How do we collect evidence and influence policy makers?

Messages from “Sound Choices” and Recent Initiatives

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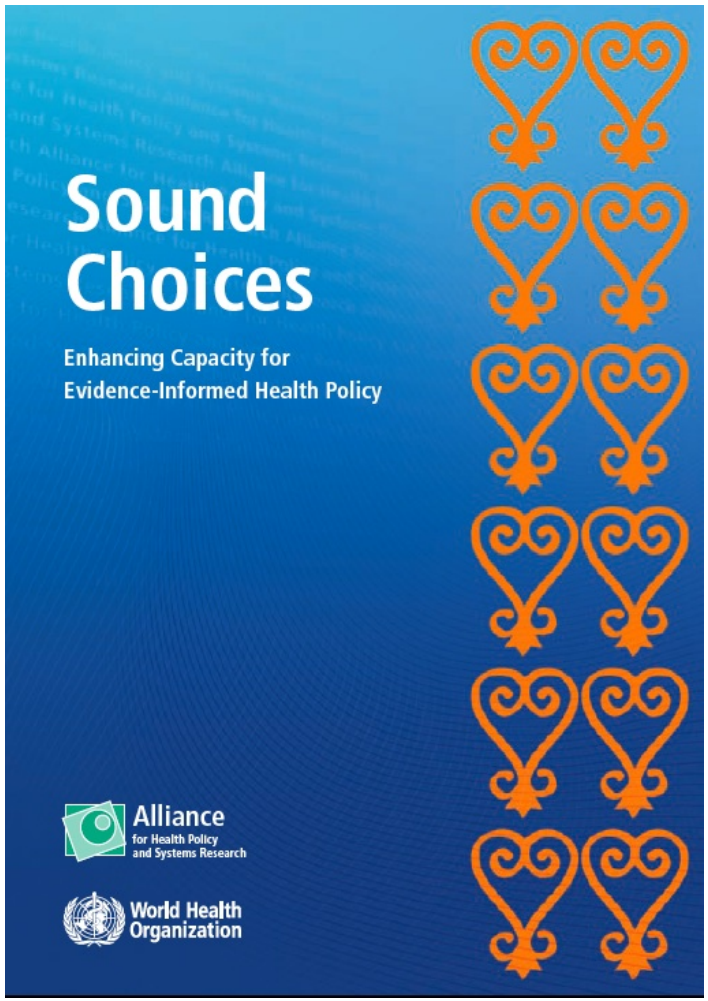
Outline

- Institutional challenges in the production of evidence for policy - Health Policy and Systems Research (HPSR)
  - Findings from WHO AHPSR “Sound Choices”
- Examples of regional and global collaborations
  - World Bank Good Practices in Health Financing
  - Equitap

Background to “Sound Choices” (WHO, 2007)

