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20 YEARS OF EXPERIENCE OF EUROPEAN COMMISSION SUPPORT

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A report to the European Commission by independent experts

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This report has been prepared under contract with independent external experts and paid from funds provided by the European Commission. Its findings are solely those of its authors and does not engage the European Commission

Directorate-General for Research
International Scientific Cooperation Policy

2004
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## Acknowledgements

The team would like to thank various people for their inputs to and support for this piece of work. Firstly, the external reference group comprising Drs Mary-Ann Lansang (Philippines), Delia Sanchez (Uruguay), Andrew Kitua (Tanzania) and Yogan Pillay (South Africa) have provided invaluable technical input to the report. Secondly, colleagues in all the institutions of the authors have provided informal support; particular thanks are given to Ana Paula Kallstrom (Karolinska Institute) and Tolib Mirzoev (Nuffield Institute) for their research assistance. Lastly, special thanks are due to Dr Anna Karaoglu and her staff in INCO-DEV for their support and openness during the process. As is usual, the authors however retain full responsibility for the content of the report.
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### Acronyms

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<th>Description</th>
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<tbody>
<tr>
<td>ACP</td>
<td>African, Caribbean and Pacific countries</td>
</tr>
<tr>
<td>AIDCO</td>
<td>European Aid Office (of EC)</td>
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<td>AHPSR</td>
<td>Alliance for Health Policy and Systems Research</td>
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<td>CAM</td>
<td>Combined Approach Matrix</td>
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<td>COHRED</td>
<td>Council on Health Research for Development</td>
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<tr>
<td>DC</td>
<td>Developing Country</td>
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<td>EC</td>
<td>European Commission</td>
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<td>ERA</td>
<td>European Research Area</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>FP</td>
<td>Framework Programme</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
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<td>GRIPP</td>
<td>Getting Research into Policy and Practice</td>
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<td>GTZ</td>
<td>German Technical Cooperation</td>
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<td>HSD</td>
<td>Health System Development</td>
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<td>HSR</td>
<td>Health System and Policy Research</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IHPP</td>
<td>International Health Policy Programme</td>
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<td>INCO-DEV</td>
<td>International Co-operation and Development</td>
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<td>INCO-DC</td>
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<td>MDG</td>
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<td>NIS</td>
<td>Newly Independent States</td>
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<td>RTD</td>
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<td>SWAp</td>
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<td>TDR</td>
<td>UNDP/World Bank/WHO Special Programme for Training in Tropical Diseases</td>
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<td>TRIPS</td>
<td>Trade-related aspects of intellectual property rights</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1 Executive Summary and Recommendations

Health systems

Health systems have been undergoing significant changes in recent years yet these changes are often not based on robust evidence.

A greater understanding of how health systems do, and do not, function is a fundamental prerequisite to improving health in developing countries. Policies to scale up add a further dimension to the need to understand health systems.

Global factors are increasingly influencing the functioning of the health sector and require policy attention.

Health systems research (HSR)

Health system research is a relatively new field of research which examines the interactions between functions, elements and actors in the health system. There have been a number of initiatives in recent years to strengthen HSR, yet there remain important challenges.

There is a need for increased levels of research funding for HSR.

Clear and transparent processes for identifying and prioritising health system issues for research are required.

An appropriate balance between applied and theoretical research and also between mainstream and risk-taking HSR is needed. Adequate provision for longer-term and conceptual and methodological research is also required. The relative youth and complexity of HSR suggests the need for continued attention to strengthening of its methods basis.

Greater research leadership and ownership by developing country institutions is needed. This requires investment in capacity-building activities.

Urgent attention is needed to find ways of addressing the Know-Do gap including seeking early interest in the research by policy-makers and identifying ways of sharing research findings appropriately through Getting Research into Policy and Practice (GRIPP).

European Union policies

Health systems in the European Union (EU) are based on values including solidarity and universal access to services, which provide a basis for EU external action on health.

European States are diverse and include a number sharing similar problems and health system characteristics with developing countries. Important insights in both directions can be gained especially from analysis of health policies, pharmaceutical policies, decentralisation and the impact of globalisation on health systems.

European Commission (EC) policies support international health systems research. However, specific support will be required to ensure that this is not compromised by narrowly oriented research needs and policy priorities addressing only specific problems.

The challenge facing EU policies in development and health is to ensure that priorities are not compromised on the basis of increasing focus on internal markets and policies on trade and security. This challenge of coherence and capacity warrants more, rather than less, emphasis on analytical skills and knowledge on health systems within the EU.
European Commission support to health systems research in developing countries

The EC has, over the 20 years of HSR support in INCO-DEV, made a significant contribution to funding HSR and building the capacity of institutions and individuals in both Europe and developing countries and has contributed to the creation of solid partnerships.

There are, however, areas in which such support could be made more effective through improved prioritisation and administrative procedures.

There is potential for further HSR learning and capacity development and transfer of existing knowledge through equitable North-South, South-South and South-North partnerships which should be further encouraged.

Capacities, both for research and for using research findings particularly in developing countries, need further strengthening requiring greater investment by the EC in this area.

Inevitable tensions between competing priorities for funding remain and this reflects a lack of a current clear prioritisation mechanism.

Further efforts are needed to promote Getting Research into Policy and Practice (GRIPP) in the INCO-DEV programme. This suggests the need for more understanding of the constraints and resultant strategies to overcome the Know-Do gap.

The Mexico summit provides an important opportunity for exploration of the general issues explored in this report and their interrelationships as part of a health system research system.

Recommendations

General recommendations

1. The research community and other key actors should engage more closely with funding agencies and policy-makers to convince them of the benefits of increased investment in HSR and capacity-building and help them to understand the context within which research institutions operate.

2. International agencies including the EC must urgently and significantly scale up their funding for HSR.

3. Support should be given by international agencies, including the EC, to the development and maintenance of Regional Health System Observatories to collect and disseminate regionally based evidence.

Recommendations to the EC

4. The EC should develop a more structured and open approach to prioritising health systems research calls involving both the research community and key southern stakeholders. This should include specific ring-fenced funding for methods development in HSR and support to conceptual and long-term research alongside support for medium-term research and capacity development.
The EC should continue to support capacity-building of institutions both through INCO-DEV and development funds in both the South and the North. This should include:

- A requirement that capacity-building is seen as a key component of every project
- Capacity-building support for policy-makers to use and interpret research findings.

