iHEA News
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iHEA News is the official newsletter of the International Health Economics Association.

Executive Update

Important Changes in iHEA Governance

At its meeting after the Boston congress, the iHEA Board approved wide-ranging changes in the Bylaws to improve governance and transparency in the association. These changes seek to address calls for improved geographic and gender diversity in the Board composition, and improvements in the nomination and election processes. There are also changes relating to the Treasurer and Executive Director.

Role for national and regional health economics associations on iHEA Board. In addition to the four iHEA Officers (President-Elect, President, Past-President and Treasurer), the Bylaws make provision for three categories of Board Directors: Directors elected by the membership (up to 5); Directors nominated by regional or national health economics associations (up to 8); and Board appointed Directors (up to 3). There is no distinction in roles and responsibilities across these three categories of Directors. One key change is that in future, all 8 positions available for association-nominated Directors will be used to ensure that there is at least 1 Board Director from each of the UN geographic regions. This will be phased in, with 4 association-nominated Directors joining the Board in 2018 and four in 2019.

Greater gender diversity on iHEA Board. To promote gender diversity, associations will be requested to consider gender when making their nominations and the Nominating Committee will ensure gender balance in the candidates standing for elected Director positions.

Early career researcher representation on iHEA Board. In addition, the Board appointed Director positions will be used to ensure that there is at least 1 early career researcher and a gender balance on the Board.

Larger and more inclusive Nominating Committee. The Nominating Committee plays a key role in identifying candidates for President-Elect and Board Director elections. Previously, this committee generally comprised the Executive Director and Past-President, and candidates were directly approached to stand in elections. In future, the Nominating Committee will be chaired by the Past-President, include three other Board members and up to two iHEA members who are not on the Board (see later call for expressions of interest from iHEA members to serve on the Nominating Committee).

Greater clarity on Nominating Committee’s role. In addition to changing the composition of the Nominating Committee, the Committee will issue an open call for nominations for President-Elect and member-elected Directors, which can include self-nominations, as well as proactively seeking candidates.
The committee will also ensure that there is more than one candidate for each available position. All candidates will be screened using the following criteria:

- **For Elected Director positions, candidates must be:**
  i. An economist working on health and health care; and
  ii. An iHEA member for at least the previous two years.

- **For President-Elect, candidates must:**
  i. Be an internationally known economist working on health and health care;
  ii. Be an iHEA member for at least the previous five years, who has made important contributions to iHEA by having served on the Board, a Board committee or congress local organizing committee;
  iii. Have networking skills and international connections; and
  iv. Be willing to be an active President and build programs for iHEA.

**Greater transparency in nomination and election processes.** To ensure transparency, the Nominating Committee will provide a detailed report to the Board on the process for securing and screening candidates for elections; an anonymized summary of this report will also be posted on the website. In addition, all nominees will be provided with individual feedback. There will be a formal period of campaigning during which iHEA will provide opportunities for dissemination of comparable information on candidates.

**Appointment of Treasurer.** In the past, a single candidate has been put forward for election as Treasurer. Recognizing the importance of ensuring that the Treasurer has financial management experience and is competent to assume responsibility for managing the iHEA finances, the Treasurer will in future be appointed by the Board.

**Clarity on role of Executive Director.** The revisions to the Bylaws also formalize practices with regard to the role of the Executive Director (ED) that have been in place since January 2016. In particular, while the ED participates in meetings of the Board and Board Committees, this is no longer as a voting member. In addition, the ED does not appoint the Association Management team; rather the Board does. These and other changes ensure that decision-making for the association rests entirely with the Board as a whole, with the ED and Association Management team implementing decisions of the Board.

- *Adam Wagstaff, iHEA President*

**Latest News**

**Remembering Jim Burgess**

Jim Burgess passed away on Monday, June 26th. Jim was well known to many for his contribution to establishing electronic Health Economics Letters (eHEL), serving as the iHEA Treasurer from 2005 to 2015 and being the driving force behind the 12th iHEA World Congress in Boston. We are deeply saddened that Jim did not see the fruits of his efforts over the past few years in leading the Local Organizing Committee for this congress.

