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Editorial

Forging Partnership Between Health Economics Researchers and Policy Makers: Better Methods, Better Policy, Better Health

Paul Revill, MSc, Manuel A. Espinoza, MD, MSc, PhD

In countries around the world, especially those in which national income is lowest, health improvement is severely hindered by limited resources and weaknesses in their health systems. Moreover, because of the system weaknesses and limited healthcare coverage, public spending is often relatively pro-rich.[1] This means important interventions are often not provided for those who could benefit the most, when and where they need them. Taking Africa as one example, the continent faces 23% of the global disease burden, yet accounts for <1% of total global health expenditures.[2] Other low- and middle-income regions, such as Latin America, South Asia, and Eastern Mediterranean, face similar challenges. Improved resource allocation to and within the health systems therefore has huge potential to improve population health and reduce health inequalities as it affects life and death. Congruently, misplaced health spending results in large forgone opportunities to improve population health. For example, £1000 of misplaced expenditure would lead to 22 quality-adjusted life-years (QALYs) lost in Malawi, compared with only 0.1 QALY in the United Kingdom.[3,4]

This begs the question of *Value in Health Regional Issues* readers and ISPOR members: What can we, especially those of us who are researchers and analysts, do to contribute to improved population health in such settings where unmet health needs are greatest and health systems are subject to the most severe of constraints?

Building a robust and, even more importantly, relevant evidence base is clearly part of the answer. Given the complexity of health systems and diverse health conditions, multidisciplinary approaches are needed, although health economics probably warrants a central role in provision of evidence to guide resource allocation. Yet, evidence alone hardly seems sufficient to lead to improved resource allocation—this requires policy decisions to be made. There is no guarantee that research, if produced, will be honed on the health challenges of greatest consequence for population health or that knowledge and trust in the research exists among policy makers for its use within decision making.

This collection of articles on the topic of "Resource Allocation in Low- and Middle-Income Country Health Systems: Methods and Their Uptake into Policy," presents a series of insightful articles that explore the challenges of bringing health economics research to bear on health policy in diverse world regions. All the articles have resulted from close collaboration between researchers and mandated policy makers responsible for resource allocation decisions. The findings from the series offer critical insights into some of the most pressing issues of healthcare resource allocation. Collectively, they present a model as to how fruitful partnership between researchers and policy makers might look also in other contexts in the future.

Sharpening the Tools of Economic Analysis to Meet Policy Needs

The first article by Connolly et al[5] details how health economic analysis, in the form of cost-effectiveness analysis, and thorough a process for policy formulation, using multicriteria decision analysis, was used to revise the health benefits package in Malawi. This revised package is now incorporated as the central basis of the country's new 8-year National Health Sector Strategy,[6] with funding prioritized toward its provision. Emphasizing the need for an integrative approach, the authors demonstrate how participatory methods were crucial to ensure integrated health service packages across all levels of care, which can be delivered within the feasible means of Malawi's healthcare system.

The choice of clinical and public health interventions for delivery, although crucial for countries to achieve universal health coverage, is not the only resource allocation choice facing ministries of health. They also need to determine how to invest in health systems strengthening to expand the capacity of health systems in delivering packages of interventions. This is a challenge that has been starkly neglected by health economists until very recently; in fact, as of 2020, there were 0 empirical examples that guided health systems strengthening beyond any one disease area.[7] McGuire et al[8] identify methodological challenges in applying economic evaluation techniques to guide health systems strengthening, which are the likely cause of this dearth of literature. They go further than this and identify how these challenges can be overcome, offering promise for a new burgeoning and highly impactful research field.

Of course, healthcare delivery is not the only way of improving population health. Some of the most (cost-)effective means to generate health gains are likely to require actions outside of health sectors, addressing determinants of health. These actions will often require multisectoral collaboration across units of governments, but the health economics toolkit has been limited in terms of how cost-effectiveness and value-for-money can best be assessed in such cases. Ramponi et al[9] present a pragmatic approach that can help and be used in practice. They make their points using real-world case studies from countries in the East Central and Southern Africa Health Community; in particular, in Zimbabwe, Uganda, and Malawi.

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Rising to the Sustainable Development Goal Promise to Leave No One Behind

Whereas the methods put forward by Connolly et al,[5] McGuire et al,[8] and Ramponi et al[9] can be used in countries in which domestic governments (eg, ministries of health) have a leading role in planning health sector development, challenges remain in meeting health needs in humanitarian situation.