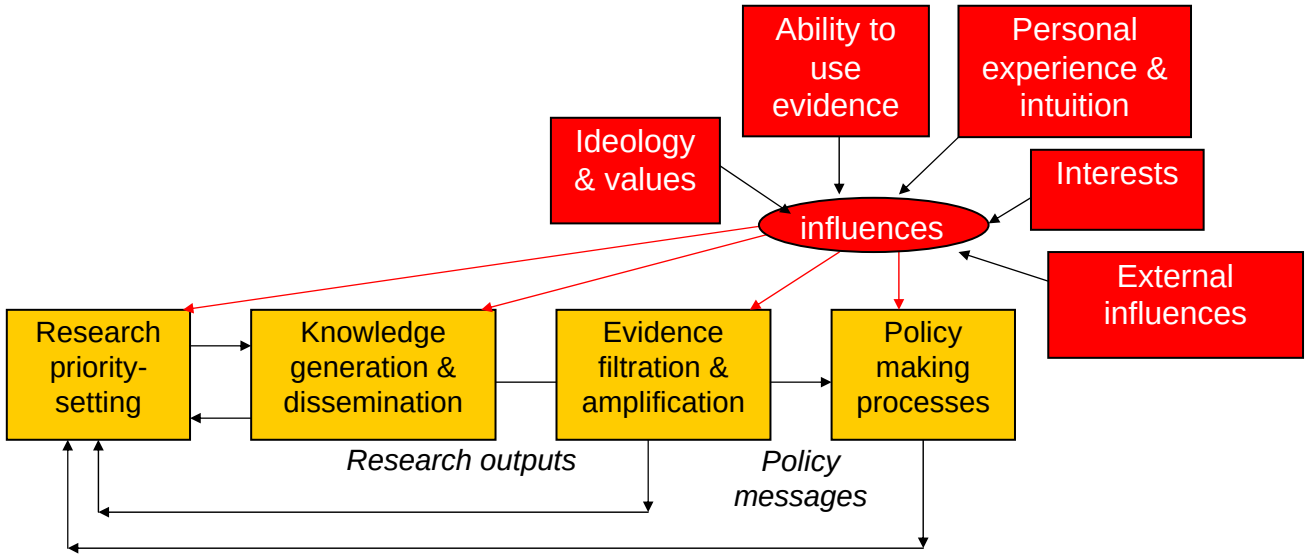


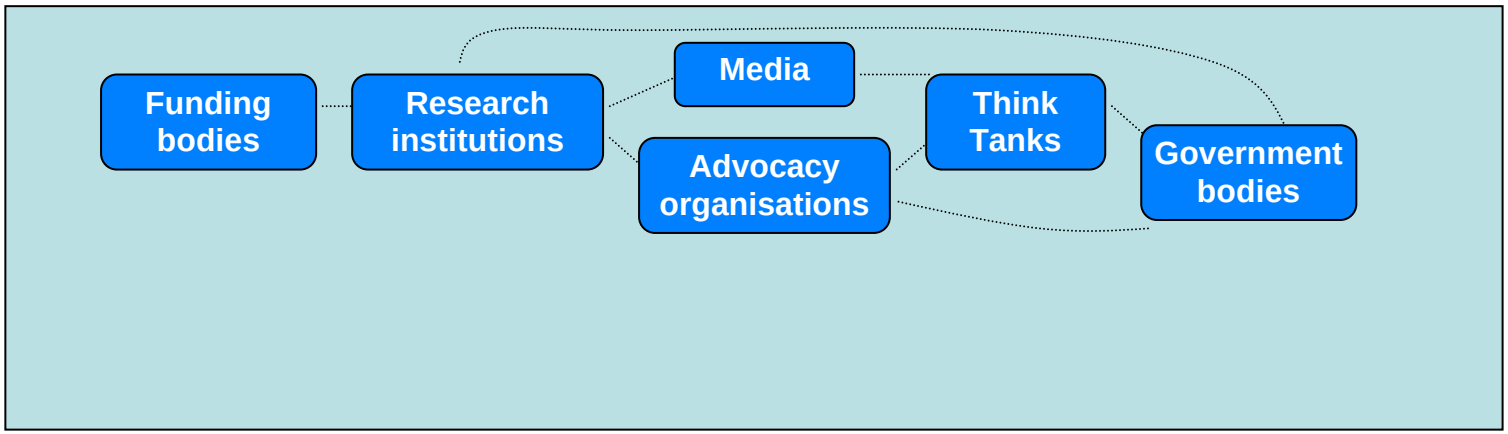
- Recognition that WHO Alliance investments in capacity strengthening itself not based on evidence of what works and what is critical
- Recognition that the key constraint is not HR, but institutional capacity at various points in the research-policy interface
- Capacity very variable – another cause and symptom of inequality
- Hence, focus of biennial review to look at institutional process of evidence to policy

WHO Alliance "Sound Choices" Framework

- Recognises:
  - Various influences on policy decisions - evidence is only one
  - Widely shared desire to increase the influence of evidence on policy
  - Policy processes are messy and non-linear but.....
- Can identify 4 key functions in the research–policy interface:
  - Priority-setting for research
  - Knowledge generation and dissemination
  - Filtration and amplification of evidence
  - Policy-making

Evidence informed policy: Functions and organisations





Global survey points to critical role of institutions

- Extent of successful, sustained HPSR varies immensely
- Critical constraints do not appear to be local financing or HR training or explicit government structures for HPSR - but lack of strong local HPSR institutions
  - Eg: China vs. India, Ukraine vs. Georgia
- Institutions needed to foster development and retention of HR, focus and enable research, and make it policy relevant
- Evidence during past decade of increasing need for or comparative advantage of specialised HPSR centres

Why does institutional capacity matter?

- Local HPSR capacity is critical
  - Needed to filter and make relevant to local context global knowledge
  - For policy-makers evidence from local agencies is often more credible, accessible and likely to engender ownership
  - To enable countries to set and implement their own HPSR priorities
  - To enable countries to manage implementation of national policies and strategies

Examples of HPSR ‘hotspots’

- Mexico - Funsalud, NIPH
- Brazil - Oswaldo Cruz Foundation
- South Africa - UCT, HST
- Ghana - HRU MoH
- Kyrgyz Republic - “Manas” Unit
- Georgia - Curatio Foundation
- Thailand - IHPP, HSRI
- China - “Health Economics Network”

What makes for successful HPSR centres?

