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Learning for Action Across Health Systems – Solomon Islands Case Study

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Executive summary

Background

The Bill and Melinda Gates Foundation wishes to better understand how low- and middle-income countries around the world improve the performance of their public health systems. This includes questions such as **why, when, and how countries learn from the experiences of each other in this area**. Importantly, the Bill and Melinda Gates Foundation also wishes to better understand what could be done better, or differently, in future to enable countries to learn from each other.

The Bill and Melinda Gates Foundation appointed Oxford Policy Management (OPM), United Kingdom, to undertake this analysis. OPM, in consultation with the Bill and Melinda Gates Foundation identified eight countries that, given their own histories of system-wide health reforms, are potentially likely to shed light on why, when, and how countries learn from the experiences of each other to improve the performance of their public health systems. The eight countries are, in alphabetical order: Bangladesh, Burkina Faso, Cambodia, Ethiopia, Georgia, Nepal, Rwanda, and Solomon Islands. OPM contracted Ian Anderson, OPM Associate, and Katherine Gilbert, of the Nossal Institute for Global Health, to undertake interviews in Solomon Islands. This paper presents our findings.

Why Solomon Islands was chosen for the case study

Solomon Islands, a lower middle-income country in the Pacific with a population of around 651,700, was chosen as a case study for five reasons. First, this is a country that has pursued broader health system reforms at various stages in its volatile economic history, including as it transitioned from low-income status to lower middle-income status and back again. Second, the country has a clear focus on health equity. For example, the poorest 20% of the population account for over 20% of public hospital inpatient care.[1] Furthermore, the country also has a focus on primary-level healthcare that was deliberately aimed to be affordable in a country of Solomon Islands size and income level. For example, to date the public health system has been largely nurse-led: the 1,189 nurses in the country comprise almost 80% (78%) of the health workforce, with the 170 medical doctors representing just 11% of the health workforce. Third, the country has a purposeful, pro-active, system-wide vision and policy of deconcentrating the health workforce and expenditure out to rural and remote island communities where the majority (80%+) of the population live. Fourth, Solomon Islands is a good example of a post-conflict country that is pursuing system-wide health reforms aimed at benefiting the whole population, despite – and perhaps because of – the significant ethnic tensions and violence that emerged from 1999 until around 2004: a period known as “The Tensions”. Fifth, the extent to which the government of Solomon Islands learns from other countries and / or itself uses evidence to shape policies is likely to be an important driver of overall health outcomes. That is particularly so because government financing dominates total health expenditure, as well as the direct provision of health services.

The development and evolution of the ‘role delineation policy’ – providing the right health services to the right people at the right cost to government – is the main means of tracing the learning process in Solomon Islands

The role delineation policy (RDP) is, in essence, a ‘tool for better defining the range and level of services – or packages of care – to be delivered to given populations across the Solomon Islands’.[2] The package of services includes the actual health services to be provided at each level,

and the staffing, medicines, equipment, and other supplies and infrastructure needed to deliver such services.

We chose the RDP as a means of tracking the learning process in Solomon Islands for three reasons. First, the RDP is designed to be a strategic and system-wide reform, delivering the right level of services (and inputs), particularly to rural areas, in a way that is financially and institutionally sustainable for a small lower middle-income country such as Solomon Islands. Second, the RDP has been a central part of health system reform in Solomon Islands since 2003. Despite some interruptions and inertia, the RDP has therefore been a core part of health sector-wide reform for the last 14 years. Third, the RDP itself is a central part of MHMS policy for improved health services at a system-wide level. This is apparent from the very prominent, central, integrating role of the RDP in the current health sector strategy.

Methodology

We undertook a review of the peer-reviewed and grey area literature: see References section at the end of this report.

We visited the capital of Solomon Islands, Honiara, over the period 4–8 September 2017. We interviewed 18 people in face-to-face interviews and four via telephone. Of the 22 people interviewed, 11 were officials of Solomon Islands and 11 were multilateral or bilateral development partners. Two of the officials from Solomon Islands were Permanent Secretaries (i.e. heads of ministries). We also interviewed the Head of the Research Department as well as the Chief Statistician within the MHMS. We specifically sought – and were able to interview – current and prior Provincial Health Directors (PHDs) so as to get a perspective regarding learning from other countries from officials working outside of the capital city. Nine of the 22 people interviewed were female. It was made clear at the outset of all interviews that responses would be anonymous, so as to facilitate candour. At the specific request of the MHMS, and with the agreement of OPM, the Chief Policy Officer of MHMS accompanied us to interviews. This did not, in our view, inhibit interviewees' ability to be candid.

The extent of learning from other countries in the evolution of the RDP

Three main observations can be made from our exploration of learning from other countries in the development of the RDP. First, learning from other Pacific Island countries, particularly Fiji and Papua New Guinea (PNG), was a useful exercise at the early conceptualisation and contextualisation stages. This learning was facilitated through professional connections between officials and/or supported by input from development partners. There is no direct evidence of learning from countries outside of the Pacific at any stage; this is likely due to the unique nature of health systems in the Pacific, which are largely government-financed and -provided, serving small remote populations. Second, learning from other countries became less important or relevant at subsequent stages. Interviewees considered that, despite their similarities, the context of health systems in the Pacific, including the degree of decentralisation and level of resources, made the experiences of other Pacific countries, particularly Fiji and PNG, less relevant. However, there were some perceived implementation failures in PNG that officials designed the RDP policy to avoid. Third, the stated goal of RDP tended to evolve in response to the ''fashions'' and priorities of the time, e.g. World Health Organization (WHO) encouraging the framing of the RDP more towards universal health coverage (UHC) and Solomon Islands being prepared to apply the international agenda-setting language to its own RDP.

Lessons from the experience in Solomon Islands

It is important to note at the outset a dilemma facing small isolated countries such as Solomon Islands. The dilemma is this: given their limited fiscal space for health expenditure, and the small size of their managerial and administrative staff, countries like Solomon Islands cannot afford to waste financial and human resources on interventions that do not work. Their limited number of managers and technical specialists means they also cannot 'reinvent the wheel' with respect to new policies and interventions. Such countries therefore have much to gain from learning and applying lessons from other comparable countries. On the other hand, the small size of the bureaucracy – Solomon Islands has only one person in the Research Department of the MHMS – means such countries find it particularly difficult to find the time and space to learn and then apply lessons from other countries. This is particularly true in Solomon Islands, where, given its geographical location, travel to international conferences is particularly expensive and time-consuming. While the MHMS in the capital, Honiara, has adequate internet access, online learning is also a poor option for many in a country where only 12% of the population has access to electricity and internet coverage is limited and unreliable.

At the international level

There is evidence that Solomon Islands officials are using international and multi-regional experiences to shape policy and programmes. Despite the unique characteristics of Solomon Islands, international and multi-regional meetings can be a useful opportunity to learn how other middle-income countries have tackled challenges that are common to all, including placing and retaining health workforce staff in rural and remote areas. On the other hand, international and multi-regional meetings can also be an expensive exercise that has little to offer in terms of learning from others. Some interviewees believed that international meetings, and multi-regional conferences that brought Pacific Island delegates together with delegates from Asia, had little to offer as regards countries learning from each other. That is particularly because Asian economies and populations are much larger than Pacific economies and societies and their health systems are structured very differently, often with large – if often unregulated – private providers and / or dual practice and large out-of-pocket payments for healthcare: characteristics that do not apply in the Pacific. The primary motive for attendance at conferences also needs to be taken into account when assessing if learning from other countries is likely to occur. There is strong anecdotal evidence that senior and middle managers may use attendance at international and regional conferences as a means to supplement income through the payment of travel per diems and allowances, rather than as a mechanism to learn from other countries. More broadly, experience suggests that the quality of international conferences varies significantly. This then raises more fundamental questions such as: who ensures the quality of supply of these conferences? Who are development partners accountable to? How can development partners work together to prioritise such events?

At the Pacific regional level

Learning at the Pacific regional level is particularly relevant and important. This is because Pacific Island countries, including Solomon Islands, face a distinctive set of challenges that are not shared by other middle-income countries. These distinctive factors, including their small population size, mean each Pacific Island country needs to learn from the others and cannot 'reinvent the wheel'. Having said that, their small population size and even smaller numbers of health planning specialists mean it is also difficult for countries like Solomon Islands to take full advantage of learning opportunities.

There are good examples of Solomon Islands learning from other Pacific Island countries. These include pooled regional training for doctors in Fiji, as well as short-term regional training, such as the World Bank's health financing *flagship* courses. Regular regional conferences, including the Heads of Health, provide a specific opportunity for formal and informal networking and exchanges. Specific country visits have helped to pass on learning from other countries in the region.

On the other hand, there appears to have been some missed opportunities to maximise the learning opportunities. Regional meetings have not always fulfilled their potential because they have had crowded agendas and / or have largely involved a presentation by one speaker, rather than a genuine dialogue between all countries. Even when regional conferences have generated new insights and learning, the *dissemination* of those insights back to others who have not attended has sometimes been weak, or even non-existent. Short-term regional training has generated regional and country learning but in some cases the lessons and insights were eroded shortly afterwards due to limited opportunities for follow-up and mentoring in terms of actual implementation. The lack of timely, comparable, comprehensive, and easily accessible published data on key trends such as the rise of non-communicable diseases (NCDs), or the prices obtained by countries for key pharmaceuticals in the Pacific, has also reduced opportunities for learning from each other.

At the country level in Solomon Islands

Solomon Islands is now making much better use of information and evidence when shaping its policies and programmes than it has done in the past. This welcome development reflects two factors. First, strong leadership from the top: senior managers from the Permanent Secretary down are asking for better and more timely data so there is a 'demand' for data as part of the overall 'doing better' culture. Second, there is a response on the supply side: there has been a significant increase in both the quantity – but also the quality – of data now being generated, collected, and analysed.

However, once again, there have been some missed opportunities. Despite the significant recent increase in the volume – and quality – of data now being generated these data do not always *drive performance* or get used to reallocate scarce resources to where they will have the highest impact in terms of public health and / or resource management. There is also sometimes a disconnect between the improved evidence base and performance, perhaps explained by gaps in a sense of accountability; weaknesses in supervision; or institutional constraints, such as inability to reallocate funding or health workers to higher impact interventions.

The MHMS has some internal constraints to using data and learning lessons to best effect. Some interviewees explained they needed assistance and capacity building in terms of being able to put together a credible proposal for 'learning' from other countries. There is not a particularly strong 'evaluation culture' in the Pacific Islands, which means opportunities to assess who is benefiting from a particular health programme, where, when, why, and at what cost, are not generated. The interview team noted that the Research Department of the MHMS consists of one person, which suggests missed opportunities to develop a strong strategic pipeline of applied research that addresses the priority needs of managers.

