



NICE INTERNATIONAL'S ENGAGEMENT IN INDIA AND CHINA

Summary Report

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Submitted by Itad
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Report

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Acronyms

CNHDRC	China National Health Development Research Centre
COPD	Chronic obstructive pulmonary disease
CP	Clinical pathway
CRMD	Confidential Review of Maternal Death
DFID	Department for International Development
DHR	Department of Health Research
FGD	Focus group discussion
GoK	Government of Kerala
HITAP	Health Intervention and Technology Assessment Program
HPS	Health Partnerships Scheme
HTA	Health Technology Assessment
ICMR	Indian Council of Medical Research
iDSI	International Decision Support Initiative
KFOG	Kerala Federation of Obstetrics and Gynaecology
KII	Key informant interview
M&E	Monitoring and evaluation
MMR	Maternal mortality rate
MoHFW	Ministry of Health and Family Welfare [India]
MoU	Memorandum of Understanding
MTAB	Medical Technology Advisory Board
NHFPC	National Health and Family Planning Commission [China]
NI	NICE International
NICE	National Institute of Health and Care Excellence
N(R)HM	National (Rural) Health Mission [India]
PHFI	Public Health Foundation of India
PMAC	Prince Mahidol Award Conference
PPH	Postpartum haemorrhage
PS	Principal Secretary
QS	Quality standard
RSBY	Rashtriya Swasthya Bima Yojana
STG	Standard treatment guideline
ToC	Theory of Change
UHC	Universal healthcare coverage

Executive summary

NICE International (NI) has been working with national governments, with the aim of contributing to “*better health around the world through the more effective and equitable use of resources.*”¹ At the heart of its approach are the principles of evidence-informed priority setting, defined as the “*effective use of evidence in the process of setting investment priorities in health*” in order to work towards universal healthcare coverage (UHC).

In 2012, NICE International was successful in gaining three years of funding through DFID's Health Partnerships Scheme (HPS). A significant focus of its work under the HPS has been in India and China, where NI supported two innovative pilot projects in evidence-informed priority setting. In India, NI worked with the state of Kerala in developing a quality standard (QS) to reduce maternal mortality. In China, NI provided support to the implementation of clinical pathways (CPs) to guide the management of stroke and Chronic Obstructive Pulmonary Disorder (COPD).

The end of the HPS funding stream, the emergence and development of the International Decision Support Initiative (iDSI) and the evolution of NICE International's portfolio of country level support make this an opportune time to reflect on what has been learnt from some of NICE International's work to-date. Therefore, this report discusses some of the key findings from work in India and China under the HPS, and reflects on the lessons learned about the methodology for analysing and reporting on complex change processes.

Key findings from India

1. Stakeholders placed high value on locally owned solutions. The QS development process in Kerala was a collaboration between the Kerala Federation of Obstetricians and Gynaecologists, (KFOG), the Government of Kerala (GoK) and NICE International. NI's bespoke technical support was highly valued, but the commitment and collaboration between the Indian partners

was seen as particularly innovative and critical to driving the development and implementation process. While fundamental to the success of the Kerala project, this also presents a challenge to the perceived replicability of the process elsewhere and therefore communication strategies may need to be tailored accordingly.

2. The NICE 'brand' is well respected and has significant convening power in India. Stakeholders perceive NICE's methodology as systematic and rigorous, and the resulting product is seen as a valuable tool to improve and standardise the quality of maternal care in Kerala. For those not involved in the development process, perceptions of value centre on the end product – this has supported the scale up of implementation of the QS in Kerala, but may suggest the need for more dissemination about the evidence-informed priority setting *process*.

The NICE International brand has significant convening power in India and this is perceived as a valuable contribution – in particular promoting South-South collaboration and raising the profile of evidence-informed priority setting.

3. The role of evidence 'champions' has been critical to date in India. Some key personalities from the Government of Kerala and KFOG were fundamental to the instigation and success of the Kerala QS project. Building relationships with these 'champions' of evidence-informed priority setting has been an effective approach to-date, in line with the context in India where partnerships are heavily reliant on trust and relationship building – NICE International have partnerships that span at least five states, as well as at national level. A reliance on personalities is perceived as both an enabler and a challenge to wider scale-up and institutionalisation.

4. The context of evidence-informed priority setting in India is evolving rapidly. There are a number of activities related to quality, quality standards and use of evidence at different levels – including in Kerala and other states, and at national level. There is a recognised need for a central coordinating body, which has stimulated the planned establishment of a Medical

¹ <https://www.nice.org.uk/about/what-we-do/nice-international>

Technology Advisory Board (MTAB) – eventually, it is anticipated that this Board will take on a NICE-type role. This is a potentially critical development in the context of evidence-informed priority setting in India.