The Sustainable Development Goal 3, to "Ensure healthy lives and promote well-being for all at all age" by 2030, comes with an accompanying promise. This is that the dignity of every individual in our world will be respected, and we must "leave no one behind."[10]

Three articles explore how health economics research may contribute to realizing this promise. In a scoping review, Tafesse et al[11] assess the health economics literature on refugee health provision in sub-Saharan Africa. Many African countries host large numbers of refugees. In total, 25.3 million refugees are hosted across the continent: 35% of the world's refugee population.[12] The welfare of internally displaced people (ie, within countries, because of conflict) are also a major concern across the continent. Yet, the authors find little health economics literature—only 29 studies met their eligibility criteria—to guide host governments and international humanitarian organizations on how to finance, cost, and prioritize health services for these populations. The authors stress the need for enhanced research to finance and build more suitable health services in future and offer research priorities.

The consequences of conflict and forced displacement are also investigated by Mazumdar et al,[13] for the Eastern Mediterranean region. They focus on complex health system financing challenges faced because of humanitarian situations, including natural disasters. In line with the theme of the issue, the authors highlight how researchers and policy makers need to work in closer collaboration to find solutions. The need to build health system resilience is highlighted as being crucial, so that essential public health functions and delivery of basic packages of care continue even through acute conflicts and humanitarian emergencies. This requires determining how the health financing functions of revenue generation, pooling, payment, and service provision can be tailored and adapted to the political and institutional realities of countries in the region, for which there are likely to be some general requirements, but analyses are required to manage some unique features in each setting.

Another region that faces a distinct and challenging humanitarian situation is Central America. Countries in this region coordinate their activities through the Council of Ministers of Health of Central America and the Dominican Republic. They face constrained health financing and challenges related to migration across national boundaries, caused in large part by high levels of violence. Miranda et al[14] outlined health policy challenges faced in the region and showed how the COVID-19 pandemic further aggravated existing structural problems, with adverse implications for health financing and other social expenditures. According to the authors, health economics research is needed to fill the evidence gaps on how to best respond.

In humanitarian healthcare responses, as well as in more stable but constrained health systems, it is crucial for researchers and policy makers to listen to and understand the preferences of those populations who are ultimately the intended beneficiaries of healthcare. Espinosa et al[15] conduct a systematic review to assess social preferences for health states in low- and middle-income countries. They find that this literature has been concentrated in high-income countries and only 19 of 82 low- and middle-income countries have nationally representative social values of health state preferences. Health utilities were lowest for those of old age, lower levels of education and income, and divorced or widowed respondents. Results from these studies can be used to increase public confidence in national health decision-making processes.

Health Economists and Health Policy Makers: Codependents But Uneasy Bedfellows?

In the final article of the theme, Nabyonga et al[16] outline how researcher and policy maker collaboration has been cultivated in a notable health economics-focused endeavor: the Thanzi Programme in Malawi, Uganda, and the countries of the East Central and Southern Africa Health Community. It has required researchers to coproduce research alongside policy makers and for policy makers to actively engage researchers in their decision making through creating fora for engagement. Finally, researchers and policy makers have been trained and upskilled together, so that the generation, use, critique, and application of evidence for decision making becomes, in some sense, a shared endeavor, although the responsibilities of each community remain distinct.

For such collaboration to be successful and to enhance the policy relevance of research requires researchers to be close enough to policy making to understand both the challenges faced (eg, navigating of politics) and the opportunities that exist in shaping policy, while remaining far enough to retain perspective and independence. Through engagement, they can also better understand the limits of their disciplines—both in methods and focus of applied analyses—for informing policy. They can also hold policy makers to account. For their part, policy makers require evidence upon which to base their decisions, but exposing themselves and their decisions to scrutiny comes with risks, and there is the constant temptation to keep a distance from researchers and obfuscate policy processes. The way forward must surely require the 2 communities of skilled researchers and mandated health policy makers to be brought together in an environment of mutual trust and where better mutual understanding is fostered, despite the inevitable challenges.

This collection of articles demonstrates there is demand from researchers and policy makers in other world regions to learn from these experiences and adapt approaches to their own contexts.

Author Disclosures

Links to the individual disclosure forms provided by the authors are available here.

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