There are also some constraints that are outside the direct control of the MHMS that can override evidence-based learning from other countries. First, the MHMS is responsible for many aspects of health services, including policy, budgets, and procurement of supplies. However, the Public Service Commission has responsibility and authority for all personnel issues, including numbers and location of health workers. Second, the Ministry of Foreign Affairs and Trade, not the MHMS, decided to accept an offer from Cuba to train up to 138 doctors in Cuba, effectively doubling the

number of doctors in the country. This decision, taken largely outside of the MHMS, has created some important challenges for the MHMS and has the potential to weaken the health promotion / nurse-led characteristics of Solomon Islands' health reform. There is even a question as to whether doctors learned 'the right things' while studying in Cuba. The third example of decisions being made outside of the control of the MHMS – and therefore the learning from other countries that the MHMS may have – involves the use of the generous Constituency Development Funds (CDFs) available to each Member of Parliament. CDFs are an increasing large and influential source of financing within the health sector that can operate outside of MHMS policies and strategies.

Development partners can be helpful in relation to learning from other countries, but they can also distort priorities. Bilateral and multilateral development partners are a potentially valuable source of cross-country learning. However, significant external financing may skew national priorities and run counter to what the latest evidence at the country level is suggesting.

Implications for the Bill and Melinda Gates Foundation

There are three implications from this study that the Bill and Melinda Gates Foundation may wish to consider, starting with the importance of leadership. First and foremost, it is an essential prerequisite to have stable and strong leadership that is genuinely interested in 'evidence' and 'outcomes', if any form of learning is to have traction.

Second, there needs to be a visible and sustained institutional *demand* for learning from other countries, a situation that arises more frequently as bureaucracies move from mechanistic input-based resource allocation decision making to more outcome-oriented decision making. The Solomon Islands MHMS has developed and evolved to the point where a critical mass of senior officials now ask for and expect to receive evidence about 'what works', for whom, when, at what cost, and under what circumstances, including, where relevant, the lessons from neighbouring countries. This has not always been the case. Partly due to the small size of the economy and society, there is also a lack of scrutiny or 'demand' for evidence-based policy from civil society in Solomon Islands, including scrutiny from the media, local non-governmental organisations (NGOs), or the limited number of academics working in the country.

Third, whether the *supply* of learning from other countries gains traction depends to a large degree on *who* is supplying the evidence; *when* it is provided in the planning, budget and political cycles; and *how* it is provided. How well those factors are managed will determine if the supply of learning and evidence gets to make it to the policy table in the first place. Whether it then gets traction will depend on perceptions about the relevance and quality of that evidence, as well as a range of broader political economy factors

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List of abbreviations

AHC	Area Health Centre
AusAID	Australian Agency for International Development
CDF	Constituency Development Fund
DFAT	Department of Foreign Affairs and Trade (Australia)
DHIS	District Health Information System
HSSP	Health Sector Support Programme
MDG	Millennium Development Goal
MHMS	Ministry of Health and Medical Services
NAP	Nurse Aid Post
NCD	Non-communicable disease
NGO	Non-governmental organisation
NHSP	National Health Strategic Plan
OPM	Oxford Policy Management
PNG	Papua New Guinea
PHC	Primary Health Care
PHD	Provincial Health Director
RDP	Role Delineation Policy
RHC	Rural Health Clinic
TA	Technical assistance
UHC	Universal health coverage
UNICEF	UN Children's Fund
WHO	World Health Organization
WPRO	Western Pacific Regional Office (WHO)

1 Introduction

1.1 Context

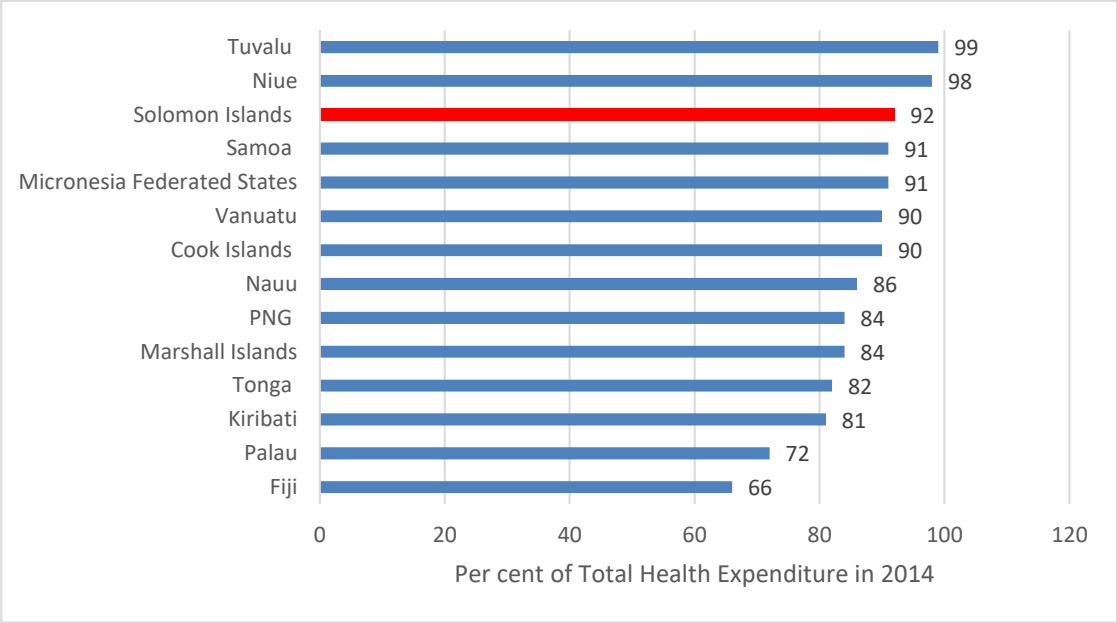
Solomon Islands is a lower middle-income country located in the Pacific Ocean to the north-east of Australia. It has a relatively small and young population: a total population of around 651,700 in 2016, with a median age of 19.4 years and a relatively high total fertility rate of 4.4 births per woman of reproductive age[3]. Solomon Islands encompasses six main islands and up to 900 smaller islands over wide tracts of the Pacific, making access to health facilities both expensive and potentially hazardous, especially during the hurricane season. Taylor notes that Pacific Island countries like Solomon Islands suffer from the 'tyranny of small size', including the limited numbers of specialised staff to generate and implement policy. Taylor concludes that 'small health services are not just scaled-down versions of large health services; they are qualitatively different'.[4] The small size of the health workforce was apparent during field interviews. As just one example, the Research Department in the MHMS – arguably a key institutional area to enable Solomon Islands to learn from other countries – consists of just one person.

Solomon Islands had a GDP per capita of $2005 in 2016. While, like much of the Pacific, there is little absolute poverty per se, there is nevertheless 'hardship'[5] and deprivation: only 12% of the population has access to electricity or flush toilets. Solomon Islands has had a volatile economic history, transitioning from low-income to lower middle-income status and back to low-income status several times since it gained independence from the UK in 1978. More specifically, Solomon Islands was classified by the World Bank as a low-income country from 1990 to 1991; graduated to lower middle-income status over the period 1998-2007; regressed to low-income status during the ethnic violence of 1998–2007; graduated again to lower middle-income in 2008; regressed to low-income status again in 2009; and regained – and has held – lower middle-income status since 2010.[6] Given the small, open, economy and distance from major markets, Solomon Islands has limited options for sustained economic growth.[7]

Solomon Islands has achieved some important health outcomes. Life expectancy improved from 49 years in 1960 to 57 years in 1990, and has improved to 68 years now (66.7 for males and 73.7 for females)[3]. While the under-five mortality rate and neonatal mortality rate has fallen to 28 and 12 per 1,000 live births, respectively, this was not sufficient for Solomon Islands to achieve the Millennium Development Goal (MDG) 4 of reducing child mortality by two-thirds between 1990 and 2015. Solomon Islands has increased antenatal coverage, but only partially met MDG 5 targets for reducing maternal mortality (always difficult to measure accurately in small populations), and the unmet need for family planning remains high. Solomon Islands also only partially met MDG 6, reducing communicable diseases. Solomon Islands also only partially met the MDG goals for reducing poverty; improving education; and improving gender equity (MDGs 1, 2, and 3, respectively), and did not meet MDG 7 (environmental protection). Like many other Pacific Island countries, Solomon Islands is facing a double burden of communicable diseases and the rise of chronic NCDs.

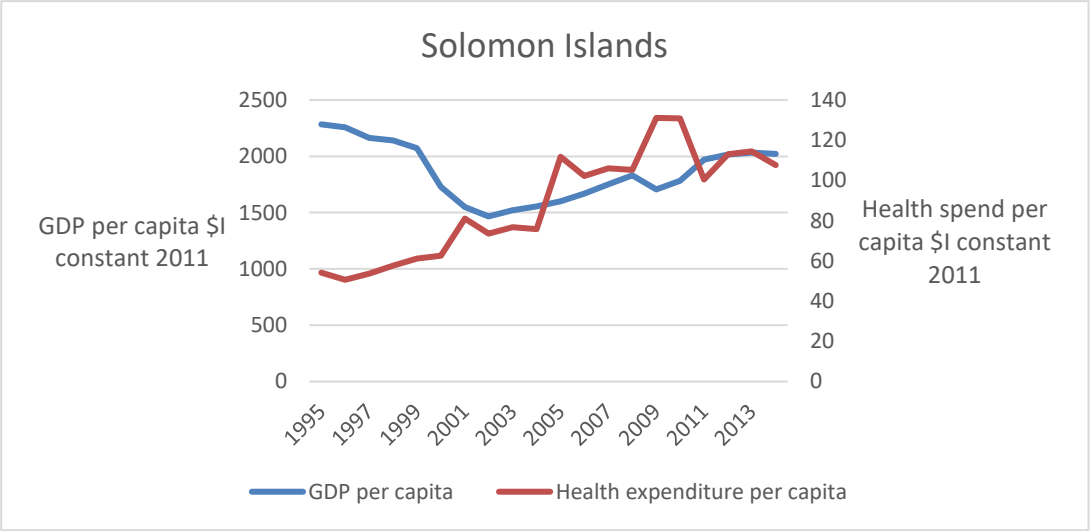
Like many countries in the Pacific, Solomon Islands' health financing is characterised by high levels of government financing – and direct provision – as well as aid dependency. Total health expenditure is an estimated $100 per person per year. Latest WHO data show that government provides an estimated 92% of total health expenditure in Solomon Islands: see Figure 1 below. Low and volatile economic growth and a high share (around 20%) of government expenditure going to the health sector means Solomon Islands has few options to expand the fiscal space for health, other than by improving allocative and technical efficiency in existing government expenditure.[8,9] Rising levels of real per capita health expenditure compared to generally stagnant real per capita GDP are putting further pressure on public health financing: see Figure 2 below.

