Evidence-based policy-making

This year has seen the emergence of evidence-based policy-making as a major theme in health policy and systems research (HPSR). In Alliance Newsletter No. 1 we reported on meetings looking at developing countries worldwide and Latin America and the Caribbean. In this issue we report on two further meetings on the subject, one in the Asia-Pacific region, the other in Africa. This year has also seen a variety of regional discussions on evidence-based policy-making in preparation for the Bangkok 2000 International Conference on Health Research for Development, while the Council on Health Research for Development (COHRED) has commissioned a series of case studies on the subject.

The Alliance contribution to the debate has been to set out the benefits and challenges of increasing the relevance of health research, supporting institutional development and financing, and increasing the demand for and impact of research. We have emphasized that the application of policy research has to be managed right from the initial stages of project conceptualization. We have also focused the discussions more specifically on the needs of HPSR institutions.

In this issue, preliminary data on HPSR capacity are presented, moving the Alliance a stage further towards the production of the evidence needed to improve the international research architecture. We are grateful to the partners that made this possible by responding to our survey, and urge the HPSR community to maintain the information flow. This assessment played an important role in the consultation on capacity strengthening just held in Bangkok and which will be reported in the next issue of the Newsletter.
International conference on evidence-based policy-making

The Institute of Public Health of the Ministry of Health in Malaysia organized a meeting entitled “Towards evidence-based policy-making in health sector development” from 4 to 6 September 2000 in Kuala Lumpur. Researchers from 15 countries in the Asia-Pacific region, experts in the field and WHO officers presented recent studies and frameworks to improve the research-to-policy process. The Health Policy Research Network (Dragonet) and the Asia Pacific Health Economics Network (APHEN) contributed to the success of the event. While evidence-based clinical practice is gaining ground, the organizers stressed the importance of improving evidence-based policy-making in public health, where decisions can substantially affect whole populations.

An interesting variety of informative presentations covered evidence-based approaches to health financing for whole populations and specific groups in India, Japan, Malaysia, Singapore and Taiwan (China), and monitoring of the effects of and response to the recent Asian economic crisis in Indonesia, Republic of Korea, Singapore and Thailand. The impact of organizational reforms in the Public Hospitals in Hong Kong (China), the National Heart Institute of Malaysia and the decentralization experience in the Philippines, and improvements in health service delivery in Beijing, Malaysia, Nepal and Republic of Korea were analysed. The meeting also heard expert presentations on national health accounting methods and health service demand studies.

Health systems research in Africa

The first regional meeting of focal points for national health systems research (HSR) in the WHO African Region, held from 19 to 22 September 2000 in Harare, Zimbabwe, attracted 40 focal points and policy analysts from 32 Member States. The main objective was to orient the participants on recent developments that have implications for HSR in the Region and to review HSR activities since 1998.

The Regional Director Dr E. Samba said that two important events in 2000 – adoption of the regional health-for-all policy for the twenty-first century and publication of The World Health Report 2000 – had highlighted the need for HSR to produce evidence that informs decision- and policy-making. Research on the processes for translating the regional policy into realistic national health policies is also required.

Future action

Discussions focused on the increasing need to strengthen the policy-orientation of HSR studies and the capacities of HSR focal points. It was agreed that greater use should be made of existing regional networks to maximize resource use. The meeting also approved a number of recommendations (see box) related to the further development of HSR at regional and country levels.

Country HSR plans of action were prepared for the period ending 2001. Follow-up activities to support implementation of these plans were presented by staff from the WHO Regional Office of Africa.

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REGIONAL MEETING OF HSR FOCAL POINTS AND POLICY ANALYSTS

Summary of recommendations

- Institutionalization of HSR, including continuous advocacy among policy-makers and integration in national health programmes.
- Decentralization of HSR to provincial and district levels
- Development of HSR methodologies for policy research and analysis
- Identification of centres for policy studies to support capacity-building for HSR focal points and foster strong collaboration and teamwork among HSR focal points, policy-makers and analysts
- Critical analysis of the reasons for the current limited use of HSR evidence in policy and programme decisions
- Promotion of a proactive role for HSR focal points in implementing the research-to-policy cycle.
- Country adaptation of the basic roles of HSR units and focal points according to local capacities and needs
- Development of career paths for researchers to minimize brain drain
- Support to countries from the WHO Regional Office for Africa through: advocacy for strengthening national HSR, in particular those at lower stages of HSR development, to ensure an acceptable level of HSR in all countries; linking HSR focal points with appropriate websites; harnessing existing skills among HSR focal points and policy analysts.
We are pleased to report good progress in developing our small grants programme, which will help finance health policy and systems research projects in developing countries (see box defining scope of research, page 4). The call for letters of intent for the programme, sent out in June 2000, resulted in 416 valid letters from principal investigators residing in 58 developing countries. August 2000 saw the conclusion of the first stage of the selection process, with the selection of 62 letters from 24 developing countries. Those chosen are being asked to participate in the next stage, protocol development, before a final selection is made in January 2001. The Alliance expects to fund 50 projects in 2001 at an average of US$ 15 000 each. WHO is also providing funding and technical support to the programme.

