

Learning to live with Health Economics

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**Chapter I
Introducing the learning materials**



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1.1 Background

This set of health economics learning materials has been prepared by the WHO Regional Office for Europe to assist health policy decision-makers, advisers, planners, managers, practitioners and other concerned groups. Health policy and practice is a large and complex area. It can benefit from a range of perspectives, including that of economics. Economics is particularly useful for decision-makers, since resource limitations and financial constraints apply in all health systems and at all levels. There are always more useful activities competing for priority than can be resourced; and this has significant implications for resource allocation decisions, health outcomes and equity. The purpose of this set of learning materials is to assist these various potential audiences to benefit from the valuable insights which can be afforded by the discipline of economics, broadly defined. It is intended to be complementary to other material on health economics, which is already available.

Together the modules cover various aspects of the public policy process, the dimensions of health policy content, and their sustainable implementation and effective practice. All of these matters would benefit from the application of the concepts and reasoning, as well as the analytical techniques, which economists can bring to the challenges of health policy, practice and performance. Often, these need to be practised in collaboration with other colleagues, both in terms of analysis and approach (e.g. epidemiology), and also in terms of application (e.g. policy-makers and practitioners).

Much of medicine focuses on individual patients, their problems and their treatment. Economics, however, tends to fit especially with those aspects of health care, health systems and health outcomes (such as sociology, political science or epidemiology) that are concerned with groups, for example people and patients and the contexts in which they live, work and play. Who should get priority in relation to the use of scarce resources? What alternative approaches or treatments are available? How do their costs, benefits and patterns of distribution vary? What implications follow for resource use and health outcomes? The economic approach fits particularly well with the “public health” view of the issues, problems and possible solutions, including the overall health for all strategy and specifically HEALTH21, the health for all policy framework for the WHO European Region, which was adopted by the World Health Organization Regional Committee for Europe in 1998.¹

The individual modules in the overall set of learning materials are concerned with a broad range of matters. For example, they consider: the general relevance of economic concepts and economic policy issues to the health field; health sector and related issues facing countries which are in economic

¹ *Health21: the health for all policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).

and political transition, especially those in central and eastern Europe and in the newly independent states of central Asia; the challenges which face all countries in one form or another in restructuring and reorienting health care and related systems at the levels of policy, management and practice; the determinants of health outcomes (only some of which lie within the direct responsibility of health ministries); the concept of health as individual and social capital and wealth; and a range of specific topics, including financing systems, costing, economic evaluation, the development and diffusion of health technology, economic modelling and forecasting, frameworks for the systematic consideration of public health management, approaches to overall policy analysis, and privatization.

The learning modules have been prepared with a practical purpose in mind: to assist various groups of potential users. They are complementary to material available elsewhere, for instance through the World Bank or the wide range of textbooks and courses on offer. No attempt has been made to duplicate what is already available (although there is inevitably an overlap in relation to some topics) and nowhere else does there exist a set of learning materials equivalent to this WHO set. The range of matters addressed in these learning materials widens the scope for the productive application of economic concepts and tools. This includes broadening an earlier concern primarily with health care (such as hospitals or doctors) to an appreciation of a multisectoral field with many varied contributions to health outcomes and overall wellbeing at both the individual and societal levels. The hope is that the availability of these learning materials will enable the various potential users to make a more extensive and more prudent use of economic concepts and tools, to be better equipped to judge what are appropriate or inappropriate circumstances, and to appraise more perceptively the quality and relevance of advice they receive from economists.

Two related points are emphasized. First, the learning materials reflect the role and *modus operandi* of WHO. For example, they focus on stewardship, including public health and equity, because “ultimate responsibility for the overall performance of a country’s health system must always lie with government”.² WHO has increasingly emphasized the importance of adopting a multisectoral and interdisciplinary approach to the analysis of health issues and the development of appropriate solutions. WHO tends to adopt a medium-term approach, encouraging adaptation to varied situations and sustaining a coherent vision of improvement, while remaining realistic about current circumstances and the practical obstacles to achieving better health status outcomes and equity. Its close interaction with individual Member States helps it stay in touch with varying developments, appreciate the wide diversity of circumstances in different countries and regions, and facilitate comparisons, as well as temper its idealistic aspirations with a strong dose of realism. In current circumstances it is only appropriate that the learning materials are influenced by a deep sympathy for the difficulties being faced by many countries in central and eastern parts of the WHO European Region.

