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The role of learning from other countries in Cambodian health system reform

Focusing on Health Equity Funds and innovative contracting

Learning for Action Across Health Systems – Case Studies

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Executive summary

Over the last 30 years Cambodia has emerged from conflict, widespread poverty, extremely high mortality rates and near international isolation into a fast growing, highly open country. Between 2005 and 2012 the official poverty rate fell from 50% to 18% and, in 2016, it achieved lower middle-income status. This all happened alongside substantial improvements in population health. Since the 1980s life expectancy has more than doubled, and, since 2000, the maternal and child mortality rates both fell by more than two thirds.

Reform of Focus

We focused on Health Equity Funds (HEF) and Special Operating Agencies (SOAs). HEFs are an innovative demand side funding mechanism used to reimburse hospitals and health centres for the user fee exemptions they afford to poor patients. SOAs are given innovative contracts to manage government health service delivery, designed to improve system efficiency.

Key Findings

Both reforms were conceptualised by international organisations working in Cambodia. Moreover, the first few rounds of domestically generated evidence were demanded by those international organisations as a means of persuading others (both nationally and internationally) that the schemes were working. Functioning internal networks were an effective vehicle for spreading these lessons among relevant stakeholders, but where one group came to dominate they were less effective. Internationally available information was not systematically canvassed for effective policies (although this does appear to be happening now). Instead, arguably, 'learning from other countries' was a matter of learning how to make these two international ideas work in Cambodia through repeated cycles of operationalisation, evaluation, negotiation and more operationalisation – domestic trial and error, or imitation and adaptation. The overall learning process has taken more than 20 years and has been 'organic'. Two of the key factors have been cumulative experience for Cambodians through 'learning by doing' working alongside international advisors, and increased opportunities for formal study and travel. The overall level of skilled human resources working within the health sector (both clinical and non-clinical) rose from nearly nothing in the early 1980s to today, where experienced Cambodians are available to lead on policy design, implementation and evaluation.

Two further key findings relate to demand. First, as the Ministry of Economy and Finance invested more in these two policies they also demanded evidence regarding effectiveness. Whereas earlier demand for evaluation was led by the international community (then the main funders), in recent years this has shifted. Second, some components of reforms can be politically infeasible, even given relatively clear evidence. For example, while parts of international community provided evidence and international learnings in favour of 'contracting out' to NGOs, this has been consistently resisted by the government

Implications for facilitating cross system learning

First, a large component of the learning process occurs within the learning country after the initial idea has been shared. Local adaptation of ideas transferred from other countries to enable application in a domestic context is complex but important (contextualisation, internalisation, operationalisation). Second, it is possible to build a critical mass of skilled nationals to lead and learn at each stage of the reform process if a long-term perspective is adopted (15-30 years).

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List of abbreviations

ADB	Asian Development Bank
DFAT	Department of Foreign Affairs and Trade (Australia)
DfID	UK Department for International Development
DPHI	Department of Planning and Health Information
GDP	Gross domestic product
GIZ	German International Cooperation
HEF	Health Equity Funds
H-EQIP	Health Equity and Quality Improvement Project
HSSP	Health Sector Support Project
MDGs	Millennium Development Goals
MEF	Ministry of Economy and Finance
MoH	Ministry of Health
MSF	Medicines Sans Frontieres
NGO	Non-governmental organisation
OD	Operational District
OPM	Oxford Policy Management
SOA	Special Operating Agency
THE	Total health expenditure
TWG-H	Technical Working Group for Health
WB	World Bank
WHO	World Health Organization

1 Introduction

Over the last 30 years, Cambodia has emerged from conflict, widespread poverty, high mortality rates, and international isolation into a fast-growing, highly open country. The economy has experienced an average annual gross domestic product (GDP) real growth rate of 7.7% over the last two decades, supported by strong garments export, agriculture and tourism (Department of Planning and Health Information (DPHI), Health Strategic Plan 2016-2020). In recent years, a rise in real estate and construction have added to this.

Between 2005 and 2012, the official poverty rate fell from 50% to 18% and, in 2016, Cambodia achieved lower middle-income status. This all happened alongside substantial improvements in the population's health (DPHI, Health Strategic Plan 2016–2020). Between 1980 and 2012, life expectancy rose from 29.6 to 71.4 years. The maternal mortality ratio was estimated to have fallen from 510 per 100,000 live births in 2000 to 170 in 2014. Similarly, the infant and under-five mortality rates are estimated to have fallen from 81.6 and 110.5 per 1,000 live births in 2000 to 28 and 35 respectively in 2014. This exceptional progress meant that it achieved Millennium Development Goals (MDGs) 4 and 5.

The current population is around 14.9 million, up from 6.6 million in 1980. Over 30% are younger than 15 years and almost 80% live in rural areas. While aggregate indicators show impressive improvement, inequalities in health outcomes by socio-economic status and geographic location are a significant challenge. The Gini index is reported to have risen from 38.3 in 1994 to 44.4 in 2007, but then fallen again to 31 in 2012[1] . The proportion of the population living below the official poverty line in Phnom Penh and other urban areas is almost 13%, whereas in rural areas it is closer to 25%, and the proportion of children under five with moderate to severe malnutrition or acute respiratory infection in rural areas is more than double that in urban areas (the same is true when the lowest wealth quintile is compared to the highest quintile).

In line with economic growth, total health expenditure (THE) per capita is estimated to have risen from US$ 18.9 in 2000 to approximately US$ 71 by 2012. The first national health accounts, published in 2014, suggest that THE was more than US$ 1 billion by 2012, or more than 7% of GDP. Out-of-pocket spending makes up 60% of THE while government and development partners each contribute 20% (DPHI, Health Strategic Plan 2016–2020). Annual recurrent government expenditure on health has grown consistently in recent years, reaching US $384 million in 2017 (or approximately 12% of total government recurrent expenditure), while donors fund nearly a third of the government health budget. Nonetheless, government health spending remains low in comparison with other low-income and emerging economy Asian countries at around 1.4% of GDP. According to the 2010 Demographic and Health Survey, 57% of unwell or injured patients sought care in the private sector the last time they used medical care.

Reform of the government health system began in the mid-1990s with the extension of physical infrastructure and a health financing charter, followed by three Health Strategic Plans (2003–2007, 2008–2015 and 2016–2020). These Health Strategic Plans have been supported by two Health Sector Support Projects negotiated between development partners and the Ministry of Health (MoH), including pooled funding between government and donors. Over time, the MoH has become a more powerful negotiator and a joint funder of the plans. The current Health Equity and Quality Improvement Project (H-EQIP) is 60% funded by the Ministry of Economy and Finance (MEF), 40% by donor funds, and is implemented entirely through the MoH.

These three strategic plans, with accompanying donor-supported funding, have included a series of supply and demand side interventions, generally with the objective of providing physical

[1] World Bank, https://data.worldbank.org/indicator/SI.POV.GINI?locations=KH

infrastructure together with financing arrangements that provide access to services for the poor. Health financing and management reforms that started towards the end of the 1990s have played a significant role in this development and are the focus of this case study.