- Not organisational form
  - Successful centres come in all forms: MoH units, public HPSR agencies, university departments, non-profit think tanks, for-profit firms
- … but key appears to be operational characteristics and approach

1. Positioning and leadership

- Sufficient operational autonomy to produce high quality work, but still close to policy-makers
- Credible and neutral
  - Solutions will vary from country to country - highly context specific and can evolve, but unless achieved, long-term sustainability unlikely
  - Situation assessment ought to be first step in any external investments
- Leadership often crucial
  - Must be able to combine both scientific expertise and management skills

2. Human resources

- Quality HPSR requires multiple disciplines
  - Ability to bring together different disciplines, as well as cross-bridgers
  - Team work is at a premium
- In the long-term requires investment in building up HR

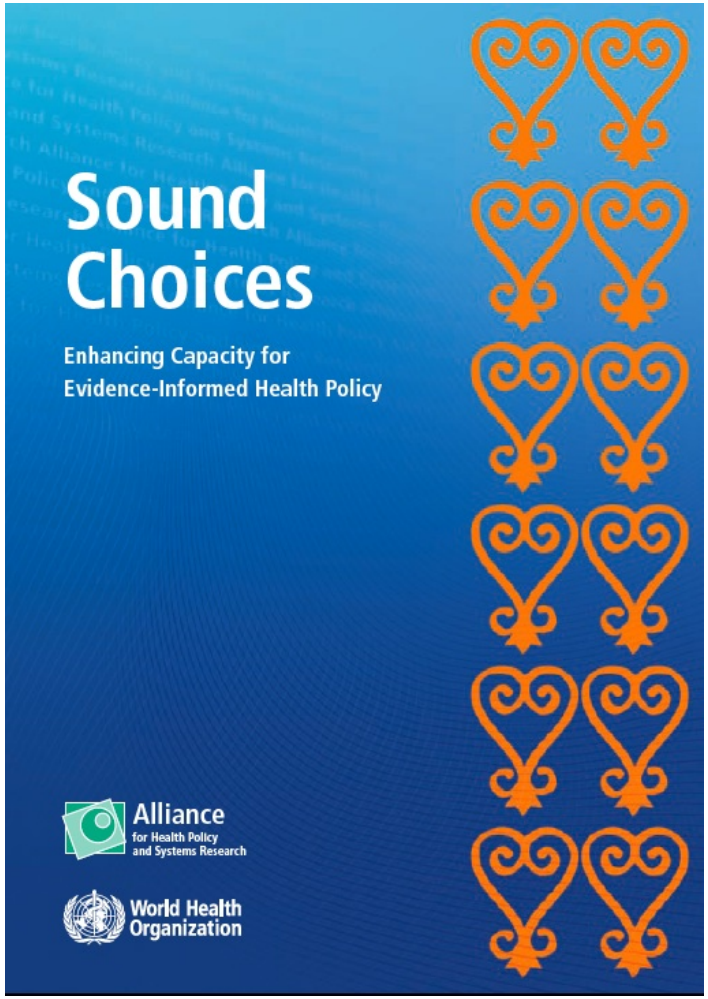
3. Financing

- Quality HPSR requires significant financing
  - For adequate compensation to attract and retain the highest quality professionals
  - For funding operational activities
  - For providing necessary infrastructure to do quality research
    - Communications, IT, information resources
    - Financial administration
- Since financing in most LICs is inadequate, ability to access and manage external funding

4. Networking

- Networking emerging as important feature of work by successful HPSR agencies
  - Recognition of importance of comparative health systems analysis
  - Means to leverage institutional capacities
  - Mechanism to share experience
  - Requirement for much funding
- Requires specific skills and orientations