Secondly, there is a wide range of potential users of the learning materials. Section 1.2 of this Introduction considers in more detail who these are, and Section 1.3 looks at how they might use the material. It follows that the basic set of learning materials has to be capable of being effectively and relatively easily adapted to the background, circumstances and needs of different audiences. There is also an important role for those who will conduct the learning sessions (the tutors). The contribution of these tutors to the effective use of relevant material, including supplementing it with local knowledge and case studies wherever possible, is vital to the maximization of learning for participants (Section 1.4). Section 1.5 considers the use of web-based material, how it might be supplemented and how, in time, it might be updated.

² World health report 2000. Geneva, World Health Organization, 2000, p. 119.

1.2 Users of the learning materials

Who might use the learning materials, accepting immediately that these will need to be selected, assembled as appropriate, presented and supplemented (perhaps substantially) by the tutor for each individual audience? Four broad categories have been identified, although in each case further subcategories could be developed.

First, there are the most senior policy-makers – ministers, their advisers, concerned members of parliament and the most senior officials, such as the head of a country's health agency, and their senior assistants. Such people are extremely influential in relation to health policy, the framework within which health practice occurs and the relationships with other important players (e.g. the finance ministry, other ministers, the private sector or the media). They are generally not economists, they are extremely busy, and they work in an oral environment, utilizing other people's contributions but rarely writing much themselves (although they may rewrite a lot). They also tend to be interacting, on complex problems, with many stakeholders and audiences simultaneously; thinking in a range of time dimensions, and seeking to match the overall vision with the practical realities.

Secondly, there are the administrators and managers who work in health-related facilities or on health-related programmes. The culture of health care managers at this level differs significantly from the culture of the civil service. They tend to be more focused on action and practice, compared to the civil servant's focus on policy and process. In decentralized health care systems, or where command and control systems permit some local discretion, managers typically are required to develop and implement appropriate policies rather than merely adopt central directives. In other circumstances their roles are more circumscribed and greater emphasis is given to carrying out instructions from superiors. The use by such people of the learning materials reflects their more circumscribed role. Their influence is more restricted to their own particular institution, region and area of activity or specialized sub-unit. However, within this restricted area they may nevertheless have significant power and the capacity to allocate and reallocate resources. They can also benefit from understanding more fully the wider environment within which their particular activities are embedded.

Thirdly, there are the health care professionals who deliver services to patients or groups of people. In the health system decisions are constantly being made by professionals, such as doctors, nurses, pharmacists, dentists and therapists. Indeed, the relationship between providers and patients in health care implies that decisions made by both users and providers affect health care processes and outcomes. This group is much larger than either of the two previous groups. In many cases, professional practitioners may believe that care of the individual patient is central and that economic considerations

are not important. In fact this is not so. Even the individual practitioner who treats one patient rather than another, or in one way rather than another, can affect outcomes, for example in terms of the cost-effectiveness of care or equity.

The fourth group is more diverse. During the preparation of the learning materials it was envisaged that this group would include people with an interest in, concern for and perhaps involvement with the health sector. Examples would include people who sit on the boards of management of health care facilities (hospitals, community health centres or old people's care facilities), or those who, while they do not have direct management responsibilities in relation to health, nevertheless have a continuing interest, such as trade union officials, many nongovernmental organizations, and religious and charitable organizations. It could also include media organizations, including TV, radio and print media journalists, presenters and opinion-formers; officials in consumer organizations concerned with health; members of lobby and special interest groups (e.g. importers, manufacturers of health technology or pharmaceutical firms); and officials in regulatory agencies, including those outside health but in related areas such as education, transport, occupational safety at work or the environment. This category of potential users of the learning materials is extremely heterogeneous. It may not be easy to gain access to them, and it will certainly require a diversity of approaches if they are to derive the maximum benefit from the learning materials. Often, they will be particularly concerned with one part of the health system, for example those who sit on the board of management for a hospital or community health centre. Others will have wider interests, for example county councillors with health responsibilities or concerns, members of regional advisory bodies or those who participate in the formulation of health policies in nongovernmental organizations, consumer groups, trade unions or political parties. Sometimes their concern with health issues will be episodic, such as for many TV, radio or print media presenters. In other cases it may be more continuous, including for specialized reporters and presenters.