An update on evidence-informed priority setting in India in 2015

During 2015, since the India country visit was undertaken, NICE International has deepened its engagement with several bodies at the state and national levels in India – including support to a Standard Treatment Guidelines Task Force, development of further quality standards, and the ongoing establishment of the MTAB. From 2016 onwards, work in India is being brought into the international Decision Support Initiative (iDSI). iDSI will continue to support these developments, which represent significant progress by the Government of India in committing to evidence-informed priority setting at a national level.

Key findings from China

1. NICE International has been effective at establishing and nurturing the right partnerships in China. Most critically, NI's partnership with the China National Health Development Research Centre (CNHDRC) has been central to its influence in China. CNHDRC bring local knowledge and experience, as well as close connections to sub-national governments and a strong position within the health system. In turn, NI have supported the strengthening of CNHDRC capacity, resulting in CNHDRC carving out an increasingly significant presence in the evidence-informed priority setting space in China.

2. The pilot has successfully deployed a range of capacity building approaches. This has included bringing experts from the UK, conducting joint NI/CNHDRC training sessions, ongoing mentoring by NI and CNHDRC, training of trainers, secondment of CNHDRC staff to hospitals, and facilitating knowledge sharing and learning between pilot sites. The range (beyond simple training) and the scope (including the management systems that are linked to the clinical pathways) of capacity building

approaches were perceived as having valuable contributions to implementation of the pilot.

An update on evidence –informed priority setting in China in 2015

From 2016 onwards, NI's work in China is being brought under iDSI. This will continue NI's engagement with CNHDRC and the National Health and Family Planning Commission (NHFPC), and include developing national tools for institutionalizing evidence-informed priority-setting, including HTA, and support to a China-wide technical assistance hub for HTA and best practice guidelines from CNHDRC. These developments come at the request of CNHDRC and NHFPC, and signify CNHDRC's increasing importance and activity as a provider of expertise within China and other countries in the region.

Reflections on the methodology

The two country visits were an opportunity to pilot the use of indicators and associated data collection and analysis protocols for assessing NICE International's work at country level. This generated some lessons learned about measuring the type of complex change NICE International is hoping to support:

1. SMART indicators may not be the most effective way to measure progress in achieving complex reforms. The changes that NI is hoping to support are very complex, and are occurring at different levels within an evolving country context with complicated political forces at play. Reporting against narrowly defined indicators generates only snapshots, and does not capture the wider contextual factors that enable or constrain progress.

2. It is important to capture short term progress towards longer term goals. The changes that NI are working towards at country level involve some fairly fundamental reforms, which take time. In the interim, it is important that the indicators are able to capture incremental progress.

3. Composite scoring scales were a useful way for plotting progress and informing strategy. They can be applied periodically and, as

composites, they can incorporate assessment of a greater number of factors than would be possible within one indicator. Both of these characteristics arguably make them a more useful tool for reflecting on progress and informing the development of future strategies for engagement.

Implications for NICE International and iDSI

NICE International's support is valued for the fact that it is not prescriptive – but rather focuses on bespoke, tailored, and country-specific strategies. **This suggests that iDSI's emphasis on demand-driven practical support is likely to be welcomed, and should continue to remain at the heart of its Theory of Change.**

The NICE brand has significant convening power, and this is seen as an important role for NICE International at country level. Given that much of its future work will fall under the banner of iDSI, there is arguably a need to **consider how the brand of NI can best be leveraged while also building the profile of the iDSI network as a leader in evidence-informed priority setting.**

The choice of country level partners has proved fundamental to the success of NICE International's work. To date, the commitment to evidence-informed priority setting, political influence, and links to the health system have arguably been more significant than extensive technical expertise. **Robust situational analyses and stakeholder mapping are priorities for iDSI and NI as they move forward with expanding their country level portfolios, in order to inform strategic partner selection.**

It is clear that evidence 'champions' have provided an important conduit for NICE International's engagement. However, there is also a need to balance this with a focus on embedding institutional partnerships, given the risks associated with an over-emphasis on individual relationships. In order for iDSI to be able to capitalise on the momentum around evidence-informed priority setting and leverage the work that NI has done to-date, **it should reflect on its individual and institutional relationships strategically and invest in**

collaborations to contribute to longer term objectives.