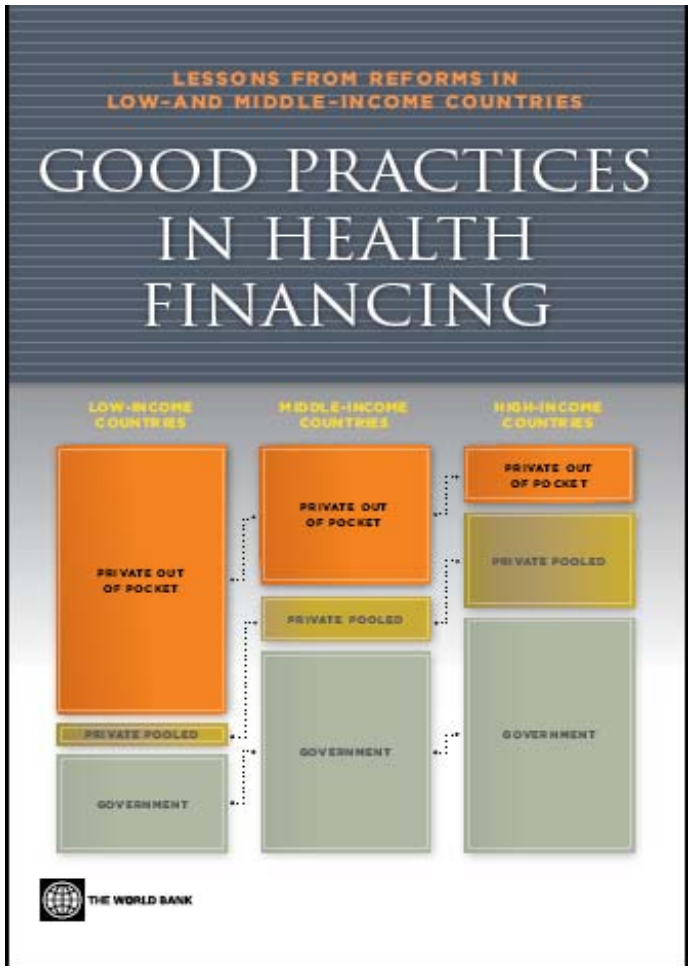
Messages



- Successful HPSR requires development of national institutional capacities
  - Institutional design is critical
- Funding is key constraint
  - Issues to be addressed by research institutions in LICs
  - Changes necessary in how international funders do their business
- Focus on HPSR and international collaboration increasingly needed

Two examples of comparative and collaborative research

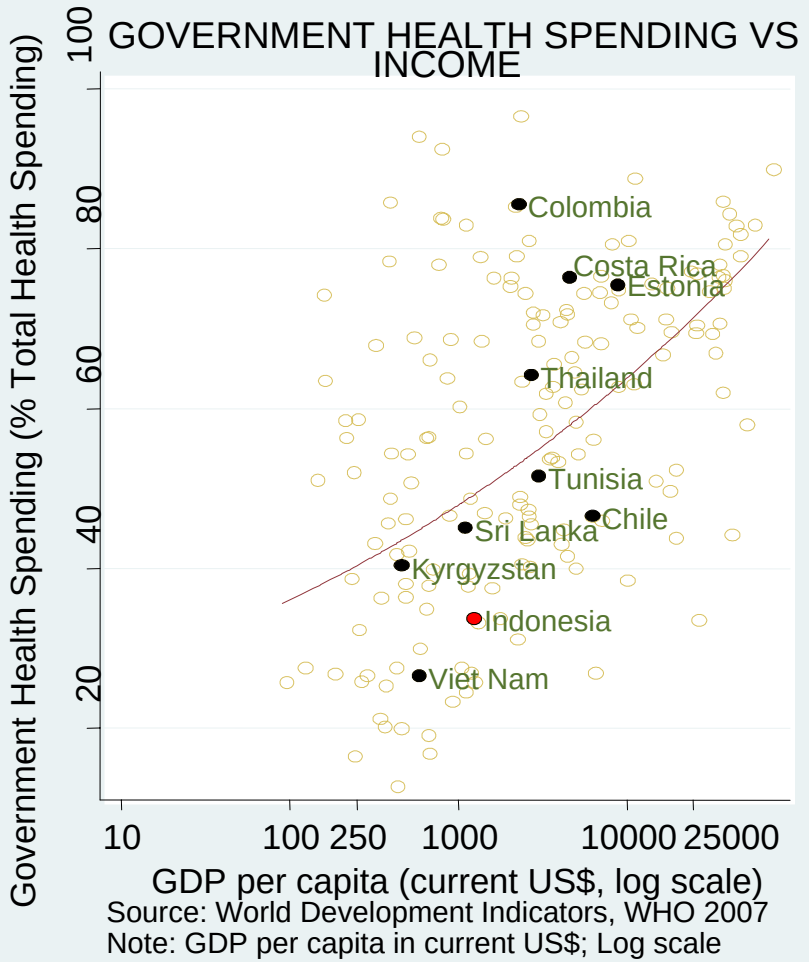
WB Good Practices in Health Financing (2008)