5. The EC should, in INCO-DEV, give greater emphasis to GRIPP, through:

- commissioning work to understand better the process, by sharing experiences in this field, or by requiring specific attention to it in project design
- enhancing the capacity of policy-makers to use research findings
- widening the current criterion of ‘dissemination’ to ‘GRIPP’
- fostering national partnerships involving researchers, practitioners and policy makers as it has fostered international research partnerships
- involvement of key parties in the identification of research topics and in the development of the research
- greater attention and investment in dissemination methods
- links to development resources to implement findings

6. The EC should build on the values of universal access and solidarity in European health systems through:

- encouraging comparative study (North-South, South-South and South-North directions) of health systems based on similar values
- explicit extension of these values to the global stage through increased support for developing country health systems

7. The EC must seek ways of strengthening collaboration between INCO-DEV and AIDCO to ensure cost-effective use of research data and GRIPP in the EC context. Both Directorates need to strengthen their analytical capacity and develop linkages which will also serve as an example of good practice for national health systems.

8. The EC INCO-DEV needs to find ways for optimal coordination with other key actors at the global and national levels. The Mexico summit meeting is a platform for strengthening that, capitalising on the presence of high level policy-makers enabling instant feedback and recommendations.

9. The EC should use a variety of instruments to support HSR, some allowing for long-term funding of larger endeavours, but others more appropriate for exploratory, innovative or more reactive research, which may thrive better in smaller projects, with shorter time-frames and with simplified approval mechanisms.

10. The EC should simplify its application (including web pages) and project management and reporting procedures, making them more transparent and streamlined, and strengthening its support to, and training for, administrative coordinators. It should develop further its electronic database as a means of monitoring research projects.

11. The EC should, in the interest of fostering equitable participation, encourage the submission of more proposals from co-ordinators in Southern institutions and should consider improving the instruments to create national networks through platforms and the possibility of granting ‘seed money’ to allow prospective research partners to meet to compile a full proposal.
12. The EC should give greater encouragement to the use by researchers of pre-proposal checks and feedback on outline proposals.

13. The EC should support a regular forum of EC funded researchers, policy-makers and practitioners to share ideas, methodologies, and research priority concerns and to provide a means of dialogue with the EC on issues related to project management. Other forms of information sharing such as web-sites could also be considered.

2 Background to the report

This document is a summary of a more extensive report commissioned by the EC Research Directorate into the experiences of its research programme on health systems in developing countries over the last 20 years. The EC has, in recent years, put significant effort into supporting research into health system questions. It has recognized however that greater efforts are needed to identify the appropriate knowledge gaps on health systems, and find answers to these in ways that will be implemented. The EC has also developed a particular way of funding research which, for example, lays stress on collaboration in research endeavour between Northern and Southern partners. The report should be seen as a case-study of one international agency’s response to the need for HSR which has wider lessons for other such agencies.

The report was commissioned in recognition of the key role that health systems play in promoting health objectives. It is expected that the report will serve two complementary purposes. Firstly the EC itself will use the results in considering improvements to its future INCO-DEV research programmes.

Secondly the report will provide an input to the 2004 Mexico summit allowing ministers to learn from the successes and failures of one particular approach as they seek means of strengthening the health systems research processes. It is one of a number of activities within this area at this time such as the Independent Task Force convened by WHO and the Activities of the Alliance for Health Policy and Systems Research including a recent evaluation.

The full report has drawn on a number of sources. These include secondary data, which included a review of final reports related to a sample of specific projects, and a limited number of interviews with key informants as well as a literature review. An important part of the process has included peer review and validation by a separate reference group who joined the team for a workshop in Brussels as part of the drafting process.

Within the report, the term Health System Research is used to include Policy-focused research, and the acronym HSR to cover the wide inclusive interpretation.

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1 The full report is obtainable from Dr Anna Karaoglou, (anna.karaoglou@cec.eu.int), European Commission – DG Research, International Scientific Cooperation, SDME 1/17 B-1049 Brussels, Belgium

2 The full report also contains the full references referred to in this summary.
Health systems throughout the world are facing an increasingly urgent set of challenges. Gross inequities in health at the global (and frequently national) level – illustrated for example by the fact that the lifetime risk of maternal death is over 100 times greater in Africa than in high income regions of the world - are being exacerbated. For many countries health systems are failing to deliver improvements in health. Whilst this is particularly the case in sub-Saharan countries where AIDS, coupled with the other major killers of malaria and TB, are having devastating effects, these failures to achieve health improvements can be found in vulnerable populations throughout the world where such vulnerability is caused by a combination of social, economic and political factors. The particular socio-economic and other contextual differences of countries lead to different patterns of ill-health and the need for different health system responses. Despite goals that range from the Health for All by 2000 objectives of the Primary Health Care movement through the International Conference on Population and Development (ICPD) charter to the most recent Millennium Development Goals (MDGs), there remains a widespread sense of health system failure.

Clearly if there is to be a serious attempt to meet the MDGs, the performance of the health system must be improved, and as a matter of urgency. This is particularly the case if health systems are to act effectively as a platform for scaling up efforts such as WHO’s 3 x 5 initiative.

Yet for this to occur, the critical question of how must be answered. The last 15 years has witnessed an unprecedented set of serious attempts to re-engineer the health systems of many countries both low and high income. Against the background of wider structural adjustment policies which sought to reduce the role of the public sector in developing countries, the World Bank led a set of health sector reform policies in the 90s which were rooted in neo-liberal market based policies. In particular the public sector reforms included a changing role in the public sector from service provision to policy direction and regulation and greater reliance on the provision of health services by the private sector which was perceived as more efficient. Linked to this was the concept of the purchaser-provider split and the introduction of public sector quasi-markets as part of general “marketization” of the health sector. Inefficiencies were also seen to result from over-centralisation. As such, reforms included attempts to decentralise decision-making to district levels and semi-autonomy for (particularly tertiary) hospitals and movement from vertical programs towards more integrated approaches. Reforms also frequently included the introduction of new health financing methods and in particular user fees and more recently, social insurance. The financing crisis put new emphasis on the need for priority setting and new forms of resource allocation, and reforms often included essential health packages and new processes of priority-setting based on cost-effectiveness techniques.

Health reform initiatives focused on introducing structural and financing changes in health systems. This focus led to the neglect of a number of issues. In particular reforms have been criticised for placing insufficient emphasis on staff issues, demand-side issues such as community involvement and needs assessment, and ignoring the overall low levels of available resources as the major constraint facing such health systems. The latter was highlighted by the Commission on Macroeconomics and Health report which suggests that the funding gaps are so large as to require significant international financing (potentially through new mechanisms such as SWAps). The reforms were also criticised for a focus on health services rather than the broader objectives of health, thus neglecting the potential for inter-sectoral health promoting activities.