Figure 1: Government expenditure is a significant percentage of total expenditure on health



Source: World Bank *World Development Indicators*[10]

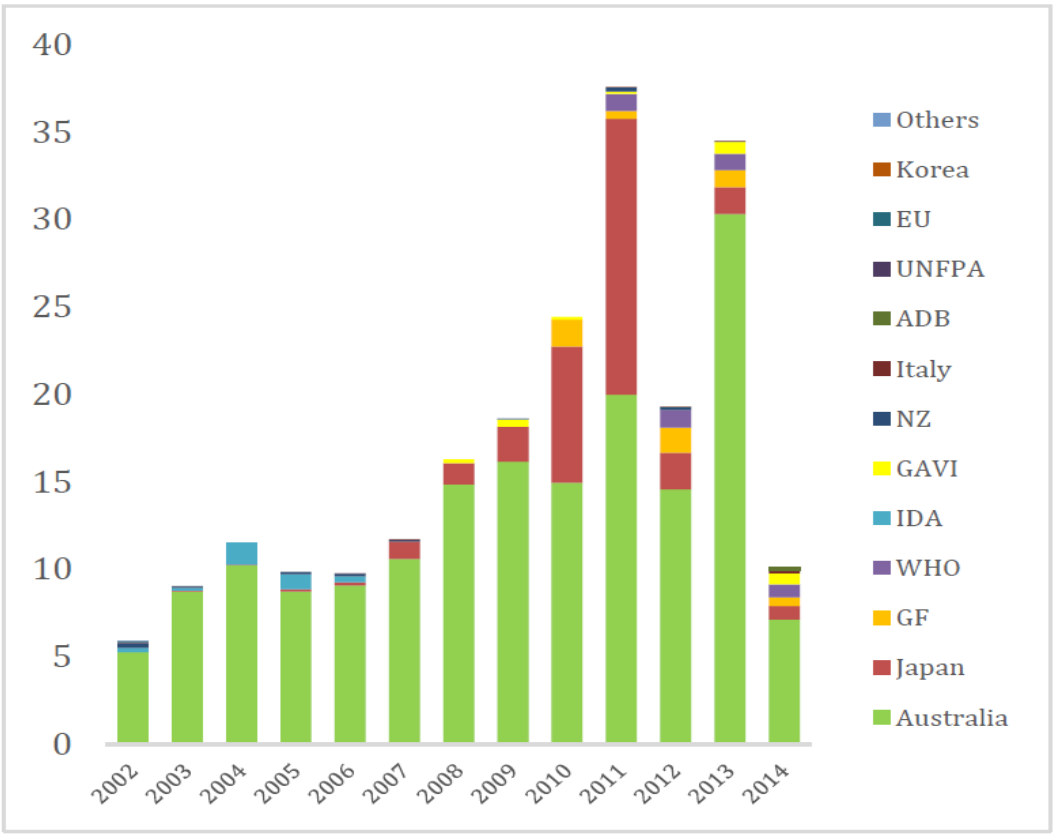
Figure 2: Rising real expenditure on health compared to declining real GDP per capita



Source: World Bank *World Development Indicators*[10]

Development partners have been a significant source of external financing – averaging around 45% of total health expenditure between 2008 and 2014 – and technical advice, with a wide range of partners. However, the overall levels of external financing have been volatile: see Figure 3. Australian aid – the largest source of external financing to the health sector – decreased by 36% in 2015 and decreased by a further 30% in 2016 as part of a global reduction in Australian aid. Financing from Gavi is now also being wound down.

Figure 3: Significant – but volatile – levels of external financing for health



Note: includes external financing for the categories of health and of population and reproductive health
Source: Organization for Economic Co-operation and Development Common Recording Standard (OECD-CRS) database

Source: The World Bank[11]

1.2 Why Solomon Islands was chosen as a case study

Solomon Islands was chosen as a case study for five reasons. First, this is a country that has pursued broader health system reforms at various stages in its volatile economic history, including as it transitioned from low-income status to lower middle-income status and back again. Second, the country has a clear focus on health equity. For example, the poorest 20% of the population account for over 20% of public hospital inpatient care.[1] Furthermore, the country also has a focus on primary-level healthcare, with a deliberate aim for that healthcare to be affordable in a country of Solomon Islands size and income level. For example, the public health system has, to date, largely been nurse-led: the 1,189 nurses in the country comprise almost 80% (78%) of the health workforce, with the 170 medical doctors representing just 11% of the health workforce. (This nurse-led health system is likely to change as a recent cohort of Cuban-trained doctors has entered the system). Third, the country has a purposeful, pro-active, system-wide vision and policy of deconcentrating the health workforce and expenditure out to rural and remote island communities where the majority (80%+) of the population live. Fourth, Solomon Islands is a good example of a post-conflict country that is pursuing system-wide health reforms aimed at benefiting the whole population, despite – and perhaps because of – the significant ethnic tensions and violence that emerged from 1999 until around 2004: a period known as 'the tensions'. Fifth, the extent to which the government of Solomon Islands learns from other countries and / or itself uses evidence to shape policies is likely to be an important driver of overall health outcomes. This is particularly because government financing dominates total health expenditure (Figure 1 above), as well as the direct provision of health services. In theory at least, once government has decided on a particular

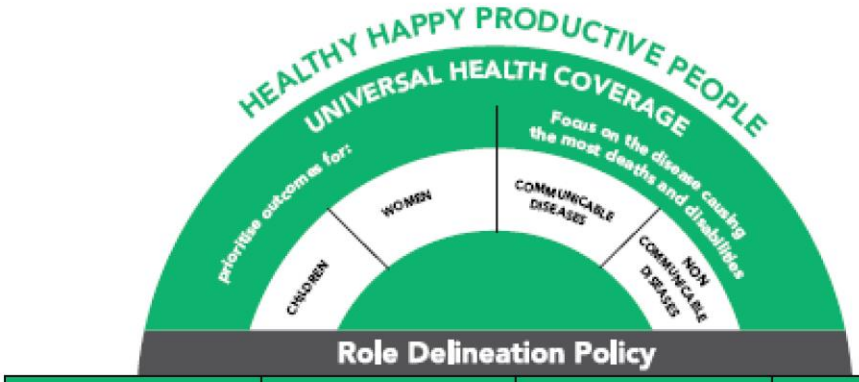
course of action it is likely to become the situation in the country. There are very few private sector providers of health services or NGOs that could undermine or obstruct government policy. (Having said that, implementation capacity and accountability for 'results' is still weak in Solomon Islands, so even well thought through and evidence-based policies can fail to get traction).

1.3 The RDP as the means of tracking the opportunities for and constraints on learning from other countries

We used what the MHMS refers to as the RDP as a means of tracking the opportunities for, and constraints on, learning from other countries. The actual definition of the RDP has evolved over time (see Section 3 below). This evolution of the definition and focus of the RDP has partly taken place in response to new international initiatives, such as, most recently, the emphasis on UHC as part of the Sustainable Development Goals. Nevertheless, the essence of the RDP is that it is a 'tool for better defining the range and level of services – or packages of care – to be delivered to given populations across the Solomon Islands'.[2] The package of services includes the actual health services to be provided at each level, and the staffing, medicines, equipment, and other supplies and infrastructure needed to deliver such services.

We chose the RDP as a means of tracking the learning process in Solomon Islands for three reasons. First, the RDP is designed to be a strategic and system-wide reform, delivering the right level of services (and inputs), particularly to rural areas, in a way that is financially and institutionally sustainable for a small lower middle-income country such as Solomon Islands. Second, as detailed in Section 3, the RDP has been a central part of health system reform in Solomon Islands since 2003. Despite some interruptions and inertia, the RDP has therefore been a core part of health sector-wide reform for the last 14 years. Third, despite its evolution, the RDP itself is a central part of MHMS policy for improved health services at a system-wide level. This is apparent from the very prominent, central, integrating role of the RDP in the current health sector strategy: see Figure 4 below.

Figure 4: The central role of the RDP in system-wide health reform in Solomon Islands



Improve Service Coverage	Build Strong Partnerships	Improve Service Quality	Lay the Foundations for the future
• Give priority to the most effective interventions • Give priority to the most underserved areas and populations • Give priority to the diseases causing the most deaths and illness	• With the People through healthy Islands/ Villages/ families/Schools/workplaces • With Provincial Government and MPs • With other government departments • With donors • With Churches, NGOs and Private sector • Within the MHMS	• Safety: First do no harm • Effective: Make sure what we do is effective • Efficient: Make best use of resources – money, people, equipment Make best use of interventions: Prevention, primary care, secondary care, tertiary care • People Centred: Place the people at the centre of all activities • Timely: Deliver the right intervention at the right time. • Equity Ensure health is enjoyed by all	• Build health infrastructure: Train and recruit the health workforce • Develop a sustainable financing mechanism • Build the information system • Prepare for disasters and climate change • Learn from each other

Source: MHMS[2]

2 Methodology

Several documents were consulted prior to the field interviews. As is common in the Pacific there are only limited peer-reviewed journal articles on Pacific Island countries. However, there are some useful grey literature resources from multilateral and bilateral development partners, and these were consulted.[1,5,7,8,11-36]

We drew on the interview guide developed by OPM and agreed to by the Principals appointed by OPM. However, given the smaller population base in Solomon Islands and the general preference for shorter, more focused questions, we shortened the interview guide somewhat, in liaison with, and with the agreement of, OPM. The interview guide we used is at Annex A.

Katherine Gilbert, who has previously worked in Honiara with the UN Children's Fund (UNICEF) and has contacts and networks there, steered the process of obtaining formal ethical approval from the MHMS' Health Research and Training Ethics Review Board to conduct field research. The ethical approval from the board was obtained, but the board asked that we include a Solomon Islands government official as part of the interview team, partly as a capacity building exercise. We obtained OPM approval for this and the Chief Policy Officer of the MHMS was therefore appointed to accompany Ms Gilbert and Mr Anderson, at no cost to OPM. The Chief Policy Officer was particularly helpful in securing interviews from key officials at short notice, and in tracking down documents. He participated in interviews and gave his own opinions. His participation did not appear to inhibit any stakeholder's ability to speak candidly. He was invited to comment on a draft four-page note that provided feedback to those interviewed. However, he was not involved in the drafting of the current report.

We visited the capital of Solomon Islands, Honiara, over the period 4–8 September 2017. We interviewed 18 people in face-to-face interviews and four via telephone. Of the 22 people interviewed, 11 were officials of Solomon Islands and 11 were multilateral or bilateral development partners. Two of the officials from Solomon Islands were Permanent Secretaries (i.e. heads of departments). We also interviewed the Head of the Research Department as well as the Chief Statistician within the MHMS. We specifically sought – and were able to interview – PHDs, so as to get a perspective regarding learning from other countries from those officials working outside of the capital city in a decentralised setting. Nine of the 22 people interviewed were female. It was made clear at the outset of all interviews that responses would be anonymous, so as to facilitate candour. Written notes were taken by both Ian Anderson and Katherine Gilbert and then used to prepare this report.

