Author’s response to reviews

Title: Funding Health Policy and Systems Research in Low- and Middle-Income Countries: how much, from where and to whom

Authors:

Karen Grépin (kgrepin@wlu.ca)

Crossley Pinkstaff (crossleypinkstaff@gmail.com)

Zubin Shroff (shroffz@who.int)

Abdul Ghaffar (ghaffara@who.int)

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Author’s response to reviews:

Reviewer #1:

This is a well-written paper that addresses a simple and straightforward research question about the changes in allocation of donor funding for health policy and systems research (HPSR). The methods are sound and replicable and the rationale is appropriate. The discussion raises the relevant issues from the results and the limitations show good reflection.

We thank the reviewer for these comments.

While the paper is fine to be published as such, I was curious to try and understand further some points that arise from the study.

We hope we have clarified your concerns below and thank the reviewer for raising these issues.

What percentage of health funding would be appropriate to be allocated for HPSR?

This is a good question but unfortunately there is no one correct answer to this question. However, we find that only a very small percentage (2%) of total health and population aid was dedicated to HPSR activities and did not appear to be increasing as a share of total aid. While we can’t answer this answer exactly, given that NIH spends 70x as much on health research in a given year, we feel this amount is too small, but agree with the reviewer that this is a subjective
assessment. As such, we have modified the language in the conclusion to be less normative, it now reads: “Donors should considering increasing the proportion of funds they allocate to support HPSR activities in order to further build the evidence base on how to build stronger health systems.” We hope the reviewer is happy with this modification.

Why did trends shift between 2000 - 2014? For example, did the Alliance have an impact and possibly the shift away from vertical-type health programmes to ones focused on strengthening health systems?

This is an interesting question. As we describe in our introduction, we believe there is a growing awareness of the importance of HPSR activities at the global level and the influence of the Alliance and other groups is likely to have had some impact. However, since this paper was not set up to investigate the reasons for why there were changing funding patterns for HPSR, we are reluctant to try to speculate too much in this paper on the reasons. Perhaps this would make for a good follow-on paper?

What type of advocacy would be appropriate to increase the proportion of HPSR funding allocated in donor funding?

Similar to our answer above, there is no right answer to this question. We have removed the sentence suggesting more advocacy efforts are needed to increase funding.

The writing style is very pleasant to read and shows careful attention to grammar, typography and formatting. I have listed a few small edits that should be corrected.

Abstract: Methods: Add 'Using...' at the start of the first sentence.

Fixed.

P2 line 47 - change '…into…' to '…in…'

I disagree with this edit. We believe into is the correct preposition in this case. It indicates movement into these types of activities.
P3 lines 19-20: 'Most recently, Adam et al. conducted a follow-up survey and found only modest growth in funding for HPSR in LMICs (12).’ Change 'a follow-up survey' to 'another follow-up survey' or 'a further follow-up survey'.

Fixed.

P3 last sentence before Methods: 'conclude' needs to have something added to it - e.g. 'conclude on the trends noted' or something similar. OR 'come to/make conclusions on…'

Fixed.

P4 lines 42-43: '…activities and those were related to research activities (see Appendix Table 3).'

Fixed.

P6: Line 30: 'Latin American' or 'Latin American countries'.

Fixed.

Table 2 - add a footnote indicating what the asterisk (*) means.

Apologies, the footnote seems to have been cut off in the version uploaded to the review system. It was in the original Excel table but seems to have been cut off in the uploaded PDF. It has been fixed.

Reviewer #2:

Overall the article is well written and structured.

Thank you.
Elucidating exact funding levels can be very difficult; especially for HPSR which is quite broad and could include funding that is "tagged" to other categories. But as the authors explain, determining funding patterns is important to highlight gaps, and to argue for more funding. Therefore the purpose of the paper is important and relevant, particularly to policy makers, but also practitioners who could act as advocates.

Thank you for this comment.

However, can there be more exploration of a "funding gap"? It is not clear if more money is needed and why. Given general funding shortages, why should HPSR receive funding over priorities? Stating the amount of funding provided to HPSR and the trends over time does not automatically mean that more funding is needed.

This is a good point, and similar to a comment made by reviewer 1. We have changed the language to one that is less prescriptive in our recommendations: we feel that donors should consider increasing the funds it allocates to HPSR activities but do not conclude that more resources are needed. We hope this addresses the reviewer’s concerns.

In rows 9-23, the term "modest growth" has been used several times. This is quite a subjective term. It would be useful to more specifically explain what the authors mean by "modest".

The reviewer alerted us to a missing citation earlier in the introduction to Adam et al. The term “modest” comes directly from this paper. Rather than re-interpreting the term used by the authors in that paper, we believe it is good practice to use the terminology that is contained in the cited paper rather than to try to interpret these findings ourselves. However, with regards to the Bennett citation, they actually say “This situation has changed little over the past 5 years” so we have updated the text to say “found that funding for HPSR had not grown based on a survey of HPSR funding agencies”.