Grants will be awarded to developing country nationals addressing HPSR in developing countries, and candidates can be based at institutions anywhere in the world. Two types of grant are offered:

- **Research-to-evidence grants** are aimed at strengthening capacity for the application of HPSR to the policy process by providing funding to experienced researchers and policy-/decision-makers for short-term research projects involving empirical study or analysis of existing data.
- **Young researcher grants** will support the growth and potential of HPSR in the medium term by providing funding to young researchers working as part of a research team or students undertaking research projects for a Masters or Doctoral dissertation in a relevant subject.

Of the 416 letters received, 118 (29%) came from Africa, 130 (33%) from Asia and 138 (38%) from Latin America and the Caribbean. E-mail was the most common method of communication (85%). Applications were about even for the two grant categories and 41% of the letters were selected.

### Topics by frequency

<table>
<thead>
<tr>
<th>Topic of Letter</th>
<th>Requested No.</th>
<th>Selected No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Community participation</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Decentralisation/local health systems</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Economic policy and health</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Equity</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Financing</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>Health Needs</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Health Reform</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Health Seeking Behaviour</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Health System Development</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Hospital autonomy/privatisation</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Human Resources</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>Information, Education and communication</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Information systems</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Knowledge, attitudes and practices</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Performance assessment</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Pharmaceutical management/regulation</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical policy</td>
<td>4</td>
<td></td>
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<tr>
<td>Physician behaviour</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Policy Process</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Poverty</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Private-public mix</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Prevention/promotion</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Programme evaluation</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Reproductive health</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Research to evidence/capacity strengthening</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Traditional medicine/Indigenous populations</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>416</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>
of the principal investigators were women. A PhD qualification was held by 21% of principal investigators: 12% for Africa, 27% for Asia and 20% for Latin America and the Caribbean.

**Review process**

Letters were reviewed and scored independently by two Alliance Board members for each region, with marks given for quality, relevance to national or regional priorities and strength of the research or academic team. Young researcher grant applications were also scored according to the promise of the researcher. Scores for the various parameters were averaged and standardized along a common scale from 0 to 10 for both types of grant. The overall average score was 5.2, with similar averages for each of the three regions: 5.0 for Africa, 5.2 for Asia, and 5.4 for Latin America and the Caribbean. However, letters from Africa had fewer scores in the extremes than the other two regions. The degree of agreement in scores between reviewers was assessed for each pair, with excellent to very good ratings (difference of less than 4 score points) in 72% of cases. Only 15 letters required further analysis to clarify discrepancies between reviewers.

**Selection options**

Given the good number and variety of letters in the above-average or “fundable” group, (168 letters; 40% of the total), selection focused on this group, although the Alliance will be considering those below average for capacity-strengthening activities at a later time. Given the Alliance’s funding and administrative capacity, the aim was to select not more than 65 letters for the next stage.

The selection process was never going to be easy, and several options were considered. The first was to give priority to highest quality projects within topics in high demand. However, this resulted in the selection of too few letters from Africa. Another option was to select all “fundable” letters in each of the most demanded topics. While this produced regional balance, it restricted the number of topics covered and risked funding weaker teams that would require more technical support than we can provide to ensure satisfactory results. The option chosen gave preference to project quality over topic, with the selection of all letters ranked in the top 15%. This option produced regional balance and a wide variety of topics selected. However, letters concerning projects on cost-effectiveness, for which there was high demand from Asia in particular, were not selected, regardless of their score, as the topic was considered to be adequately funded through other initiatives.

Given the funding available we were able to select 62 proposals for protocol development: 17 from Africa, 21 from Asia and 24 from Latin America and the Caribbean. Of the principal investigators funded, 36% were women and the top qualification held was as follows: PhD, 25%; Master’s degree 50%; Bachelor’s degree 25%. Table 1 presents the distribution of topics demanded and those actually supported for protocol development.

Selection of the 62 successful letters represents a significant step forward in supporting HPSR capacity development, good quality research and its integration into the research-to-policy cycle. We are convinced that Alliance grants will contribute to improved health by encouraging relevant, valid and sustainable research and its application to the health policy and management process.