3 Results

Part 1: How did interviewees position themselves in relation to the six phases of policy transfer: 1) conceptualisation; 2) formation; 3) internalisation; 4) contextualisation; 5) operationalisation; and 6) evaluation?

It should be said at the outset that interview data were not consistent with the process progressing in six neat, well-defined, linear steps. Rather, the RDP progressed in fits and starts, with several of the abovementioned steps overlapping. The RDP has been refined and developed within MHMS over the years but has yet to become official government policy. The RDP will go to Cabinet for approval by the end of 2017.

In essence, however, the history of the reform dates back to 2003 as the country was then emerging from a five-year conflict (known as 'the tensions'). In 2003, the MHMS developed the *Role Delineation of Health Care Services in Solomon Islands* (the Role Delineation guideline), which focused on services to be delivered at hospitals, but also covered lower-level facilities.[37] The policy was listed as part of the goal in the National Health Plan (2004–05) to improve access to and quality of health services, thereby ensuring a 'reasonable minimal level of essential health care to all individuals and families, in an acceptable and cost-effective, affordable way, and with their full involvement.'[37, p.7] However the Role Delineation guideline was not implemented (see further explanation under Part 2, below). The idea resurfaced in 2010 (see further explanation under Part 2) and has since been through three iterations. The current RDP policy redefines the levels of health services, the services to be provided at each level, as well as the associated staffing, medicines, equipment, and other supplies and infrastructure needed. In addition, the policy is associated with a broader restructuring of the MHMS and a devolution of the authority and resources to each MHMS PHD necessary to enable them to coordinate and deliver integrated services. The history of the RDP policy is described in Table 1.

As Solomon Islands has a small population (approximately 651,700 people) policy reform in the MHMS is driven by a few senior-level officials whose roles and responsibilities often change. Thus, few have worked on the policy consistently over time. Most (but not all) development partners had no detailed knowledge prior to 2015, given their own high turnover of staff. Most interviewees described participating in one of the first four phases of policy development.

Table 1: History of RDP development in Solomon Islands

Year	Status of policy
2003	*Role Delineation of Health Care Services in Solomon Islands* developed
2005–06	*Guidelines for Minimum Standards for Health Clinic Infrastructure* developed and National Infrastructure Review undertaken, but no plan developed
2011–12	*National Health Strategic Plan* (NHSP) 2011–2015 flags development of 'role delineation'. National infrastructure assessment undertaken. *RDP Version 1* developed by February 2012
2013	RDP Version 1 Implementation Plan developed
2014–2015	RDP Version 2 developed, with a greater focus on the basic service package. Pilots commence in Western province, dialogue with and site visits to Guadalcanal and Western province
2016	RDP Version 3 developed by the RDP Committee, further outlining delegation of authority to manage health service delivery to Provincial Health Office
2017	RDP Version 3 presented at National Health Conference, approved by MHMS Senior Executive Committee and to be approved by Cabinet by the end of September. RDP Committee to prepare action plan for implementation. Delegation of authority to provincial health offices associated with the RDP begins to take place
2018	Implementation due to begin. Nursing and medical graduates (trainees trained in Cuba) to be posted to provinces

Part 2: Use of systematic evidence and learning from other countries with respect to the conceptualisation stage

There is evidence that the MHMS was inspired to some extent by similar policies in Fiji – a more populous country and at the time a higher income country in the Pacific, with a more mature epidemiological transition, that often served as a 'first mover' in health sector reform in the Pacific. Some interviewees also noted that policy developments in PNG may also have influenced the RDP at the conceptualisation stage.

No interviewees had detailed knowledge of policy development during the initial start-up period of the RDP. Some hypothesised that the 2003 Role Delineation guideline may have been inspired by or based on an existing RDP in Fiji. This may have been shared directly between officials from the MHMS in the respective countries, or it may have been shared through development partners or implementing partners (the same managing contractor was leading Australia's health support in both countries at this time). In turn, one development partner thought that the idea behind Fiji's RDP may have been inspired by Australia, where RDP is a term commonly used to define the roles of service levels.

Under the Role Delineation guideline, the MHMS developed *Guidelines for Minimum Standards for Health Clinic Infrastructure* (Minimum Standards), covering Area Health Centres (AHCs), Rural Health Clinics (RHCs) and Nurse Aid Posts (NAPs).[38] The Minimum Standards covered not only infrastructure but also the clinical and public health interventions to be provided at each level, as well as related management actions. The purpose of the Minimum Standards was to ensure that facilities are accessible, user-friendly, safe, and equipped to meet the basic standards.

The Minimum Standards were used to undertake a 2006 *National Health Infrastructure Review*.[39,40] A sector-wide approach was also initiated in 2007 (called the Health Sector Support Programme (HSSP)), with the Australian Aid Agency for International Development (AusAID) as its major bilateral donor. The initial HSSP Implementation Plan from 2007 notes that the MHMS and donors will support the development and implementation of a Health Infrastructure Plan, drawing on the

Health Infrastructure Review.[40] It justifies the need for the infrastructure plan based on the 'degradation' of health facilities at that time, and the unmet needs of the growing population in rural areas.[40]

The Health Infrastructure Plan had not been developed as at early 2009 and there is little evidence of later development or implementation.[41] This may be because the MHMS decided to review the RDP. At a parliamentary Public Accounts Committee in 2007 the then Permanent Secretary of the MHMS referred to the Role Delineation guideline, noting: 'we have decided again to look at what sort of master health service plan that would determine the needs and the demand for services we would have to determine what sort of institutions we are going to have in the various places and that would enable us or give us some of those budgeting guidelines.'[42] (Fiji had revised its RDP in 2005–06, which may have inspired Solomon Islands officials to do the same, but this could not be verified.)

Efforts to revise the RDP came back onto the MHMS's agenda in mid- to late-2010. There was little direct knowledge among interviewees as to why the RDP came back onto the agenda at this point. The NHSP 2011–2015 refers to the need to define levels of care and packages of services based on 'optimal' organisation and with a focus on primary healthcare, as well as stating a commitment to the development of 'role delineation' by the end of 2011.[43] One MHMS senior official thought that this may have been due to some exposure to PNG's RDP during the 2009 Pacific Health Minister's Meeting in Madang; however, this could not be verified and there is no discussion of the RDP in the minutes from the meeting.[44] (There was a session on health systems strengthening and primary healthcare so it is possible that it was discussed in this context.)

Version 1 of the RDP was drafted in 2011 and finalised in February 2012. The purpose of the policy was to develop a 'consistent basis for service development and for allocation of resources including workforce, infrastructure and equipment'. Version 1 defines the levels of services and packages of care covered, and describes the associated infrastructure and equipment standards for general hospitals and lower-level facilities (it does not cover the National Referral Hospital). Version 1 drew on the existing Minimum Standards, although it proposed some major changes to the nurse-led system. Most notably, it proposed to abolish the lowest level facility (NAPs) and the associated cadre of Nurse Aids, and to place medical doctors within some AHCs.

Two further iterations of the policy have taken place since Version 1, this time with significant WHO involvement (the impact of WHO's involvement on the policy content is discussed in more detail in Part 3 below). The changes proposed by Version 1 have been maintained, but there has been greater focus on developing the service packages, and on outlining associated structural reform in the MHMS. The policy rationale has also changed. Interviewees described the two most recent versions as a policy developed to deliver UHC. This perspective is reflected in the most recent NHSP 2016–2020, which explicitly links the RDP to UHC and notes that the job of the MHMS is to 'go beyond serving only those that knock on the clinic door, and [to] make sure our services reach everyone in the community', taking a population health approach.[45] One MHMS senior official referred to one WHO Western Pacific Regional Office (WPRO) UHC meeting which was particularly useful for grounding the RDP in the principles of UHC.

In addition to learning from Fiji, and possibly PNG, the following values were referenced by interviewees and policy and planning documents as influencing the rationale for the RDP:

- UHC coverage, with an emphasis on ensuring resources are available for PHC;
- equity, particularly with respect to promoting service delivery in provinces, which has been a common theme within the National Development Strategy since the tensions; and

- efficiency, particularly given the limited growth in government revenue (with an increase in the share of the budget to health being unlikely) and declining aid, and the need to spend better.

Interviewees identified two immediately pressing issues that they thought influenced the evolution of thinking about the RDP and introduced a sense of urgency into its formulation:

- the return of trainees from the Cuban medical training programme, potentially increasing the number of medical doctors in Solomon Islands from 86 to 182[46]; and
- the need to expand preventive services, including those relating to NCDs, although it is unclear to what extent this has been taken into account.[45]

Part 3: Use of systematic evidence and learning from other countries with respect to the formation/contextualisation stage

Again, there is evidence that both MHMS officials sought to learn from the experience of other countries, namely Fiji and PNG, in the drafting of each of the three iterations of the RDP since 2010. This learning has taken place through professional connections and technical assistance (TA), both specific short-term TA and longer term general TA provided by HSSP advisers. However, the applicability of the experience of Fiji and PNG was seen to have clear limits, with Fiji having greater fiscal space for health and better prospects for economic growth than Solomon Islands, and PNG focusing its service reforms on physical infrastructure. Interviewees thought additional learning may have also taken place through TA and input from WHO advisers.

In drafting Version 1 of the RDP in 2011, the MHMS reached out to their counterparts in Fiji to find out who had supported the revision of its RDP in 2005–06, and it engaged the same consultant, with AusAID funding. The consultant worked under the guidance of the Director of Planning and a committee of senior leadership from across the MHMS. The Version 1 draft drew on the existing Role Delineation guideline and Minimum Standards, a survey of the existing infrastructure at facilities, as well as the consultant's experience in supporting the revision of the RDP in Fiji during 2005–06. Interviewees felt that the relevance of Fiji's revised RDP was, however, limited, as the level of general health services in Fiji was considered to be higher, with doctors present at more facilities than is affordable in Solomon Islands, where nurses are more commonly deployed.

Once Version 1 was drafted, MHMS senior officials noted that 'then we did not know what to do'. A senior WHO consultant from Fiji (a former Permanent Secretary within the Fijian Ministry of Health and Medical Services) was working in Solomon Islands at the time on another task and was asked to review Version 1. He advised that the policy was 'unimplementable' as it was too prescriptive (e.g. the required facility infrastructure standards were too specific and costly) and MHMS senior officials agreed with his opinion.