I agree that committed funds may be better for tracking priorities than disbursed funds, and for the majority of analysis this seems fine. However, in the current climate, some donors are no longer meeting their committed obligations. Therefore some discussion and brief exploration of the data relating to this might be helpful for examining any mismatch in committed vs disbursements, and how this might impact on total HPSR funding.
To our knowledge there has not been a formal investigation of commitments vs. disbursements of DAH in the literature (although it would make for a good paper!). We did, however, find some evidence of trends of DAH in the appendix to the IHME’s global health financing report. Overall disbursements rates are quite high for most health projects and most donors, including the top donors in our analysis. Based on a discussion with the author of this report, they found them to be well over 90% for all health projects and likely increasing over time, but not formally tested. We have added the following text to the manuscript and added a citation to this report: “Other research has shown that over the study time period, actual disbursements track well with commitments and disbursements rates for health projects has been quite high (18).”

The content analysis methodology is interesting and appears comprehensive. Obviously there are limitations to this design, but they appear to be highlighted and mitigated as much as feasible.

Thank you for this comment, it seems balanced.

The variability of multi-lateral funding is quite stark, and potentially concerning as it could undermine established research agendas. Perhaps this should be highlighted. Or is the variability largely due to the tracking of committed rather than disbursed funds? A little extra clarity here may be helpful.

Both bilateral and multilateral funds are tracked using commitments, which are by nature more variable than disbursements, so we do not believe this is an explanation to the reviewer’s concern. We believe the reviewer is referring to the relatively large increase in multilateral funding for HPSR around 2009/2010. This jump was due to a one-time increase in funding by bilateral donors, in particular to IBRD, in response to the financial crisis (and in particular in Latin American countries, which can be seen to some extent in figure 3). We already have in the text “In 2009, there was a large jump in funding from multilateral donors. This jump was due to increased aid from the IBRD in response to the economic crisis and then declined substantially (over 50%) until 2012 when it began to increase again.” We hope this further clarifies for the reviewer this one time increase in variability. Otherwise both bilateral and multilateral donors exhibit largely similar patterns of year-to-year variability in funding. We have also added a citation to an IHME research paper that also documented an increase in support from the IBRD during the financial crisis.

The discussion provides a clear summary but may benefit from some additional interpretation, especially around a "funding gap" as noted above. The comparison with NIH spends is helpful,
so providing more context like this will help readers appreciate the findings. I think there could also be elaboration of the point that HPSR is arguably needed to ensure capacity to absorb and leverage the products of other investments. Currently I am left wondering the implications of these findings and there is somewhat of a jump to the claim that more funding is needed.

As with the comments from reviewer 1, we have made our recommendations less prescriptive and instead have used the language “…donors should consider increasing the share of aid allocated to HPSR activities and there is a need to diversify the funding base for HPSR activities.”. We have also modified the conclusion to state “Continuing to grow the evidence base on how to build and sustain these health systems will continue to require sufficient and stable funds for HPSR.”

Reviewer #3:

It is an interesting article that attempts to estimate the funding commitments for health policy and systems research in low- and middle-income countries. The article is timely due to the lack of firm evidence. However, there are several points that need author's attention and clarification, and revision.

Major comments and points:

Abstract:

Do authors mean HPSR related activities in place of HPSR activities? From the introduction and methods sections, it is evident that the funding commitment analysed only partially covers HPSR activities, which are frequently only one of the components of larger multi-sector and multi-component projects. More comments on this issues below.

We agree with the reviewer on this nuanced point. What we are tracking are aid flows in support of HPSR related activities, including activities that are purely HPSR as well as a broader set of activities. We have modified the text so that we describe how our estimates should be
interpreted (‘..and should be interpreted as funding in support of HPSR related activities”) and have added “related activities” when we refer to our estimates of aid.

The introduction explains well the relevance of the paper, however, the specific aims and goals of the analysis are less clear. Additionally, are you actually focusing on funding of all HPSR-related activities (where HPSR activities are only a component of a larger project) or actually you are able to tease out the proportion of funding for HPSR activities and estimate it?

As we previously state, we cannot tease out specifically the amount of aid provided to pure HPSR activities. As a result, we have modified the text as described above to call this HPSR related activities and have clarified this in our description of our estimates.

The Abstract and the Introduction focus on HPSR activities, however, a reader might get confused after reading the Methods section and what exactly you are focusing on (see the comment above).

Hopefully our modifications described above have addressed this concern.

Also, it would be beneficial to define the scope of your focus more precisely and justify your selection of topics. For example, you focus on several codes in CRS classification, but omit others. One could wonder why you did not focus on 140 (Water and sanitation) as a relevant aspect highly relevant to HPSR activities, or 700 on Humanitarian aid, 930 on Refugees in donor countries. These comments can be addressed by specifying the limitations of your research or clearly explaining why you believe these codes are irrelevant. Also, it would be beneficial to elaborate a bit more on what is actually being included into CRS sector code 120, as those not familiar with the database will not have a good idea that it actually covers a big variety of health-related topics - basic and general health (such as medical education, services, Malaria/TB/infection disease control, and similar).

