Health economics and economists in the NHS

EDITOR,—Techniques drawn from health economics are being applied in the evaluation of clinical services with increasing frequency. This trend can be expected to continue as evidence from studies of cost effectiveness and other methods of economic evaluation is drawn on by district health authorities developing their purchasing strategies. There is, however, a danger that these techniques may be applied inappropriately—or the evidence they produce misinterpreted—if the methodology is not understood fully by those using it. This raises the question of the level of skill in economics currently available to the NHS.

During May this year, as part of a more general study of purchasing and priority setting in the NHS, the King's Fund Institute distributed a short postal questionnaire to 187 district health authorities. The questionnaire asked them about employment of health economists, their access to external sources of expertise, and their familiarity with techniques in health economics. Replies were received from 131 authorities.

We found that qualified health economists are rare in the NHS. Only four districts reported a full time economist on their staff; another six employed one part time. This represents 8% of the districts that responded. However, 16 authorities indicated that they planned to appoint a health economist and another five mentioned this as a long term possibility. Seventy four authorities did not have plans to appoint a health economist, and 12 did not specify their plans. Of the remaining 14 authorities, eight employed non-economists with relevant experience, three were training staff, two were considering making an appointment after a merger of districts, and one was looking for an epidemiologist with evaluative skills.

Among those authorities without a specialised appointment, several mentioned that other staff—particularly epidemiologists and public health specialists—had acquired the necessary skills to be able to apply health economics techniques. Shortages of skills were also being addressed by widespread use of in service training, such as the correspondence course on health economics offered by the University of Aberdeen. Many authorities also tended to draw on outside consulting advice; 24 districts cited the York Health Economics Consortium as a source of such help. It is, however, striking that over half of the districts reported that they had not used any in house or external advice on economics.

The table shows how familiar the authorities considered themselves to be with techniques in health economics. Interestingly, respondents claimed greater familiarity with one specific outcome measure used in some forms of economic evaluation—namely, the quality adjusted life year.

Finally, we sought to examine the extent to which evidence on quality adjusted life years had been used to assist decision making. Twenty seven districts replied that they had already used these data in this way and 23 that they planned to do so; 44 said that they had no plans to use them.

Knowledge of methods of economic evaluation

Question	Very familiar	Fairly familiar	Not very familiar	Totally unfamiliar	Total
"Is your health authority familiar with methods of economic evaluation?"	12	56	54	8	130*
"Is your health authority familiar with QALYs?"	20	89	22		131

*One authority did not answer this question.

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Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

Sexual harassment

EDITOR,—I wonder whether Peter Forster[1] has any suggestions to my problem. I had been sexually harassed by a senior member of a health authority at work. He committed most of the defined acts of sexual harassment and, the most despicable of all, he demanded sexual favours in return for his influence, support, and supervision during my attendance at the university. Due to his influence I was given a place on the course at the authority's expense. My refusal to grant sexual favours led to his rejection of me. He refused to supervise my course work, humiliated me in front of others, and finally (in his own words) kicked me out of the department.

My request for help from the regional medical officer was answered with advice to leave the job. The unit general manager (a woman) to whom I was accountable refused to help. The director of personnel (another woman) suggested that I stop complaining. The professor at the university listened to my problems but was unsympathetic. Finally, the district general manager listened, with the help of my association's representative. Management investigations dragged on for months.

Eleven months later, at a health authority disciplinary hearing, he was found guilty and received a written warning. However, he still maintains his position. Because of my complaint I was moved to another hospital under some pretext, to protect me from further harassment. The next day I was told that my public health duties were terminated.

If the complainant was made to suffer in the era before reform of the National Health Service, what prospects would employees in trust hospitals have when they complain of sexual harassment? They would be sacked immediately, I suppose. Equal opportunities do not exist.

ANON

1 Forster P. Sexual harassment at work. *BMJ* 1992;305:944-6.

EDITOR,—Harassment of female doctors recently described in your columns as occurring in the NHS[1] does not stop at the sexual level. Our statistics clearly show that over the past six years attempts to get rid of hospital doctors through disciplinary or pseudoredundancy methods are between five and eight times more common for female doctors than for male doctors. But there is a double jeopardy. The present disciplinary system (HM 90 9) whereby a doctor is investigated before disciplinary action allows for even more abuse, as could occur when the person doing the investigation (or making the judgment) has previously had his sexual advances spurned by the falsely suspended woman doctor. Should the General Medical Council be asked to make sexual harassment by doctors an offence that could lead to erasure from the Medical Register?

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1 Unprofessional behaviour. *BMJ* 1992;305:1161-2. (7 November.)

EDITOR,—The two letters from anonymous women[1,2] highlight a male weakness which we men must own—the unwillingness and perhaps frank inability to talk about personal sexuality. The just drive for equality in our society minimises real gender differences and emphasises the needs of women and children. However, gender differences do exist, and one difference is in the area of communication. Women seem to talk freely with women about themselves, their sexuality, and their problems. In contrast, men tend to talk about issues, generally not venturing to gossip about themselves, share emotional needs, or broach the topic of personal sexuality.

The lamentable failure of male doctors within a team to confront a male colleague physically and emotionally abusing a female senior house officer within the team is, I believe, predominantly a gender rather than a professional issue. The failure of a husband to discuss sexual matters with his son again illustrates a male relationship problem.[2] Men often lack the emotional courage and skill to discuss sexual issues with partners, friends, or family, and frustration and misunderstanding abound.

Male gender issues are generally not debated in our society, and I can offer no easy solutions to prevent the experiences described by your correspondents. In the welcome drive for improved sexual health in *The Health of the Nation*[3] the agenda must be wider than sexual knowledge, contraception, and condoms. Men need help to discuss personal sexuality, share sexual problems, and negotiate within physical relationships. Empowering women is undeniably important but does not address the need of men to develop verbally and emotionally in these areas. Until they do, traumatic incidents will continue to abound.

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1 Unprofessional behaviour. *BMJ* 1992;305:1161. (7 November.)
2 Adolescent perpetrators of sexual abuse. *BMJ* 1992;305:1157. (7 November.)
3 Department of Health. *The Health of the nation: a strategy for health in England.* London: HMSO, 1992.