Engaging strategically requires an in-depth understanding of the country context, including the political economy and stakeholder dynamics, as well as the ability to build and maintain relationships in those spaces. To-date, NICE International have been very successful in doing this – **however, this requires a substantial commitment of time and resources, suggesting the need for ongoing prioritisation of country level engagement.**

Communication around pilot projects as a proof of concept has been undertaken but appears somewhat ad hoc and opportunistic, rather than as part of a strategic and systematic communication plan. Perhaps as a result, there are mixed perceptions of value on the replicability and wider relevance of some of the projects. **Communication around pilots as demonstration of proof of concept, with a greater focus on generalizability, might represent a workstream that could be strengthened in future.**

1. Introduction

1.1. Overview of NICE International's work in India and China

NICE International (NI) is an arm of the National Institute for Health and Care Excellence² (NICE) – since 2008 it has been working with national governments, with the aim of contributing to “*better health around the world through the more effective and equitable use of resources.*”³ At the heart of its approach are the principles of evidence-informed priority setting, defined as the “*effective use of evidence in the process of setting investment priorities in health*” in order to work towards universal healthcare coverage (UHC).

In 2012, NICE International was successful in gaining three years of funding through DFID's Health Partnerships Scheme (HPS), to provide advice on the processes and methods of using evidence to inform policy in low-income and middle-income countries. NI works in a number of countries, in addition to engaging with international stakeholders such as donors and other development partners; however, a significant focus of its work under the HPS has been in India and China, where NI supported two innovative pilot projects in evidence-informed priority setting. In India, NI worked with the state of Kerala in developing a quality standard (QS) to reduce maternal mortality. In China, NI provided support to the implementation of clinical pathways (CPs) to guide the management of stroke and Chronic Obstructive Pulmonary Disorder (COPD).

Building on the successes and experience of some of its earlier work, NICE International is now a key driving force behind a new initiative, in partnership with a network of organisations working in evidence-informed priority setting. Through its partners,⁴ the International Decision Support Initiative (iDSI)⁵ aims to provide policy-makers with bespoke, tailored and demand-driven practical support to evidence-informed priority setting at country level. iDSI creates effective partnerships to help build stronger country institutions, which in turn supports better decisions in health policy development and implementation and resultant improvements in health.

1.2. Developing a Theory of Change for NICE International's Work

NICE International has been collaborating with Itad as its monitoring and evaluation (M&E) partner since 2012. Early work was centred on the development of country level Theories of Change (ToCs) for NI's engagements in China and India under the HPS to provide a frame for monitoring and evaluating its impact; however, during 2013-2014, this evolved to a focus on developing a more overarching ToC for NI's work (see Annex A). While not losing sight of the country-focused work that is at the heart of what NI does, there was a felt need to reflect the other aspects of its engagement in evidence-informed priority setting – particularly at a more international level, under the heading of “global health diplomacy.”

The intention was that this ToC would provide a framework for allowing NI to monitor and evaluate its work at different levels as well as informing thinking about future strategies for engagement. To that end, a basket of six indicators to track various different elements of the ToC were selected through an extensive consultation between Itad and NI. Associated data collection and analysis protocols were also designed, for piloting at country level in India and China with the intention that they could then be refined, and rolled out across NI's portfolio.

With the emergence of iDSI, much of NI's work at country level is now situated under this initiative, which has its own Theory of Change. However, given the common underlying theory that cuts across NI and iDSI's work, the lessons learned from the early indicator development and piloting processes remain highly relevant, and

² Formerly the National Institute of Clinical Excellence

³ <https://www.nice.org.uk/about/what-we-do/nice-international>

⁴ Founding partners include Health Intervention and Technology Assessment Program (HITAP), the Center for Global Development, and the University of York, with other partners listed at <http://www.idsihealth.org/who-we-are/partners/>

⁵ <http://www.idsihealth.org/>

indeed are being applied in the ongoing development of the monitoring framework for iDSI. The end of the HPS funding stream, with the parallel emergence and development of iDSI and the evolution of NICE International's portfolio of country level support make this an opportune time to reflect on the lessons learned from some of NICE International's work to-date. Therefore, this report discusses some of the key findings from work in India and China under the HPS, and reflects on the lessons learned about the methodology for analysing and reporting on complex change processes.

1.3. Methodology for piloting in India and China

Piloting of the indicators, with associated data collection and analysis protocols, was undertaken during the course of two country visits in India and China, during October and November 2014 respectively. The methodology for the country case studies combined a desk review with primary qualitative data collection at country level. Key informants from NICE International, the Indian and Chinese governments, clinical staff, and other development partners working in evidence informed priority setting were all interviewed and the transcripts analysed thematically against the indicators. Evidence was then analysed against each of the indicators – bringing together the findings of the document review with the qualitative data collected during the country visit, to generate two country reports. (Further details on the methodology are available in Annex B and the individual country reports for India and China.)

This report presents firstly a summary of some of the key headline findings from the India and China reports, as well as a brief update from NI about how things have evolved at country level over the past year since the teams' visits. The report then reflects on the data collection and analysis processes, generating some lessons learned about the experience of measuring complex change processes. The report concludes with a discussion of the potential implications for NI's and iDSI's future engagements at country level.

