Author's response to reviews

Title: Priority Setting and Health Policy and Systems Research

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Author's response to reviews: see over
Referee 1:

1) In Section 3, it is worthy of consideration that a number of working paper and one or two high quality publications have emerged from the three phases of the research. Potentially, the paragraphs would be strengthened by adding the citation to the papers at the end of the appropriate paragraph—without necessarily listing them, discussing them or otherwise further mentioning what they include.

We have added citations to the first paragraph of Section 3 -- two corresponding to papers "In Press" and one corresponding to a technical paper that is freely available online.

2) On page 13, you use the phrase “Proposals were made comparable cross sectors...” This sentence is very confusing. Do you not mean, “across sectors”?

Yes, this should have read "across sectors" and has been changed accordingly.

3) On page 14, the sentence starting “Priority setting exercises inevitably need to..” might strengthened through rephrasing as Priority setting exercises inevitably need to take into account their (the) target audience” or “Priority setting exercises inevitably need to take the composition of their target audience into account.”

We have changed the wording to correspond to the reviewer's second suggestion.

4) Similarly on page 14, the sentence that begins with “However…” and includes “and there is therefore” needs a fresh look.

We agree that this sentence was poorly constructed and we have re-worded it.

5) Also, I find the coloring of Figure 1 and Figure 2 difficult to read on the computer. I recommend changing to black lettering for the column and row titles and a less vibrant background overall.

We have removed all color from Tables 1 and 2, leaving black text on white backgrounds.
The paper contributes to the discussion of the role and methods of priority setting for health policy and systems research. The conceptual framework is innovative in terms of identifying levels of analysis, comprehensiveness of topics, balance of interpretative vs. technical approaches and stakeholders involved. The paper provides empirical evidence on priority setting processes, highlighting the experience by the Alliance HPSR.

Discretionary Revisions

It would be useful to refer to the literature (such as Cassels & Janovsky Health policy and systems research issues, methods, priorities. In: Janovsky, J. ed. Health policy and systems development. an agenda for research. Geneva, World Health Organization, 1996) that made pioneering efforts in contrasting HPSR priority setting with disease priority setting.

This is indeed a reference that we consulted as part of our background work; however, we made the decision not to cite it in the paper. Indeed, as part of their background work for the Ad Hoc Committee on Health Research Relating to Future Intervention Options, Janovsky and Cassels did indeed struggle with the issue as to whether and how three areas of research -- disease control interventions, health systems and household behaviour -- could be assessed using a common standard. While their document is interesting, and highly relevant, they did not come to any firm conclusions. And ultimately, the Ad Hoc Committee used a five-step, highly quantitative approach for prioritizing disease-specific research issues. But they recognized that this process was not suitable for assessing "the inequities and inefficiencies of health services and the lack of information to guide policy formulation", so such issues were considered separately. We have made reference to the Ad Hoc Committee's work, in Table 1, listing it as one of the priority setting processes at the global level that has considered HPSR separately.

Also, the literature pertaining to the framing of HPSR problems, which is pertinent with the dimension of comprehensiveness of topics (Gonzalez-Block, Health policy and systems research agendas in developing countries. Health Research Policy and Systems, 2:6 2004. http://www.health-policy-systems.com/content/2/1/6).

The excellent paper referred to by the referee is one of several that attempt either to frame HPSR problems, or to quantify current levels of health systems research or related funding. Others include (but are not limited to): (Alliance for Health Policy and Systems Research, 2004, 2007; Bennett, Adam, Zarowsky, Tangcharoensathien, Ranson, Evans et al., 2008) The issue of defining the scope of HPSR problems, while important, is not addressed in the paper at present. As such, we feel that there is no obvious or appropriate place to introduce this literature into the paper.

The authors state "More succesful approaches for consdiering HPSR are typically interpretive and engage a range of stakeholders" (p12). However, the case has been made as to the possibility of quantifying performance shortfalls due to health system function...
limitations, such as health service financing, effective coverage and quality of care (Chapter 4, Strengthening Health Systems, the role and promise of HPSR, Geneva, Alliance HPSR, 2004).

The sentence quoted by the referee is actually from page 1 (the abstract) rather than page 12. Indeed the case has been made that it is possible, theoretically speaking, to quantify (in monetary terms) the burden of health systems problems. In the chapter referred to, the most relevant passage reads:

_The costs and relative severity of health system constraints (as opposed to the disease burden and its direct ramifications) could be estimated on the basis of specific equity and efficiency indicators. These could also include the disease burden that is not being redressed due to health system constraints. The results of such exercises could then point to the relative merits of investments in system-wide vis-à-vis disease-specific research._ (p. 43, Alliance for Health Policy and Systems Research, 2004)

But as far as we know, such a data-driven (versus expert-opinion-driven) quantitative approach to assessing health systems constraints has never been applied. In our paper, we have chosen to focus on priority setting approaches for which there exist real world examples.

_The fact that to date HPSR priority setting has been qualitative (as compared to disease-focused approaches) should not be interpreted as a matter of choice, but possibly one of limitations in the framing of health system problems. It would perhaps be more appropriate to discuss the extent to which interpretive approaches can/are based on hard data regarding health system performance as well as on policy/managerial judgement and bargaining._

We agree that it is important to highlight that interpretive processes can indeed incorporate "hard data", and have added the following sentence to the discussion paragraph which otherwise focuses on the importance of the composition of stakeholder groups:

_The outcome of an interpretive research priority setting exercise will depend also on whether data on health system performance (and constraints) is used as part of the process, and if so, how this is incorporated and weighted relative to the judgement of participants._

_The Alliance HPSR publication cited would also be an appropriate reference regarding a compilation of HPSR priority setting methods and approaches._

Agreed. We have now cited this as one example of comprehensive reviews of previous health research priority setting processes.

_It underscores the observation the authors make regarding the design of priority setting methods according to anticipation as to who will fund research (p. 14)._
We have added this citation at the beginning of the discussion paragraph on the importance of the "target audience", but without citing any particular passage from Chapter 4 of the book.

While it may be true that insufficient funding is determined by insufficient priority setting, it could also be due to insufficient human and institutional capacity, a fact in developing countries. It would be interesting to identify how HPSR priority setting could also address capacity strengthening as a balance between investments in direct research funding and in institutional and human development. This pertains to the breadth of topics considered, or is possibly a new dimension that could be suggested for future consideration.

We think that this is a very interesting point, and one that deserves further analysis. We were stimulated by this comment to consider the points presented and discussed in the final section of the paper, and ended up making a number of changes to the format and structure of this final section. As part of the restructuring we inserted one additional paragraph on the need for greater thought about the links between capacity development and priority setting as follows.

*Understanding the implications of HPSR capacity constraints for the identification of research priorities. The fact that few priority setting processes properly address health systems research is one reason why funding for the field has been relatively limited. However another factor undermining funding for HPSR, that could perhaps be better taken account of in priority setting processes, is the weak capacity to conceptualize, develop, and implement HPSR in low and middle income countries. Good analyses are needed of how limited research capacity shapes the nature of research priorities, and how HPSR priority setting could also address capacity strengthening so as to strike a balance between investments in direct research funding and in capacity development.*

We also hope that the restructuring of this final section has sharpened the messages, and in particular distinguished areas where we have clear guidance for how to move forward, versus those where we believe further analysis is required.

**Minor Essential Revisions**

*Some acronyms in both tables need spelling out.*

We have removed all acronyms from the tables.