A celebration of Jim’s life was held during the Congress, where some of Jim’s friends and colleagues were able to speak about the impact that he had on them. We have uploaded some
photos from the memorial service that was held, as well as memories that were shared from those who could not attend. To view these, please [click here](#).

**iHEA 2017 Congress in Photos**

Just over 1,540 people attended the iHEA World Congress in Health Economics recently held in Boston.

![Congress Photos](image1)

![Congress Photos](image2)
There was an exciting and well attended series of pre-congress sessions. Presenters and organizers of the very popular “Teaching Health Economics” pre-congress session below. Thank you to Anthony Scott, Ana Balsa, Allen Goodman, Randall P. Ellis, David Bishai, Arin Dutta, Kathryn McCollister, Peter Rockers and Winnie Yip for organizing the pre-congress sessions.

The congress was opened by Randy Ellis, Co-Chair of the local organizing committee.
In addition to the plenaries, there were 312 concurrent sessions.

The student paper prizes and Arrow Award were presented.
Lunch times were packed with activities, including a mentoring lunch and HEA members’ meeting as well as an opportunity for delegates from Asia to get together and explore opportunities for greater engagement.

There were several opportunities to network during social events, including the opening reception and the gala evening at the Boston Museum of Science.
Many of those who were not able to attend the congress viewed the live streams of the plenaries, the Special Organized Sessions and the Student Paper Prize session. For those who missed these sessions, video recordings will be posted on our website in the near future.

iHEA Members’ Meeting

Thank you to all those who attended the iHEA members’ meeting during the Boston Congress. This is an important opportunity for the iHEA Board to report back and consult with members directly. The key items discussed during this year’s members’ meeting were: the changes that the Board has been working hard to implement to reduce operational costs, improve the quality of the Congress and improve transparency and governance within the organization; as well as consultation with members around activities that would benefit them between the Congresses.

iHEA Treasurer, Audrey Laporte, highlighted the 60% reduction in association management costs and 73% reduction in non-congress operational costs since the beginning of 2016. Congress registration fees were reduced substantially for Boston and the iHEA Board will continue to engage with members on how these fees can be further reduced at future Congresses. Those who received the post-event survey will notice that a question around options for reducing Congress fees has been included. Membership fees have also been reduced and allow for 2 or 4 year memberships, in an effort to grow iHEA membership and make it more affordable for all.

iHEA President, Adam Wagstaff, reported on changes in the association management team and proposed changes in the composition of the Board to promote regional and gender diversity, and led a conversation with members around activities and benefits they would like to see in between Congresses. The comments from members were extremely helpful and the conversation was positive and engaging. It was wonderful to have so many members of iHEA willing to share their ideas for improving iHEA member benefits and activities. Some key takeaways from this discussion around non-congress member activities were:

- An ongoing effort to support health economics teaching – this could include a web archive of training materials, including video clips, and information on courses.
- Opportunities for members to engage in a mentorship program outside of the Congress. Mentors and mentees really enjoyed the mentoring lunch at the Boston Congress and would like to have more formal engagement between early and mid-career researchers.
- Promoting engagement / networking around specific health economics topics.
- Support of regional associations and promoting more regional interactions and activities.
We do encourage members who were unable to attend the members’ meeting to continue to send in your thoughts and ideas on member benefits and activities to us at ihea@healtheconomics.org.

Thank you again to all who attended and contributed to the members’ meeting and we look forward to exploring all the shared ideas and continuously increasing member engagement and benefits within iHEA.

**Mentoring Lunch**

The mentoring lunch was essentially a well-designed matching mechanism. The demand side were PhD students and early career researchers. The supply side, the mentors who survived that process with flying colors.

There was obviously a huge demand for advice and encouragement from those who have and continue to build the field of health economics. The fact that there was an equally, if not more, enthusiastic supply side shows that the economics of health and healthcare are in good hands.