Our choice of sector codes was driven by a similar approach that has been widely used in the literature to define development assistance for health. We note this in our methods as follows “This approach, which has been used widely by others, allows us to capture all aid that has a primary intent to improve health and population outcomes.” We have added additional citations to papers that further describe this approach. We have also added the following sentence in our limitations: “We also limited ourselves to projects with CRS sector codes for health and
population, but it is possible that other projects not identified this way may also support HPSR activities.”

On page 4, line 3, ref 16 - is this a correct reference in the context of the sentence or is it a typo?

Yes, this citation was included as an example of a study that used this methodological approach. We have also added a citation to the Countdown group’s method, which is similar in its focus on health and population to define DAH.

You mention that you focus on commitments rather than disbursement and explain why you do so. Yet, one might wonder, is there a significant discrepancy between commitments (donor priorities) and actual spending. This could give some evidence for further discussion on whether HPSR activities are receiving even less funding than intended.

Please also see our response to the previous reviewer’s question on commitments vs. disbursements. As we describe previously, to our knowledge there has not been a formal investigation of commitments vs. disbursements of DAH in the literature. In an IHME report, we found some evidence on commitments vs. disbursements. Overall disbursement rates are quite high for most health projects and most donors, including the top donors in our analysis. Based on a discussion with the author of this report, they found them to be well over 90% for all health projects and likely increasing over time, but not formally tested. We have added the following text to the manuscript and added a citation to this report: “Other research has shown that over the study time period, actual disbursements track well with commitments and disbursement rates for health projects has been quite high (18).”

You mention that you used both CRS and data on core funding to the Alliance for HPSR activities. Did you have a chance to check whether some of the data on donors overlap?

We would not expect these two data sources to overlap since core funding to the Alliance would not qualify as official development assistance and thus be captured in the CRS.
The description of content analysis of HPSR related projects is somewhat confusing. First, it is not clear why you have chosen major recent publications published by the Alliance and not any other sources for your analysis, a justification could fix that.

This is a valid point. We have modified the description of our methods to now read: “Given that the Alliance has published extensively on the topic of HPSR, we used all flagship reports and manuals that were available in mid-2014 and available in English, French, or Spanish (see Appendix Table 2) and used these documents to generate a list of HPSR keywords using an online application to identify the most frequent words and word combinations (word combinations could have a maximum of three non-article words).”

Also, it would be beneficial to know the total number of publications/reports reviewed and excluded (as well as inclusion and exclusion criteria), the same applies to the number of projects reviewed. Perhaps, you could consider adapting and presenting something similar to a PRIMSA protocol flow. Just a suggestion.

We used all flagship reports published by the Alliance as well Alliance Manuals, Methods, and Guidance Materials available by mid-2014. We have updated the text accordingly above. We did not exclude any documents and do not believe a more sophisticated methodology is really warranted. We got very high convergence in words across the documents.

You mention that you create final keyword lists, which you split into HPHS activities and research activities. One could questions why you focus on anything else but research, integral part of your focus - HPSR esearch. Perhaps, rewording could explain why you had to split and create lists and what is the difference. It gets even more confusing, after you search using HPHS list and only then, within identified projects, you look for at least one of the Research related keywords. This is quite confusing and you might consider restructuring and rewording the description to make it easier to understand for external reader.

This is a valid point, we apologize for not be more clear on this explanation. In order to be classified as a HPSR project, the search algorithm required there to be both a keyword that identified the project to have a health policy or health system keyword AND a research keyword. It was not sufficient if a project had only one of components: only a health policy/health systems
keyword (e.g. a health system project that did not involve any research component) or just a research keyword (e.g. a clinical research project). We could have first searched for research keywords and then within it, searched for those that had health policy or health systems keywords; this part of the search was symmetric. We did it in the order described in order to also identify the subset of projects within health and population that were health policy or health systems specific, which we felt was itself an interesting indicator. We have modified the text as follows: “Using a python-based search algorithm, we then searched the project titles, short descriptions and long description for all of the projects in the CRS database that contained both a HPHS and a research keyword, which were categorized as HPSR projects. For the purposes of also identifying donor support of overall health policy and health systems activities, we also report on all projects that contained at least one HPHS keywords, regardless if it contained a research keyword as well.”

Your results and discussion label funding and commitments as HPSR activities in LMICs. This requires careful formulation and rewording. As you have stated earlier in the Introduction, such activities are only a part of the bigger projects. As per earlier comments, you can broader your research to HPSR-related overall projects, if it was not possible to tease out only the research directly related activities share. Otherwise, drawing conclusions could be very misleading and considerable overestimate the funding that goes to actual HSR activities, even given the assumption you specified earlier. Same applies to the abstract.

The manuscript has been modified throughout with the term “HPSR related activities” in order to address this concern.