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## Health economics in the UK: Capacity, constraints and comparisons to US health economists

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### ABSTRACT

This paper presents the results of a survey of the demographics, appropriate training and professional perceptions of UK health economists. In addition, information on what motivates health economists to enter the discipline and views on how to motivate individuals to study health economics were obtained. This was done with the intention of contributing to the debate on ways of increasing capacity for health economics across the UK. Information on appropriate training, the working environment and working activities was revealed by this survey. Where possible, the results are compared to a similar survey (Morrissey and Cawley, 2008) of US health economists.

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## 1. Introduction

In the current economic climate in which many European and other developed countries have announced public sector funding cuts, demand for health economics skills has never been greater. To analyse economic data, decision making bodies such as the UK National Institute for Health and Clinical Excellence (NICE) require well-trained health economists to work with them (Williams et al., 2008). Often, health economists' skills are sought to help with decisions over the fair and most efficient use of limited health care resources. A survey of public health researchers and practitioners in the US revealed that one of the barriers to using health economics in decision making was a lack of health economics expertise (Ammerman et al., 2009). Gulacsi also reports that the numbers of essential health economics research institutions or professionals are not sufficient in the new European Union

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member states (Gulacsi, 2007). Similarly, most would agree that within the UK, demand for health economists far outweighs supply. Health economics, relative to mainstream economics is a new discipline (Madden et al., 2009). There are many potential career pathways for a graduate in health economics and this is testament to the diversity of skills that a health economist can possess. Within academia, health economists often find themselves in the 'middle ground' positioned between the discipline of mainstream economics and Medical Schools/Public Health departments. Health economists can enter into the discipline from a variety of backgrounds, for example, from mainstream economics, public health or from operational research. Outside academia, health economists might be based within Government departments, work for consultancy firms or have chosen a career within the pharmaceutical industry. This can lead to a situation where there are many health economists from a variety of backgrounds, working across different sectors doing very different roles. Similar to the US setting reported by Morrisey and Cawley in their survey published in 2008 (hereafter simply referred to as 'the US survey'), in the UK, little is known about the demographic characteristics and other features of health economists. This paper presents the results of an online UK-based survey of health economists undertaken between 16 May and 30 June 2008. Results on demographics, training and professional perceptions are presented. Attention is also given to what motivates health economists to enter the discipline and therefore how we can motivate undergraduate students to undertake a postgraduate degree and choose health economics as a potential career. Where possible, the results are compared to the US survey.

### 1.1. Data and methods

The Health Economists' Study Group (HESG) is an organisation of health economists that is based in the UK but membership is not restricted to the UK (90% of its members are within the UK). The organisation exists to support and promote the work of health economists and has been in existence since 1972 (Blaug, 1998). The HESG was selected as the forum to conduct the UK survey as the group presented the largest UK-based mailing list of health economists. At the time of the survey, the HESG had a mailing list that comprised 355 health economists working in different sectors (commercial, government and academia) which was created to enable the effective and quick transmission of health economics information (e.g. jobs, events, surveys, etc.). The online questionnaire used in the survey was first piloted among staff based at the Health Economics Unit within the University of Birmingham, UK in April 2008. Initially the survey replicated the US survey but in response to comments and suggestions revealed during the pilot work, questions were modified to give the survey more clarity and a UK-focus. The questionnaire comprised 25 multiple-choice and 10 open-ended questions. The questions were categorised into different themes: professional identify (whether respondents described themselves as health economists or not, professional organisation membership, views on accreditation); attraction to discipline (reasons for studying health economics, reasons for deciding to pursue a career in health economics, ideas on how to target potential health economists); training (highest qualification attained, timing of qualifications, appropriate training requirements for health economists); current job details (work sector, job title contract details, team arrangements, income generation policies); time allocation (split between research/administration, consultancy and teaching); areas of expertise (economic evaluation, government policies, etc.); and satisfaction with peer review process and employment environment (ease of collaboration both within and outside the discipline).

The online survey was emailed to all members of the mailing list on the 16 May 2008. To encourage a good response, two follow-up email reminders were sent to members of the mailing list within the survey period.

## 2. Findings

Out of a possible 355 individuals, 156 responded giving us a 44% response rate overall. About 79% were members of the HESG and 62% held joint membership of the HESG and the International Health Economics Association (iHEA). In line with the US survey we focused our analysis on the respondents

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