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**SCOPE OF HEALTH POLICY AND SYSTEMS RESEARCH**

The Alliance defines HPSR as the production of new knowledge and applications to improve the ways in which societies organize themselves to achieve health goals – how they plan, manage and finance activities to improve health, as well as the roles, perspectives and interests of the various participants in these efforts. HPSR contributes to sound, socially relevant and ethically acceptable guidance for more effective, efficient and sustainable health policies and systems.

- HPSR focuses on the health system functions of regulation, organization, financing and delivery of services.
- Broader determinants with a direct impact on health systems are also considered, such as social and economic policies that affect key health system structures and processes.
- HPSR does not include research focusing on environmental, political, cultural and economic determinants and processes that affect health indirectly.

Additional vital funding for this programme from the Government of Norway is gratefully acknowledged.
STATE OF THE ALLIANCE

Health policy and systems research institutions in developing countries

The Alliance has so far made contact with 406 institutions (or departments within faculties) that are producing health policy and systems research (HPSR) in 71 developing countries. Contact has also been established with over 70 HPSR institutions in the developed world and 14 national and international agencies supporting HPSR. Institutions that become Alliance partners are asked to provide a profile of their structure, activities and capacity development through a questionnaire. To date the Alliance has analysed the responses of 97 partners.*

This is a study in progress. The full implications for the design of capacity-strengthening for HPSR in developing countries will only be known when we have a more complete picture. However, the information received so far provides the most extensive directory of active HPSR institutions in developing countries available and throws light on their distribution and characteristics.

Preliminary analysis of incoming data

HPSR is in the process of consolidation in Africa, Asia, and Latin America and the Caribbean. The 406 institutions are distributed across the majority of countries, and their activities involve more than 3500 individuals working on some 1200 projects. Over half of the institutions have more than 5 years of experience in this field, and their directors are generally well experienced. HPSR is also a growing area of interest: about 3% of institutions – some 10 – are newly established or initiate activities in the field of HPSR every year. The overall amounts invested from external resources are considerable, at an estimated US$ 13 million for 1999. However, when viewed at the country and institutional level, HPSR activity is concentrated in a few countries, external project funding is low and short term, with overall expenditures tentatively estimated at about 0.002% of national health expenditures.

The number of PhD-level researchers in the three regions is significant, at around 20% of the total, although their research experience may be limited. Indeed, among those applying for support under the Alliance small grants programme researchers with a PhD were not more successful than those with a Master’s degree (see page 3). Human resources are highly dispersed and less than 22% of institutions have more than 10 researchers in the field. This raises doubts as to the capacity of these institutions to achieve the critical mass necessary for good academic work of sustained quality, although smaller consulting institutions and medium-sized think tanks may be better placed to respond to short-term needs. Furthermore, PhD-level researchers tend to be concentrated in the larger institutions, while researchers in smaller institutions may lack this support. HPSR includes a wide range of disciplines, although public health to Master’s level and medicine to MD level are still the most popular. The question remains as to whether researchers with appropriate social science and economics training are sufficiently specialized in policy and health systems research.

In Africa, HPSR institutions are more closely tied to the centralized, national public sector (75% of cases) than in other regions. However, African governments participate much less in project initiation, have less influence on the research agenda and contribute much less to funding. Asia is the region with the most independent institutions in terms of legal and financial standing, and research agenda.

Most research institutions have representatives of national government and other important bodies on their Boards. However, these are mostly from the health sector and there is little participation by the financial and private sectors, which are vital for public policy. The participation of stakeholders in the HPSR process is still less than adequate, again being mostly related to the health sector. While this link may be adequate for some health systems research projects, it is clear that policy research is not being well supported.

Respondents to the Alliance survey believe that government backing for conducting research is greater than its willingness to discuss and use research results. Researcher-driven approaches to influencing the policy process are still predominant, with few demands for and even less autonomous use of research by policy-makers.

Activities to increase the relevance of HPSR are least successful in the area of research-to-policy impact assessment, training of stakeholders in HPSR (with the notable exception of Africa), and gaining community-wide recognition for institutions/units as producers of high-quality, objective HPSR. Improving the reliability of public domain databases is the research capacity-strengthening activity that is considered least successful, besides improving the physical infrastructure. At the global level, the top priority in requests for support by the Alliance is increasing access to international information on HPSR, closely followed by development of methodologies and tools, and support for regional networking and communication. Indeed, the study shows that less than a third of institutions participate in international networks.