Sally Stearns lead us all in what looked like well-choreographed musical chairs. 3 mentees to 1 mentor, 15 minutes. The whistle blows, reshuffle, find your new table, and off you go again. Repeat 3 times and there is your recipe for a fruitful lunch time break. By the end of it, we were finally able to catch our breath and take notes for future reference.

We talked about how to write, revise, and resubmit. We were reminded that rejection is part of the game and that perseverance pays off. We were told where to focus our energies and what to leave for life after tenure. What is more, we were encouraged to collaborate, read, write, talk, reach out, and speak up. We were told people are willing to help, but more importantly we saw it happening.

It is always helpful to know that we have all been through the ups and downs of academia, pre- and post-PhD graduation. It was particularly interesting to hear about success stories on how to overcome being alone in a hostile department, a stubborn referee, or a paper that seems to be doomed to the drawer of everlasting unpublished regret.

The mentoring lunch was a networking event, yes. We exchanged contacts and learned who does what with whom and where. But it was much more than that. It was a genuine display of collegiality. Matching mechanisms like this mentoring lunch are essential to promote true collaboration and interchange of ideas. Competition can only do so much for academia. Collaboration is what moves us forward, individually and as a field.

- Sarah Machado, London School of Economics
Regional News

Latin America: "Frontiers of Health Economics Research in Latin America: highlights from iHEA's 2017 pre-congress workshop"

In the past few decades, many Latin American (LAC) countries have introduced reforms aimed at strengthening health systems and universalizing access to health care. Some countries have taken the route of regulating and extending population coverage via social health insurance. Others have opted for national health systems. Still, a considerable number of individuals remain without access to care either due to economic or geographic barriers, and the effects of the new coverage schemes and regulations are not well understood. At the same time, epidemiological and demographic changes (higher prevalence of obesity and chronic diseases, and aging populations), together with increased health care costs and weak incentives, raise new challenges that need to be addressed.

A pre-congress workshop “Frontiers of Health Economics Research in Latin America” was held at the recent iHEA congress in Boston to bring together research economists working on LAC-related health issues, with the purpose of building a community of practice to promote quality research in health economics in LAC, share knowledge and data, inform policy decisions, and contribute towards stronger health systems. More than 40 participants attended the workshop, which featured keynotes by Rodrigo Soares from Columbia University and Igal Hendel from Northwestern University. Eight additional papers were selected for presentation and discussion after a competitive process sponsored by CAF (Latin American Development Bank).

Rodrigo Soares focused on the effects of the Brazilian Family Health Program, a program that started in 1994 as part of the Unified Health System and that expanded primary health clinics inside local communities in Brazil, reaching around 100 million people and changing the mode of delivery towards outreach and prevention. He showed that the program contributed to large and sustained declines in infant and maternal mortality, delivering at the same time a rationalization in the use of resources by decreasing hospital density. Igal Hendel focused on the tensions between adverse selection and reclassification risk involved in the regulation of health insurance markets (exchanges). While adverse selection can be countered with by pricing health conditions, this policy leads to more premium uncertainty and exacerbating reclassification risk (the risk of facing health type changes if health conditions are priced). Based on simulations of one-period contracts, Hendel showed that the Affordable Care Act did well banning the pricing of health conditions as the welfare costs of adverse selection are much lower than those of reclassification risk.

Gabriella Conti from University College London and Sebastián Fleitas from University of Leuven explored specific aspects of health insurance reforms in LAC. Conti analyzed the consequences of an expansion of non-contributory health insurance in Mexico in 2002 on the labor market. Using a household search model, she found evidence of a small increase in informality in low socioeconomic status families, compatible with a small willingness to pay of working families for the new non-contributory health insurance. Fleitas, on the other hand, explored the effects of an increase in competition among health maintenance organizations in Uruguay on physician’s wages and average quality (as reflected by the hours worked by high skill relative to low skill physicians). He found that the increase in competition increased returns to skill, but did not increase average quality, an effect probably due to a very inelastic supply of high quality physicians in the short run.