2. Summary of Findings

2.1. Quality Standard Development in India

Introduction

The scope of NICE International's engagement in India has evolved over time, but during the period 2012-2014 it was centred on a pilot project to develop a quality standard for reducing the maternal mortality rate (MMR) in the state of Kerala. NI had been engaging in Kerala since 2009, but the pilot project started in 2012 following a meeting between NI and the Principal Secretary of Health for Kerala⁶ and NI's receipt of funding through the HPS. Maternal mortality was chosen as the focus in light of the fact that Kerala was struggling to achieve substantive reductions.

The QS project was a trilateral partnership between NI, the Government of Kerala (GoK),⁷ and the Kerala Federation of Obstetricians and Gynaecologists (KFOG), intended to help reduce maternal mortality in Kerala through the development and implementation of evidence-based standards.⁸ During 2012, a number of workshops were held in Kerala to develop the QS – focusing on identifying the problem and developing quality statements to address it. Multiple stakeholders from across Kerala were involved, under the leadership of the Principal Secretary Health, and NICE International provided technical assistance to support the process. The first edition of the quality standard was launched in January 2013, and it was rolled out to eight pilot hospitals in Kerala for implementation during April 2013.⁹

Key Finding 1: Stakeholders placed high value on locally owned solutions.

Stakeholders in Kerala placed high value on the process being locally owned and driven. The quality standard development process was a collaboration between KFOG, the GoK, and NICE International. Whilst KFOG provided the clinical leadership, the GoK supported the operationalisation of the product and NI played a technical support and facilitation role. Interviewees identified local commitment and ownership as critical to the process, and the partnership between KFOG and GoK was perceived as particularly innovative in the Indian context, and vital in terms of promoting implementation, because the process was instigated not as an academic exercise but as something which was planned to be rolled out and implemented.

The commitment of representatives of KFOG and GoK to evidence-informed priority setting was fundamental to the success of the pilot. The involvement of NICE International in Kerala was a product of the engagement of the then Principal Secretary of Health, as well as others in GoK, in identifying ways to effectively reduce the MMR in Kerala. However, pre-dating the involvement of NI in Kerala, KFOG drove the implementation of a Confidential Review of Maternal Deaths (CRMD) in the state,¹⁰ in order to try and accurately identify the causes of maternal mortality and make recommendations for improvements in practice as a result of this data. Since the development and launch of the QS, various stakeholders from Kerala have authored or co-authored reports and journal articles,¹¹ presented at international conferences,¹² and contributed to newspaper articles about the pilot. This is suggestive of a level of commitment to, and a belief in, the principles of evidence-informed priority setting that goes beyond direct involvement in the QS development process.

⁶ PMAC Conference, January 2012

⁷ Including representatives from the National Rural Health Mission (NRHM)

⁸ Kerala Federation of Obstetrics & Gynaecology. 2012. Second Report of Confidential Review of Maternal Deaths, Kerala 2006 to 2009. Why Mothers Die Kerala 2006-2009, Observations. Recommendations. (Ed VP Paily, K Ambujam Betsy Thomas)

⁹ Community Health Center, Kanyakulangara; Thaluk Head Quarters Hospital Chirayinkezhu; District Hospital Perrorkada; District Hospital Ernakulam; W and C Hospital, Trivandrum; SAT Hospital Trivandrum; SUT Thriruvananthapuram; Mother Hospital, Thrissur

¹⁰ Kerala Federation of Obstetrics & Gynaecology. 2012. Second Report of Confidential Review of Maternal Deaths, Kerala 2006 to 2009. Why Mothers Die Kerala 2006-2009, Observations. Recommendations. (Ed VP Paily, K Ambujam Betsy Thomas)

¹¹ Paily, V.P. et al. 2014. Confidential review of maternal deaths in Kerala: a country case study. *BJOG*, 121 (Suppl 4): 61-68.

¹² For example, the Guidelines International Network (G-I-N) conference on "Measures to Reduce MMR in Kerala"

NICE provided bespoke, tailored support to the process of QS development. Stakeholders were appreciative of the fact that NI did not adopt a prescriptive approach. The development process was viewed to be Kerala-owned and KFOG-driven. More generally in its engagements at a central level, NI has avoided being directive about what evidence-informed priority setting in India should look like, which is welcomed by local stakeholders. There is value attached to products being “made in India”, and therefore, playing the role of facilitator and convenor, as NI did in Kerala, is an effective approach to gaining buy-in.