Cambodia's Health Equity Funds (HEF) are an innovative demand side funding mechanism used to reimburse hospitals and health centres for the user fee exemptions they offer to poor patients. The 1996 Health Financing Charter allowed all government health facilities to charge nominal user fees according to a defined schedule. These user fees do not cover the total cost of service provision but do provide facilities with additional disposable income. Infrastructure, payroll, and the procurement of drugs and medical consumables are funded by the central government. The HEF is defined as a mechanism or fund managed by a third-party payer to purchase health care for poor people from government health providers (MoH, 2009). The first HEFs were piloted by international non-governmental organisations (NGOs) in two health districts in 2000. By 2015 the HEF had achieved national coverage of the poor in every health district, including every referral hospital and every health centre. The HEF also covers the costs of transport, food, and funeral expenses for beneficiaries and in 2016 was described as Cambodia's 'most significant social security scheme, covering the poorest one-fifth of the national population' (Annear et al., 2016, p. 6).

The second reform of focus for this case study changed the way health districts are managed. Cambodia has had a long and varied experience with contracting the management of government health service delivery, initially to non-government providers, in an attempt to improve the efficiency of the government health system. Different forms of external contracting-in and contracting-out were piloted in a few health districts from the late 1990s. Since 2009, internal contracting arrangements between the central, provincial, and operational health district levels and health facilities have been established within the MoH. This sub-set of MoH health providers are designated as Special Operating Agencies (SOAs) under a national government administrative reform. These designated health operational districts have greater management flexibility, staff autonomy, and additional motivation through performance-based measures with financial rewards built into the contracts. Further direct funding is provided to facilities in addition to MOH budget allocations, paid directly from the MEF in the form of a Service Delivery Grant comprising a fixed grant component and a performance-based component. By 2015, 31 of a total of 77 health operational districts had been granted SOA status.

Both the HEF and SOAs are central components of the recently launched health sector support project (H-EQIP). The government and development partners have decided to focus their attention on these two areas of the health system in an effort to improve the quality of service delivery and access to care for the poor. At the same time, it is anticipated that the achievement of lower middle-income status will trigger a fall in donor support. The 2017 government budget includes increased expenditure on social protection (including health) by about 1% of GDP. While government revenue collection is rising, expenditure is rising faster (including government health expenditure), particularly due to necessary increases in the government payroll. As a result, the fiscal deficit is widening.

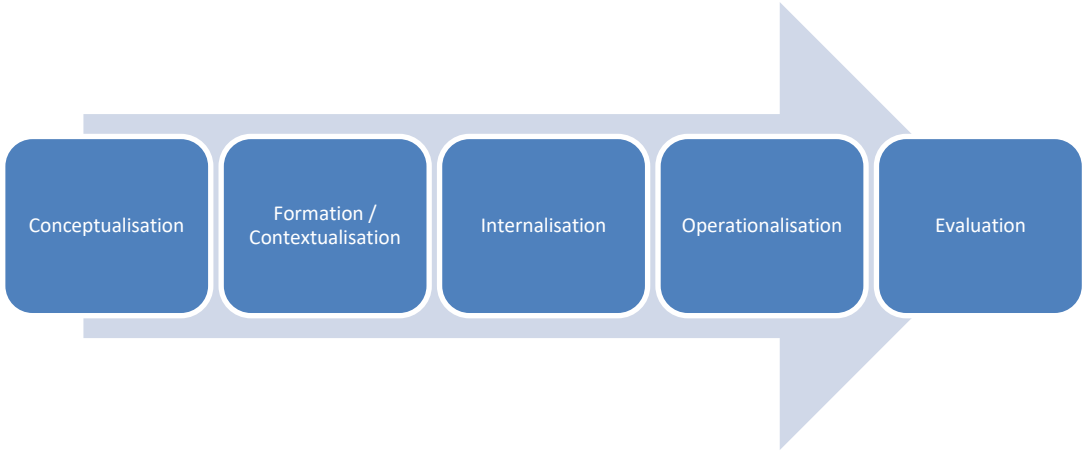
2 Methodology

We analyse the reform processes that have led to the adoption of the Health Equity Fund and SOA internal contracting arrangements in the national health policy in Cambodia. Our aim is to understand what was learned from other countries in these reforms, and why and how.

This is a case study of health system reform in a low-income country that had made significant progress against the health-related MDGs by 2010.[2] This progress was assessed by replicating an approach used by the Center for Global Development (Leo & Barmeier, 2010), but focusing specifically on MDGs 4, 5, and 6 using their publicly available dataset.[3]

We use a phased conceptual framework of international policy transfer to guide the exercise and a narrative approach to describe how the reform evolved. The conceptual framework (depicted in Figure 1) starts with conceptualisation. This is the beginning of the policy transfer process and refers to the development of the broad idea of the policy itself. Formation and contextualisation refer to the processes by which the key conceptual and operational tenets of policy are concretised and then modified to the social, economic, political, and cultural norms of the country. Internalisation is the process by which a policy is accepted and transformed by in-country policy systems. Operationalisation is the process of actually carrying out or implementing the reform. Finally, evaluation refers to critical assessment of any component of the reform. These concepts are outlined in further detail in the project's previously published Landscaping Review Part 3.[4]

Figure 1: Phased conceptual framework for international policy transfer



Key informant interviews were the main source of information, backed up by document review. Informants were selected purposefully and interviewed between 7 and 12 August 2017, with a view to including a wide range of participants who have played direct roles, either past or present, collectively across each phase of the selected reforms. Interviews were conducted face-to-face, led by the second author as principal investigator, and accompanied by the first author as overall project manager. The second author also fulfilled the role of informant/insider as described by Fontana and Frey (1994) – able to act as a guide through the Cambodian health system – set up the interviews, bring extensive background understanding, and establish trust with those being interviewed. An interview topic guide was developed in advance with sections and suggested prompts for each of the policy transfer phases, as well as general questions on whether these

[2] Low income as defined by the World Bank. At the time of writing Cambodia had graduated to lower middle-income status. However, for most of the period during which the reforms took place, it was considered low income.
[3] Dataset accessed on 19 June 2017. Available at www.cgdev.org/page/mdg-progress-index-gauging-country-level-achievements
[4] The phased conceptual framework is marginally adapted from one constructed in the project's Landscaping Review Part 3 – available at www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-3

reform experiences were common in Cambodia, whether there were particular barriers to learning in policy reform, and whether other countries had attempted to learn from Cambodia regarding these reforms. Each interview lasted approximately one hour. Notes were taken during the interviews, and subsequently typed up, by both authors individually. These were then compared by the first author. Data from the document review was primarily used to corroborate information gathered during the interviews, as well as for background information in advance of the interviews. In some cases, documents were also the object of study in themselves (evaluation reports that were considered to have played a role in the reform process). The study was approved by the Ethical Review Committee of Oxford Policy Management (OPM) and the Chatham House Rule is observed throughout.[5]

Data from the key informant interviews and document analyses were used to address, at each stage of the policy transfer framework, what, why, and how (if at all) learning from other countries played a role. Learning from other countries is distinguished from learning from systematised evidence to give a sense of whether information and learning played a role at all. A better understanding of these issues will contribute towards the wider project's final recommendation to the BMGF on future investments that may facilitate health sectors in low-income countries to learn from the successes and failures of other countries as they develop their own system reforms.