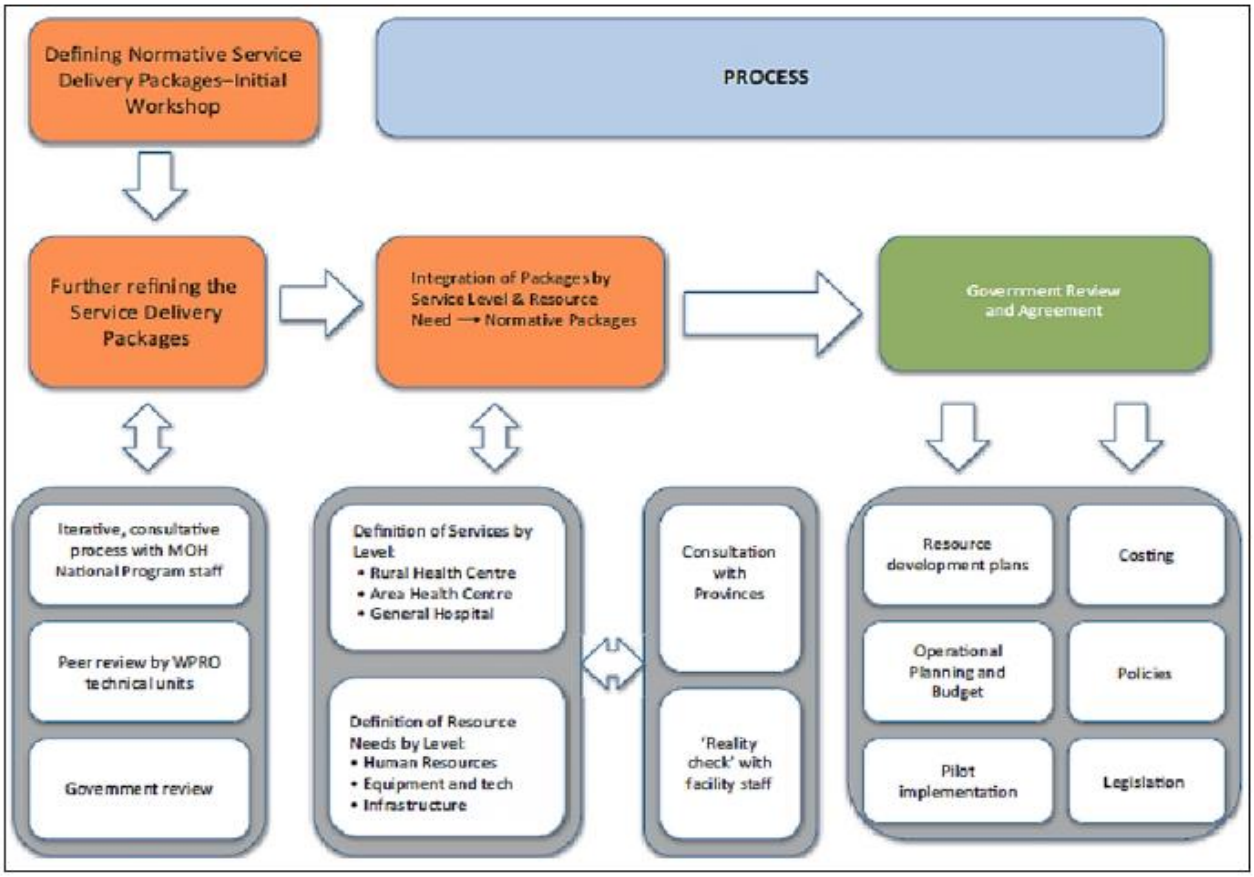
The same senior WHO consultant went on to develop an RDP implementation plan 2014–2016, which foreshadowed the changes to be made in the next two iterations. As UHC began to gain greater traction internationally, the implementation plan placed greater emphasis on UHC. It also called for the policy to be piloted in the three largest provinces of Solomon Islands (which was undertaken to some degree after Version 2 was developed).

Version 2 of the RDP was next developed under the leadership of the then Undersecretary for Health Improvement (with responsibility for public health functions). He tasked the Director of Nursing, with support from WHO advisers, with revising the policy, beginning in 2014, with a greater focus on the further development of the basic service package. There were four possible rationales for this:

- As noted above, there was a growing connection between the policy and the government's efforts to pursue UHC.[47]
- As also noted above, there was a need to make the policy more 'implementable' and less prescriptive. It appears this message was now coming from multiple sources. MHMS senior officials referred to standards from PNG in drafting Version 2 (obtained through professional connections in the region) but noted that implementation had been limited. They thought that part of the challenge that PNG faced with implementation is that their policy was too prescriptive and placed too much emphasis on infrastructure standards, rather than service delivery. (They also saw that PNG's health system – which is decentralised – is much more complex that their own, and thus the applicability of the policy had its limits.)
- One MHMS senior official also suggested that the MHMS was influenced by a Health Facility Costing Study undertaken with the support of the World Bank, and wanted a greater focus on the basic service package to better understand the costs.[48]
- Interviewees also observed that the evolution of the RDP policy may have also reflected the shift of responsibility for the RDP policy within the MHMS from the Undersecretary responsible for Policy and Planning (where infrastructure sits) to the Undersecretary responsible for Health Improvement.

In 2016 WHO advisers (together with the then Undersecretary for Health Improvement, who is now the Permanent Secretary) published a peer-reviewed journal article in which they outlined their approach to developing the basic service packages during 2014–2015, shown in Figure 5.[47] The packages were first developed by relevant national programme staff in the MHMS and then reviewed by relevant technical units in WHO WPRO. It is likely that learning indirectly took place through the involvement of WHO staff. Little is known about the nature or the quality of the evidence presented by WHO colleagues.

Figure 5: Process for developing the basic service packages 2014–2015



Source: Whiting *et al*. (2016) (47)

A consultation with provincial-level staff was then undertaken and a pilot was planned at a number of AHCs across the three largest provinces, with funding available from the Australian Department of Foreign Affairs and Trade (DFAT), into which AusAID had now merged. In the event, the pilot was only implemented at one site. One interviewee noted that the pilot was not particularly useful as a trial or proof of concept of the RDP. That was because RDP required a coherent and coordinated, yet flexible package of inputs at a systems-wide level, including financing, health workforce, medical supplies, infrastructure, and policy standards. Such a coherent and coordinated package of inputs essentially needed policy guidance from the capital, Honiara, which at that stage were largely a description of services, equipment and infrastructure for each level of the health system, as distinct from something that was system-wide, and that could be applied, budgeted and implemented. There was therefore little actual trialling of coordinated inputs at the pilot sites in the provinces. However, interviewees did consider there were some lessons to be drawn from the pilots. These included: the need to better communicate the policy to facility staff and engage them in the change process; and the need to better plan for the associated changes in human resources (e.g. new roles, changes in job descriptions, and reporting lines), medicines and other supplies, and infrastructure. In addition, one development partner reported that they had received advice from a technical consultant on the implementation challenges that would arise through the current draft. This consultant had significant experience of working in PNG and other Pacific contexts, and thus may have indirectly shared their experience of the implementation challenges faced in such contexts.

Based on this internal learning associated with the pilot and expert advice, it was then decided that the RDP should be further revised. The Undersecretary for Health Improvement was now Permanent Secretary and concluded that the RDP could only be implemented in the context of a

broader organisational restructuring of the MHMS and a devolution of authority and resources to the PHD (e.g. to ensure that staff in the province are accountable to the PHD and can be deployed by the PHD across the province as needed, as currently most civil servants are managed centrally). The interest in, and commitment to, the RDP on the part of the new WHO Representative may also have been a factor.

At the request of the Permanent Secretary, Version 3 was developed by a RDP Committee, chaired by the Undersecretary, and supported by the HSSP lead technical adviser, who had significant experience in PNG and Vanuatu, as well as prior experience in Solomon Islands. The RDP Committee also includes one PHD. Version 3 of the policy reflected lessons from the pilot and was also extended to include associated structural reforms taking place in the MHMS to devolve responsibility for managing health service delivery to the PHD, as discussed above.

WHO was again asked to support the revision of Version 3 and engaged expertise from WPRO in a 'unique' way: relevant WPRO staff visited Solomon Islands as a team and ran parallel workshops to revise the policy. One MHMS senior official reported that the Committee has benefitted from input from WPRO and the experiences that WPRO staff shared from other countries. Most notably, the interviewee recalled learning about the importance of political commitment to health system reform in Rwanda. Again, little is known about the nature or the quality of the evidence presented by WHO colleagues.

With respect to the support provided by development partners during this phase, senior MHMS officials reported some were initially sceptical of the cost implications of the policy and others were more disease-focused. They viewed WHO, and more recently DFAT, as most supportive and thus this is where some of the learning opportunities have been initiated. This is an interesting observation from interviewees as it could be argued that the World Bank-supported health facility costing study was particularly influential in shaping the RDP as it provided, for the first time, detailed baseline evidence of the extent and number of facilities, health workforce deployment, access and patient contact data, and the financial costs of servicing different levels of facilities. It may reflect the level of appetite for understanding the full cost implications of the RDP before implementation begins (which was low among officials interviewed from the MHMS and WHO).

Part 4: Use of systematic evidence and learning from other countries with respect to the internalisation stage

No specific evidence emerged during the interviews of learning from other countries in relation to this internalisation phase. That is largely because the internalisation process involves, by definition, decision making processes that are specific to Solomon Islands institutions and practices. Looking to Fiji, PNG, or Vanuatu, each of which have different political structures and institutional characteristics, would be unlikely to be particularly helpful.

The MHMS has taken steps in recent times to embed the RDP within the *National Development Strategy 2016–2035* (which refers to basic service packages) and the NHSP 2016–2020. Version 3 was also presented at the National Health Conference in May 2017 and approved by the MHMS Senior Executive Committee in July 2017. The policy is due before Cabinet prior to the end of September. A further meeting with parliamentarians is planned during September 2017, to brief them on the policy, with WHO support.

This effort to now seek approval from the MHMS Senior Executive and Cabinet is being taken to ensure that there is government sign-off on the large structural reforms that the MHMS has proposed as part of the RDP. It is possible that key stakeholders in Solomon Islands have learned

about the importance of political commitment to the success of reforms in other contexts (e.g. Rwanda) but this could not be confirmed.

Implementation of the RDP is also part of the explicit performance measures associated with the HSSP. (DFAT's agreement with the MHMS includes a performance component which is payable as sector budget support based on the proportion of measures implemented.)

Part 5: Use of systematic evidence and learning from other countries with respect to the operationalisation stage

Solomon Islands is just approaching this phase with respect to the RDP. The RDP Committee is now referred to as the RDP Implementation Committee and has been tasked with developing an implementation plan. The HSSP adviser has been encouraging the use of evidence from the District Health Information System (DHIS) and human resources data in the development of the implementation action plan. The plan has not yet been costed.

MHMS senior officials noted that they would benefit from experiences from similar countries that have undertaken similar reforms. In particular, one MHMS senior official expressed an interest in learning more about the implementation challenges faced in PNG's effort to introduce a similar policy. WHO has offered support to support a study tour in this regard but nothing has been planned at this stage.

Some reforms associated with the delegation of authority from the Permanent Secretary to the PHD have been implemented as at 2017, but there is no evidence that learning from other countries has been associated with this implementation to date.

Part 6: Use of systematic evidence and learning from other countries with respect to the evaluation stage

Not applicable at this stage.