External perceptions of the replicability of the Kerala QS development process may be a challenge to future scale-up. A number of stakeholders interviewed felt that the specifics of the context in Kerala were vital to the success of the QS development and its implementation – particularly, the comparatively better health system in Kerala, the availability of data on causes of maternal death (from the CRMD), and the drive and engagement of KFOG and other key stakeholders. As a result, some stakeholders expressed concern that the QS development process could not be as easily applied to other conditions and other contexts, because there was a perception that Kerala is quite different to some other Indian states in terms of its health system and progressive history - “you can’t say because it’s been successful in Kerala that it will be successful elsewhere.” Therefore, while on the one hand, Kerala could be considered a good model for other states, conversely success in Kerala is not universally perceived as a sign that a similar process could be applied elsewhere. This has implications for how NI and others tailor communications around the pilot project, if the experience in Kerala is to be effectively used as a demonstration of proof of concept.

Key Finding 2: The NICE ‘brand’ is well respected and has significant convening power in India.

For stakeholders involved in QS development, the application of a NICE-type approach was perceived as systematic and rigorous. Most of the clinicians who were closely involved in the development process articulated the value of the NICE approach, in terms of use of evidence, convening of different stakeholders, and the adoption of a systematic and rigorous process. In comparison to how treatment protocols are commonly developed in India, there was perceived added value in taking into account beneficiary views and drawing on other internationally accepted guidelines. While it was highlighted that the QS development had been long and resource-intensive, the perception was that this was necessary to ensure rigour.

Stakeholders perceive the quality standard as a valuable tool to improve and standardise quality of maternal care, and catalyse reductions in maternal mortality in Kerala. Improved quality of care and/or clinical outcomes through implementation of quality standards was the key area of value highlighted by almost all interviewees who were involved in the QS development process and who were implementing it. The perceived benefits of the NICE-type quality standards, highlighted specifically by a number of the clinicians involved in the development, is that when compared to other sources of guidance the QS is very detailed and explicit and thus is more effective in ensuring standardisation of care.¹³

For stakeholders not involved in the development process, perceptions of value were centred on the end product rather than the concepts of evidence-informed priority setting. They focused on the value of the QS as a specific tool for reducing maternal mortality and improving quality of care. They spoke less about the value of the QS as a concept more generally, or of the evidence-based development process. Emphasis on clinical benefit has clear value as a tool to promote implementation and to gain buy-in among staff. There is evidence of this happening already in Kerala, as networking between health professionals and the perceptions of the NICE label as a marker of quality have led to additional hospitals wanting to join the pilot or independently implementing the QS. However, this may also present a barrier to scale-up of the development and application of QS more broadly, if the QS is perceived as a solution to maternal mortality in Kerala rather than as a process which can be replicated in other geographic locations and for other conditions.

The brand value and convening power of NICE had a significant contribution to the success of the Kerala pilot and is perceived as a valuable role of NICE in India more generally. As an independent organisation of

¹³ For example, the QS does not just specify which uterotonic is to be used, it also gives the dose and route.

international repute, NI was well-positioned to facilitate collaboration between KFOG and the Kerala government and to provide technical assistance in relation to the adaptation of guidelines and use of evidence.

More broadly in India, NI are perceived to have a key role in promoting South-South collaboration and facilitating Indian contact with stakeholders from other low and middle income countries (LMICs) that are implementing evidence-informed priority, such as Thailand. Stakeholders see this as a key area of added value of NI in India, in terms of demonstrating proof of concept and building buy-in around evidence informed priority setting.

Key Finding 3: The role of evidence 'champions' has been critical to-date in India.

Some key personalities were fundamental to the success of the Kerala QS. A critical conduit for NICE International's presence in India is the former Principal Health Secretary in Kerala, whose engagement with the issues of evidence-informed priority setting as a way to reduce MMR led to the initiation of the Kerala project. Similarly, the commitment of some senior personalities in KFOG was perceived as essential to both the development and implementation of the QS. Both Dr. Paily and Dr. Nair (who led on QS development from KFOG) are very well regarded in their field – and those involved not only appreciated their expertise at the initial training but also their ongoing support in addressing queries or challenges in relation to the implementation of the standards.

Building relationships with 'champions' of evidence informed priority setting has been an effective approach to-date in India. NICE International has paid significant attention to partnerships in India, and the type of partnership has been wide ranging and mixed - with a combination of individuals and institutions. These partnerships span at least five states in the country, as well as some at the centre in Delhi and some that could be considered more 'global' but that are playing out in the India context (see Annex C). Many of NI's partnerships in India are personality driven, built on relationships developed with individuals in leadership positions in research institutions and professional organisations, senior administrators and decision makers in state and central government departments and ministries, bilateral and multilateral donor and aid agencies and individual professionals. This is in line with the context in India, where partnerships are heavily reliant on trust and relationship building, as opposed to legal and contractual frameworks. Both at individual and organisational levels, mutual respect and willingness to provide support in challenging circumstances can be a driver of deeper partnerships. This has proved to be an effective approach to-date. For example, the former PS of Health in Kerala is now the Chief Executive Officer (CEO) of a government health insurance scheme, Rashtriya Swasthya Bima Yojna (RSBY), which has started the development of clinical pathways based on reviews of international guidelines and evidence. While not a direct scale-up of the pilot project, this is clearly linked through the relationship of NICE International with RSBY's CEO and his engagement with the issues of evidence-informed priority setting.