Two presentations dealt with the regulation of pharmaceutical markets in Chile and Colombia. Juan Pablo Atal (University of Pennsylvania) analyzed whether stricter quality regulation in the Chilean pharmaceutical market (specifically the requirement that generics be bioequivalent to the innovator “reference drug”) affected competition and prices. The policy decreased the number of products in the market, due to higher exit rates, and reduced prices of reference and branded generics. Mauricio Romero (University of California, San Diego) showed that including a new drug in Colombia’s social insurance benefit plan (POS) reduced its price, increased utilization, and lowered the price of competing drugs. He
attributed these effects to the purchasing power of managed care in Colombia, through an ability to negotiate sizable discounts off the manufacturer’s wholesale price.

Other papers explored the effects of higher income on health and health behaviors. Kevin Feeney (UC Berkeley) reported that the gradual implementation of a universal non-contributory pension program for elders in Mexico (beginning in 2007) resulted in a 5% increase in mortality. This increase was driven mainly by cardiovascular disease related deaths, which could be related to increases in the consumption of dairy, meat and carbohydrates, and to decreases in labor supply. Nieves Valdés (from Universidad Adolfo Ibáñez) exploited a major change of the Chilean pension system in 1981 from a pay-as-you-go to a defined contribution system to assess the effect of expected wealth on current health outcomes. Unlike Feeney, she showed evidence of a positive effect of increases in the Expected Pension Wealth in Chile on reported health outcomes for women.

The other two papers dealt with policies aimed at controlling health-compromising behaviors. Mariana Gerstenbluth (Universidad de la República in Uruguay) presented a study assessing the effects of cigarette packaging on risk perception of tobacco use. Results from conjoint analysis and eye tracking revealed the importance of rotating warnings on packages, of enhancing the image component of warning (rather than text), and of showing explicit morbidity images rather than symbolic warnings when trying to increase risk perceptions. Finally, Emilio Gutierrez showed that the soda tax introduced in Mexico in 2014 increased the prevalence of gastrointestinal diseases in areas with low groundwater quality and low access to piped water. Through a substitution effect, the introduction of soda taxes may have had undesired health effects in the short run in contexts with low access to safe drinking water.

The workshop succeeded not only in drawing a rigorous body of research on current health issues in Latin America but also in triggering discussion that will hopefully strengthen research in the region and engagement among LAC health economics researchers.

- Ana Balsa, Universidad de Montevideo and National Agency for Research and Innovation, Uruguay

**North America: The Affordable Care Act past, present, and future: Tense**

The attempt by the Republican government to 'repeal and replace' the Affordable Care Act (ACA, also known as Obamacare) dominates news in the USA at present. The US Affordable Care Act of 2010 is a landmark piece of federal legislation that was passed with the intent of reducing the number of Americans without health insurance, promoting a wide number of measures that are intended to bring health care costs under control, and doing so without increasing the federal deficit, which it did largely by raising taxes on high income individuals and selective health-related corporations. Before the ACA, the uninsured population in the US was on average relatively poor, young and healthy, and because much of the increased coverage was through expansion of the Medicaid program (a government insurance program for low income households) and public subsidies for low–to-middle income households, there were strong redistribution effects of the ACA. At the heart of the current debate around whether or not the ACA should be repealed is disagreement over the desirability of this redistribution effect. Most Democrats favor increased health care access through taxes and subsidies and are willing to have the government play a large role in sponsoring health insurance for needy individuals. Most Republicans oppose the tax increases, the subsidies to the poor, and the expansion of Medicaid coverage that can sometimes give low income or high health cost individuals better insurance coverage than working individuals.