1.3 Use of the learning materials

As Section 1.4 below emphasizes, the learning materials need to be carefully considered and customized for the different potential groups of users and for their particular circumstances and interests. Despite this, there are clearly broad differences between the four main groups of potential users outlined in Section 1.2. These differences relate particularly to the approach which is likely to be most appropriate for them, and the parts of the learning materials in which they are likely to be most interested.

The first group comprised the most senior policy-makers, at the political and bureaucratic levels. They seek to establish appropriate parameters for decision-making by practitioners, to manage intersectoral relationships, and to obtain sufficient resources. For them it is particularly important to know what the economics perspective can add to their knowledge or capacity. Where is it useful and where not? How does it interact with other issues of importance to them (e.g. in intersectoral relationships, in discussions with key stakeholders, in negotiations with the finance ministry)? How are they to appraise the economic component of the advice they receive or identify when it should be present but is missing? Given the multifarious other demands on their very limited time, firm choices will need to be made about priorities, taking account of how much they can be expected to absorb and retain and to avoid overload. Probably they will tend to be more interested in the “thinking” modules than in the “practical” modules (except, perhaps, when a current issue dominates their thinking). The conceptual framework adopted by health economists can be useful to them, for example in understanding the balance between costs and benefits, the differing values of individuals and groups (including for risk and uncertainty) or efficiency and equity, the distinction between the average and the margin, the discounting of future costs and benefits, the importance of who gains and who loses, and X-inefficiency where production possibilities are not fully realized.

In general, such people will be more interested in the economic way of thinking than in the minutiae of techniques and approaches. Clearly, this audience will not wish to work systematically through the full set of learning materials. The tutor will need to tailor the approach to their particular concerns, probably in a very limited time. Ideally, matters of pressing immediate interest to them can be used to develop the broader insights which will be of benefit to them in the longer term. For example, what are the incentives built into current arrangements or proposed changes, and how are these likely to alter the behaviour of important stakeholders and thus the health (or other) outcomes which emerge over time? It may be appropriate for the tutor to consult the users prior to the learning materials being used and ascertain where their special concerns lie. He or she can then develop a

programme which addresses them, but which leads into discussion of more fundamental concepts and related approaches.

The second group are the administrators and managers working in health care, the wider health system or in health-related programmes (e.g. reducing road traffic accidents through work in engineering and road construction, justice or police agencies). They could find it useful to know about such factors as the determinants of health, individual and social health capital, the framework for the analysis of public policy, and likely future developments as a broad background to their work. However, they tend to focus on current and possible future problems which affect them, where they have some influence and where they bear some responsibility. They are likely to be more interested in some modules, such as administration and management, or the bargaining and negotiation elements of the module on policy analysis, than the members of the first group. Like them, however, they will benefit from understanding the economic way of thinking, the criteria economists use (especially efficiency and equity), where economists' advice could be useful and how it can be most effectively used in their environment. For example, they may be interested in costing, having a better idea of the concepts underlying health outcome measurement, how health technology is developed and diffused, and how economic evaluation, modelling and forecasting are undertaken. They are unlikely to carry out studies themselves but will benefit from knowing how these are done, what are their strengths and weaknesses, when to use them, and what to beware of in any studies they consult or commission.