Part 7: Perspectives on what helps and hinders learning from the experiences of other health systems (questions 8–10)

Please see Section 4 below.

4 Analysis/discussion

4.1 Key findings

This section steps back from the evolution of the RDP in Solomon Islands and, based on the literature review and field interviews, examines the role of learning from other countries in a country like Solomon Islands.

It is important to note at the outset a dilemma facing small isolated countries such as Solomon Islands: given their limited fiscal space for health expenditure, and the small size of their managerial and administrative staff, countries like the Solomon Islands cannot afford to waste financial and human resources on interventions that do not work. Their limited number of managers and technical specialists means they also cannot 'reinvent the wheel' with respect to new policies and interventions. Such countries therefore have much to gain from learning and applying the lessons from other comparable countries. On the other hand, the small size of the bureaucracy – Solomon Islands has only one person in the Research Department of the MHMS – means such countries find it particularly difficult to find the time and space to learn and then apply lessons from other countries. This is particularly true in Solomon Islands where, given its geographical location, travel to international conferences is particularly expensive and time-consuming. While the MHMS in Honiara has adequate internet access, online learning is less of an option for individuals and those in more remote provinces and islands in a country where only 12% of the population has access to electricity and internet coverage is limited and unreliable.

The analysis below begins by assessing how Solomon Islands learns from other countries at the international and multi-regional level. It then moves down to learning at the Pacific regional level. It then moves down again to learning and use of evidence at the country level.

4.1.1 At the international and multi-regional level

There is clear evidence that Solomon Islands officials are using international and multi-regional experiences to shape policy and programmes. Despite the unique characteristics of Solomon Islands, international and multi-regional meetings can be a useful opportunity to learn how other middle-income countries have tackled challenges that are common to all, including placing and retaining health workforce staff in rural and remote areas. Interviewees confirmed that such meetings can be useful venues for learning about other countries' approaches. As just one example, interviewees noted that Solomon Island officials learned from a recent WHO / UNICEF meeting held in Vietnam that Mongolia had a system of rapid diagnostic testing for syphilis, which improved coverage of early detection and primary care. The rapid diagnostic testing was particularly useful and appropriate given the nomadic / migratory populations in Mongolia. This had prompted Solomon Island officials to consider the possible advantages in applying such rapid diagnostic testing in Solomon Islands.

On the other hand, international and multi-regional meetings can also be an expensive exercise with little to offer in terms of learning from others. Some interviewees believe that international meetings and multi-regional conferences that bring Pacific Island delegates together with delegates from Asia have little to offer in terms of learning from each other. Asian economies and populations are much larger than Pacific economies and societies, and their health systems are structured very differently, often with large – if often unregulated – private providers and / or dual practice and large out-of-pocket payments for healthcare. Some interviewees think that the most important thing they have learned from such conferences is how diverse the Pacific is.

The primary motive for attendance at conferences also needs to be taken into account when assessing if learning from other countries is likely to occur. Salaries for health workers are low in Solomon Islands, as they are in other parts of the Pacific. There is strong anecdotal evidence that senior and middle managers may therefore use attendance at international and regional conference as a means to supplement income through the payment of travel per diems and allowances, rather than as a mechanism to learn from other countries. This is a particular challenge in the Pacific given the well-documented problem of there being a large number of international and regional conferences, and the resulting frequent absence of key, specialist, personnel attending such conferences. [49] More broadly, experience suggests that the quality of international conferences varies significantly. This then raises more fundamental questions, such as: who ensures the quality of supply of these conferences? Who are development partners accountable to? How can development partners work together to prioritise such events? Such questions are relevant to the process of learning from other countries but are largely beyond the scope of the current exercise.

4.1.2 At the Pacific regional level

Learning at the Pacific regional level is particularly relevant and important. The Pacific Island countries, including Solomon Islands, face a distinctive set of challenges. These include relatively small – but often rapidly increasing – populations; a relatively high cost of service provision given low population densities and remoteness; a rapidly changing set of health challenges, including the rise of expensive to treat diseases, such as diabetes; a particularly high dependence on government expenditure – including dependence on external assistance - for healthcare; and limited scope to expand health financing, given broader economic conditions. Taken together, these factors mean Pacific Island countries cannot afford to each 'reinvent the wheel'. Instead, there are significant benefits in learning from the successes – and failures – of other countries' experiences.

There are good examples of Solomon Islands learning from other Pacific Island countries. Interviewees explained the importance of long-term medical training tailored to the specific needs of the Pacific, including through university courses in Fiji and PNG, as well as tailored short-term training, such as the World Bank's health financing *flagship* courses. Interviewees noted that regular regional conferences, including the Heads of Health, provide a specific opportunity for formal and informal networking and exchanges.

Other interviewees noted the importance of special 'themed' conferences of particular relevance to the Pacific, such as the *Pacific NCD Summit* held in Tonga in June 2016, with interviewees learning about, for example, the important role played by local communities in Samoa in the early detection of NCDs and the role of churches in promoting physical activity. It is quite common for each participant at a conference to be given a flash drive containing the key documents and presentations. However, what may have helped the findings of the *Pacific NCD Summit* to reach an even wider audience – including those who did not attend – is the fact that all presentations from this conference were made available on the web.[1]

Several interviewees confirmed that one-off country-specific exchanges or visits had been directly useful in shaping Solomon Islands officials' thinking about policy. This included, for example, drawing on policies and experiences in Fiji and also PNG, on the design of their service package, which helped shape Solomon Islands officials' thinking about its own RDP. More recent visits to Fiji identified the potential effectiveness of on-the-spot fines as part of tobacco control. Some interviewees noted that development partners that focus on the Pacific can also facilitate the

[1] Available at www.pacificncdnetwork.org/pacific-ncd-summit--key-presentations.html

sharing of knowledge from other countries in the region, provided those institutions and the staff they employ or contract have a good 'institutional memory'. One interviewee referred in positive ways to the recently established *Partners for Tropical Health*: an initiative of the Australian Institute of Tropical Medicine & Health which had provided relevant training to Solomon Islands and other middle-income officials to build capacity in health research, and which included training modules on data collection, data analysis, and effective dissemination of research findings.

On the other hand, there appear to be some missed opportunities to maximise the learning opportunities. Regional meetings on health are potentially very valuable venues for sharing lessons about good practice – and mistakes to avoid. However, some interviewees think such meetings do not always fulfil their potential because they have crowded agendas and / or largely involve a presentation by one speaker, rather than a genuine dialogue between all countries. Even when regional conferences generate new insights and learning, some interviewees think that the *dissemination* of those insights back to others who did not attend is sometimes weak, or even non-existent. Several interviewees think specific regional training courses, such as the World Bank health financing *flagship* courses, do facilitate 'learning' at the time, but feel the lessons and insights erode shortly afterwards due to limited opportunities for follow-up and mentoring in terms of actual implementation.

There may also be some missed opportunities in terms of learning about current, common, challenges. Pacific leaders have declared that the Pacific is experiencing an 'NCD Crisis'.[50] This suggests a sense of political commitment and urgency. Nevertheless, it is often difficult to obtain up-to-date, comparable data from other Pacific Island countries on trends and developments in comparable countries. More specifically, WHO has been supporting STEP surveys that assess risk factors for NCDs. Comparing trends across the Pacific highlights the commonality and differences in risk factors for NCDs, emphasising, for example, that the Pacific has some of the highest rates of diabetes and obesity in the world. The limited peer-reviewed articles comparing trends across the Pacific demonstrate how valuable this shared knowledge product is.[51] However, the problem is that the actual dissemination of WHO STEPS data can take around three to five years from the time of the survey. This limits the ability of countries, and their development partners, to learn of trends in other countries in relation to an issue that is deemed an NCD 'crisis' in the Pacific.

Reliable, comparable data on financial costs are a strategic, regional and global 'public good' but there are missed opportunities to learn from each other. Most countries in the Pacific are in the process of scaling up the WHO-supported Package of Essential NCD (PEN) 'best buys' to address the NCD crisis in the Pacific. However, there is only limited sharing of data on the relative costs, benefits, cost-effectiveness, affordability, and implementation lessons from different countries in the Pacific. Similarly, pharmaceuticals are often a large part of government health expenditure in the Pacific but it is not always easy for officials in any one country to compare the latest prices they pay for particular drugs with prices paid by all other countries in the region, or to compare with 'best practice' prices obtained in the region. One interviewee also noted that one Pacific Island country may invest scarce money and human resources in a drug recall, but key evidence is not easily or quickly shared regionally, meaning each country must, in effect, go through the same process. Many Pacific Island countries are working out how best to integrate Cuban-trained doctors into their health systems, and what the financial and other costs and benefits might be, but more could be done to share knowledge and insights at a regional level, and then use that knowledge to integrate the Cuban-trained doctors into a country's health system in a way that maximises public health outcomes and is financially sustainable. DFAT and WHO have attempted to promote learning on this to the extent possible. Perhaps for political economy reasons countries may not feel they have a need to learn from each other – and particularly from countries with smaller populations – with respect to this issue.

4.1.3 At the country level in Solomon Islands

There was a unanimous view among all those interviewed that Solomon Islands is making much better use of information and evidence when shaping its policies and programmes than it has done in the past. This welcome development reflects two things. First, strong leadership from the top: senior managers from the Permanent Secretary down are asking for better and more timely data so there is a 'demand' for data as part of the overall 'doing better' culture. Second, there is a response on the supply side. Numerous interviewees commented on the significant increase in both the quantity – but also the quality – of data now being generated, collected, and analysed, including via the DHIS reports, including the core indicator reports and provincial profiles. Interviewees gave numerous examples of how better data were now being used to 'ask the right questions' and challenge long-held assumptions. Examples include using better data to identify immunisation coverage gaps in peri-urban settings, and analysing why antenatal care coverage rates in rural areas had been relatively high but skilled birth attendance rates appeared to be low. The recent Health Facility Costing Study identified numerous 'outriders': particular facilities doing well above average – or sometimes well below average – for a given level of input, which then stimulated thinking about what those facilities were doing that made them so different from others. Importantly, new data and evidence are also being presented and tabled at critical points in the planning and budgeting cycle so that – at least in theory – it can influence the Annual Operating Plans of work units.

However, once again, there are some missed opportunities. Despite the significant recent increase in the volume – and quality – of data now being generated these data do not always *drive performance* or get used to reallocate scarce resources to where they will have the highest impact in terms of public health and / or resource management. One interviewee conceded that even the 'core indicators' – which, as their name implies – are a set of strategic-level data are sometimes used more for basic reporting and accountability than as a basis for making more informed and better public policy choices. There is also sometimes a disconnect between the improved evidence base and performance, perhaps explained by gaps in a sense of accountability; weaknesses in supervision; or institutional constraints, such as inability to reallocate funding or health workers to higher impact interventions.