Leveraging individual relationships is perceived as both an enabler and a barrier to scale-up of evidence-informed priority setting. Many interviewees described the engagement of KFOG and other key personalities in Kerala as particularly critical to the success of the QS process, and some expressed concern that this would not be replicated elsewhere, for example in states or clinical areas where the professional bodies have less of a presence, or there is less of a commitment from the administration - "*it remains personality driven unless it is institutionalised.*" In Kerala, there has been interest in scaling up the use of QS to new conditions (and indeed an infant mortality QS was almost complete at the point of data collection in 2014); however, what is notable is that, to-date, these have all been linked to maternal and child health and to a large extent involve obstetricians from KFOG. On the one hand, this allows the new initiatives to draw on the commitment, expertise and experience of clinicians who have already been involved in development of a QS and should have positive implications for quality of care. However, on the other hand, it arguably provides more limited evidence for wider buy-in, scale-up and prominence given to QS because the new process is being implemented by the same group of stakeholders.


Key Finding 4: The context of evidence-informed priority setting in India is evolving rapidly

Evidence-informed priority setting is at a fairly nascent stage in India; however, there are a number of activities related to quality, quality standards and use of evidence ongoing at different levels in India. As part of the India case study, the team mapped out the areas in which there has been scale up of the development of quality standards or clinical pathways in India (see figure 1 below).

Building on learning from the MMR QS experience, in Kerala, an infant mortality quality standard was developed by the National Health Mission Kerala in collaboration with the state branch of the Indian Association of Paediatrics and ACCESS.¹⁴ There has also been evidence of early interest and engagement in QS from other states in India, namely Bihar and Odisha - delegations from Bihar and Odisha visited Kerala on a study visit to learn about the QS development process and the Kerala CRMD. In the state of Karnataka, the Suvarna Arogya Suraksha Trust (SAST) have developed standard treatment guidelines (STGs) for oncology, and plan to develop STGs in six more specialties. The intention has been to develop guidelines using an approach similar to that of the NICE model in order to standardise care in participating hospitals, ensuring that patients get the highest quality care and that wasteful medical interventions are minimised.

At national level, RSBY¹⁵ has commissioned the development of clinical pathways, drawing on the quality standards development process for MMR that took place in Kerala. The objective is to bring reform in the insurance scheme and eliminate the practice of wasteful and expensive medical procedures, which may also be harmful to patients – for example, the overuse of hysterectomy. There are also currently various other organisations, with whom NICE International has partnerships, including the Indian Council of Medical Research and the National Health System Resource Center (NHSRC) working in developing guidelines.

Figure 1. Overview of scale-up of quality standard and clinical pathway development in India¹⁶

Phase	Interest	Early engagement	Scoping	Initiation of development	Product finalisation	Product implementation
Type of scale-up	Phase reached and supporting evidence					
Development of new QS/CP for focal condition within focal location					Maternal mortality QS in Kerala	
Development of QS/CP for new condition within focal location	Antenatal care QS in Kerala				Infant mortality QS in Kerala	
Development of QS/CP for focal condition in new location						
Development of QS/CP for new condition in new location	QS in Bihar	QS in Odisha		Development of clinical pathways by RSBY 		Development of standard treatment guidelines in Karnataka

¹⁴ ACCESS Health are an organisation that works in India to design and manage programmes to drive improvements in healthcare, for example linked to health finance systems and understanding how these systems can be applied to improve the quality of healthcare services (<http://accessh.org/india/>)

¹⁵ RSBY (Ministry of Labour 2008-2015; MoHFW from April 2015) is a government health insurance scheme for the poor and is headed by Rajeev Sadanandan, who previously was Principal Health Secretary, Ministry of Health Kerala and instrumental to the engagement of NICE International in QS in Kerala.