The third group covers the large number of health professionals who deliver services to patients and groups of people. The members of this group can benefit from the learning materials in two ways. First, they can gain a better appreciation of the broader context in which their particular contribution to health, costs, benefits and processes takes place. They may find this interesting in itself. More important, it provides them with possibilities for more effective practice in the future, including a more proactive approach, resulting in more efficient and equitable outcomes. Each individual has a contribution to make, even though it can seem very minor in a large system. These learning materials can assist professionals, both individually and in groups, to make their contributions more effective.

Specific modules can also help in more direct ways (depending, of course, on the particular work and circumstances of the individual practitioner). For example, costing could assist them, as could a better understanding of how health technologies are developed and diffused, economic modelling and forecasting, aspects of primary health care in a changing society, bargaining and negotiation, administration and management. At a more general level their practice with particular patients or groups might be informed, and subsequently improved, by a greater understanding of the basic determinants of health, individual and social health capital, and the respective roles for the individual, the family, the health care system and the broader society. To recognize that one cannot control everything does not mean that one can influence nothing.

The fourth category of potential users is very heterogeneous. If they have special interests (e.g. if they are representatives of pharmaceutical companies, manufacturers of health technology or members of hospital boards) or are concerned about a specific issue (e.g. general journalists, members of consumer groups or trade union officials with members who are affected), these will need to be emphasized in the presentations if the audience is to become involved and remain interested. For example, some users are likely to be especially concerned with financing issues. Even if wider aspects of the learning materials are to be included in the tutor's presentations, it may often be appropriate to start with the area or issue which is of immediate interest and only subsequently proceed to more general aspects. Secondly, even if their initial interest is relatively narrow, participants may realize the benefit of using

the opportunity of the learning sessions to explore the wider contributions which a health economics perspective can make to related matters. In such cases it may be desirable not to constrain the content of the discussions too tightly at the beginning. A more flexible approach can allow interests to develop among the group and be followed up in more detail, as appropriate. Thirdly, some individuals or groups may, from the beginning, see value in using the learning materials to develop a more coherent overall understanding of what health economics can contribute for them personally, the institutions with which they are involved, and the issues with which they are primarily concerned. Some will appreciate, even initially, that many of the matters considered in the learning materials are interrelated and that they can only be considered in isolation at some cost.

In general, it is desirable that all the members of this group who use the learning materials receive at least some idea of the broad approach of health economics, some of the tools and approaches it can offer (and where they are likely to be helpful), the challenges facing health systems in most (if not all) European countries, the special circumstances of their own country and sector, and the intersectoral and interdisciplinary nature of health change, and understand health outcomes in terms of individual and social processes. Clearly, the degree to which this broader use of the learning materials could be incorporated into the discussions for a particular group would vary, depending on a range of factors including the skill of the tutor.

1.4 The role of the tutor

The role of the tutor is critical if the learning materials are to be used effectively. Partly this is because the users will have a wide diversity of knowledge, backgrounds and interests. They will come from the health care sector, other parts of the health sector and other sectors. They will be drawn from various levels of both the public and private sectors, ranging from ministers to relatively junior professional workers. Some will be employed in health-related activities, other will be commentators on them, and others will be interested observers.

The learning modules do not purport to cover all possible relevant topics. Indeed, this would be impossible. Consequently, it is critical that tutors are aware of as many other relevant sources as possible and that they bring them to the attention of the users. Some material will relate to concepts and other topics which are either not covered in the learning materials, give a different perspective or provide complementary material. For example, there is extensive material available through the World Bank, textbooks, relevant journals and courses which could be useful in amplifying and extending, and especially complementing, the material presented here by WHO.