The MHMS has some internal constraints to using data and learning lessons to best effect. Some interviewees explained they needed assistance and capacity building in terms of being able to put together a credible proposal for 'learning' from other countries. Some interviewees observed there was not a particularly strong 'evaluation culture' in the Pacific Islands, which means opportunities to assess who are benefiting from a particular health programme, where, when, why, and at what cost, are not generated. The interview team noted that the Research Department of MHMS consists of one person, which suggests missed opportunities to develop a strong strategic pipeline of applied research that addresses the priority needs of managers.

There are also some constraints that are outside the direct span of control of MHMS that can override evidence-based learning from other countries. There are at least three different sources of power and influence that are outside of the MHMS that can distort or undermine the evidence-based learning policies of the MHMS. First, the MHMS is responsible for many aspects of health services, including policy, budgets, and procurement of supplies. However, the Public Service Commission has responsibility and authority for all personnel issues, including the numbers and location of health workers. This can lead to different perspectives on priorities.

Second, the Ministry of Foreign Affairs, not MHMS, decided to accept the offer from Cuba to train up to 138 doctors in Cuba, effectively doubling the number of doctors in the country. This decision, taken largely outside of the MHMS, has created some important challenges for the MHMS. For example, the arrival of a relatively large cohort of Cuban-trained doctors raises fundamental

questions about the focus up to this point on a nurse-led primary healthcare and health promotion focus in Solomon Islands. Furthermore, external observers of the Cuban trained doctor programme across the Pacific question whether the doctors are actually 'learning the right things'. Anecdotal evidence suggests the medical competence of some trainees is very questionable on their return (all students pass the Cuban training programme, no one fails). Furthermore, there is some anecdotal evidence that the Cuban-trained doctors learned in a theoretical and academic curriculum, with virtually no hands-on experience (for example, no touching of a pregnant patient). Interviewees in Solomon Islands confirmed that some doctors returning from Cuba and currently working as interns at the main hospital would not qualify to become registered doctors in Solomon Islands and would need to be reassigned, possibly as doctors' assistants, although this category currently does not exist and may undermine the authority and efficiency of nurses. One interviewee speculated that the worst outcome in terms of public health would be to have those 'doctors' who are unable to work in clinical practice as doctors being transferred to the MHMS to work on health policy.

The third example of decisions being made outside of the span of control of the MHMS – and therefore the learning from other countries that MHMS may have itself prioritise and needed – involved the use of the generous Constituency Development Funds CDFs, available to each Member of Parliament. CDFs are, in principle, intended to better link MPs with their constituents and provide a rapid response mechanism for delivering small-scale services to local communities, including feeder roads, lighting, and other services. CDFs are a relatively large and growing part of the Solomon Islands budget, totalling $38 million in the 2017 budget and around 10% of the government's total budget outlays and one-third of the development budget, further supplemented by grants from Taiwan. One analysis suggests the Solomon Islands' CDFs are larger in absolute and relative terms than other comparable countries', but that issues of governance, transparency, waste, and inefficiency similarly arise.[52] CDFs have implications for the health reform programme in Solomon Islands, or evidence-based planning and lessons learned from other countries. One interviewee noted that an MP had funded the building of a small rural health clinic without consultation with the MHMS, thereby duplicating a nearby facility and raising basic questions about staffing, medical supplies, and recurrent financing.

Development partners can be helpful in regard to learning from other countries, but can also distort priorities. Bilateral and multilateral development partners are a potentially valuable source of cross-country learning. This is particularly true in the Pacific, where some officials specialise in Pacific Island economies and can personally draw on decades of experience from different countries. One interviewee from a bilateral development partner said there had been some good models for sharing experiencing experiences and learning between countries in the Pacific in the past but these had, unfortunately, withered and were no longer operating. One initiative was called the *Pacific Senior Health Officials Network*, initiated by the Australian Department of Health and chaired at a Secretary level. It had been an effective forum for exchanging views on very practical implementation issues arising in the health sector, especially involving cross-border and regional health challenges. The initiative lapsed after some years due to lack of consistency in representation and, more importantly, the morphing of what was originally to be a platform for discussing shared regional health challenges into a 'show and tell' exercise.

Another initiative for generating and sharing evidence and learning were the health 'knowledge hubs' established by the Australian aid programme in 2008. The goal was to build knowledge, evidence and expertise to inform health policy dialogue relevant to Asia and the Pacific. Four knowledge hubs were established, housed in four different Australian universities, each of which had academic and research links to counterpart research institutions in Asia and the Pacific. The four knowledge hubs covered four different thematic areas where there were known gaps in applied research in the region: health information systems; health policy and finance; human

resources for health; and women and children's health. The four knowledge hubs generated a wide range of applied research findings and policy briefs across the Asia and Pacific region, provided short-term training, and provided a 'help desk' to respond to enquiries. AusAID ceased to fund the knowledge hubs in 2013, as part of significant budget cuts to the Australian aid programme.

However, there can be confusion and conflicting signals when technical advice is not well coordinated. Some interviewees noted that development partners had not always had a clear and coherent approach, even when the global scientific and evidence base was particularly clear and strong – for example, in assessing the relative costs and benefits of expanding the existing suite of vaccines. Furthermore, significant external financing may skew national priorities and run counter to what the latest evidence at the country level is suggesting. There is clear evidence,[53] for example, that development partners have favoured increased policy attention and external financing for HIV and AIDS in the Pacific, which is disproportionately out of alignment with the actual burden of disease in the region (with the exception of PNG, which does have high rates of HIV and AIDS). One interviewee noted that well-intentioned consultants or volunteers would, for example, recommend particular interventions based on their experiences in Australia or New Zealand or other parts of the Pacific, with little consideration of the affordability or feasibility of applying such interventions in Solomon Islands. In other parts of the Pacific, provision of a large tertiary hospital by an emerging non-OECD development partner drew financial and health personnel away from rural clinics and rural hospitals to the capital city, the opposite of what the host government's health policy had aimed to achieve.

4.1.4 Implications for Solomon Islands

Solomon Islands has established a good foundation for using evidence and learning from its own experiences, and those of other countries, but more needs to be done. Solomon Islands is undertaking an ambitious, system-wide, reform process through the RDP and similar initiatives. Evidence and learning from within Solomon Islands and from other countries has played an important role at various points in the evolution of that reform process. The need to continue learning from Solomon Islands' own experience, and those of comparable countries, will only increase in future months and years. That is particularly because Solomon Islands is facing some important challenges, including the reduction in external financing from key bilateral and multilateral partners; the need to now effectively and efficiently *implement* the RDP; and the need to absorb the Cuban-trained doctors and health workers in ways that builds on the existing strengths of the nurse-led primary healthcare system in the country.

4.1.5 Implications for Bill and Melinda Gates Foundation

There are three implications from this study that the Bill and Melinda Gates Foundation may wish to consider, starting with the importance of leadership. First and foremost, it is an essential prerequisite to have stable and strong leadership that is genuinely interested in 'evidence' and 'outcomes' if any form of learning is to have traction. There is a widespread consensus among those interviewed in Solomon Islands that the reform efforts undertaken so far in Solomon Islands would not have occurred if it had not been for the determination, resilience, competence, and leadership of Permanent Secretary Tenneth Dalipanda. There are several examples in other Pacific Island countries where ministers and permanent secretaries in the health portfolio are purely political appointees, and often in the position for just a few months. In such circumstances, having an abundance of learning from other countries makes virtually no difference to health reforms and health outcomes, as a means of improving outputs and outcomes.

Second, there needs to be a visible and sustained institutional *demand* for learning from other countries, a situation that arises more frequently as bureaucracies move from

mechanistic input-based resource allocation decision making to more outcome-oriented decision making. Solomon Islands' MHMS has developed and evolved to the point where a critical mass of senior officials now ask for and expect to receive evidence about 'what works', for whom, when, at what cost, and under what circumstances, including where relevant the lessons from neighbouring countries. This has not always been the case. Traditionally, officials had no particular incentive to seek out lessons from other countries or use evidence to shape policies if budgets were essentially based on historical expenditure patterns; officials were not accountable for results; or officials simply did not have the institutional authority to change budget allocations or personnel based on new evidence.

Third, whether the *supply* of learning from other countries gains traction depends to a large degree on *who* is supplying the evidence; *when* it is provided in the planning, budget, and political cycles; and *how* it is provided. *Who* provides evidence and learning is an important starting point. Interviewees were generally of the view that WHO was the obvious partner to provide up-to-date, disinterested*, technical* advice about health issues that would be based on global lesson-learning, but generally adapted to Pacific Island circumstances.

Interviewees were also generally of the view that the World Bank was the obvious partner to obtain advice on health financing, procurement, and contracting, again on the basis that the World Bank would be able to draw on global experiences but adapt that to local Pacific conditions. It is clear however, that while WHO and the World Bank enjoy strong reputations as institutions per se, the actual influence of those organisations in small countries such as Solomon Islands depends very much on the personalities from those organisations on the ground. From experience in other assignments it is also clear that views differ as to whether the provision of financing adds to or detracts from the ability of an organisation to advocate policies. Some officials in low- and middle-income countries believe the combination of strong technical advice and concessional finance gives the World Bank a dominant seat at the policy table, especially if ministries of finance are involved. Other officials believe the opposite: that the lack of lending by WHO makes them a more 'pure' and disinterested partner, raising their credibility and influence. Interviews in Solomon Islands also reconfirmed yet again a well-known finding about the preferences that officials have for learning from different countries, particularly in countries with small populations: personal friendships and networks are often seen as a more trusted and reliable source of advice and knowledge than institutional or impersonal sources of advice.

When evidence and learning is provided is also a key factor. Organisations that provide lessons at critical stages in the planning and budget cycle are more influential than those that provide the evidence at other times.

How the evidence is presented is a critical factor. Development partners are generally more influenced by strong, detailed, technical reports. Government officials in the Pacific may often have a preference for learning through oral presentations from trusted individuals. Internet-based research is problematic in Solomon Islands. Government departments in the capital, Honiara, including the MHMS, have adequate and reliable internet access. However, the situation is more problematic for individuals, civil society, and those working and living in the more remote provinces and islands, given that only 12% of the country has electricity and the country has poor, expensive, and generally unreliable internet connections.

Managing of these supply-side issues – the 'who, when, and how' – will influence the extent to which learning from other countries and evidence more broadly makes it to the policy table in the first place. Judgements then tend to be made by decision makers as to whether the evidence is relevant and / or the quality of the evidence is sufficient to take matters forward.