The manner in which reforms were introduced was also criticised as being top-down, internationally imposed and, most importantly in the context of this report, evidence-poor.
The above does, however, suggest that the last 15 years has witnessed increasing interest in health systems and their internal workings. This has been shown in both greater conceptual thinking about health systems (such as evidenced by the WHO framework which is elaborated on in Figure 1), and recognition of the importance of understanding the challenges they face and the opportunities they provide to improving health. It has also seen controversial attempts to measure and indeed compare the performance of health systems.

Figure 1: Function/action-based view on health system
Source: based on Murray and Frenk, 2000
This period has also seen an unprecedented rise in global influences on health. These range from global political and economic initiatives to those that are more health specific. The implications of some of these are still to emerge clearly. However within the health sector, growth of Public Private Partnerships (such as GAVI – the Global Alliance for Vaccines and Immunisation and the more recent Global Fund for AIDS, Malaria and TB) are seen by some analysts as major new forces. Whilst set up as mechanisms for tapping funding, they are also viewed in some quarters as the birth of a new form of international verticalisation, and criticised for diverting resources away from the broader health system which is seen as a necessary platform from which to scale up responses to these major diseases. Who for example, given the human resource crisis in Sub-Saharan health systems, will be available to scale up access to ARV treatment? Their governance and accountability back to national health systems is also questioned raising issues as to where policy power now lies.

The health system changes described above were, however, often based on, at best poor evidence of what works, and at worst, crude ideology. Despite calls for greater evidence-based decision-making, led by agencies such as WHO, the reality is that there are huge gaps in our understanding of how health systems operate, and what policies could feasibly be deployed to improve them. In particular at present there are no international mechanisms for sharing experiences between countries or regions. There remains a significant imbalance in the level of research effort between the search for technical answers (such as new drug developments) compared to system answers (such as how successfully to deliver proven therapies). A classic example of this lies in TB, the cause of 2 million deaths per year, where there is significant knowledge of the clinical requirements for TB detection and treatment, but far less understanding of the constraints to ensuring appropriate access and utilization of these therapies. Furthermore, even where there are robust answers to health system questions, these may often be ignored by health policy makers, leading to the infamous ‘Know – Do’ gap.

Greater globalisation is also bringing new challenges to national health systems including trade-related agreements and trade in health services, intellectual property rights and migration of professionals. Globalisation is based on political processes with a need for change in global governance and economic and trade policies. In the context of trade policies special attention needs to be drawn to multilateral and bilateral agreements concerning trade in services and intellectual property rights. Globalisation brings opportunities, but these are not without costs including over equity and universal provision of services. There is a need for further attention to international collaboration and regulatory measures including those related to human resources.

In order to support national health systems a new focus on global regulatory measures, standard setting as well as evaluation of new technologies and products for the benefit of health systems and national health policies will be required.

4 Health systems research

The above has suggested that there is increasing recognition of the importance of strengthening health systems and hence a critical need for greater understanding of how they operate and the challenges they face. Health systems research (HSR) has improved our understanding of who uses health services and why, challenged medical claims about the value of specific interventions, helped shift the balance from practitioners’ to patients’ concerns, identified ways of improving the financing, organisation and management of services, improved our understanding of the impact of new technology and contributed to improve the performance of services. However to improve the performance of health systems in low and middle-income countries it is necessary to scale up the efforts in research at every level, including local, national and international in different areas such as
financial and human resources, organisation and delivery of health services, governance, stewardship and knowledge management.

Whilst there are a number of definitions we define Health Systems Research (HSR) as: ‘the production of new knowledge and applications to improve how societies organize themselves to achieve health goals, including how they plan, manage and finance activities to improve health, as well as the roles, perspectives and interests of different actors in this effort’ (AHPSR 20000)

Figure 2 sets out graphically the characteristics of HSR.

Despite its critical importance, health systems research is relatively new with its origins as a separate area of investigation distinct from the more well-known area of clinical and laboratory research being only 20 – 30 years ago. The youth of the discipline brings inevitable challenges, particularly where it is contrasted, and indeed competing, with the more established biomedical research approaches.

Such challenges are firstly methodological. Whilst there have been significant strides in methodological development over the last 25 years, challenges remain. The nature of the questions investigated in health systems research requires contributions from many disciplines including, for example, economics, sociology, anthropology, epidemiology, operational research, and political science, and the use of both qualitative and quantitative research methods. How such disciplines can be combined in a genuinely multidisciplinary way poses new methodological challenges. The appropriate balance between disciplinary specialism and broader multi-disciplinarity is also difficult to gauge and achieve. Furthermore, breaking new methodological ground poses risks to researchers which funding agencies need to recognise and be prepared to accept.

Related to the above, is the importance of context in health system research. Each health system is unique in terms of the range and combination of factors affecting it. This raises
issues in terms of how to interpret HSR and in particular its generalisability versus its context-specificity.

Furthermore, many HSR questions require significant time periods to answer. Changes in health systems can be slow and not identifiable within the short time frame available to many research projects, or acceptable to funding agencies. Health system research needs to find an appropriate and acceptable balance between short-term and long-term research.

There are also ethical issues in health systems research. Each research domain has its own ethical challenges – with those of biomedical and laboratory research being well-known. Health system research faces a number of challenges including those of confidentiality, treatment of values (such as equity), and approaches to socially sensitive areas such as corruption. It also raises questions as to the use and ownership of findings (for example between communities and researchers) and the need for greater participation by the subjects of the research in the actual conduct of research. Underpinning these concerns is the recognition that HSR deals with issues that relate to relative power between different actors within the health system.

The complexity and ever-changing nature of the health system means that there are, and always will be, a myriad of questions which HSR can usefully attempt to answer. There have been various attempts to identify such topics (such as by the Alliance and in the Lancet). Box 1 sets out a number of examples of topics that we would suggest are currently under-researched. However such list is personal and has no claim to basis in a scientific methodology. Rather, it is an illustrative list. It does raise however two further challenges for HSR.