[5] 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, may be revealed.

3 Results

Twelve key informants were interviewed, including current technical officials of the MoH, Australia's Department of Foreign Affairs and Trade (DFAT), German International Cooperation (GIZ), and the World Bank (WB), as well as current and former officials of the University of Health Sciences, the National Institute for Public Health, and a former employee of a local research institute who wishes the institute to remain anonymous.

Position of interviewees	Selection categories defined in the Terms of Reference
	Politicians with health policy portfolios over the period of the development of the selected policies/reforms
1. National Institute of Public Health (MoH)	Senior civil servants in health ministries and equivalent at state/provincial level as relevant, in office over the period of the development of the selected policies/reforms
2. Bureau of Health Economics and Financing, Department of Planning and Health Information	
3. Department of Planning and Health Information	
4. Senior health programme officer, DFAT (Australia)	Senior health advisors in UN agencies; health systems experts in specialist health agencies in office over the period of the development of the selected policies/reforms
5. GIZ German International Cooperation and P4H Partners for Health	
6. DFAT health sector advisor	
7. WB health advisor	
8. Reproductive Health Alliance of Cambodia	Senior health advisors and similar NGOs identified as involved in the selected policy/reform processes
9. University of Health Sciences	Academics (from university health-related departments) and staff members identified as providing advice to the selected policy/reform processes
10. Public Health, University of Health Science	
11. Independent health researcher	
12. Former Rector of the University of Health Science	

3.1 How did interviewees position themselves in relation to the six phases of policy transfer?

Many interviewees (particularly, but not exclusively, the Cambodian nationals) had been working in the health sector for their entire careers, some beginning in the early 1980s immediately following the fall of the Khmer Rouge. They had been in several different roles consistent with the different stages of our conceptual framework and were able discuss the two tracer reforms within the much wider health system context and history. Others (mainly international advisors) who were newer to

Cambodia's health system had direct experience of perhaps only the recently launched H-EQIP. Various interviewees explained that to understand the development of the two tracer reforms it was necessary to look back to the unique circumstances of Cambodia's health system in the early 1990s. In the wake of the devastation caused by the Khmer Rouge, there were under 40 medical personnel in the country, the health infrastructure was destroyed, and capacity was extremely low. Throughout the 1980s, Cambodia remained under relative international isolation as the UN General Assembly had voted to seat the ousted Khmer Rouge as the Cambodia representative, and foreign assistance was extremely limited.

One respondent spoke of a development partner (one of the few that were active in country at the time) smuggling medical literature in through their diplomatic bags. The French government, for example, offered assistance with accelerated training of healthcare practitioners and specialists, both in Cambodia and in France, with former medical students asked to come and train new ones. The respondent spoke of the need to start with two things – to train enough staff, and for that training to be of a good quality. At first about 100 people were sent to France (part training in France, part in Cambodia). This became the backbone of the Cambodian health system. In addition, retired professors from France came to teach parts of modules on a voluntary basis, following the French curriculum.

Following UN-sponsored national elections in 1993, the country opened up to foreign aid. In 1988, there were 23 international NGOs and no local NGOs operating in Cambodia; by 1995 there were 164 and 160, respectively (APO, 2015). Therefore, just prior to the conceptualisation and implementation of the HEFs and contracting reforms, the health system's capacity was uniquely low in terms of institutional, infrastructural, and human resource capacity. Even at that time, Cambodian health officials and staff had to 'learn from nothing', policy decisions were made by 'very few people', and there were limited readily available source materials in country about the experiences of other countries.

One interviewee said that when health system reform began through the MoH in 1995, this was led 90% by the World Health Organization (WHO). Other development partners involved were UNICEF, the Asian Development Bank (ADB), and the WB. A Health Coverage Plan and a Health Financing Charter were developed in 1995 and 1996 with technical assistance from WHO and funding from development partners under the ADB's Basic Health Services Project. The Health Coverage Plan established health Operational Districts (ODs) based on population coverage to be responsible for service delivery; the Health Financing Charter authorised charging of nominal user fees (according to a defined schedule) at government facilities.

This picture has changed. After 2000 – and more so in recent years – there has been great change in Cambodia society, with many more people completing higher education, much more knowledge of the English language, many more effective local agencies and actors, and much more capacity to achieve goals. As will be discussed in Section 4, the conceptual framework for this study needs therefore to be interpreted dynamically, that is, as understood as a repeated cyclical process from conceptualisation to evaluation occurring at multiple points in the unfolding reform process. Even H-EQIP, which may be considered a stage in the operationalisation of the HEF and SOA reforms, has its own complete cycle.

3.2 Use of systematic evidence and learning from other countries with respect to the conceptualisation stage

According to various interviewees, it was generally accepted in the late 1990s that improved efficiency of the health system was needed in order to accelerate reductions in mortality indicators. The HEF and contracting reforms were conceptualised in the late 1990s principally by international

NGOs and development partners concerned with the low utilisation of district health facilities, generally because poor people were unable to pay user fees and facilities could not afford to extend exemptions.

While the HEF pilots drew on concepts of solidarity and social assistance that were, in a broad sense, already understood in Cambodia, Medicines Sans Frontieres (MSF) and UNICEF together with the MoH developed from 2000 the notion of a small facility-based fund to reimburse rural health facilities for the user fee exemptions they provided. In Phnom Penh, a parallel experiment took the form of urban 'health rooms' established under a project funded by the UK Department for International Development (DfID). In 2010, Bigdeli and colleagues commented that the first HEFs and the health rooms were designed for poor patients 'who needed referral [but] could not afford to pay hospital user fees and other related costs, [and] forwent the treatment or fell into debt. Similarly, in Thmar Pouk and Sotnikum [HEF sites] … the hospital user fees became a barrier to access for the poor' (Ir, Bigdeli, Meessen, & Van Damme, 2010) p.203). These innovations, which grew from practice and a general understanding of social welfare principles, were thought to be uncomplicated but had not been tried elsewhere.

The origins of SOA internal contracting can be traced back to innovative contracting-in/out pilots launched by the ADB in Cambodia through the Basic Health Services project in 1997 (Bhushan, Keller, & Schwartz, 2002). While contracting to the private sector had been trialled earlier in Brazil, one interviewee explained that Cambodia had learned about this only after it piloted contracting-in/out. One Cambodian expert and the WHO had reportedly introduced the idea of strategic purchasing to improve efficiency. Khim and colleagues argued that the contracting innovation was 'influenced by a global move toward adopting private sector methods in the public sector, particularly performance based incentives' ((Khim, Ir, & Annear, Factors driving changes in the design, implementation, and scaling-up of the contracting of health services in rural Cambodia, 1997-2015, 2017) p.110). At another district hospital (Takeo), the Swiss Red Cross worked with the MoH to introduce its own performance-based method for staff remuneration, with WHO support.

