Oxford Policy Management

Chairperson's Summary – Learning For Action Across Health Systems

First Expert Convention, London, 9 May 2017

Background to the meeting and purpose of this summary

The Bill & Melinda Gates Foundation (BMGF) is seeking to add to the body of knowledge and understanding on how low- and middle-income countries (LMICs) learn from other country experiences as they improve their health systems and health outcomes.[1] Based on this improved knowledge and understanding, BMGF would like to invest in programmes that facilitate 'improved' learning and conversion of lessons into practice.

As part of a planning grant to inform such investment, Oxford Policy Management (OPM) convened a meeting of international experts to discuss the issue in London on 9 May 2017. Sixteen experts participated, drawn from a wide range of countries and professional experiences: policy-makers in LMICs, academics, and representatives of bilateral and multilateral organisations. We are extremely grateful to all who contributed. Participants are listed in Annex A. Representatives of the BMGF participated as observers. Discussion was held under the Chatham House Rule.[2] Discussion involved each of the three groups considering a series of specific, sequential topics using the 'World Café' [3] model for generating discussion and insight.

This Summary is prepared by the Chairperson of the meeting.[4] It is a reminder of some of the key points that emerged from the discussion. It is not an official record of the meeting or intended to be a consensus document.

Background documents: The landscape for learning between countries

OPM prepared and circulated three background documents prior to the meeting. The three documents were designed to quickly survey what is currently known about what, how and why countries learn from each other, and to serve as a starting point for discussion at the meeting. The documents involved illustrative examples, and were not intended to be definitive or exhaustive in scope.

The first document identified 231 examples of published articles that draw their analysis from comparisons between health systems. That document noted the growing interest in comparative learning in the health sector, including among LMICs. It observed a research interest in all aspects of health systems, especially health financing, but an apparent lack of published research in two areas: the drug supply chain and health information systems. The second document looked at what types of institutions facilitated learning between countries. That document identified 166 examples of different organisations or platforms, grouped under 15 different institutional types (universities, UN and multilateral organisations, think tanks, conferences, etc.). The document noted the difficulty in independently assessing the effectiveness of most platforms. The third document looked at the international health policy transfer process, i.e. what was known about the *process* of learning from another country's experience. That document identified six key stakeholder groups involved in policy transfers: international agencies; national elites; political systems; civil society; policy beneficiaries; and the private sector. It also identified six phases of the policy transfer process: conceptualisation; formation; internalisation; contextualisation;

[1] More specifically, the BMGF wish to better understand: *What* can countries learn from one another's experiences? *How* do countries learn from one another's experiences? *Why* do policy-makers sometimes want *or not want* to learn from one another's experience?
[2] When a meeting, or part thereof, is held under the Chatham House Rule participants are free to use the information received but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, can be revealed.
[3] Further details are available at www.theworldcafe.com.
[4] Alex Jones, Health Economist, Oxford Policy Management.

operationalisation; and evaluation. The reviews have since been updated[5] to reflect written feedback received following the first Expert Convention.

Some broad, overarching themes identified at the London meeting

The following summarises some of the higher-level themes raised by experts:

- **What is meant by 'learning'**? The term has different meanings according to context. What ministers of health wish to learn in terms of health system reform may be different from what a minister of finance wants to learn, or a mid-level official in a ministry of health wants to learn. This assumes an open mind about *what* is being learnt – but it may be necessary to define this at some point. Do we want to focus on how policy makers learn 'globally accepted good practice', for instance? Incentives matter: as one participant noted, 'some want to know; others have it pushed on them'. Learning is more than just sharing information and evidence. Nor does it involve simply copying from others. Rather, it ultimately involves digesting and adapting lessons to the country perspective and then internalising and institutionalising that learning.
- **The political economy of learning is always and everywhere important**. What evidence, whose evidence, how that evidence is presented, and the timing of that evidence in the political and budget cycle are all important determinants of how effective knowledge transfer and learning might be. Medical professionals and other organised stakeholder groups may support – or may oppose – reforms based on other country learning and evidence as well as their own self interest. Development partners also have political economy incentives and 'agendas' as well. Some experts referred to 'policy coercion' from such development agencies and the skewing of priorities through the availability of funding.
- **Failure to learn, and learning from failure.** Some countries fail to learn, even from clear evidence and lessons within their own borders. All countries can benefit from 'learning from failure', yet there are usually strong disincentives to document and disseminate lessons from failures. There is also the possibility that countries 'learnt the wrong lessons' from the experience of other countries.
- **Factors outside, and inside, the health care system affect the learning process**. This project has so far focused on the health system and health service delivery. Nevertheless it is clear that factors outside the health care system – for example girls' education, food security and nutrition, water and sanitation, and social determinants of health – also affect health outcomes and offer opportunities for learning from other countries. Informal and/or traditional healers within a country may also not be easy to reach in terms of system learning.