There are nearly 900 000 000 people in the countries included in the WHO European Region. They have some things in common. For example, 18 of the 20 countries in the world with the largest proportion of elderly people are located in the European Region. However, in other respects there are great differences. For example, in 1996 per capita gross domestic product ranged from US \$255 (in the Republic of Moldova) to US \$44 693 (in Luxembourg). Since 1996, the majority of countries in the Region have shown some increase in life expectancy at birth, but for the Region as a whole average life expectancy fell from 73.1 years in 1991 to 72.4 years in 1994. For every 1000 live births, an infant born in Finland has ten times the chance of survival compared to an infant born in Tajikistan. Even in western Europe there are concerns about increasing disparities in income, persistently high unemployment and a growth in the health gap between rich and poor. Armed conflicts, as in the Balkans, the central Asian republics and the Caucasus, have resulted in large numbers of displaced persons and refugees throughout the Region. Many of the 51 Member States continue to struggle with the consequences of economic, social and political transitions. In some cases progress has been halting, in others it has been negative. For example, there has been a re-emergence, particularly in the newly independent states of the former Soviet Union and in some countries of central and eastern Europe, of infectious diseases, such as tuberculosis, malaria, typhoid, hepatitis A and cholera. There has been a dramatic increase in sexually transmitted diseases, leading to a rise in the numbers of people infected with HIV and syphilis. Against the background of these differences it is a critical responsibility of

tutors to ensure that the learning materials are used in a way which is appropriate for the participants in their particular context. In many – if not all – cases the material should be supplemented with local experience and case studies and presented with sensitivity to local traditions, circumstances and values. Learning materials which have been developed against the background of north American or western European experience are not necessarily appropriate without adjustment to other countries in the European Region.

Indeed, it has been suggested that, for example for some countries in transition, there may be mindsets, attitudes and expectations derived from their recent experience which could lead to misunderstandings relating to material in some of the learning modules. These may change over time but be powerful at present, at least in some countries and in relation to some issues. A colleague from central and eastern Europe, commenting on an earlier draft of the learning materials, suggested that an exercise might help to articulate these matters, facilitate a more open discussion and, by confronting them directly, assist in removing the misunderstandings.

Exercise

To what extent are the following statements commonly expressed in your country, or other countries of which you are aware? To what extent are they accurate? If they are held, what implications do they have for health policy, health practice and health status outcomes? If they are not accurate, how can they be confronted in the minds of different stakeholders who hold them?

- The declining real value of public health expenditure is the cause of (all) our problems.
- An increase in health costs, as observed in many western European or north American discussions, would be a good thing. It would definitely be better than our present state of affairs.
- Individuals are responsible for their own decisions, including health decisions, in the new society which is emerging, with less central direction and control. Therefore, poor health outcomes are the individual's own responsibility and do not justify collective action.
- Politicians can decide freely whether they wish market forces to shape their health systems or not.

Tutors can use the learning materials at three levels: appreciation; appraisal; and analysis. They need to be sensitive to their audiences' skills, background and experience and to their prospective needs in choosing what level(s) to address and how to do it. *Appreciation* aims to help users gain a fuller understanding of where particular concepts, approaches or tools might be used in health policy or practice. *Appraisal* is concerned to assist users to assess critically particular studies or uses, including potential uses, of health economics in their work or the related work of others. *Analysis* is a more ambitious aim, to assist users to apply the techniques or tools. The learning modules are, in general, not intended to result in users being able to undertake competent economic analyses of health care policies or practice themselves. However, some of the modules, such as that on economic evaluation and that on citizens' participation, patients' rights and ethical frameworks, are closer to analysis than others. Increasing users' skills in analysis, even fairly rudimentary analysis, can hone their appreciation and appraisal capacities and thus enable them to apply the economic way of thinking more appropriately and more consistently.

Finally, finding and preparing tutors and learning from their experience in using the learning materials, are further tasks for the future. First, it is desirable that tutors are matched with the particular learning backgrounds, skills and expectations of the learners. For example, it would not generally be

appropriate for a recently appointed junior academic to use the learning materials with ministers or very senior bureaucrats. The needs of learners will differ widely, as will their capacity to benefit from particular aspects of the learning materials. Consequently, tutors will need to be drawn from a range of backgrounds, not just academics. Also, given the broad range of materials covered in the modules and their relevance for a wide range of audiences, not all the tutors will necessarily be economists. Secondly, there is a danger that the very areas where the learners' needs are greatest may correlate closely with the areas where competent tutors are hardest to find and retain. This could apply among the different learning module areas and in relation to different geographical regions. Thirdly, it would be valuable if the experience of the tutors (as well as those of the participants) could be collated on a consistent basis and retained for subsequent evaluation by WHO. This would also make it easier to advise tutors about how best to undertake their important task.