Various interviewees commented on the remarkable openness of MoH officials to piloting new ideas from development partners; they hoped, in fact, to learn from the experience. One interviewee argued that the MoH accepted these pilots simply because they did not have the resources to do otherwise and feared the general public would blame the government if nothing was done. Others believed that Cambodians were simply 'learning by doing' – implementing the ideas of a small group of people. In addition, there may have been 'a desire to be further integrated into the international and regional communities after decades of conflict, limited fiscal resources, and the need to speed up reconstruction of the health sector' and that, for these reasons, 'MoH officials… were receptive to proposals for the piloting and evaluation of new service delivery approaches' (Khim, Ir, & Annear, 2017, p. 110).

In recent years, there has been a more systematic approach to collecting evidence from the experience in other countries. Today, with support from the government-donor national health sector programme, known as H-EQUIP 20016–2020, Cambodian health officials are visiting countries such as Thailand, Indonesia, Vietnam, and the Philippines to investigate their service delivery and social protection programmes. In the preparation of H-EQUIP and the Health Strategic Plan 2016–2020 that it supports, health officials visited Kyrgyzstan (with support from the WB) to develop a better understanding of interventions to improve quality of care (a central concern of the strategic plan), and a WB advisor from Washington presented ideas to the MOH. In the development of national social security arrangements – in which the health sector plays a leading role – the responsible ministry, the MEF, sought technical advice from the German development agency (GIZ) and the international alliance P4H but instead was provided with capacity-building

assistance as well as financial support to meet the MEF request for tours to gather information in Thailand, Japan, the Philippines, and Vietnam.

3.3 Use of systematic evidence and learning from other countries with respect to the formation/contextualisation stage

Contextualisation of both reforms occurred gradually, through an ongoing process of piloting, implementation, and adaptation. In the early years, MoH officials relied strongly on their development partner colleagues to pass on experience from other countries. At the same time, the MoH itself was determined to develop interventions that fitted into the Cambodian context. This creative tension between local and international planners has been a feature of the unique developments in Cambodia, leading to eventual outcomes that are now fully contextualised.

Contextualisation was a matter of defining practice, in which the MoH and donor partners did not always agree on the direction to take. Negotiation rather than evaluation appears to have driven the contextualisation over time of the HEF and contracting reforms. At the same time, the systematic evidence that supported the reform designs came mainly from disparate research efforts in Cambodia. Led principally by international researchers and development partners, the research efforts generally included representatives from the MoH or local research institutes. With such evidence in hand, the MoH and development partners jointly arranged national workshops to share operational details for the HEFs, for example in 2006 and again in 2010, which led to further refinements of the HEF design.

Among the published evidence base for HEF implementation were research studies that showed:

- that village-based pre-identification of eligible population was both feasible and cost-effective;
- that pre-identification may be superior to post-identification in terms of increased awareness and utilisation, but that post-identification provided an opportunity to adjust for changes in the target population;
- that referrals to tertiary care should be included in the benefits package;
- that a mixed committee in charge of the HEF (or at least of monitoring and evaluating it) is both effective and inexpensive;
- and that participation by the local community throughout the process reduced administrative costs and increased local ownership (Ir, Bigdeli, Meessen, & Van Damme, 2010).

Contextualisation of the contracting reforms came through implementation practice in various forms. Evidence from the implementation of the first contracting-in/out models piloted in five ODs in 1997–2002 came from research sponsored by the ADB, which found that the contracting-out of service delivery to NGO providers produced the best outcomes (Bhushan, Keller, & Schwartz, 2002). The results (which were derived partly from the methods used) did not have a direct influence on the way in which contracting policies evolved, and the MoH was concerned particularly about issues of cost, sustainability, and stewardship that had not been resolved in the pilot studies. Interviewees suggested that the MoH never committed in full to implementation of the model, partly because it was not willing to transfer service delivery to NGOs.

In the broader environment of social protection policy (in which health is the pilot sector), the MEF is the leading agency, working in close collaboration with the MoH to incorporate the lessons

learned in HEF development. A new national Social Protection Framework has recently been developed. To do so, a high-level task force was established between the MEF, MoH, and donor partners; teams were sent to various countries to learn about the social assistance approaches. Based on this evidence, and on Cambodian experience, a model of social health protection was developed that includes the unification of private sector workers and civil servants in a single National Social Security Fund and the national expansion of the HEF to include the informal sector. It is anticipated that by 2018 there will be, under the SPF, a single UHC agency. Further investigations will be arranged in China and Indonesia to look more carefully at the question of how to provide coverage to the informal sector.

3.4 Use of systematic evidence and learning from other countries with respect to the internalisation stage

The internalisation of the HEF and contracting reforms occurred through a process of project implementation and evaluation alongside the national health strategic planning process. Internalisation happened in at least two arenas, first in the health sector, including both the MoH and the development partners, and then in the government as a whole, including the MoH and the MEF in a process of negotiation about the future strategy for the health sector and its fiscal and administrative limitations.

Since 1993, MoH officials and donor partners have met in regular Technical Working Group for Health (TWG-H) meetings, with Provincial TWG-H meetings playing the same role regionally. Local and international NGOs involved in health activities formed the MEDICAM association, which also had a seat at the TWG-H. From early 2000, a Sector Wide Management mechanism – similar to the Sector Wide Approach adopted elsewhere – pooled some funding and aligned donor activities with national health plans (but without channelling donor funds through the MoH budget process). According to interviewees, these networks facilitated information-sharing about the pilot projects (and were the means by which the MoH was introduced to the HEF pilots). They also provided the opportunity for local officials to become increasingly familiar with the international literature and with similar health system reforms globally. This was reinforced by travel opportunities arranged through the donor partners.

With very few barriers to entry and low overall costs, the district-based HEF model expanded organically after 2005. With different donor sponsors and sources of funding, the number of ODs with HEF rose rapidly, based on the evidence from the initial pilot projects. As one interviewee explained, while WHO were supporting the Phnom Penh health rooms, they recognised the value of the rural HEF model (easy to manage; third-party payer; reimbursement to providers). At the time, the health rooms supported by the Urban Sector Group in Phnom Penh (backed by WHO and DfID) were taken over by the University Research Co. (a US NGO) with USAID funding and converted to the HEF form. Other rural district HEFs were initiated by local NGOs (such as the Cambodian Association for Assistance to Families and Widows), UNICEF, Health Net International, and in one area local Buddhist pagodas (supported by Health Net International). The results from these initiatives corroborated earlier evidence (Ir, Bigdeli, Meessen, & Van Damme, 2010).

Initially, the view that HEFs were financially unsustainable was common among various development partners and foreign advisors. Some expressed the idea, said one interviewee, that community-based health insurance was a more sustainable option. In its 2002 Poverty Reduction Strategy Paper (RGK, 2002), produced to access WB funding, the government identified the pilot HEF schemes. This gained the attention of the MEF, which saw that the HEF was well aligned with

the national poverty reduction strategy. The MoH then endorsed the HEF as the model for providing financial access to services for the poor on its first Health Sector Strategic Plan 2003–2007 (RGK, 2002), which many interviewees considered an important moment in the history of the reform. By 2015, with evidence from the HEFs and the obvious failure of community-based health insurance schemes to cover any significant proportion of the population after years of practice, the MoH removed its support from the community-based health insurance model. This was reinforced in Health Strategic Plans in 2008–15 and 2016–2020, where the HEF became the foundation for a national social health protection policy.