*The full working paper is available on the Alliance Website (www.alliance-hpsr.org).
Disciplines available within institutions

HPSR project initiation

Setting the research agenda

The Alliance web portal currently under construction will soon offer a meeting point where the HPSR community can exchange information, consolidate priorities and disseminate opportunities.

The Alliance has strengthened its collaboration with regional networks, and will provide modest financial support to the Asia Pacific and China Health Economics Networks, the Health Systems and Services Network in the Southern Cone of Latin America, and the Health Economics and Policy Network in Sub-Saharan Africa.
World Health Report 2000, Interview with Philip Musgrove, Chief Editor.


In WHR2000, WHO recognizes that health systems should be just as concerned with ensuring fair financing and an adequate response to population expectations relating to the non-health aspects of care as they are with improving health. What was the contribution of health systems and policy research to this new perception?

This report would have been unthinkable without the research undertaken in the last two decades, in particular, on estimation of burden of disease, disability-adjusted life expectancy, health expenditures and health-seeking behaviour. Research also contributed a new conception of health system functions and the changing roles of government and other actors. In addition, WHR2000 stimulated and incorporated research on areas such as the role of taxation in health expenditure and the responsiveness of health services. Of course research is not just important for WHR2000. One of the conclusions of the report is a recognition of the large part played by research in health improvements, not just in clinical terms, but also in the area of health system performance.

How do you expect health advocacy and leadership to change at the country level as a result of the conclusions on health systems expressed in WHR2000?

This will of course depend on each country, but changes can be expected in three general areas. WHA2000 demonstrates the larger role disability plays in countries with higher mortality when compared with countries with lower mortality. Disability is therefore an area that will require greater attention in poor countries. The report also argues that the way in which health systems are financed can make a big difference in health outcomes. Furthermore, financing is simpler than service provision in many respects, and financial reforms show fairly rapid results, as observed in Colombia and Argentina. Finally, improving responsiveness enhances well-being and is not expensive to achieve.

What are the implications of WHR2000 for health research priorities nationally and at regional and global levels?

WHR2000 raises many questions but gives few answers on the role of health system performance in health outcomes. First of all, there is a need to improve the description of functions such as stewardship and financing—little research has been undertaken in these areas compared to service provision. What are investments really like? How can the poorer members of society be incorporated into general risk pools, or how can subsidies across pools be obtained? At the global level, comparative research could help identify the features of health system functions that have the greatest impact on health, responsiveness and fair financing. Priority should be given to building or, where it already exists, strengthening national capacity to carry out relevant research, especially in developing countries. The Alliance and WHO have an important role to play in supporting long-term development of research priorities so as to monitor the performance of health systems.

WHR2000 ranks national health systems according to their performance. What are the research implications of this ranking?

It is not the ranking itself that is important, but the identification of areas that can be improved. Countries that spend little on health appear to do worse than might be expected with those resources. But do we have the right notion of what is possible? And what are the major barriers to achieving it? In the case of Africa, HIV/AIDS is clearly affecting outcomes. But what are the health system obstacles? More importantly, what road should we follow to overcome them? Just as there are long-term strategies for eradicating poliomyelitis, we need to establish routes for improving health system performance. This is a very fertile area for research, and WHO technical assistance should be guided by the results.

Will WHR2000 lead to a renewed dialogue between health system researchers and policy-makers and advocates? How can the Alliance support this process?

The report could well give added impetus to research and promote greater attention to research in policy circles. The Alliance can play its part by providing stimulation and support to researchers and policy-makers alike.


The full text of the report is available in English and French on the WHO Website (www.who.int/whr), which also gives details of how to order printed copies.
Alliance Working Papers now available

1. Health policy and systems research in Africa, Asia, and Latin America. Sadia Afroze Chowdhury, Miguel A. González Block & David Harrison.


5. Situation of Health Policy and Systems Research Institutions in Developing Countries. Preliminary Analysis of Incoming Data. Miguel A. Gonzalez Block.

6. Trends and Evolution in EU policies and Funding of Health Systems Research in Developing Countries. Debarati Guha-Sapir.


8. The international research architecture from the African perspective. Diane McIntyre.

9. The international research architecture from the Asian perspective: V. R. Muraleedharan.

The papers are available on our Web Site, and they may be requested in writing.

In the next issue…

Launching in Beijing of the China Health Development Forum by the China Health Economics Institute and the Institute of Development Studies, in support of rural health policy for 800 million rural Chinese.

Report of the consultation for the design of the Alliance HPSR capacity strengthening programme. This consultation was held in Bangkok, 14 October 2000.