1.5 Further steps

A full set of learning materials is now available. The copyright rests with WHO. The Organization wishes the material to be used as widely as possible, but asks two things. First, it expects users to acknowledge that the originator of the learning materials was the Secretariat of the WHO European Region and to acknowledge the authors of the specific modules they use. Secondly, it asks that users provide feedback to the WHO contact officer (address below) who can supply a pro forma to guide responses on:

- who participated in the mission where the learning materials were used;
- how the material was used, and which module, when (as will frequently be the case) only a selection of the full set was used;
- what worked well and what worked badly;
- what has been (or should be) added or deleted; and
- any other suggestions.

The contact officer is situated in the WHO Regional Office (Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark, e-mail: postmaster@who.dk). It is the responsibility of this person:

- to encourage the widest possible use of the set of learning materials: to the extent that these are available through centres such as universities or other research and training institutions, the WHO contact officer would monitor where the materials were being offered, identify areas of need which were being inadequately met, and seek to facilitate greater use of the learning materials there;
- to ensure that those who seek to use the learning materials have a central point of contact so that they can know what is available elsewhere; liaise about other users and possible tutors, and collect and disseminate information on different groups' experience in using the materials;
- to collect the evaluation material from tutors and users, so that the evaluation task should not be too onerous for them.

WHO encourages the development of as many case studies as possible, especially those that illustrate matters important to users and illustrate significant aspects of the set materials in the context of individual countries or groups of countries. This is especially desirable for those countries that are making use of the materials, or that could be encouraged to do so if relevant case studies (or other local materials) were more readily available. Tutors and users who possess such case studies, or who develop them, are asked to contribute them to the WHO contact officer and authorize their widespread distribution. If other relevant modules are found and the authors are willing to have them included, it

would be appreciated if these too could be similarly sent to the WHO contact officer for distribution. The WHO contact officer is responsible for quality control of the case studies, extra modules and other material and authorizing any distribution of them as part of the expanded set of learning materials.

It is the responsibility of the nominated WHO contact officer to review the use of the learning materials two or three years after these have been put onto the worldwide web, in the light of reactions over the period from tutors, users and others, and to see whether the materials:

- are serving useful purposes;
- should be updated and developed (and if so, how?);
- should be revised so that an updated version could be put onto the worldwide web; and
- should also be published as a book.

Finally, it is a pleasure to acknowledge the valuable contribution to the development and finalization of the learning materials which has been made by the members of the Core Executive Group. In addition to the editors this included David Gunnarsson, Secretary-General of the Ministry of Health and Social Security in Iceland, and Professor Yannis Yfantopoulos, National and Compodistrian University of Athens in Greece.

The draft modules have been tried out by authors in their own teaching settings. They have also been applied in Kazakhstan (by Maksut Kulzhanov and Naila Zhuzzhanova) and Romania (by Victor Olsavszky), and have benefited from feedback on policy relevance from David Gunnarsson, Mihalyi Kökenyi (Hungary) and Yannis Yfantopoulos. Contributions were also made by some young scientists spending short periods at the WHO Regional Office for Europe (Antoine Danzon, Susanne Grosse-Tebbe, Claire Gudex, Rikke Olesen, Anna Skygge). Joy Bartrup, Janet Leifelt, Connie Petersen and Karen Taksøe-Vester arranged review meetings in Denmark, Greece, Romania and Sweden, chased up contributions and arranged the documentation. The WHO advisers Josep Figueras, Kees de Joncheere, Jibek Karagulova, Suszy Lessof and Nata Menabde peer-reviewed the technical content of the draft book, making valuable suggestions for publication. Rosemary Bohr edited the book on behalf of WHO and the layout was by Shirley and Johannes Frederiksen.

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