In 2003, a vigorous discussion had taken place between the MoH and donor partners about the structures and the sustainability of the contracting model. The outcome led to adoption of a 'hybrid' arrangement under which international NGOs were contracted by the MoH to oversee and assist an OD and health facility managers in the administration and delivery of health care. This hybrid model was designed by an external consultancy company working under the direction of the MoH. Then, in 2009, the MoH was selected by the government to pilot a new public-sector management reform, under which selected ODs and health facilities became SOAs with increased management autonomy and performance measures. An internal contracting arrangement between management and service-delivery units within the MoH (and excluding NGOs entirely) was introduced. A process of scaling-up SOAs to national coverage is now underway, replacing all previous forms of contracting.

The internalisation of reforms such as the HEF and contracting took hold when the MoH moved to integrate these mechanisms into their existing administrative structures and in line with their own preferences and priorities. Following the national consolidation of the HEF after 2010 a third-party NGO (the URC) had been contracted to oversee the scheme nationally alongside MoH administrative processes (to authorise payments to facilities following utilisation by an identified eligible person); by 2016 the MoH had fully taken over HEF administration national, district, and facility level, arguing that efficiencies were needed. Now, no NGOs at all are involved in HEF implementation and all functions will in future be transferred into the prospective National Health Insurance Agency, independent of the MoH.

Under enormous pressure from development partners (who all seemed to want to maintain control of contracting and the HEF), the MoH and the government nonetheless moved to bring the schemes within the MoH administration. Facing a key criticism of the donor partners, the MoH made a commitment to establish some sort of third-party role within the MoH, a solution which it argued would internalise the models.

3.5 Use of systematic evidence and learning from other countries with respect to the operationalisation stage

The years since the late 1990s can be split into four health sector operational periods. The Basic Health Services Project (1996–2002) covered the period in which the HEF and innovative contracting reforms were conceptualised. Contextualisation came largely during the first Health Sector Support Project (HSSP) of 2003–2008. Government internalisation and operationalisation were features of Phase 2 of the HSSP in 2009–2016, during which time the financial contribution from the MEF grew from 10% to 40% of the total project funding. The H-EQIP project (with a national HEF and internal contracting), which was launched in 2017, is 60% funded by MEF.

With the first HSSP, the MoH operationalised the HEF through guideline provided under the Strategic Framework for Equity Funds and a National Equity Fund Implementation and Monitoring Framework. To do so, the MoH contracted an international consultant (Ricardo Bitran) to help develop HEF structures and mechanisms, though interviewees confirmed that not all of Bitran's

recommendations were implementable. The Framework identified three possible management models: one followed the donor-led pilots and included an NGO as a third-party fund operator; in the second model, the OD office was the implementer; and in the third, the health facility itself was left in charge of management. (Effectively, the MoH now follows the third model.)

From 2005, attempts had been made to harmonise the disparate district HEF schemes. The 2006 National HEF Forum, led by the MoH, brought together government and international technical staff (Secretary of State for Health, the MEF, the Western Pacific Regional Office of WHO, BTC Brussels, and DfID) to address design issues and to move towards greater operational uniformity. A second national HEF Forum (sponsored by the MoH, WB, USAID and AusAID) in 2010 agreed on a common strategic approach as well as the benefit package, the targeting mechanism, the links with service delivery, financial sustainability, the links with other financing mechanisms, and the institutional arrangements for HEF implementation.

The HEF national network had grown organically from 2000, district by district, with donor partner financial and technical support. With support from the MoH, a single HEF provider (URC, a US NGO) took control of all district HEFs in a single programme and administration, using local NGOs as operators at OD level. After a protracted and difficult process of discussion and negotiation, the MoH took over the role of national administration from URC in 2015. Today, the HEF is administered nationally by a unit within the MoH. Under the Health Strategic Plan 2016–2020, the MoH has moved to apply the HEF facility-payment system and the performance measures associated with internal contracting to provide incentives for increased quality in service delivery in line with the Plan goals.

The experience shows that a degree of trust and mutual respect was needed for the government to buy into something that appeared to be led (initially) by development partners. Similarly, the move to internal contracting was prepared by the government's National Program for Administrative Reform (2004–8 and subsequently 2009–13), which included a 'Policy on Public Sector Service Delivery' to improve the quality of and access to government services. Under the first phase of the National Program of Administrative Reform, the external contracting model moved to the 'hybrid' form, a compromise between contracting in and contracting out (Khim, Ir, & Annear, Factors driving changes in the design, implementation, and scaling-up of the contracting of health services in rural Cambodia, 1997-2015, 2017). One interviewee who had experience in one of the contracted NGOs believed that someone 'high up' in government circles must have told the OD staff to work alongside the NGOs because (at least in some cases) it functioned well. The move to the SOA form of internal contracting during the second phase of national administrative reform was a relatively smooth process as the donor partners came to see the need for administrative efficiency within national budget restrictions.

Operationalisation continues under the H-EQIP process, co-designed and co-funded by development partners, the MEF, and the MoH. H-EQUIP prioritises the consolidation of the HEF and the service delivery grant component of the SOAs, though it is not clear what evidence is driving the push for performance-based payments (which is strongly supported by the development partners). H-EQUIP – administered entirely through the MoH – also aims to institutionalise the two reforms to improve their sustainability. According to one interviewee, the plan is for the donor partners and the MoH to work together and gradually pass the task onto a new domestic administrative entity.

3.6 Use of systematic evidence and learning from other countries with respect to the evaluation stage

For about two decades after 1993, the MoH was prepared to accept a broad and varied process of donor-led innovation in the health sector. One reason for this was to provide evidence about what worked most effectively in Cambodia. Based on various evaluations, the MoH eventually narrowed its view, choosing principally the HEF and the SOA models. A series of early evaluations had suggested that the first set of HEF pilots were broadly successful (Hardeman, et al., 2004) (Meessen, Van Damme, Por, Van Leemput, & Hardeman, 2002), (Van Damme, et al., 2001), and (Knowles, 2001). This encouraged a second donor-led wave of HEF pilots in new districts, all with slightly different operational structures, generating a second wave of evaluations (Jacobs & Price, Improving access for the poorest to public sector health services: insights from Kirivong Operational Health District in Cambodia, 2006), (Noirhomme, et al., 2007), (WHO, 2003), (Annear, Wilkinson, Chean, & Van Pelt, 2006) (Jacobs & Price, 2004) (Jacobs, Price, & Sam, 2007), (Jacobs, Price, & Ouen, 2007) and (Nguyen, 2004).

The initial contracting-in/out pilot was evaluated by the ADB in 2001 (Bhushan, Keller, & Schwartz, 2002). There was no formal evaluation of the 'hybrid model' of contracting but some interviewees referred to various informal assessments. One interviewee pointed to information gained from the first Health Sector Support Program as influential in moving from the hybrid model to the SOA and suggested information from other countries was not needed at that stage. A 2007 review of contracting for the MoH (MoH, 2007) reported that progress in service delivery indicators had been achieved but also revealed deficiencies in the extent to which the international NGOs had strengthened the capacity of local officials (which had been a key component of the contracts).