Box 1: Examples of neglected or emerging HSR topics

| Importance of the Health System to MDGs |
| Prevention and role of the health care sector in cross-sectoral promotion |
| a. Role of public policy measures in prevention and promotion of health; |
| b. Effectiveness of different incentive leverages in promoting cross-sectoral collaboration. |
| Community/Demand side/Civil society |
| a. User involvement in health care; |
| b. Community and citizen views; |
| c. Gender issues in health and health care. |
| Governance in the health system |
| a. Mechanisms and systems; |
| b. Corruption; |
| c. Regulatory measures in health systems; |
| Global aid and trade policies and health systems |
| Globalisations including the need for regulation and pressures of commercialisation in health care. |
| Non-financial incentives in health systems. |
| Scaling up. |
| Integration of essential vertical programme into health system. |
| Human resources issues including international migration |
| Accreditation. |
| Private sector |
| How to make effective links between Evidence, policies and practice. |

Firstly, it is clear, and has been acknowledged in a number of quarters, that insufficient resources are put into HSR. Whilst funding levels have increased significantly in recent years, not least in agencies such as the EC, HSR is still the poor cousin when compared to biomedical research. In the recent publication from The Alliance for Health Policy and Systems Research (2004) *Strengthening health systems: the role and promise of policy and systems research*, it is estimated for example, that 0.02% of total health expenditure is allocated to health systems research. Yet many of the challenges facing developing country health systems are system-based rather than biomedical. For many health problems, technical solutions exist, but are not
(effectively) applied through weaknesses in the health system.

Related to the above are concerns as to the availability of research capacity. Research institutions face particular pressures. For example within Europe core support to research institutes is declining and there are pressures on researchers which may conflict with their mainstream research work. In many developing countries there is currently very little HSR capacity. Building research capacity may not always be viewed as high priority by health policy-makers either at the national or international level and yet, without such capacity, HSR of an appropriate quality is impossible to achieve.

Secondly, it is also clear that, even if budgets for HSR doubled tomorrow, there would still be a massive shortfall between research questions and available research funding to answer such questions. This raises questions as to how priorities are, and should be, set, and in particular by whom, and using which criteria. HSR needs transparent priority-setting mechanisms at the relevant levels. It remains to be shown whether the Combined Approach Matrix (CAM) model is adaptable to fit this purpose for HSR or if other models should be developed.

The above issues are well-known to the health system researcher. However less well-recognised is the gap between health system research and resultant evidence-based action. The Know-Do gap is still wide and both health system researchers and policy-makers need to pay more attention to how it can be bridged. The gap appears both at national and international levels. Indeed within the EC itself there is little interaction between the directorates responsible for developing knowledge and for applying it.

Strategies such as giving greater emphasis to HSR commissioned by policy-makers appear attractive as means of increasing ownership of the resultant findings, but raise questions as to the need for a balance between research topics identified by other including researchers themselves who may have fewer pressures to take a short-term policy view. Other strategies relate to the mechanisms for dissemination of results with less focus on traditional academic dissemination means and more on those likely to be accessible by policy-makers and users of services.

5 The European Union, and Health Systems and Development Policies

The division of European Community health policies between public health policies and health services has meant that health systems issues as a whole have not been the subject of EU policies. There has not been substantial accumulation of expertise and knowledge on health systems. The unclear mandate has also led to fragmented approaches between two Directorate Generals: Health and Consumer Affairs and Social Affairs and Employment. European health policies have become increasingly influenced by decisions and processes outside the health sector. European Court of Justice decisions, the quest for competitiveness of the European economy, industrial policies and protection of interests of European industry and the developments of internal markets have all set the context for health services, pharmaceutical policies and public health policies, leading to consideration of health systems increasingly as part of the economic and commercial interests.

The EU involvement in research and development intersects EU health policies at various levels. The commitment to ensure a high level of health protection in all policies is of relevance to research and development efforts. Furthermore the EU has also been actively supporting research efforts concerning health services.

Policies in other sectors may impose substantial cost implications to health systems. The aim of ensuring consideration of health in other policies has been a challenge for the EU and also is important in development policies.

EU development aid is substantial and in the field of health carries weight. Therefore it is
particularly important that the EC ensures a strong and analytically based set of health development policies which includes support to health systems research.

Various European health systems (and in particular those based on Beveridge and Bismarck principles) embody key values and approaches to health systems development, such as solidarity and equity of access to health services. The lack of sufficient analytical capacity within the EC to underpin development strategies carries the danger of the adoption of policies that are not consonant with these values.

INCO-DEV research on health systems fits and supports the core development policy efforts on poverty and health as well as the overall research policy priorities. However there is also a risk that more targeted measures with respect to poverty-related diseases, HIV/AIDS and research and development in pharmaceuticals may restrict EU support to health systems development into vertical programmes and specific diseases.

The international role of the EU is changing. In future the European Commission may play a greater role in representing member states in international organisations such as WHO. The new strategic partnership with WHO strengthens their relationship. This highlights the importance research within the EU on health systems and health policy to ensure that European positions are empowered with knowledge, analytical capacity and a genuine European approach based on dialogue, research and analysis and are grounded in European academic and institutional networks and collaboration with developing countries.

However, there needs to be an improvement in transfer of knowledge on research and programming between the EC directorates. In particular, it is unclear to what extent INCO-DEV links and resources have been used, and recognised, in the European Community aid policies.

International exchange is of crucial importance in the context of health sector reform. While it is necessary to view European solidarity as part of broader European values, it is also important to recognise the potential for mutual learning and exchange in the context of health policies. In terms of the INCO-DEV work this suggests more dialogue and exchange between health managers and researchers involved in research within Europe and developing countries in a context of comparative studies and analysis.

Finally, globalisation and increasing economic integration create new challenges to health systems in Europe and the developing world. There is a need and opportunity to further expand and exchange analysis of health policy priorities and regulatory matters to ensure universal access, cost-containment and solidarity in health systems. This is important both to articulate concerns about common trade and intellectual property rights in the sphere of health policies, and to minimise human resource shortages in developing countries. Research and understanding of health policies in this area needs to be expanded within the EU. This raises a challenge both in the context of European external and aid policies and it is important to ensure policy coherence is not sought predominantly on the basis of trade interests.

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3 Within this report this term is used generically to cover STD1-3/INCO-DC
6 EC support to Health Systems Research and Capacity-Building

The EC has been a key funder of HSR over the last 20 years. This review of these experiences may help both the EC and other agencies to address the above challenges for Health System Development (HSD) and HSR.

Programme overview

Research co-operation on health with developing countries has been part of the EC’s overall research agenda under its regular research budget since 1983 and continues to be one of the main priority areas with co-operation programmes in ACP, Asian and Latin American countries, and Mediterranean Partner countries, Western Balkans, Russia and the other NIS. The EC’s scientific co-operation for development has gone through a number of phases as set out in Table 1. While RTD for collaboration with Developing Countries is only a small fraction (around 0.01 - 0.017%) of the total Framework Programme research budget it has benefited from the overall increasing research budget (42M€ to 153M€ between 1983/86 to 2003/2006). The total health research budget within this framework increased from €10.5m in 1983/86 to €62m in 1998/2002 and remained at 25-30% with a peak of 35% in 1991/1994. The budget for HSR, as far as data is available for FP4 and 5 is around 30% with 70% for Biomedical Research.