How countries learn in practice: Some useful approaches but also some important gaps identified at the London meeting

- **There are many routes to learning.** Several experts from LMICs said they approached the country representative of the World Bank, the World Health Organization (WHO) or other multilateral/bilateral organisations asking for examples of other countries that had undertaken a particular policy reform (e.g. defining an essential benefits package, design of national health insurance systems, insights into user fees, tobacco taxation, etc). But there were many other routes to learning too. These included formal training – especially through World Bank/WHO 'flagship' courses that examined different country experiences, formal 'South–South' study tours, informal learning from visits to other countries (including as officials, students or even as

[5] Landscaping review part 1: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-1
Landscaping review part 2: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-2
Landscaping review part 3: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-3

hospital patients), health sector work undertaken by international organisations, international conferences, internet searches[6] and simply by 'contacting ex-classmates'.

- **There is an absence of basic data at country and regional level that inhibited learning, but there is also 'too much information'.** Experts noted the absence of some key, basic, comparable data that was important for policy planning, including, for example, data on comparable hospital admission rates, health worker attrition rates or the administrative costs of a national insurance organisation. Other experts agreed, but noted that ministers of health and officials in many LMICs were also often 'overcrowded with information' from multilateral/bilateral agencies and/or the private sector. Some of that information was regarded as contradictory, misleading, incorrect or based more on ideology than evidence.
- **There is a pronounced gap in learning about implementation – the actual 'how' of reform in the health sector.** Several experts from LMICs stressed this. Policy-makers in LMICs were looking for practical implementation advice on issues such as how to reduce the outflow of health workers to richer countries, how to encourage health workers to stay in rural areas and how to provide universal health coverage in countries with a large informal sector, etc. Some experts also felt that here is a lack of implementation experience among many of the donor organizations in numerous reform areas.
- **Is there a gap in evidence on supply chain management and/or health information systems?** The landscape review of the literature found there is apparently relatively little published, peer-reviewed comparative analysis on supply chain management[7] or health information systems. Yet these two areas are important in any health system reform effort. They are also key 'implementation' issues, which LMIC experts stressed were a priority for them. Supply chain management and health information systems were also a priority area for the BMGF.
- **Various factors limit the ability for countries to learn about implementation.** Some experts called for a 'step-by-step manual for implementation' for particular policy reforms. They argued that academic journals have a different audience to programme implementers and thus do not help to fill that space. Multilateral and bilateral development partners may have their own detailed implementation plans, including financial and other resource costs, but such information was not always accessible. In other cases they don't have implementation expertise either. One of the problems is that some policies are so complicated, interactive, and dependent on the very detailed country institutional specifics that an implementation manual cannot address all the issues. South–South study tours could be helpful, but the tours were often too short for participants to really understand the 'how' of implementation. Visiting innovative pilot programmes may involve schemes that are too small to yield valid or replicable learning. It was also important to have an opportunity to talk with those who had actually implemented particular reforms, i.e. not just rely on written reports.

Some specific suggestions

- **A one-stop shop for evidence?** Several participants, particularly but not exclusively from LMICs, noted the proliferation of advice and 'tools' from multilateral and bilateral development partners. Some participants called for a 'one-stop shop' for evidence or 'policy advice under one roof'. Some argued the need for greater global, or at least institutional, accountability for the quality of advice being offered by multilateral and bilateral agencies. One expert called for a Code of Ethics among those institutions proffering advice. Another expert suggested developing a global database of evidence, perhaps involving an academic effort to review and screen the quality of evidence. One expert recommended trying to get periodic agreement on so-called global good practices as an international knowledge base in specific areas. Several experts agreed with the overall principle and vision of a one-stop shop, but questioned its feasibility, given the expected reluctance of each institution to have 'its' evidence questioned

[6] One participant described how he found good information and guidance quickly on how to respond to an outbreak of meningitis C by searching on the Centers for Disease Control and WHO websites.
[7] One expert noted during discussion that research and writing on drug supply chains might appear more frequently in professional trade journals, supply chain systems journals and the grey literature.

and vetted through some external process, and political appropriateness, given the relationship between ideologies, influence and information.