Further evidence on management and service delivery outcomes in the transition from hybrid to SOA contracting was provided in a doctoral study by a Cambodian researcher based at the University of Melbourne (illustrating a further aspect of the ongoing knowledge transfer process) (Khim and Annear, 2017; Khim, 2016; Khim and Annear, 2013; Khim and Annear, 2010). The MoH and WHO conducted a joint evaluation of the SOA experience during 2017. While the report is yet to be published, interviewees who worked on the study indicated that health service delivery indicators had been maintained or improved under the SOA arrangement and that there was evidence that health service management arrangements had improved.

Cambodian researchers and research institutes have played a key role in the research and evaluation process since 2000. One interviewee recalled that the evaluation process had at first been driven by international organisations looking for evidence on the effectiveness of the various Cambodian pilots (such as contracting-in/out) but in more recent years that had changed. Another interviewee stressed the importance of this achievement for informing Cambodian health policy (with work carried out jointly, in many cases, by international and local evaluators). These functioning networks between local and foreign researchers had enabled more effective dissemination of results, had brought MoH officials into the evaluation process, and had facilitated translation into policy outcomes.

Donors continued to play an important role. For development of the H-EQUIP design, the Australian DFAT in 2015 commissioned a value-for-money analysis of HSSP2 outcomes, authorised by the MoH. The findings, according to various interviewees, identified the HEF and innovative contracting as the most effective components of HSSP2. The MoH used the results, together with the donor partners, to realign funding under H-EQUIP towards these programmes, along with initiatives to improve quality of care.

One interviewee (who had experience with a local-international research consortium) pointed to the distinction between doing research and getting research into policy, with the latter being much more complex. Getting research into policy is about the contextualisation, internalisation, and operationalisation of the ideas and information that comes out of the research. The consortium steering committee included representatives from the MoH, which is common practice. Even so, attendance at the policy meetings and conferences, both national and international, where results were reported consumed an inordinate amount of time and hindered further research work. Presenting the results to decision makers in other countries was encouraged. The interviewee suggested that this may be because the donors were stronger there.

Despite the greater role of Cambodian researchers, one interviewee felt on balance that evaluation is still led by international experts and supported by local researchers, partly because, as the international partners have the resources, they decide the questions. Furthermore, much less attention has been paid to rigorous impact evaluation, perhaps because this is less politically attractive in an environment where positive outcomes are valued.

3.7 Perspectives on what helps and hinders learning from the experiences of other health systems (questions 8-10)

Several interviewees thought that, particularly in the early years of health system reconstruction, contact with the technical advisors and managers of international agencies had been important in the learning process. Talking with international advisors, studying overseas, making trips to neighbouring or similar countries, and working with donor-funded projects had all been helpful. But the key feature was partnership. Foreign advisors who work alone or impose ideas on a local situation without due consideration of context or capacity run the risk of seeing their advice fall on deaf ears. Fortunately, there has been consistent progress in building peer-to-peer respect and long-term collaboration, which has been instrumental in defining many of the productive policies that now characterise Cambodia's health sector.

With an understanding of the Paris Declaration on Aid Effectiveness, respondents placed value on harmonisation among donors and donor alignment with national health policies. The TWG-H was one effective vehicle for the expression of these practices and assisted the at times difficult dialogue. In addition, the health donor partners in Cambodia have for many years met together regularly to discuss and harmonise their activities in support of MoH colleagues. Increasingly, Cambodian policymakers, planners, and researchers have developed the capacity to lead the process of piloting, evaluation, institutionalisation, and financing of policy initiatives in the health sector. Interviewees argued that, for research to be incorporated into policy, its conceptualisation must start with the policy itself, linked to national priorities.

The government's recent adoption of the National Social Protection Framework 2016–2025 is a significant example. The national framework was, in fact, built on the lessons learned from the HEF experience, combined with overseas experience. Healthcare is the most advanced aspect of the Framework implementation to date. Working at the request of the Ministry of Economics and Financing, donor partners assisted in establishing a Task Force and in sending officials for overseas training in social security mechanisms. This worked well, and the officials returned to Cambodia to develop the National Social Protection Framework, which incorporates the HEF as well as social health insurance schemes for civil servants and private sector workers. This signified a move by donor partners to supporting capacity-building activities (for Cambodian policymakers), rather than giving direct technical assistance (using foreign advisors).

One interviewee emphasised that placing international staff within government departments works well to provide regular collaboration, producing joint reports, group presentation and plenary

workshops (for example). One interviewee thought that HEFs had perhaps developed more rapidly than contracting reforms because they had emerged much more organically with purely Cambodian interests in mind. A limitation in the learning process had been, however, that there were not enough people available to learn, and not enough people with the capacity to learn in the required manner. While regional bodies can assist in the learning process, it was thought they were useful only to the extent that they were well known and provided support to the strengthening of local research institutes. Even so, nothing lasts forever, and what plays a positive role at one point may not do so at a later time. The challenge is to make the learning process a sustainable feature of health system functions.

4 Analysis/discussion

4.1 Patterns from across the six stages

Over the last two decades, the pattern of learning from experiences in other countries and building policymaking capacity in Cambodia has been somewhat 'organic', that is, it has evolved in stages during which Cambodian policymakers have gained cumulative experience and knowledge by carrying out the work of health system reconstruction and strengthening, working continuously with support from international advisors. This has involved a process of formal and self-education, travel, and increasing familiarity with the experiences of other countries.

Finding evidence of what works and does not work has been a critical part of this process. A central feature has been the process of piloting and evaluating various innovative health system interventions (often through international agencies). Sensitive assistance from international advisors has been of great importance. The opportunity to complete formal postgraduate education and participate in international gatherings has increased local capacity to understand and absorb lessons from abroad. It is difficult, however, to identify occasions on which Cambodian policymakers and technical advisors simply canvassed the world for effective policies and then introduced them into the Cambodian health system. The situation therefore appears to be more nuanced and complex than may seem the case otherwise.

For example, the HEF was initiated as a uniquely Cambodian intervention to improve access to health services for the poor. A different approach had been more evident in other countries, particularly in Africa, under the heading of 'community-based health insurance', and schemes of this kind were also introduced in Cambodia, particularly under the influence of foreign advisors and agencies. For Cambodian policymakers, the objective was to test these different approaches under Cambodian conditions, a process that was increasingly led by the MoH and carried out in collaboration with donor partners. The evidence in support of the implementation of effective interventions (that is, contextualisation, institutionalisation, operationalisation, and evaluation) therefore came from inside Cambodia, but a constant (informal) comparison with unfolding interventions in other countries accompanied the process.

Interviewees consistently referred to the evaluations of the early HEF pilots as critical to the national expansion of the scheme. Evaluations of the HEF focused on operational details, and these findings influenced future structure and scaling-up of the scheme in a way consistent with perceived local health policy needs. Evaluation of the first contracting-in/out pilot was carried out through the ADB as the implementing development partner. This evaluation did not, however, consider the wider questions related to national ownership and sustainability, which became the determining factors in the transition to internal contracting arrangements.