Table 1: Framework Programme 1 – 6 Budget and RTD Budget for Health and HSR

<table>
<thead>
<tr>
<th>FRAMEWORK PROGRAMME</th>
<th>Research and technology for Development</th>
<th>Total budget €m</th>
<th>Health budget €m (% of total) RTD</th>
<th>No. HSR contracts</th>
<th>No. HSR contracts</th>
<th>HSR budget €m (% of health)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 1984 – 87</td>
<td>STD 1</td>
<td>42</td>
<td>10.5 (25%)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>2 1987 – 91</td>
<td>STD 2</td>
<td>85</td>
<td>25.5 (30%)</td>
<td>154</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>3 1991 – 94</td>
<td>STD 3</td>
<td>125</td>
<td>43.7 (35%)</td>
<td>140</td>
<td>26</td>
<td>n.a.</td>
</tr>
<tr>
<td>4 1994 – 98</td>
<td>INCO-DC</td>
<td>209</td>
<td>62.9 (30%)</td>
<td>154</td>
<td>n.a.</td>
<td>19.6 (31.2%)</td>
</tr>
<tr>
<td>5 1998 – 02</td>
<td>INCO-DEV</td>
<td>230</td>
<td>62.0 (27%)</td>
<td>63</td>
<td>26</td>
<td>17.9 (28.9%)</td>
</tr>
<tr>
<td>6 2002 – 06</td>
<td>INCO-DEV</td>
<td>153</td>
<td>50.0³ (33%)</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

Figure 3 shows the evolution of the international cooperation research budget and the health component over this period and the allocation for funding for health research between developing countries and the EU.

4 In FP6 specific INCO activities involve all regions (DEV, Mediterranean Partner Countries, Western Balkans, Russia and the other NIS); the total budget for all regions is 325 M€.
5 This figure is approximate and excludes funding for research into the three diseases (TB, Malaria, HIV/AIDS) which from 2002 is funded separately. In FP5 in INCO this was at a level of approximately a further 15M€.
These programmes show an interesting shift in approach by the EC. Initially they focused on bilateral activities between the EU and recipient countries, then on specific programmes in the Framework Programme structure. Within FP5 a new strategic objective of policy issues was introduced. In December 2002 the EC launched the first calls for the 6th Framework Programme with a different structure and philosophy.

The innovation is the creation of a European Research Area (ERA) for better co-ordination amongst European Institutes and open to the world. Developing countries are now able to access funding in all European Programmes such as studies of European health systems.
In FP6 it was decided through bi-regional dialogues to launch Platforms on health (and other areas) with the Specific Support Actions instrument with EU and partners from other continents to help consolidate regional education and research capacities, to innovate technologies and implement, wherever required, better standardisation in health technologies and methodologies. These EC-bi-regional dialogues aim to establish priority areas to solve problems specific to those regions. A Platform is a forum of equal partnerships in Research and Development, where common issues are identified, solutions formulated and new research proposals formulated.

The development of the EC research programme demonstrates some of the challenges facing any research funding agency and are outlined below.

Firstly, any research programme needs to have a clear purpose and objectives. For the EC there are the key principles on which their funding programme are based:
- **Thematic approach to all Developing Countries (DCs)**
- **Partnership based on Europe-DC dialogue; and**
- **Regional differentiation among DCs.**

At a broad level research under this programme is intended to meet the needs of Developing Countries with a clear link into the development of relevant policy. However there are other key objectives. These include increasing emphasis on the need for research projects to support the research infrastructure in developing countries through capacity-building activities with adequate participation and involvement of such countries in the programme. However there are some inbuilt tensions in the objectives. Firstly their key objective of supporting developing country health systems may sit uneasily with the overall Framework objectives to strengthen the scientific and technological basis of the EC to make it more competitive. Furthermore, the programme was initially (and to some degree still is) viewed by some European Tropical Medicine Institutions as having a key role in providing support for them. Indeed given the increasing pressure on such institutions to generate funds this remains a tension in terms of objectives.

Secondly the programme has contributed to getting HSR on the map through the EC role as an institution that explicitly funded research into health systems and health policy. Linked to the above has been a role for the INCO-DEV research programme in supporting the development of the role, concept, definition and methodology for HSR both through project support and through, for example, support to meetings.

The EC research programme has also explored different mechanisms for funding research projects including both ‘regular’ research projects and mechanisms to develop networks of researchers already working in a particular field. **Box 2** provides an overview of these.
Box 2: Some instruments used in support to HSR in developing countries


<table>
<thead>
<tr>
<th>Instrument</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination action</td>
<td>These are actions (concerted and thematic networks) where research is ongoing elsewhere and researchers get together for concertation or thematic networks where they are ready to involve all stakeholders to implement research results</td>
</tr>
<tr>
<td>Shared Cost/STREP</td>
<td>These are research projects into new areas of investigation. STREP (Specific Targeted Research Projects) replaced Shared Costs projects in FP6.</td>
</tr>
<tr>
<td>SSA</td>
<td>Specific Support Actions for wide dissemination of results, for identification of new research areas and policy implementations</td>
</tr>
</tbody>
</table>

It is also important to recognise that the INCO-DEV programme has faced difficulties, most recently in 2002 when its individual nature was under threat, with proposals to absorb it into the wider EC research programmes\(^6\). Whilst, lobbying by research institutions contributed to the reversal of this decision, it is clear that complacency over the sustainability of the programme may be misplaced. However in FP6 INCO is a Directorate and in FP7 its specificity should be ensured together with the opening of International Cooperation to all EU programmes.

Analysis of EC sponsored HSR projects

The review analysed completed projects funded in FP4 and FP5 using reports as the primary source of data. There are limitations to the methodology used which are discussed in the report but the general conclusions are considered as valid. Boxes 3 and 4 provide case-studies of EC funded support to HSR in Thailand and Burkina Faso.

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\(^6\) Kroeger A, Falkenberg T, Tomson G et al 2002
Box 3: Success story of Thailand HSR and EU contributions

Source: Personal Communication Nitayarumphong S 2004

Thailand was supported to develop a model of integrated healthcare in one province through HSR from EU fund before and after INCO-DEV up till 1996.

The development of a provincial healthcare model attracted demand from other provinces to follow the same development, at the same time other ongoing health care development in the country also need innovative approach to be pushed to go further. This urged to develop a national project covered the development of integrated healthcare in five other provinces and later in nine provinces.

