding is still made by international NGOs and donor organizations; 3) limited understanding of health economics potential contribution to policy analysis and development including implementation, monitoring and evaluation by policy-makers and decision-makers—much as there has been an improvement in regard to this situation—it still remains a challenge in the ECSA-Health Community region especially where there is heavy biomedical expertise concentration among policy-makers and decision-makers in public health institutions; 4) limited engagement between policy-makers/decision-makers and researchers—this situation remains a challenge in ECSA-Health Community—even though some few countries have formed engagement groups e.g. Malawi has formed a Health Economics, Policy and Ethics Think Tank that comprise senior government technical officials in the Ministry of Health, Malawi College of Medicine, and collaborating researchers in health economics.

In summary, in terms of efforts to strengthen research capacity in general in LMICs, the literature shows much stronger evidence on problems and challenges identification than on interventions implemented to strengthen research capacities and capabilities, and of the few interventions implemented, the evidence of their effectiveness is limited, but broad guiding principles and good practices are identified (Fosci et al., 2019). As such, further search for innovative strategies for improving the research capacities and capabilities in health economics e.g. in the ECSA-Health Community region need to be vigorously pursued and implemented.

6 Limitations

This assessment is not without some few limitations: first, is the unclear definition of a health economist [though a consensus had been reached on the key feature defining a health a health economist as someone with a formal postgraduate training or extensive expertise in health economics (McIntyre and Wayling; 2008)], this might have affected the respondent's ability to correctly identify health economist (s) availability and institution of work in their respective countries, as such, the figures presented in this report need to be read with caution and need further scrutiny by member states. However, key informant interviews with some well-known health economists in the ECSA-Health Community member states helped to validate the responses. Second, some respondents in member states were only responding to questions in reference to their institutions of work without further enquiry of the whole health system actors as per survey instructions. However, this was also

compensated by key informant interviews with some well-known health economics experts in member's states or in the ECSA-Health Community region and document reviews.

7 Recommendations

Based on the results of this study, the following recommendations have been made as follows:

4.1 Supply-side: Training/research institutions in ECSA-Health community

- Review and update the contents of health economics modules embedded in undergraduate courses in economics, medicine and public health to include recent knowledge, tools and practices in health economics
- Review and update contents of short-courses offered to policy-makers/decision-makers in the ministry of health and senior officials and technocrats in the ministry of finance to include recent knowledge, tools and practices e.g. design of health benefit packages using cost effectiveness analysis approach; resource allocation mechanisms; linkages of fiscal, space, public financial management and provider payment methods, and performance-based financing, among others.
- Review and update modules included in postgraduate courses e.g. economics and public health to include recent knowledge, tools and practices in health economics
- Strengthen the capacity of existing staff in health economics through short-term and long-term training courses—Masters and PhD in health economics and also develop training skills such as interactive training, learner evaluation, thesis supervision among others
- Strengthen the institutional capacity through development of enabling policies, physical infrastructure and ICT infrastructure for research production, management and communication e.g. e-journals, e-books, online databases, etc.

4.2 Demand-side: ECSA-Health Community member states and Regional Bodies

- Regional bodies such as ECSA-Health Community and WHO-Africa Regional Office need to continue strengthening sensitization of its member states on the need and importance of health economics in health planning, policy analysis and development, monitoring, implementation and evaluation
- ECSA-Health Community member states need to identify and strengthen one institution in ECSA-Health Community region to offer postgraduate Masters and PhD courses in health economics and thereafter offer scholarships to would be students
- ECSA-Health Community member states need to create positions for health economists in ministries of health and other public health institutions such as Institutes of Public Health, Health Economics Units etc. with clear career paths etc.
- ECSA-Health Community member states need to strengthen coordination between research/training institutions and government institutions within countries e.g.

formation of working groups within countries e.g. the Health Economics, Policy and Ethics Think Tank in Malawi; and within the ECSA-Health Community region e.g. the the Thanzi La Onse (Health of all) Health Economics Community of Practice; and strengthen collaboration with African Health Economics and Policy Analysis Network (AFHEA) (formed in 2009 with the main aim of contributing to the promotion and strengthening of the use of health economics and health policy analysis in achieving equitable and efficient health systems and improved health outcomes in Africa, especially for the most vulnerable populations. URL:https://afhea.org).

4.3 Development Partners

- Provide direct financial and technical support for increasing the capacities and capabilities of training/research institutions in ECSA-Health Community region e.g. providing scholarships to Masters and PhD students in health economics, development of teaching materials, ICT infrastructure etc.
- Provide financial support to International training/Research Institutions to technically support ECSA-Health Community member states ministries of health, and training/institutions in developing health economics research capacities and capabilities
- Engage with national institutions to set the research priorities prior to supporting research activities and define clear roles and responsibilities of national experts in the whole research

4.4 International Training/Research Institutions outside Africa

- Provide technical support to training/research institutions in the ECSA-Health Community training/research institutions through development of curriculum for Masters and short-term courses in health economics, review and updating of existing health economics courses embed in other courses; teaching methods, learner evaluation, thesis supervision etc.
- Second experienced staff or post-doctoral students to ECSA-Health Community member states training/research institutions to provide mentorship
- Work with local teams to develop research priorities/agenda based on country needs and priorities and jointly undertake implementation

8 Way forward

The report is produced for sharing among the COP members in Health Economics and will be presented at the next ECSA-Health Community Directors meeting (Mauritius, January 2020). The report contains recommendations on how TLO may start to help addressing the challenges/ gaps in health economics capability in the region. These will be considered by both the TLO Executive Group as well as the COP to agree the next steps and priorities for TLO over the next 24 months.