- **Building on where – and how – the WHO European Observatory works well.** Experts noted that the WHO European Observatory had demonstrated the capacity to be a catalyst for learning between countries over a sustained period. Part of the explanation appeared to be that the Observatory was seen to be 'neutral' and objective in its evidence and policy advice. Good-quality comparable data also allowed for policy-rich benchmarking by each country. Furthermore, European Observatory policy briefs are prepared by analysts, but reviewed and commented on by policy makers to ensure the advice is practical and realistic before publication. Could we learn from this model – including regions where it has perhaps not gained traction in countries as a vehicle for learning – and adapt it to other regions?
- **The experience of the Joint Learning Network.** Experts noted that the Joint Learning Network produces manuals on costing and other aspects of health sector implementation and reform. It would be instructive to see to what extent, why and how those manuals and resources are used in practice by LMICs to facilitate learning between countries.
- **What do LMICs ask the major multilaterals and bilaterals for in terms of learning?** Perhaps it would be useful to ask WHO, the World Bank and other key institutions what, specifically, it is that LMICs ask them for in terms of cross-country learning. Understanding that issue would help to better understand *which* countries are seeking learning through that process (and which countries are not) as well as *what* learning issues are most frequently asked for. However, it is also recognised that the knowledge about who is asking for what may itself be dispersed through these organisations, with some requests coming in through individual country offices and others coming in at headquarters level. There is also the risk that this would be biased towards the sorts of 'learning' that these organisations are offering and pushing.

Further questions without clear answers

- How can the effectiveness of platforms to facilitate learning across countries be defined and measured?
- How can a 'knowledge broker' institution establish trusting relationships with policy makers?
- How can 'learning' and 'knowledge' institutions be sustainably established in LMICs?
- How can the mid- and lower- level workforce (district staff, operational technocrats, etc.) be reached and their learning needs met?

Next steps

The next steps involve in-country interviews to gather evidence and insight about how countries learn – or do not – from each other. The in-country interviews will be conducted in a selection of countries that were considered low income in 2000, and made significant progress against the Millennium Development Goals. They are scheduled to take place in between July and September.

A second Expert Convention is scheduled for November 16th. This is to review the findings and recommendations that are emerging at that point in the project. Some participants thought a slightly longer period – for example two days – would be a better use of time and might mean more international experts would be able to attend. The project team will select experts to invite based on the needs of the project as it develops.

Further questions

- Which important groups were missing from the London meeting and should be targeted for the second meeting? Two early suggestions have been the big funding agencies such as the

Global Fund and Gavi, as well as implanting non-government organisations like Oxfam and Medicins Sans Frontiers.

- What else can we improve on at the second meeting?

Alex Jones, Chair of the First Expert Convention, Oxford Policy Management Limited, June 2017

Annex A List of participants

#	Name	Institution/role
1	William Hsiao	Harvard School of Public Health, Department of Health Policy and Management
2	George Schieber	Independent Health Economics Consultant
3	Valery Ridde	University of Montreal
4	Josep Figueras	Director, European Observatory
5	Kevin Deane	University of Northampton
6	Julia Watson	UK Department for International Development
7	Sara Bennett	Professor, Johns Hopkins Bloomberg School of Public Health
8	Irene Agyepong	Ghana Health Services
9	Nnenna N. Ihebuzor	Director of Primary Health Care Systems Development at the National Primary Health Care Development Agency, Nigeria
10	Mustapha Jibril	Niger Health Commissioner, Nigeria
11	Steve Goaija	National Ebola Response Committee, Sierra Leone
12	David Sanders	Emeritus Professor, School of Public Health, University of the Western Cape, South Africa
13	Yot Teerawattananon	HITAP, Thailand
14	Waranya Rattanavipapong	HITAP, Thailand
15	Ali Ghufron	Former Minister of Health, Indonesia
16	Mohammad Alameddine	American University of Beirut
17	Kara Hanson	Faculty of Public Health and Policy at the London School of Hygiene and Tropical Medicine
18	Barbara McPake	Nossal Institute for Global Health, University of Melbourne
19	Tim Ensor	Leeds Institute of Health Sciences
20	Sophie Witter	Queen Margaret University, Edinburgh
21	Ian Anderson	Independent Health Economics Consultant
22	Jack Langenbrunner	BMGF
23	Jean Kagubare	BMGF
24	Mariam Zameer	BMGF
25	Caitlin Mazzillli	BMGF
26	Nouria Brikci	OPM
27	Alex Jones	OPM
28	Matthew Roxborough	OPM
29	Blandine Binachon	OPM
30	Nitin Bhandari	OPM
31	Charity Jensen	OPM
32	Martin Gorsky	Guest dinner speaker, Centre for History in Public Health, London School of Hygiene and Tropical Medicine