The support of EC fund was shifted to DGI development fund started from 1996 to 2000 with the intention to develop a package of policy and plan for overall healthcare reform in the country. The outcome of DGI-supported fund did not only end with the outcome of a package of health policy and plan for reform, but also a model of appropriate healthcare in various provinces and a draft legislation on universal coverage for healthcare for all Thai citizen.

These products were adopted by the newly elected government in January 2001 especially the implementation of universal coverage. Lessons drawn from out were that EU had contributed a certain level of technical assistance from the research project to national program in Thailand and process of learning through interaction between Thai and EU researchers including networking with other countries did bring the increase of capacity of human resources to implement the Thai healthcare reform more effectively. In addition, more integration among EU different departments from knowledge to actions could generate a real impact for changes to happen in healthcare development.

Burkina Faso Case-study
Box 3: Burkina Faso Case-study

Source: Personal Communication Diesfeld, HJ 2004

The development of the Programme for Science and Technology for Development by the EC in 1984 provided the opportunity for collaboration between Heidelberg University, the MoH and the Department of Public Health, Faculty of Health Sciences University of Ouagadougou. Research was designed to measure the quality, effectiveness and utilization of preventive and curative health services at the district and community level and accepted by the MoH and the EC.

The Ministry of Health seconded a national researcher, the Faculty of Health encouraged 3 medical students to act as junior researchers and Heidelberg seconded a Principal Investigator, responsible. DED and GTZ provided technical assistance and transport. Field research was completed by 1985 and data analysed in a participatory evaluation with the health services in 1986. In December 1986, the medical students defended their theses successfully - the first time that medical students did their thesis work “in the field” of basic health care up-country rather than the protected area of the University Hospital. In the course of this event a “Partnership” between the Faculty of Health Sciences Ouagadougou and the Medical Faculty of Heidelberg was officially inaugurated.

As a consequence of the evaluation the Ministry of Health planned a further project for action research which was again submitted to, and approved by, the European Commission in 1990 under the title “Action research on the utilization of health services in Burkina Faso” with the Ministry of Health providing the Principal Investigator. The study, based in Nouna, aimed to assess the output and outcome of newly organized rural health services. The major policy changes to be tested were: participation of the target population in financing and management of health services enhancement of service quality through standardization of medical tasks increased attraction by better integration of services, introduction of a delivery system of essential generic drug, strengthening of mother’s skills in treating key childhood illnesses.

The study population comprised all 6000 households in Nouna hospital catchment and 3 health centres - around 30,000 individuals. Health impact was monitored through changes in age and cause-specific mortality using censuses and vital events registration and verbal autopsy of all child deaths. A sub-sample of 600 households was studied by periodic household surveys which yielded information on changes in health service utilization, health care expenditure and time lost due to illness.

This Demographic Surveillance System (DSS) still exists and enabled the MoH to become part of the INDEPTH network (International Network of Demographic Evaluation of Populations and Their Health) in 1997. The new research programme studied different topics. Several new research assistants were engaged at the expanding research station in Nouna. The MoH provided a building complex within the Nouna District Hospital, a former epidemiological field station. Field investigators, interviewers and data entry clerks were recruited and trained. Research aiming at improving child health, equity and efficiency implications of prepaid schemes and health insurance were undertaken.

The iterative process between MoH and Nouna Research Station and the growing number of completed research projects led to increasing acceptance of this kind of scientific cooperation by the MoH. This and efforts to seek further funds alongside favourable developments in the acceptance of HSR, internationally, within the University of Heidelberg and within the German scientific and research sponsoring community as well as the Federal State of Baden Württemberg, paved the way towards establishment by the Burkina Faso Government of a ‘Centre de Recherche en Santé de Nouna’ in 1999 as a national reference centre, in line with EC policy to develop research partnerships and structures for strengthening European and African research capacity.
Focus of research projects

Each EC call specifies broad domains, such as ‘rational organisation of health services’ or ‘policies for improved practices’ resulting in a variety of project proposals being submitted and approved. These are reflected in the titles of the projects funded in FP4 and FP5 (examples are given in the report), and in the classification of the 43 projects reviewed, according to a typology in 9 categories (see Table 2).

Table 2: Typology of the 43 research projects reviewed

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determinants of health</td>
<td>1</td>
</tr>
<tr>
<td>Implications of specific health issues</td>
<td>2</td>
</tr>
<tr>
<td>Impacts of intervention</td>
<td>8</td>
</tr>
<tr>
<td>Health sector reforms</td>
<td>10</td>
</tr>
<tr>
<td>Quality of care and of services</td>
<td>8</td>
</tr>
<tr>
<td>Inputs in health systems (human resources, drugs, and others)</td>
<td>7</td>
</tr>
<tr>
<td>Research methods</td>
<td>1</td>
</tr>
<tr>
<td>Citizen perspective and user involvement</td>
<td>3</td>
</tr>
<tr>
<td>Health policy</td>
<td>3</td>
</tr>
</tbody>
</table>

There are currently 36 ongoing projects from FP5 and new ones from FP6 in a variety of HSR areas.

The opportunity to choose research topics within a broad arena is valued by researchers, who consider they can apply for funding for research they prioritised themselves. However, the requirement of working out detailed plans including deliverables at the stage of submission is also seen to limit the freedom of research. Some of those interviewed also think that this ‘academic freedom’ is one of the reasons for the lack of synergy between the EC ‘research for development’ programme and the EC’s national and regional development cooperation programmes.

The EC is aware of this challenge, and has sought to improve the ‘relevance for development’ of its health research, especially HSR. Various tracks are being pursued such as promoting the involvement of practitioners, policy-makers and other stakeholders, as research partners and the review by regional panels of research proposals which have passed through scientific review to judge on relevance and relative priorities. However the information on the criteria and processes used by these panels are not always clearly disseminated.

Concerns have been expressed about these mechanisms, and suggestions made that the EC should develop procedures, involving a mix of different stakeholders from the South and the North, for selection of domains of research, and of more specific topics for the calls on which to invite more focused research bids. Such a process might be part of an annual meeting of such stakeholders organised by the EC.

Partners and Partnerships

One of the prominent features of the EC research programme is its cooperative nature, both among European countries, and between European and Southern partners. The creation of a research partnership is seen as both an end in itself and a means to achieve the research end. As such it is an absolute pre-condition imposed by the EC for accessing project funding. Initially a minimum of one European and one Southern partner was required (1:1), but this evolved to a 2:2, and then 3:3 minimum, partly triggered by the requirements of the wider RTD programme.
The increased number of partners (see Figure 5 also led to increased budgets per project. In the 1990s a typical HSR project had a budget of €400 - 800,000 for 3 or 4 years. Many new projects however now have budgets of €1,500 - 2,000,000 for a similar duration. The current trend is towards encouraging larger projects and partnerships. However it is considered that a variety of instruments is desirable, some allowing for long-term funding of such larger endeavours, but others more appropriate for exploratory, innovative or more reactive research, which may thrive better in smaller projects, with shorter time-frames and with simplified approval mechanisms.