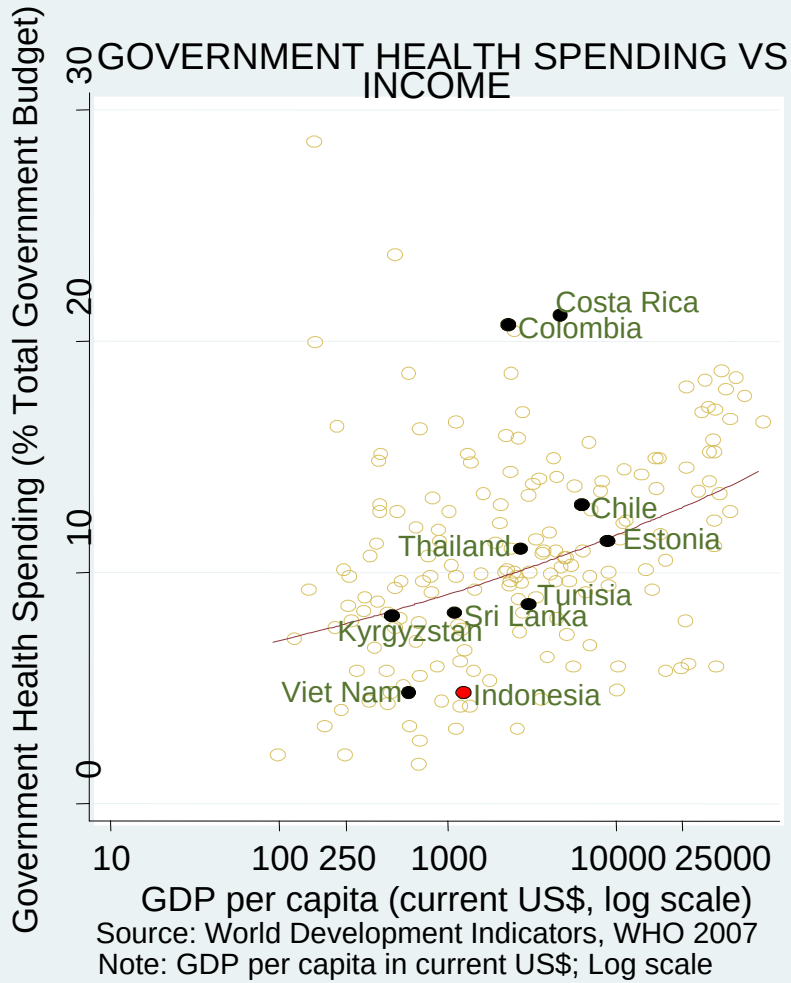
Background

- MDGs and push to expand coverage and risk protection focusing attention on what works
- Evidence base on what works limited
- Case study approach necessitated since RCTs or pre/post studies not possible owing to time frames of system development and lack of possibility for experimentation
- Nine good performers selected

Government Share of Total Health Spending and the Budget Relative to Income



Source: World Development Indicators, WHO 2007
Note: GDP per capita in current US$; Log scale