¹⁶ As classified at the point of data collection in 2014

At the central level, the issue of quality is becoming more prominent and there is a recognized need for a central coordinating body. The need for a central coordinating body for evidence-informed priority setting is being addressed through the establishment of a Medical Technology Advisory Board (MTAB) – designed to support identification of cost-effective technologies for implementation through Health Technology Assessments. There is a widespread recognition that the MTAB will need to build its role and capacity over time, but the intention is that it will become a NICE-type body that can coordinate and commission guidelines. There is an advisory group, including NICE International, who are consulting on the development of the MTAB and Ministry staff commissioned with managing its establishment went on a study visit to NICE.¹⁷

To stimulate further scale-up, there is a need to generate increased demand and capacity for evidence-informed priority setting at every level. There are clear champions, but still a need to generate more widespread demand at every level. For example, from the perspective of clinicians, it was reported that there is not a universal felt need for guidelines or standards to replace individual professional judgement. There are also perceived challenges around the rigour required to generate products and some people noted that there is a lack of capacity that needs to be addressed. Interviewees made various suggestions for stimulating demand, particularly around proof of concept. For example, the utility of hearing experiences from other countries was valued, and by association NICE International were valued for their ability to convene different stakeholders.¹⁸ Similarly, some people referenced the need to take both a top-down and a bottom-up approach – i.e. demonstrating proof of concept in states, while also getting central level buy-in.

An update on evidence-informed priority setting in India in 2015

Overview

During 2015, since the India country visit was undertaken, NICE International has deepened its engagement with several bodies at the state and national levels in India. Collaboration between NICE and Indian health authorities was welcomed in 2015 by Prime Ministers of both countries during the UK-India summit, as an outstanding example of health cooperation.¹⁹ From 2016 onwards, work in India is being brought under the international Decision Support Initiative, which will continue to the task force developing national STGs (discussed further below), and contribute to the formation of the Indian MTAB. Both of these developments represent significant progress by the Government of India in committing to and coordinating priority-setting at a national level.

NICE support to the Standard Treatment Guidelines task force

The focus of NICE International's technical support at the national level has been working with the MoHFW's Task Forces to address priority-setting issues. These task forces are convened on areas contributing to universal health care in India, including STGs, Primary Care, and Costing.²⁰ The STG task force is coordinated by the NHSRC and will oversee the development of authoritative, national STGs for healthcare services, which can be adopted by states and insurance schemes to expand access to effective care. NI is contributing as a member of the STG Task Force, providing technical support to ten Clinical Subgroups on specific STGs and support to the development of the process and methods manual underpinning the guidelines and associated QS for India.

This engagement is significant both for the political commitment displayed in India to improving public healthcare, with a wide range of expertise across different sectors brought together to define national standards, and for the appreciation of NI's technical support to the Government of India. NICE was also

¹⁷ Six people went to NICE to understand its functioning

¹⁸ For example, the HTA conference where representatives from countries including China, Afghanistan and Thailand attended

¹⁹ IDSI web update: <http://www.idsihealth.org/blog/nice-international-acknowledged-in-joint-statement-from-british-and-indian-prime-ministers/>
Prime ministerial joint statement: <https://www.gov.uk/government/news/joint-statement-on-the-united-kingdom-india-summit-2015>

²⁰ NICE International is working with the STG Task Force to develop national clinical guidelines, and associated processes and methods, for conditions with high burdens of disease <http://www.nice.org.uk/about/what-we-do/nice-international/nice-international-projects/towards-national-standard-treatment-guidelines-stgs-for-india>

mentioned as a potential technical partner and model in the draft National Health Policy document (the only institution outside India referenced by name).²¹

Technical assistance to RSBY quality programme

The participatory model championed by the Government of Kerala has also been employed at the national level by RSBY, which led development of an early set of national quality standards for high-frequency procedures during 2014-15. NI supported the Topic Expert Groups developing these standards by advising on process and technical methods. The most intensive technical support was delivered to the first group (hysterectomy), who subsequently used this as a reference and exemplar for the later groups. NI also facilitated the independent peer-review of the guidance by UK experts. Seven pathways were completed with NI input in March 2015, and formally submitted to Ministry of Health and Family Welfare (MoHFW) for approval in April 2015.

Work with the Indian Council of Medical Research and the MTAB

NICE International is contributing to a consultation, opened in 2015 by ICMR, on international models for HTA and priority-setting. This will draw on research and activity by NI and partners in iDSI, in particular examples of HTA activity in other middle-income countries (Health Intervention and Technology Assessment Program [HITAP] in Thailand, and growing initiatives in Philippines and Indonesia) as well as the experience of NICE and other European agencies.

NICE and iDSI colleagues are also participating in a joint steering group on HTA convened by ICMR and the Department of Health Research (DHR), which is preparing for the launch of the Medical Technology Advisory Board.²²

NICE support to South-South collaboration and learning

In 2015, representatives of Indian health and research bodies have given oral presentations at the Prince Mahidol Award Conference (PMAC) and also engaged in study activities facilitated by NICE International. Two high level representatives from the Government of India visited China in March 2015, to observe field implementation of the HPS-funded project developing clinical pathways and payment reforms,²³ and subsequently, two members of the STG task force attended the dissemination workshop in Beijing to learn about the impact of implementing these pathways and lessons for STG quality standards.