Among the 43 projects reviewed, there was a even split between those with between 4 research partners - the minimum required in FP4 and FP5, 5 - 7 and 8 - 12 partners (see Figure 5). Most partnerships have similar numbers of partners in the North and the South, resulting in roughly half of total partners from the North, and half from the South.

Figure 5: Number of partners per project in 43 HSR projects reviewed

Geographical representation

Figure 6 provides information on the source of partners by region. Northern partners are always European, and Southern partners within one project are usually from the same region. Among Southern partners, slightly over half are ACP countries followed by, in decreasing order, Latin America, Asian and Mediterranean.

It is understood that there has, in recent years, been an increase in Asian partners7 (This geographical spread of partners in HSR projects is very similar to the entire INCO program. Projects still largely focus on research in Southern health systems though there is potential for greater learning in both directions, particularly given the new Accession countries.

7 Anna Karaoglou personal communication
**Types of partners**

Among the Northern partners, there is strong representation of Schools of Tropical Medicine and other academic institutes in international health. In the South there is a strong presence of universities and research institutes, with some representation of Ministries of Health, co-operation agencies or civil society organisations. This may reflect one original objective of the international cooperation component to support research infrastructures.

**Quality of partnerships**

Many partnerships are brought together for the formulation of an INCO research project, and relatively few are long-standing stable partnerships. Although such ‘dynamic networking’ can be seen as a factor of the success of the programme, it is also perceived in some quarters as unstable and jeopardising the research.

A positive feature of the INCO-DEV programme has been its concern for equitable partnerships to attain a balance between institutions in the North and the South at a number of levels including funding streams and research leadership. This balance has not yet been reached though there appears to be an increasing number of projects led by Southern institutions and a trend towards more equally shared budgets.

There are constraints to achieving a better balance including current capacity. Whilst this is partly being addressed by projects in which capacity-building is a key component, the North-South difference in project leadership is still perceived to be substantial. Factors contributing to the Northern dominance include the costs of project preparation and meetings, the difference in experience and tradition, and the capacity to disentangle and interpret the information on calls, priorities and procedures from the EC. Another difficulty reported is a lack of joint development of research methods arising from the proposal writing process and the complex methodological nature of HSR.

**Production of knowledge, dissemination and impact on health systems development**

HSR faces particular problems in terms of measurement and attribution. Knowledge produced through research is disseminated to a variety of audiences and through different channels. Publication in peer-reviewed journals remains the cornerstone of measurement of academic impact, and the main report gives examples of the many publications arising from EC funded research. However there is little evidence on the relation between such academic impact and societal impact.
Such considerations lead to a tension for INCO-DEV objectives in terms of attaining a balance between contributing to science or to development.

For the EC, HSR has a mandate to support health policy and planning. However, whilst the individual scientific and technical evaluation asks for “deliverables” of the proposed projects and most research proposals attempt this, there is no mention of the research outcome beyond “expected outcome” in the project overviews. Indeed the timeframe of INCO-DEV project funding/monitoring may be too short, with outcomes occurring beyond the funded period not automatically coming to the attention of the Commission.

Most projects state that ‘research results will influence health policy’. This goal is pursued in different ways, such as communicating research results to policy-makers, and involving them in the research to enhance the ownership of results, using results in teaching, writing reports, policy briefs, and scientific publications.

Few EC-funded HSR research projects are stand-alone. The academics involved in the EC-funded HSR projects are often located within influential institutions which are also involved in other development activities and which the research may influence.

One aim of the ‘Accompanying Measures’ (now ‘Specific Support Activities’) in the INCO-DEV programme is to promote dissemination and use of research results. It is our impression that this needs further attention. How research feeds into policy, or how policy uses research, is still unclear for most researchers and policy-makers alike.

The different time horizons between research projects and health policies may also hamper such input. INCO research projects have typically a 3 - 4 years horizon, while health policies can have very short or very long timeframes.

However, most researchers interviewed confirmed that many HSR projects did not get beyond the formulation of recommendations to policy makers, and that they remained often in doubt whether they had actually been taken up. But most interviewees could point to an example where they thought research projects had been successful in influencing policy. This was often attributed to the early involvement of policy-makers in the project. One recognised success where research in Thailand (see Box 3) evolved through different phases spanning well over a decade, resulting in a major health care reform for the entire health sector. This resulted from a long-standing North-South collaboration, spanning various framework programmes, and EC development agreements, in which the researchers progressively became the policy-makers.

Strengths and weaknesses of the INCO set-up and procedures

Strengths perceived by researchers are that the programme allows considerable freedom for the researchers to define the research projects, that it works towards equitable research partnerships and that it supports capacity building, in both the North and South. As in any programme, however, there are areas where strengthening is required.

Transaction costs

One challenge faced by the EC is to develop administrative procedures which meet accountability requirements, are efficient, and not too onerous for researchers. There is, however, a perception that EC funding carries significant transactions costs, which may be a barrier, particularly for small institutions. In particular the co-ordination of a large partnership is very time-consuming, during both the preparation and management of the project. Investment in proposals is, of course, uncertain to lead to funding, and this, coupled with the perception of falling ‘success rates’, may be a considerable disincentive for research groups and even an absolute barrier for most Southern research institutions, at least to act as co-ordinators.

The procedures for application are complex. The instruments are multiple and eligibility criteria not always easy to comprehend. Such procedures may contribute to difficulties in creating equitable partnerships, as Southern
partners have additional difficulties in understanding them, including access to the website or phone. There are also concerns as to the level of allowable costs, and disbursement schedules, given the changing nature of national research support.

Administrative reporting requirements, and the advance payments procedures, cost statements and payments, which cause very long delays in money transfers are also criticised. Steps already taken, such as the running of training workshops for co-ordinators, are to be commended but there may be other areas in which dialogue between the INCO Directorate and researchers could be productive. A regular meeting of involved researchers may provide a useful opportunity for discussion with the EC over how such procedures can be improved.

Selection process

The selection process for projects involves two steps – scientific review and regional review. Some respondents judge that the nature of the peer review process by experts leads to conformity in themes and methods rather than innovation and relevance. Many people do not understand the role of the regional panels and the basis on which they judge. However, most people accept that any such selection processes have their inherent limitations, and judge the track record of STD and INCO-DEV as being fair.