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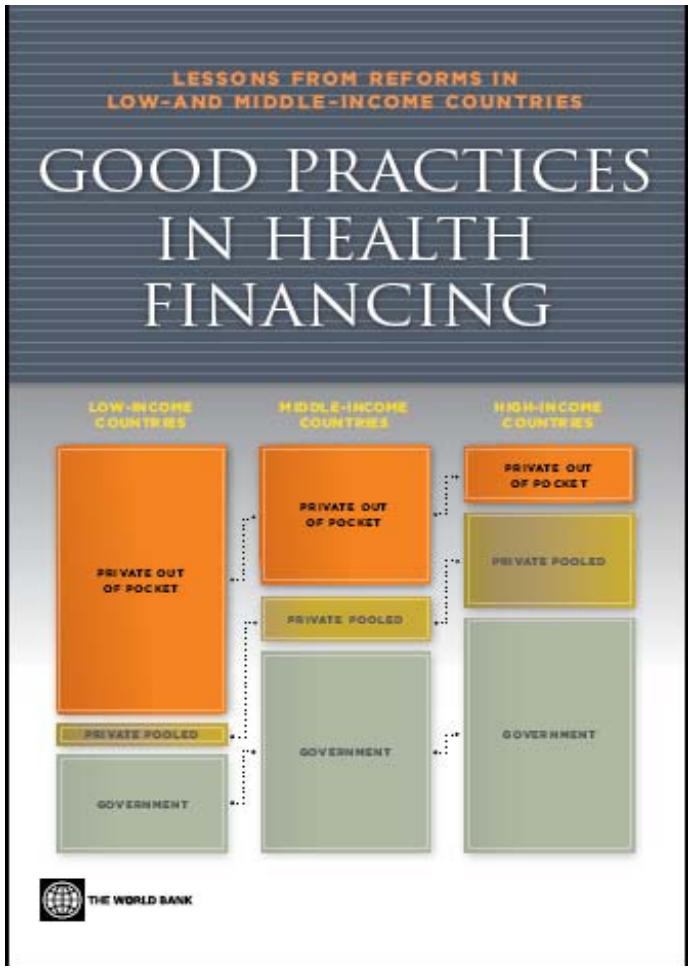
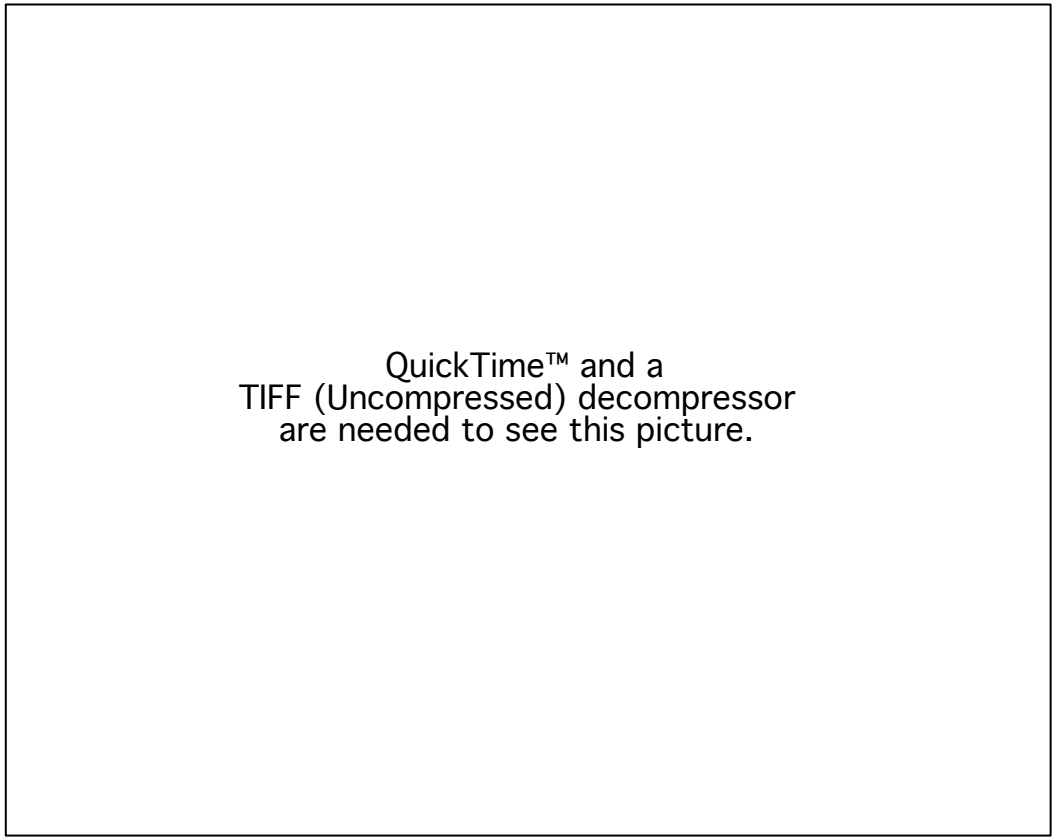


Key lessons

- Need definitions of ‘successes’ and ‘good practices’
- Need to collect appropriate and standardized qualitative and quantitative data
- Need detailed health systems characteristics information
- Need to do rigorous evaluations
- Need to disseminate evidence in policy relevant and user friendly manners

Equitap Collaboration

- Collaborative research project conceived and initiated in 2001 to examine equity in health systems
- Local research groups initially in Bangladesh, Nepal, India, Sri Lanka, Thailand, Philippines, Indonesia, Malaysia, China, Kyrgyz, Mongolia, Taiwan, Hong Kong SAR, Korea, Japan
- Expanding in 2008-2010 to Mekong and South Pacific countries
- Initial EU technical support, but now self-reliant
- http://www.equitap.org/



Equitap - original Equitap - new

Equitap Research

- Comparative analyses of equity in financing, delivery and outcomes in national health systems using standard protocols and methods
  - Equity in payment for health care
  - Equity in distribution of health spending
  - Catastrophic/impoverishing impacts
  - Equal treatment for equal need
  - Adult mortality differentials
- Comparative health systems studies
  - Tax systems, Extension of social insurance
- Focus on building national capacities to undertake high quality scientific analyses using existing data