A vigorous ongoing discussion about the best way to arrange the national management of the HEF has taken place between international and local policymakers. In the earlier form, an international NGO had retained responsibility for the monitoring and auditing of health facility claims for the reimbursement of user-fee exemptions provided to the poor, with district-level operation carried out under contract by local NGOs (creating a purchaser–provider split). Today, as part of a broader transition to the introduction of national social security process, the national and local administration of the HEF has been assumed by the MoH. Evidence from other countries about the need for and nature of the purchaser–provider split is well known to Cambodian health planners, who often argue that they work to protect the principle even while administering the HEF from within the MoH. This may in fact be a temporary (though extended) solution while the MoH and the Government both work towards the establishment of an independent or semi-government social protection agency.

The majority of the evidence used to inform both the HEF and SOA policy pathways, however, has been nationally developed. The lessons from other countries appears perhaps to have influenced the conceptualisation of policy options but not so much as the evidence base for designing and refining interventions. Moreover, initial rounds of domestically generated evidence were demanded by the implementing international organisations as a means of persuading others that their schemes were working. Arguably, the process of 'learning from other countries' has been about learning how to make these ideas work in Cambodia through repeated cycles of operationalisation, evaluation, negotiation between the government and the development partners, and more operationalisation.

4.2 What/who were the institutions, individuals and mechanisms by which (a) systematised evidence and (b) learning from other countries were introduced into the policy process?

Today, health policymaking, strategy, and planning in Cambodia is led by the MoH, particularly through the DPHI. Many of the individuals who now lead the MoH and its main departments were those who, after 1980, led the reconstruction of the health system. Others were recruited into the MoH around the time of the 1993 national election. The manner in which these individuals drew on evidence and learnt from other countries has been explained here as an organic process.

During the last two or three decades, the role of the international agencies in this learning process has been critical, especially through key individual advisors, particularly through the ADB, WHO, UNICEF, GIZ, and NGOs such as MSF and URC:

- The ADB and WB were instrumental in introducing the contracting initiative.
- WHO has been a constant source of technical assistance in the development of national health priorities and strategies.
- MSF and UNICEF were instrumental in inventing the HEF form and URC central to its national development.
- GIZ has provided constant support to health research and education and to the development of social health insurance approaches.

At first, systematic evidence gathering and learning from other countries was facilitated by international organisations present within Cambodia and then picked up by a second wave of international organisations and the MoH. Such evidence was used as advocacy to persuade relevant stakeholders (both international organisations and government) that the schemes were effective, manageable, and affordable. Much of the HEF literature also appears to have been targeted at other countries, suggesting that this was a scheme worth trying elsewhere as well.

Two local research institutes have also been prominent in producing the evidence for the development of the HEF, SOA, and other interventions. Over time, these two institutes have become stronger. GIZ has supported the National Institute for Public Health continually over two decades and has helped to carry out operational research as well as introduce academic programmes in public health. Leading researchers from these institutes now play a crucial role, alongside international colleagues, in conducting the research required for producing evidence.

A further dimension emerged as the MEF increased its financial contribution to the government-donor health sector projects. To justify the additional spending, it was imperative that the MoH could produce the evidence that the schemes in question – the HEF and SOA arrangements – were effective in producing better health service outcomes and greater efficiency. Today, there is a 'critical mass' of researchers, technical staff, and policymakers in Cambodia who can successfully gather the evidence from Cambodia and overseas and use it in the formulation of effective policies.

4.3 What are identified as the potential institutions, individuals, and mechanisms by which (a) systematised evidence and (b) learning from other countries could be better introduced into the policy process?

Many interviewees considered studying abroad as a critical part of their own learning process. Following the fall of the Khmer Rouge, among the first Cambodians to gain education abroad were medical doctors who received part of their specialist training in France (among whom some were key informants in this study). The numbers increased as the years passed and government staff found new opportunities for study. Ministry departments worked on a rotation-based system in which several people may be available to carry out particular functions while others were studying abroad. As the capacity of staff increased through education, the range of tasks they could carry out increased.

Well-managed and accountable study tours were also generally valuable, though not particularly in the context of HEF or contracting policy. Study tours have taken place to inform policy design for health insurance and social protection. All those who mentioned the tours highlighted the need for very clear objectives, with hard deliverables for those participating.

From the author's perspective, the key mechanism by which systematised evidence and learning from other countries occurred was through domestic operational research on the implementation of the reforms, discussed through functioning internal networks that connected the relevant stakeholders. Participation in these activities was an important mechanism through which Cambodian capacity was developed, both in research and policy fields. It was also a vehicle for discussing the strengths and weaknesses of the schemes, within an evidence-informed arena as well as a space for bringing in ideas from other countries (both the original conceptualisation of the ideas as well operational details).

4.4 What implications does this case study have for the final recommendations made to the Bill & Melinda Gates Foundation?

This case study shows that a significant component of the 'learning for action across countries' process occurs within the learning country after the initial idea has been shared (through the conceptualisation stage). Tailoring the ideas learned from other countries to enable application in the domestic context is a key part of the learning process (contextualisation and operationalisation). Clearly, learning occurs over time as part of an ongoing process; one contribution from this current project is in identifying the elements – individually and sequentially – that comprise this longer-term process. A significant number of platforms and mechanisms for sharing ideas and lessons between countries already exist. These may provide the opportunity that is needed for sharing experiences of effective interventions, and this already occurs to some extent. Having the opportunity to join such networks is a prerequisite to learning from them. In policymaking, there may in fact be a greater gap at the internalisation stage than in conceptualisation. Ultimately, developing the capacity within country to identify, absorb, and adapt ideas as they take up and develop effective interventions from other countries is essential if the cross-country learning process is to offer significant results in low-income countries.

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Annex A Method and Topic guide

1.1 Field Interviews

The overarching purpose of the exercise is to understand the opportunities for countries to make better use of the experience of other countries in developing their health systems' policies. The intention is therefore to understand the current contribution of international evidence to the overall evidence base used to guide policies in a selection of case study countries; and to gather country level stakeholders' perspectives on how they could better use other countries' experience.

1. How do decision makers at country, state and province levels access ideas and evidence about how to make their health systems work better and where does international evidence fit in that picture?

This will inform us about the mechanisms that are currently made good use of that might be further strengthened through investment.

2. What gaps do decision makers at country, state and province levels perceive in their access to appropriate evidence in general, and evidence about other countries experiences in particular?

This will inform us about the spaces for new initiatives that we might design and propose for investment.

Objective

The field interviews aim to understand the perspectives of decision makers in case study countries, and gather their knowledge about the processes involved in using evidence including that derived from other countries' experience in decision making in their setting. This will allow us to understand motivation to use evidence from other countries in decision making, the types of evidence demanded, and mechanisms for sharing international evidence that are currently effectively used.