References

1. World Health Organization (2015) Solomon Islands Health System Review.
2. Government of Solomon Islands Ministry of Health and Medical Services (2016) Role Delineation Policy for Solomon Islands Health Facilities. Honiara.
3. Secretariat of the Pacific Community (2016) Updated mid year 2016 population estimates. http://prism.spc.int/regional-data-and-tools/population-statistics/169-pacific-island-populations (accessed 21 May 2017.
4. Taylor R. (2016) The tyranny of size: challenges of health administration in Pacific Island states. *Asia Pacific Journal of Health Management* 2016; **11**(3): 65.
5. The World Bank (2014) Hardship and Vulnerability in the Pacific Island Countries 2014.
6. The World Bank (2017) World Bank Country and Lending Groups for the 2018 Fiscal Year. https://datahelpdesk.worldbank.org/knowledgebase/articles/906519 (accessed 6 August 2017.
7. The World Bank (2010) Solomon Islands growth prospects: constraints and policy priorities.
8. The World Bank (2010) Health Financing Options Solomon Islands. Washington DC: The World Bank.
9. Anderson I, Ivatts S, Somanathan A, Rolfe B. (2014) The challenges of health financing in five South Pacific countries. *Asian-Pacific Economic Literature* 2014; **28**(1): 29-46.
10. The World Bank (2017) World Development Indicators. http://databank.worldbank.org/data/reports.aspx?source=2&series=SH.XPD.PUBL&country= (accessed 20 April 2017.
11. The World Bank (2017) Solomon Islands Health Financing Assessment: Spending Better. DRAFT version. Washington DC.
12. The World Bank (2005) Opportunities To Improve Social Services: Human Development in the Pacific Islands. Washington DC.
13. The World Bank (2016) Strengthening public financial management reform in Pacific Island countries.
14. The World Bank (2014) Non Communicable Disease Roadmap Report (circulated June 2014 for consideration by the Joint Forum Economic and Pacific Health Ministers' Meeting held in July 2014). Washington DC.
15. The World Bank (2017) Pacific Possible: Long-term Economic Opportunities and Challenges for Pacific Island Countries Discussion Draft. Washington DC.
16. Tin STW, Lee CMY, Colagiuri R. (2015) A profile of diabetes in Pacific Island Countries and Territories. *Diabetes research and clinical practice* 2015; **107**(2): 233-46.
17. Tobias Haque, David Knight, Dinuk Jayasuriya (2012) Capacity Constraints and Public Financial Management in Small Pacific Island Countries. Washington DC.
18. Tuitama LT, Young-soo S, Clark H, Tukuitonga C, Beaglehole R. (2014) Acting on the Pacific crisis in non-communicable diseases. *The Lancet* 2014; **384**(9957): 1823-4.
19. Tukuitonga C. (2016) Diabetes remains major health challenge in the Pacific. http://devpolicy.org/diabetes-remains-major-health-challenge-pacific-20161026/?utm_source=Devpolicy&utm_campaign=b2efb0c490-RSS_EMAIL_CAMPAIGN&utm_medium=email&utm_term=0_082b498f84-b2efb0c490-312068301.
20. UNFPA (2008) Problems in 'Paradise': Addressing Reproductive Health in the Pacific Islands.
21. UNFPA (2010) Reproductive health status in the Pacific Island Countries.
22. UNICEF (2005) Solomon Islands: a situation analysis of children, women and youth.
23. United Nations Fund for Population Activities (2010) Population ageing in the Pacific Islands: a situation analysis. Suva, Fiji.
24. Van Lerberghe W. (2008) The world health report 2008: primary health care: now more than ever: World Health Organization.
25. WHO (2010 Key components of a well functioning health system. www.who.int/healthsystems/EN_HSSkeycomponents.pdf.
26. WHO (2010) World Health Report 2010: Health System Financing - The Path To Universal Coverage. Geneva.

27. WHO (2015) Pacific year in review 2014.
28. World Bank (2008) The political economy of policy reform: issues and implications for policy dialogue and development operations. Washington DC.
29. World Bank (2009) Good Practices In Health Financing: Lessons From Reforms In Low and Middle Income Countries. Washington DC: World Bank.
30. World Bank (2011) Public Expenditure Review for the Solomon Islands Government. Washington DC.
31. World Bank (2013) The Economic Costs of Non-Communicable Diseases in the Pacific Islands: A Rapid Stocktake Of The Situation In Samoa, Tonga and Vanuatu. Washington DC
32. World Health Organization (2003) Health care decision-making in the Western Pacific Region: Diabetes and the Care Continuum in the Pacific Island Countries. Manila.
33. World Health Organization (2010) Package of Essential Noncommunicable (PEN) Disease Interventions for Primay Health Care in Low Resource Settings.
34. World Health Organization (2016) Assessing fiscal space for health expansion in low-and-middle income countries: a review of the evidence. Geneva: World Health Organization.
35. World Health Organization (2017) Global Health Observatory data repository. http://apps.who.int/gho/data/node.home.
36. Zimmet P. (1979) Epidemiology of diabetes and its macrovascular manifestations in Pacific populations: the medical effects of social progress. *Diabetes care* 1979; **2**(2): 144-53.
37. Ministry of Health (2004) National Health Plan 2004-5: Priority Strategies and Program of Actions. Honiara.
38. Ministry of Health and Medical Services (2005) Guideline for Minimum Standards for Health Clinic Infrastructure: Area Health Centres, Rural Health Clinics and Nurse Aid Posts. Honiara, Solomon Islands.
39. National Parliament of Solomon Islands (2007) Hansard, Monday 1 December 2008. Honiara, Solomon Islands.
40. Ministry of Health and Medical Services (2007) Health Sector Support Program: Implementation Plan 2007–2012. Honiara, Solomon Islands.
41. Office of Development Effectiveness (2009) Working Paper 2: Solomon Islands Country Report (Evaluation of Australian aid to health service delivery in Papua New Guinea, Solomon Islands and Vanuatu).
42. National Parliament of Solomon Islands (2007) Inquiry into the 2007 Draft Estimates - Head 276 – Ministry of Health and Medical Services. Public Accounts Committee.
43. Ministry of Health and Medical Services (2011) National Health Strategic Plan 2011-2015. Honiara, Solomon Islands.
44. World Health Organization and the Secretariat of the Pacific Community (2009) Eighth Meeting of Ministers of Health for the Pacific Island Countries.
45. Ministry of Health and Medical Services (2016) National Health Strategic Plan 2016-2020. Honiara, Solomon Islands.
46. World Health Organization (2016) Integrated People-Centred Health Services Case Study: Role Delineation Policy, Solomon Islands.
47. Whiting S, Dalipanda T, Postma S, de Lorenzo A, Aumua A. (2016) Moving towards Universal Health Coverage through the Development of Integrated Service Delivery Packages for Primary Health Care in the Solomon Islands. *International Journal of Integrated Care* 2016; **1**(3).
48. Lorgelly PK, Gilbert K, Mortimer D, *et al*. (2015) Solomon Islands Health facilities Costing Study. Honiara, Solomon Islands: World Bank.
49. Negin J, Morgan C, Condon R. (2012) Regional Health Meetings in the Pacific and their Impact on Health Governance. *Global Health Governance* 2012; **5**(2).
50. Pacific Islands Forum Secretariat (2014) Joint Forum Economic and Pacific Health Ministers Meeting Outcome Statement. http://forumsec.org/resources/uploads/attachments/documents/2014_Joint_FEMM_PHMM_%20Meeting_Outcomes_Statement_July14_approvedbyMinisters1.pdf (accessed 17 September 2015.

51. Kessaram T, McKenzie J, Girin N, *et al*. (2015) Noncommunicable diseases and risk factors in adult populations of several Pacific Islands: results from the WHO STEPwise approach to surveillance. *Australian and New Zealand journal of public health* 2015.
52. Batley J. (2015) Constituency Development Funds in Solomon Islands: State of Play. *SSGM In Brief* 2015; **67**.
53. Negin J, Robinson H. (2010) Funding for HIV and non-communicable diseases: implications for priority setting in the Pacific region: The Nossal Institute for Global Health, 2010.

Annex A Interview guide circulated to Solomon Island interviewees prior to interviews

How countries learn from each other when undertaking health reforms.
Suggested interview guide for Solomon Islands

Purpose of this note

The purpose of this note is to give further background to the proposed visit to Solomon Islands by Ian Anderson and Katherine Gilbert, currently planned for 4–8 September 2017.

Background to the visit

The Bill and Melinda Gates Foundation wishes to better understand how low- and middle-income countries around the world improve the performance of their public health systems. This includes questions such as **why, when, and how countries learn from the experiences of each other in this area**. Importantly, the Bill and Melinda Gates Foundation also wishes to better understand what could be done better, or differently, in future to enable countries to learn from each other.

The Bill and Melinda Gates Foundation has appointed Oxford Policy Management (OPM), United Kingdom, to undertake this analysis. OPM is now in the process of organising field interviews in seven countries to explore these issues. The seven countries are, in alphabetical order: Bangladesh, Burkina Faso, Cambodia, Ethiopia, Nepal, Rwanda, and Solomon Islands. OPM has contracted Mr Anderson and Ms Gilbert to undertake the interviews in Solomon Islands. This note sets out OPM's initial thinking for how to organise the interviews, and what to focus on.

Suggested approach and key questions

Solomon Islands is well known for implementing some important and interesting reforms that are designed to improve health outcomes. Examples include:

- the decentralisation of health services;
- the Role Delineation Policy and the basic services package, including how to address the existing challenges of maternal health and communicable diseases, as well as the emerging challenges of non-communicable diseases, and how to do so in an integrated fashion;
- health sector governance, including the role of performance monitoring, incentives, and lesson-learning;
- relationships with development partners: ensuring advice and inputs are well coordinated and coherent at a sector level; and
- health workforce reforms, including for nurses as well as for doctors.

Each of these reforms could be an interesting case study of how decision makers in Solomon Islands used evidence, and the experience from other countries, to shape and implement those reforms. It probably makes sense to focus on just two or three of those reforms, and to discuss them in depth. We would be happy to work with Solomon Islands officials to identify which two or three reforms we focus on.

For the two or three case studies it would be to discuss questions such as the following:

- To what extent did international or regional 'evidence' inform those reforms, starting from the initial idea that reform was needed through to the subsequent stages of policy development, implementation, and review and evaluation? Was there learning from other countries in the Pacific, or elsewhere, as part of that process?
- There are several opportunities for senior policymakers in Solomon Islands to learn from (and teach) other countries in the Pacific region about reform efforts in the health sector, including,

for example, regional meetings. What are the strengths, and weaknesses, of those opportunities if a country wishes to learn more about the successes (and perhaps failures) of other countries' reform efforts? What could have been done better that would mean countries can learn from each other more easily?

- Looking to the future, what are policymakers in Solomon Islands currently working on where lessons from international experience might be useful? Is there a need to improve opportunities for learning from each other in those areas and, if so, what could be done at a practical level to improve the situation?

Next steps

These are just our initial thoughts. We will be very pleased to discuss this approach with you, and to get your advice on what two or three case studies we should perhaps focus on.

We confirm that all responses from interviewees will be anonymous. We will not mention anyone by name but will simply say 'One senior official said …XYZ…Another senior official thought that XYZ …'.

Please feel free to contact Ian or Katherine if you wish to discuss any of this further, or to suggest some particular case studies of reform or specific questions. Our emails are as follows:

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