Poverty impact of health OOPs on Pen Parade in Bangladesh (US$1.08 poverty line)

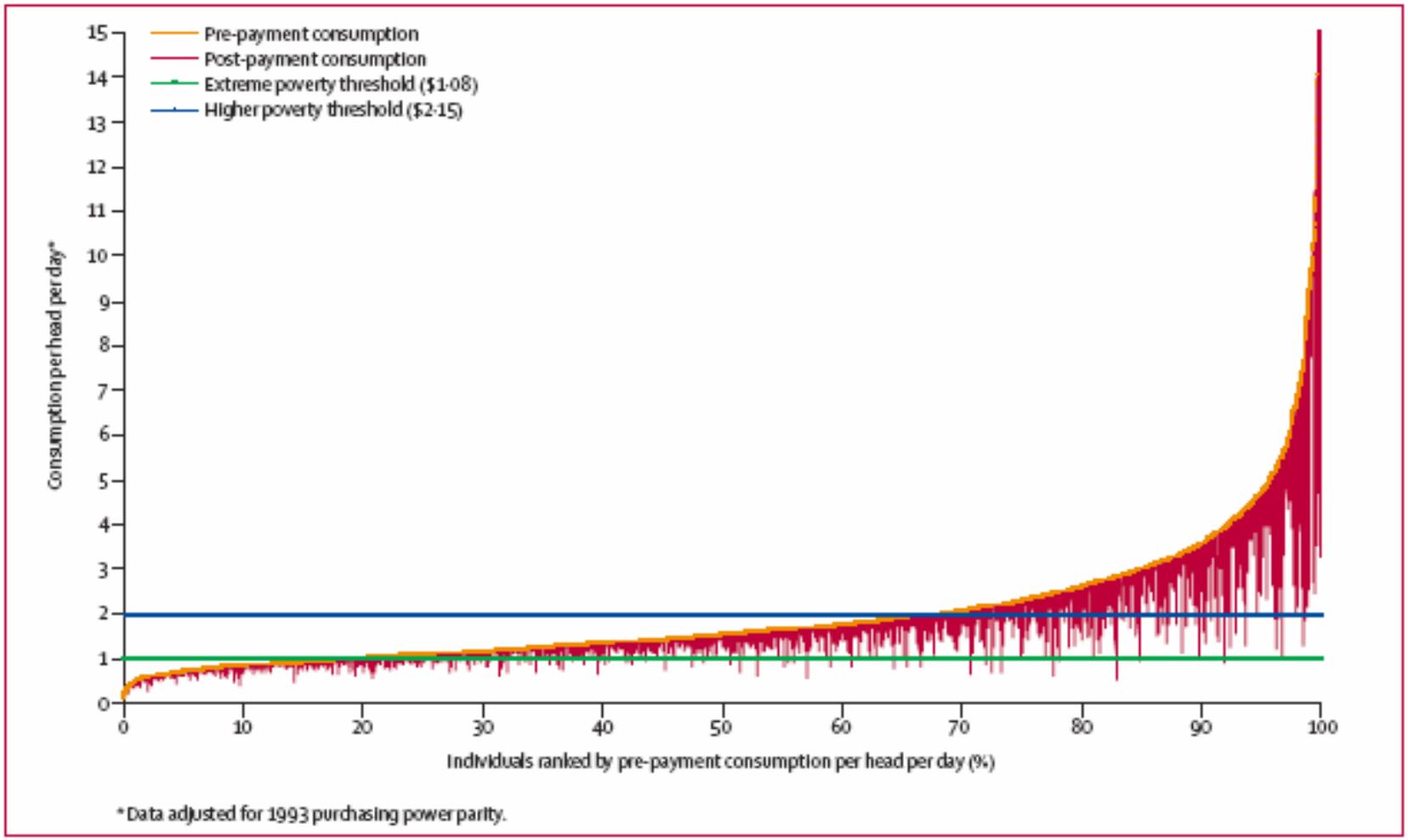
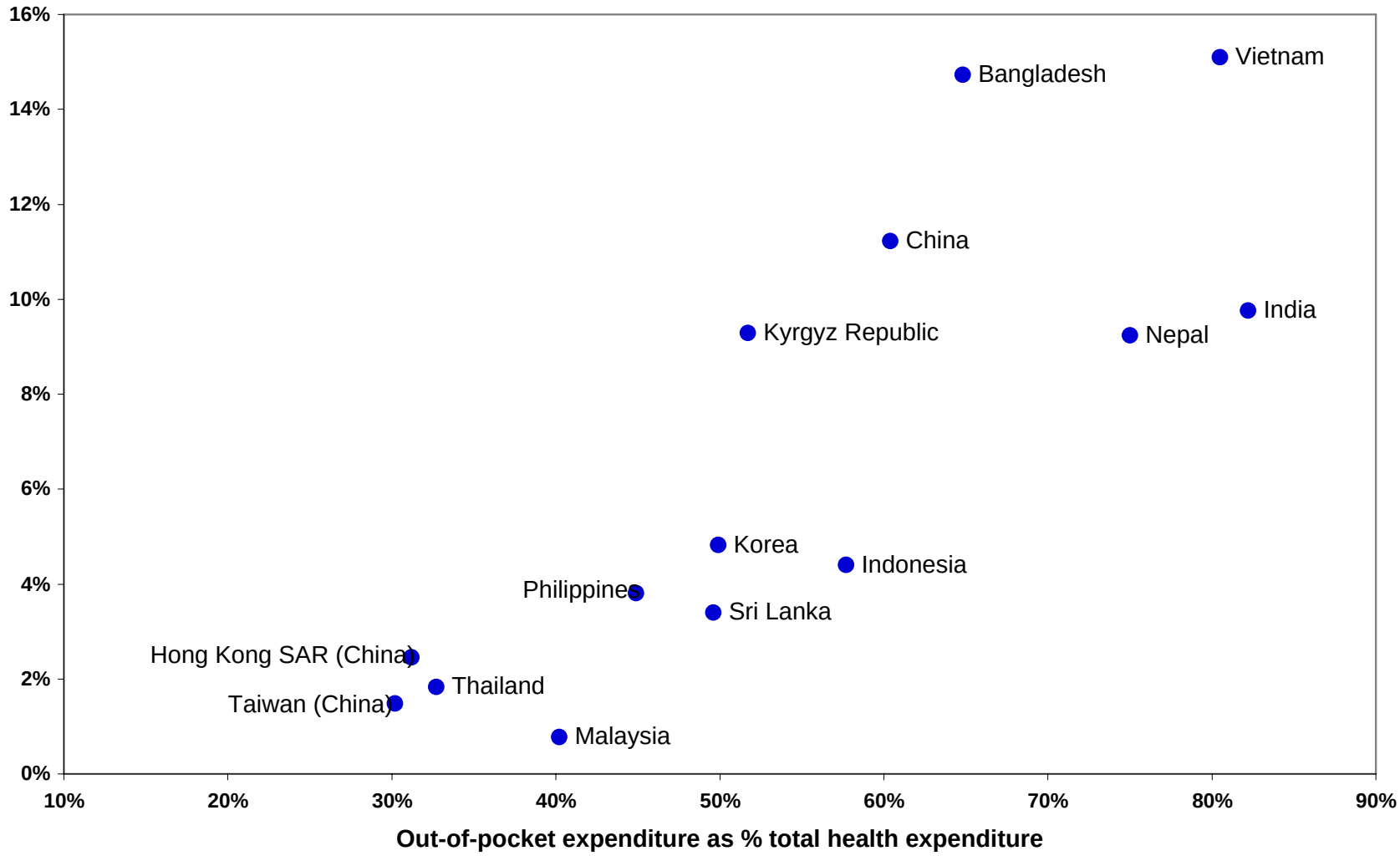


Figure 3: Distribution of total consumption before and after subtracting health-care payments–Bangladesh (2000)

Correlates of financial catastrophe



Impacts of Equitap Research

- National
  - Results and skills used in several countries for ongoing policy reforms and evaluation, E.g., Indonesia, Thailand, etc
- Scientific and policy audiences
  - Probably the definitive source of data on health financing/delivery inequalities in Asia
  - Demonstrated feasibility of high quality health systems comparative work led by southern research institutions
- International partners
  - Results used extensively by WHO, World Bank, ESCAP, ILO, High Level Asian MDG meetings, etc
  - DFID - Evidence used in committing UK DFID to support abolition of user fees at global level

Final messages

- Building national institutional capacity for HPSR critical for effective research to policy impact, but requires new approach by countries, funders and research institutions
- Comparative and collaborative health systems research especially valuable for policy
- Institutional arrangements for collaborative, health systems research viable and needed in Asia-Pacific region

Thank you