There is a view amongst researchers that there should be a two-stage process, as practised by other research funders. This is seen as a way of reducing the heavy burden of the current application procedures. However the resource implications of this are seen as prohibitive by the EC. There is also a process of pre-proposal checking within the EC for obtaining feedback on outline proposals early within the application. There is however recognition within the EC that attention needs to be given to making the overall application procedures less complex for applicants.

Capacity-building and Getting Research into Policy and Practice

There is a need to build up and strengthen the existing limited capacity in HSR. In the last decade, health development in developing countries was retarded, not only due to financial and human resource limitations, but also by limited capacity to produce their own policy.

Very few studies have been carried out regarding HSR capacity. One such assessment of HSR in developing countries was conducted through a postal and web survey to 176 HSR institutions in developing countries. It concluded that HSR producers need to increase their capacity and build up a critical mass to engage effectively in policy development as well as to absorb a larger volume of resources. The relationship between funding and critical mass needs further research to identify the best funding support, incentives and capacity-strengthening approaches.

There are differences in HSR experiences between regions which reflect their varying contexts. This is well reflected in an Alliance report which points out, for example, the significant history of HSR within the Latin American region and more recently its development in South East Asia.

In the above study of successes and failures of capacity-building of institutions different programmes such as TDR, IHPP, and COHRED were analysed. This suggested a number of different strategies including a general need for national mechanisms for institutionalisation of health systems research including enabling dialogue with policy-makers.

The EC INCO-DEV programme has emphasised the importance of capacity-building and GRIPP. This is, for example, reflected in its application process which includes explicit consideration of this. However there are various aspects to capacity-building which call for more detailed and

delineated strategies. In particular capacity-building:

- has different implications for individuals and institutions
- needs to relate both to researchers’ ability to disseminate effectively and to the policy-makers’ ability to use research
- needs to recognise the different needs of Southern and Northern institutions.

A major element of the EC INCO-DEV HSR programme has been mechanisms for collaboration between researchers from the North and the South. This is supported by a main conclusion of a study of the International Health Research Programme of the EC9.

It is important however to recognise that alongside the overall objectives of any programme in this area, the specific project mechanisms deployed by any funder, including the EC, are key. Thus the specific mechanisms such as priority-setting, application and reporting will all have implications for capacity-building. There is, for example, within priority-setting criteria, a need to strike a balance between short term project goals and long term HSR capacity-strengthening - for “sailing while mending the boat”.

The recent phenomenon of international and national mobility of human resources is a major emerging threat to the research community with both ‘push’ and ‘pull’ factors. A high turnover of national health authorities has also resulted in the frequent “loss” of institutional memory and policy-makers who have been sensitised on HSR. There is a need to develop human resources, institutions, and the research environment. A critical mass of researchers representing different disciplines such as physicians, epidemiologists, health economists, bio-statisticians and social scientists needs to be linked to visible institutions, since the HSR area needs good links between policy-makers, planners and the institutional set-up. Communication and dissemination of results from researchers should reach these people to foster a positive research climate enabling evidence-based policy-making. Collaborative research networks could also play a role in research capacity-building and promoting utilisation of research findings.

Tools to accomplish the above include allocation from national health expenditure as well as earmarking a proportion of project funding from development agencies for research capacity-strengthening. Training of young professionals could employ a staggered (sandwich) model with research carried out in their respective countries and course, with analysis outside to safeguard the relevance of the research. Networking or twinning of institutions (South-South or North-North) would assist in building institutions. Grants for supporting returnee graduates enabling them to maintain and further upgrade their competence will be of crucial importance. The maintenance of a long-term perspective in these relationships will be equally important.

Producing and using research results is one of the major operational components of a national health research system. However, the current weakness is that the research process and the policy process tend to exist in different domains, with research often having limited impact on policy. Researchers and decision-makers tend to interact only around the product of their processes which may be, for example, the results of a study for the researcher and a set of priorities for the decision makers. More attention needs to be given to establishing and maintaining ongoing links between these.

Many scholars defend a linear relationship on GRIPP, in which research automatically leads to rational policies, but most argue that the relationship is more hazy. Even the best designed research with clear results does not necessarily get translated into practice. The relationship between research and health policy is rarely ‘rational’, but based on an interplay of personalities, context and political expediency. Researchers and policymakers belong to overlapping communities of interest, which sometimes work closely but at other times pursue separate paths.

They have different concepts of time. For policy-makers, timing is urgent and short term and public opinion is important. Researchers

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9 Guha-Sapir D (2002)
often take a longer-term view and refer to a peer group who value political impartiality. Research findings will therefore only reach policy agendas when various factors come together, namely, when the solutions offered are considered feasible; when there is support for such solutions; and when policy makers feel it is legitimate to take action.

There has been an over-simplification of getting research into policy and practice through the strengthening of researchers’ communication skills. This is based on an assumption that proper packaging would ensure the best use of research. There is a need to incorporate several other factors, for example, the active participation by key stakeholders in the research planning process and the involvement of researchers in the policy process, social marketing of research results to the general public through an informed media\textsuperscript{10}. This requires a national mechanism with a dynamic, interactive, and inclusive process. Skill and understanding of the concepts and practices of knowledge management for change are essential for this national mechanism.

Both governments and international research community have major roles to play to stimulate research into action.

**Health Systems Research System**

In conclusion, this review of the EC support to HSR has focused on a series of different elements of health systems research. It is important however that these are not viewed in isolation but as part of an overall health research system\textsuperscript{11}. Changes to one part of the system are likely to result in effects elsewhere. Any system includes explicit and implicit ‘carrots’ and ‘sticks’ which influence the behaviour of the actors within the system. The EC has, through its recognition of the importance, not only of the production of knowledge, but also of capacity and the GRIPP process, have made important interventions in all parts of the research system. It is important that these interrelationships are also recognised and better understood. Mexico will provide an important opportunity for this process.

\textsuperscript{10} Chunharas, S (2000)

European Commission

**North South Partnership for health systems research: 20 years of experience of European Commission support**

OIB

2004 – 24pp. – 21.0 x 29.7 cm
The EC has, over the 20 years of Health Systems Research (HSR) support in INCO-DEV, made a significant contribution to funding HSR and building the capacity of institutions and individuals in both Europe and developing countries and has contributed to the creation of solid partnerships. This document is a summary of a more extensive report prepared by independent experts commissioned by the EC Research Directorate into the experiences of its research programme on health systems in developing countries over the last 20 years.