# Eight key messages about how lessons spread between health systems

**Policy brief**
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**Authors**
Alex Jones

In 2000, the World Health Organization (WHO) attempted to rank the total health system efficiency for each of its 191 member countries.[i] It wanted to say, given the resources available, which systems were performing best and which were performing worst. It did this by comparing health expenditure *per capita* against a combination of outcomes, responsiveness, financing sources, and equity. The idea was to encourage healthy competition, but also to identify strong performers from whom lessons could be learnt.

Since then, the internet has transformed the accessibility of information. What, then, has happened to the idea of countries learning from each other as they build their health systems? Over the past 18 months, **Learning for Action Across Health Systems** has tried to understand what, why, and how (if at all) lessons spread between health systems in sub-Saharan Africa, and what external funding agencies might do to help.[ii]

The project, funded by the Bill & Melinda Gates Foundation, asked policy stakeholders (such as politicians, ministers, and civil servants), academics researching health systems, and people working for international organisations (such as the World Bank, WHO, and bilateral donors) about their views and relevant experience on this topic. This was complemented with eight country case studies. Learning for Action looked at long-term reforms, such as the Health Extension Programme in Ethiopia, to unpack the role that learning from other countries might have actually played in informing policy design and implementation. This leaflet outlines eight of the overarching points that emerged from the project to help understand what may be needed to realise the ambition WHO encouraged nearly 20 years ago.

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### 1. There is a demand from policy stakeholders in sub-Saharan Africa for a better regional coordination mechanism that facilitates learning between countries.

In practice, this means linking countries that are likely to have something to learn from each other—for example, using a mechanism to identify countries that are struggling with a certain aspect of their drugs supply chain and linking them with other countries that have recently managed to implement solutions to a similar problem. At present, many countries face challenges that other countries have recently battled, but neither knows of it.

### 2. Policy stakeholders struggle to navigate the complex body of research, data, lessons, networks and communities of practice that already exist.

The project began by trying to map all the existing platforms that are designed to help countries learn from each other (although, by the time it reached 170, it was not even close to finishing).[iii] Policy stakeholders often do not know where to start. Simple questions like 'which network is useful for me?', 'how do I use a community of practice?', and 'which databases can I trust?' are difficult to answer. Without the time to inform themselves, they simply stop looking. Because of this, there is a common desire for a trusted 'one-stop shop' for quality vetted information about other countries and best practices. Whether realisable or not, the demand is clear.

### 3. Policy stakeholders would like more information about 'how' rather than 'what'.

Most of the information policy stakeholders say they are currently able to find pertains to *what* other countries have done and *what* the results were, as well as providing suggestions about what policies they should implement. What keeps policy stakeholders up at night, however, is not '*what* policies to implement' but '*how* to implement the policies they have'. There is much less information available about this.

### 4. The model of a 'teaching' country and a 'learning' country is not attractive.

No policy stakeholders want to feel inferior to their counterparts in another country. Similarly, policy stakeholders are less willing to put in the time to tell others about their experience and insights if they feel they aren't getting anything in return. Wherever possible, learning environments should recognise that information and lessons can flow in two directions at once.

### 5. Most of the instances of cross-border evidence flow were mediated by trusted brokers.

Trust and personal relationships are incredibly important ingredients in the 'learning across countries' process. Where it was clear that lessons had crossed borders, it was often possible to identify a small number of specific individuals who played central and long-term roles in the transfer. They were close enough to the decision-making powers over a long enough period to build trust and had prior personal knowledge of the international information.

### 6. There is a need to build confidence in the relevance of other countries' experience.

Policy stakeholders tend to have an in-depth understanding of one place – their own country – and the simple reality is they may not know much at all about other health systems. Most people who advocate learning from other countries have an international focus. They often know a bit about several places, but may not have an in-depth understanding of any one location. These advocates of learning from other countries need to understand that policy stakeholders may not immediately grasp the value of information about another health system.[iv]

### 7. The learning process must be owned by those who are able to act on it.

Much of the research into health policy transfusion to date has examined the role played by international organisations in spreading ideas.[v] Very little research has looked into the role played by countries themselves, even though their role is crucial. To be acted on, information about international experience must answer the questions that keep *the local policy stakeholder* up at night. Put simply, national, not international, institutions need to be defining the questions; and yet we know very little about how one country formulates questions about another.

### 8. Different countries face different challenges when learning across health systems. Even within one country, the challenges change over time.

When trying to understand why learning across countries is not happening, it is useful to consider three possibilities. Perhaps there is no clear answer to the challenge a country faces (demand, but little supply), and Nepal was arguably in this position when it started working out how community health workers could contribute to newborn care.[vi] Perhaps the information exists, but policy stakeholders have already made their decisions (supply, but little demand)—for example, Georgia during its hospital privatisation reforms.[vii] Or maybe there is both supply and demand, but the mechanisms and resources (including internet, HR, and financing) available for bringing the two together are failing.[viii] Or is it a mix of all three?

The idea that countries should learn from each other is clearly appealing. But if it is actually to reap benefits, we need to think more about how that learning process works beyond just the availability of information. Not learning from available information is a waste, but that does not mean that learning will happen or be acted on.

[i] www.who.int/whr/2000/en/.

[ii] www.learningforaction.org/.

[iii] https://learningforaction.org/research-papers/landscaping-review-part-2/.

[iv] That this situation exists is succinctly expressed in a short compilation of interviews, found at https://learningforaction.org/video/learning-for-action-across-health-systems-a-short-film/.

[v] https://learningforaction.org/research-papers/landscaping-review-part-3/.

[vi] https://learningforaction.org/video/nitin-nischal-bhandari/.

[vii] https://learningforaction.org/video/learning-for-action-across-health-systems-tata-chanturidze/.

[viii] https://learningforaction.org/video/ahoefa-vovor/.

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Or email: **alex.jones@opml.co.uk**

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**Oxford Policy Management Limited**

Registered in England: 3122495

Registered office: Clarendon House,

Level 3, 52 Cornmarket Street,

Oxford, OX1 3HJ, United Kingdom