The national debate has become quite tense. On the one hand, ACA opponents, led by the current Republican national leadership, assert that the ACA is a disaster, that it is increasing costs, and that the health insurance marketplaces (which provide online information allowing those who are not covered through their employer to compare insurance plans) are unsustainable. The Republicans have been
pushing to repeal and replace the ACA with substantial cuts in Medicaid coverage, cuts in most taxes, and emphasis on privately purchased insurance. ACA proponents highlight that it has clearly increased coverage, has slowed the rate of national health care cost increase, and that the marketplace is working in states that have expanded Medicaid coverage and public subsidies. They argue that Republicans have been undermining the ACA ever since it was passed, with renewed efforts under President Trump to increase uncertainty, allow states to deviate, and fail to enforce key features of the Act. Central to the discussion is whether the country maintains the very popular requirement that plans cannot exclude enrollees based on preexisting conditions (guaranteed issue), whether plans must provide reasonable levels of coverage for a full set of services (mandated coverage), and whether individuals or employers face any penalties for not offering or purchasing insurance (increased tax penalties for being uninsured).

A pre-congress session, sponsored by the Aetna Foundation and Social Insight, and held at the recent iHEA Congress at Boston University, provided a detailed overview of the main reforms introduced by the ACA, what the ACA has achieved, why the Republicans want to repeal it and the likely implications of such a repeal. The video recording of this session will be available shortly online here.

- Randall P. Ellis, Ph.D., Professor, Department of Economics, Boston University

iHEA Members

Get Involved in iHEA Activities

The iHEA Board would like to continue to involve more iHEA members in the various Board committees and other activities to ensure we take full advantage of the many talents in the iHEA membership. We urge all interested iHEA members to submit expressions of interest; the involvement of all members, including students and early career researchers, is welcome.

At present, the main committee for which we are seeking non-Board iHEA members’ participation is the Nominating Committee (see earlier overview of governance changes). The Nominating Committee oversees the entire selection and election process for Board Directors and President-Elect. It proactively identifies potential candidates, issues an open call for nominations, screens all nominees, compiles a final list of candidates, oversees campaigning and the election process, and reports on and ensures transparency in these processes. The committee will work intensively during the period August to November in election years, beginning 2017. Expressions of interest to serve on the Nominating Committee close on August 18th 2017.

iHEA members are also encouraged to express an interest in serving on the Arrow Award Committee and Student Paper Prize Committee. The Arrow Award is presented to the author(s) of the paper judged to be the best paper published in health economics in English in the award year. The committee considers a shortlist of 10-15 papers; all committee members are expected to review and score each paper using specified criteria (e.g. importance and originality of contribution, appropriateness and innovation in methodology, and clarity of presentation). The Arrow Award Committee works intensively during the period February to April annually, and committee members serve a three-year term, with the possibility of serving a second three-year term. Members of the Arrow Award Committee are expected to be well-established health economics researchers. The iHEA Student Prize is awarded annually to the Masters or Doctoral student paper judged as best in the award year. Similar criteria are used as with the Arrow Award. Although all eligible papers are reviewed and scored at least twice, members have to read and score in total 10-15 papers. The Student Prize Committee works intensively during the period December to February annually, and committee members serve a four-year term, with the possibility of serving a second four-year term. The Committee consists of experienced health economists, rising stars,
and a past winner. Committee membership should reflect all backgrounds, genders, and regions represented by iHEA. **Expressions of interest to serve on the Arrow Award or Student Paper Prize Committee close on September 29th 2017.**

We call on iHEA members to submit expressions of interest to serve on one of these committees. Please submit your CV and a covering letter, indicating which committee(s) you would like to serve on and your reasons for being interested. Please also summarize any relevant experience that would add value to the work of the committee. Expressions of interest should be sent to ihea@healtheconomics.org. It is unlikely that we will be able to accommodate all members who express an interest in serving on a particular committee, but we will keep all information on file for future committee work and will also seek to engage you in other iHEA activities.

In addition, we would like to receive expressions of interest (including from those offering to serve on iHEA committees) from members wanting to initiate or simply get involved in other iHEA activities. These could include: sharing research and training materials; improving social media communication; establishing interest groups (e.g. for doctoral students; for post-doctoral early career researchers; on specific areas of health economics research).

Calls for expressions of interest to serve on the iHEA Finance Committee and Ad-hoc Committees of the Board will be issued when positions become vacant.

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