9 References

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10 Appendices

Appendix 8.1: Population and Health Expenditures in ECSA-Health Community

Country	Population (millions) (2016)	Current Health Expenditure as percentage of Gross Domestic Product (GDP) (2016)	Domestic General Government Expenditure as percentage of General Government Expenditure (2016)	Current health expenditure per capita (2016) (US$)
ESwatini	1.3	8	15	221
Kenya	48.5	5	6	16
Lesotho	2.2	8	11	86
Malawi	18.1	10	10	30
Mauritius	1.3	6	10	553
Tanzania	55.6	4	10	35
Uganda	41.5	6	5	38
Zambia	16.6	4	7	57
Zimbabwe	16.2	9	15	94

Source: World Health Organization. Global Health Expenditure Database: URL: www.who.int/nha/database

Appendix 8.2: Survey Questionnaire for assessment of health economics training capacity in ECSA-Health Community

The ECSA Health Community in collaboration with Centre for Health Economics, University of York and Health Economics and Policy Unity, Malawi College of Medicine under Thanzi La Onse (Health of all) Program is undertaking an assessment of health economics training capacity in ECSA Health Community.The specific objectives of this assessment are to:

1. obtain existing training materials available to ECSA members: (i) health economics courses and materials available and accessed in the region; (ii) the general content/ focus of these courses; (iii) the types of individuals who access these courses (students, technical analysts, researchers, policy-makers etc.); and (iv) gaps in training provision; and
2. understand the needs and demand for health economics training in the ECSA region.

In order to obtain this information, we would like to request your cooperation in filling the short questionnaire below and submit to….. by August 31, 2019. Your cooperation will be greatly appreciated.

1.	**Name of respondent**	
2.	**Position of respondent**	
3.	**Institution of respondent**	
4.	**Name of Institution being reported on (if not same as 3 or *if more than one institution in one country, please fill one questionnaire for each institution)***	
5.	**Physical/postal address of institution being reported on**	
6.	**Website of institution being reported on (if available) or email or telephone contacts for the institution**	
7.	Does the institution offer health economics courses? (Mark only one oval)	YES or NO
8.	If YES, which courses? (Tick all that apply)	1. Short-term e.g. pure health economics course for 1 or 2, 3 or 4 weeks or up to 3 months. 2. Long- term e.g. Diploma, Degree, Masters or PhD 3 Other e.g. Health economics modules embedded in general economics long-term courses; health economics embedded in Public Health/Medicine courses etc.

<table>
<tr><td>9.</td><td>Please indicate the target group for each course e.g. students, technical analysts, decision-makers/policy-makers etc mentioned in Question 8.</td><td></td></tr>
<tr><td>10.</td><td>Please indicate the general content of the course(s) mentioned above or provide a website where to find the content of the course(s) mentioned</td><td></td></tr>
<tr><td colspan="2">11. In your opinion, do you think the health economics course(s) fully meet the expectations of the participants? (Mark only one oval)</td><td>YES or NO</td></tr>
<tr><td colspan="2">12. If YES, Please explain your answer</td><td></td></tr>
<tr><td colspan="2">13. If No, Are there any areas of health economics that are not currently well covered but for which you think participants have interest in and would benefit from learning more about them?

14. Please provide reason why the area(s) are not currently covered (e.g. lack of capacity within the institution to provide such training; lack of funding etc.)’</td><td></td></tr>
<tr><td colspan="2">15. If health economics is currently not well covered in your country; is training for health economics sought from outside of the country (e.g. Masters degree or short courses delivered by other African institutions or even in Europe/ US etc.)? Mark only one oval.</td><td>YES or NO</td></tr>
<tr><td colspan="2">16. If YES, please explain the type of training/ programme sought</td><td></td></tr>
<tr><td colspan="2">Training demand: policy- and decision-makers</td><td></td></tr>
<tr><td colspan="2">17. In your opinion, do think there is demand for health economics in your country from policy-makers or decision-makers (e.g. commissioning/requesting health economics research studies so as to obtain evidence to use in health sector or financing reforms)? Mark only one oval</td><td>YES or NO</td></tr>
<tr><td colspan="2">18. If YES, please explain your answer</td><td></td></tr>
<tr><td colspan="2">19. If No, in your opinion, what do you think are the issues affecting lack of demand for health economics in your country among decision-makers/policy-makers?</td><td></td></tr>
<tr><td colspan="2">Training demand: researchers and analysts</td><td></td></tr>
</table>

20. In your opinion, do think there is demand for health economics in your country from researchers/analysts? Mark only one oval	YES or NO
21. IF YES, please explain your answer	
22. If No, in your opinion, what do you think are the issues affecting lack of demand for health economics in your country among researchers/analyts?	
Would you please indicate the number of trained Health Economists currently working in your country by employer type as follows:	
23. Public sector (e.g. Ministry of Health)	
24. Domestic universities	
25. Other domestic research institutes	
26. International Universitie/Research Institutes with an office in your country	
27. Donor/development partner	
28. National/International NGO	
29. Other (please specify)	
Personal reflections	
30. Please provide your reflections on where most health economics capacity is currently housed in your country	
31. Do you think increasing the number and skills of health economists working in your country would improve the ways in which health care is financed and organized, leading to health benefit? Mark only one oval.	YES or No
32. Please explain your answer	