Case studies

Case studies have been selected from those countries that were low income in 2000 and performed well in meeting MDG targets by 2015 (had achieved at least 1.5 on the Centre for Global Development's health score). From those countries that met these criteria (23), 7 were selected as initial case study candidates on the further criteria of geographic spread, representation of francophone Africa, and feasibility for the team to achieve access to appropriate interviewees. These were Bangladesh, Nepal, Vietnam, Cambodia, Burkina Faso, Ethiopia and Rwanda. A further three countries (Solomon Islands, Georgia, and Nicaragua) were selected as additional possibilities should resources allow, primarily as representatives of still unrepresented geographies.

Method

In advance of the field work, literature review will be conducted to enable a description of health system development and major health system policies and reforms covering the period 2000-2017. This literature review will be augmented by the gathering of additional documentation in countries where this could not be accessed remotely and the further evidence summarised in the country reports.

Interview guide

The primary purpose of the fieldwork will be to undertake a series of interviews aimed at gathering evidence to answer the study questions and objective. The interviews will be conducted by a senior consultant with in-depth knowledge of the selected country and a thorough understanding of the purpose of the exercise. The senior consultant will be accompanied by a research assistant who will take a note of the conversation (whether or not recorded) and may ask additional questions where appropriate. Interviews may be recorded where, in the opinion of the senior consultant, this will not inhibit the interviewee. Where not recorded, interviews should be spaced so there is time to immediately review and annotate the research assistant's notes before the next interview, to the point of a detailed agreed account of each conversation. No public document will record the names of the interviewees, only a general description of their position which could identify a minimum set of at least 5 individuals.

The case unit is the country and we will investigate this case through 'tracer' policies and reforms before concluding with reflection on the typicality of the experience of those policies and reforms at the country level.

In each country, 2-3 policies/reforms will be identified prior to field work and attempts made to identify 1-2 interviewees per reform who will be able to elucidate the decision making process and the use of evidence at each stage of the development of that policy/reform from initial consideration to implementation design. A snowball sampling method will be used by asking these interviewees to identify other potential interviewees who in their view were important in the process from initial consideration to implementation design until the case study team consider they have a comprehensive understanding of the reform development process and recognising time restrictions. This snowball sampling process will be undertaken prior to fieldwork so that interviews can be arranged as far as possible in advance of the team's arrival in country while a few additional interviewees might be identified during the interviews themselves and additional interviews arranged at short notice where possible.

A typical interview will use the following set of questions and probes at the discretion of the senior consultant who may identify additional questions or divergent approaches demanded by the particular circumstances.

1. We believe you were actively involved in the development of policy/reform x. Could you describe the role you played?

Probes: When did this potential policy/reform first arise in the relevant agenda? Describe all the stages of the development of the policy in which you were involved? At each stage: Who were the advocates? Were there opponents? What was your position? What were the critical factors that influenced the progression of the debate to the point that the policy/reform was able to proceed?

Depending on the stage(s) at which the interviewee acknowledges involvement in the policy/reform development, and the extent to which the stages implicit in the questions below reflect the actual policy development process, the following question(s) can be selected. A priori, these are divided into the six phases of policy transfer identified in the Landscaping review part 3. In practice, these phases may not fit the interviewees' understanding of the steps involved in the specific policy under discussion, and the interviewee may modify the phase descriptions accordingly.

2. Conceptualisation: To what extent was the identification of a possible policy initiative influenced by formal forms of evidence (written accounts of the experience of similar policies or reforms in other national or international settings).

Probes: What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested would be the impact of the

policy.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this? Was the team able to identify all the evidence it wanted; and where there were gaps identified, how was the way forward decided? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

3. Formation and contextualisation: Once the policy had gained traction and a more detailed proposal started to be developed, to what extent were discussions about the detail of that proposal influenced by formal forms of evidence?

Probes: What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested should be thought about in policy detail.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this? Was the team able to identify all the evidence it wanted; and where there were gaps identified, how was the way forward decided? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

4. Internalisation: Once a detailed proposal for the policy/reform had been finalised, to what extent were discussions aiming to ensure formal consent (such as approval through a constituted committee or legislative process) informed by formal forms of evidence?

Probes: What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested would be the impact of the policy or supported the policy design.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this? Was the team able to identify all the evidence it wanted; and where there were gaps identified, how was the way forward decided? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

5. Operationalisation: As implementation mechanisms were worked out, to what extent were those informed by formal forms of evidence?

Probes: What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested should be included in implementation design.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that and were there any individuals or institutions that supported you in this? Was the team able to identify all the evidence it wanted; and where there were gaps identified, how was the way forward decided?

6. Evaluation: As the policy was refined on the basis of experience (either pilot or full operational experience), what kinds of evidence were gathered and applied? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

Probes: What evidence was offered? (Please summarise it, including from where the evidence was drawn – locally or internationally, and what the evidence suggested should be included in implementation design.) Who identified that evidence? Do you know from where they sourced that evidence? Did you identify any relevant sources of evidence? How did you go about identifying that

and were there any individuals or institutions that supported you in this? Was the team able to identify all the evidence it wanted; and where there were gaps identified, how was the way forward decided? Was there evidence put forward at any stage that it was decided could not be trusted, or could not helpfully contribute to the debate?

For all respondents:

7. Do you think the experience of identifying, developing, gaining approval and designing implementation strategy for this policy is typical of the processes that are usually involved here?

Probes: what other policies/reforms have you had detailed involvement in (a few examples if the list is long)? What factors drive those involved to seek out evidence or to fail to seek out evidence? Are there differences in the kinds of evidence or the sources of evidence used by different participants in the process? What specifically is typical or atypical in relation to interest or lack of interest; use/lack of use of other countries' experiences.

8. What gaps do you perceive in your to appropriate evidence in general, and evidence about other countries experiences in particular?

9. What mechanisms can you imagine, or are aware of operating in other contexts, that you think would better support the use of evidence in this kind of decision making?

Probes: Is there an existing organisation that you think is well placed to encourage learning from other countries? What would that organisation need to do to improve the ability of countries to learn from each other?

10. Are there institutions or individuals that constrain the use of evidence in this kind of decision making?

Probes: raise types of evidence and knowledge broker that the respondent has not mentioned; ask about their potential to be helpful or tendency to be unhelpful; ask specifically about some of the ideas we are considering/that came out of the consultation such as use of observatories, relationships with individuals in UN agencies, study tours, academic research groups.

Who to interview (potential categories to think through in identifying first 1-2 interviewees per policy/reform and otherwise contingent on the snowball process, in order or priority –we anticipate a total of 10-15 interviews across the case)

- Politicians with health policy portfolios over the period of the development of the selected policies/reforms

- Senior civil servants in health ministries and equivalent at state/provincial level as relevant, in office over the period of the development of the selected policies/reforms

- Senior health advisors in UN agencies; health systems experts in specialist health agencies in office over the period of the development of the selected policies/reforms

- Senior health advisors and similar of NGOs identified as involved in the selected policy/reform processes,

- Officials of health professional bodies identified as involved in the selected policy/reform processes,

- Academics (University (health related department) staff members identified as providing advice to the selected policy/reform processes

- Directors of health-related advocacy groups identified as seeking to influence the selected policy/reform processes