In a further example of South-South cooperation, NI has facilitated communication between HITAP and Indian institutions, including both NI and HITAP presenting at a joint workshop in December 2015 in Chandigarh run by the Public Health Foundation of India (PHFI). Several high level individuals from the MoHFW and ICMR participated in the 2015 PMAC in Bangkok, and four NHSRC and ICMR colleagues will be presenting or contributing to panel discussions at the PMAC 2016 conference, "Priority-setting for universal health coverage."

2.2. Implementation of Clinical Pathways in China

Introduction

In 2012, NICE International and the China National Health Development Research Centre (CNHDRC) started implementation of a pilot integrating clinical pathways with other supporting systems for stroke and COPD in three (subsequently increased to four) counties in China.

The NICE/CNHDRC project was designed as a pilot of an integrated reform ('clinical pathways+') in which clinical pathways were combined with other reforms, rather than being implemented as a standalone pilot of clinical pathways. Therefore, core components of the pilot design included development of contextually-appropriate

²¹ National Health Policy 2015, Draft: <http://www.mohfw.nic.in/showfile.php?lid=3014>

²² iDSI 'Mapping of priority-setting in India' – in press

²³ See report on NICE website: <https://www.nice.org.uk/about/what-we-do/nice-international/nice-international-projects/clinical-pathways-and-payment-reform-in-rural-china#Indian>

clinical/care pathways; development of related data management systems and software in project counties; negotiation and development of remuneration systems for medical personnel to increase their support for clinical pathways; standardisation of clinical behaviour, in order to increase quality of services and control unreasonable growth in medical spending; enabling hospitals to provide convenient, safe, effective and reasonably-priced services; improvement of capacity for evidence-based decision making; and promotion and propagation of a model of clinical pathways and payment reform. This built on learning from the separate roll out of a national policy on clinical pathways in 2009 – the lack of link to other necessary reforms led to a limit on effectiveness. County-level hospitals were chosen as the target of the intervention as there was felt to be good potential for strengthening standardisation of disease management at this level.

Key Finding 1: NICE International has been effective at establishing and nurturing the right partnerships in China.

NICE International has four key partnerships in China, at different scales and at different levels of maturity. Two partnerships, namely those with CNHDRC and with Renmin University, are classified as mature (see Figure 2 below, and Annex C). CNHDRC has emerged as NI's core partner in China and the relationship is clearly a source of strength, while NI's long-standing partnership with Renmin University continues to flourish. One partnership, with Qingdao Bureau of Health, is classified as emerging. There are signs of nascent relations with a number of Chinese government departments, at both the central and provincial levels.

Figure 2: Overview of NICE International's partnerships in China²⁴

Nascent	Emerging	Established	Mature
<ul style="list-style-type: none"> National and provincial government actors 	<ul style="list-style-type: none"> Qingdao 	<ul style="list-style-type: none"> National Health and Family Planning Commission National Development and Reform Commission 	<ul style="list-style-type: none"> CNHDRC Renmin University

NICE International's partnership with the CNHDRC is central to its influence in China. The CNHDRC is a core part of the health system and a key policy research institute and think tank to the Chinese National Health and Family Planning Commission (NHFPC, formerly Ministry of Health). It represents a strong partner for NICE International, given its connections to sub-national governments, its strength in brokering and managing pilots, and its position within the Chinese policy system and close link to the Commission. The partnership with CNHDRC is invaluable to the success of NI's work in China, bringing local knowledge and experience. The partnership is clearly perceived as mature by NICE International, for whom it is routine. Communication around project management is second nature, and arising issues can be dealt with swiftly through direct phone communication. It is clear that there is a high degree of complementarity in the relationship between NICE and CNHDRC and that this has been key to the success of the clinical pathways pilot.

NICE International have supported the strengthening of CNHDRC capacity. The current project builds on NICE International's collaboration with CNHDRC during earlier clinical pathways work, run since 2009. Aside from the core activities of managing the pilot, there is evidence of other forms of interaction between NICE and CNHDRC, including NICE hosting multiple visits to the UK by CNHDRC since 2010. In 2014, two members of staff from CNHDRC did a three week placement at NICE in the UK, the aim of which was to provide a means to increase CNHDRC learning about NICE and its methods through direct interaction. CNHDRC have been effective at leveraging their contacts and they are now carving out an increasingly significant presence in the evidence-informed priority setting space in China – they are in great demand, and are unable to take on all the work they're being asked to do.

²⁴ As classified at the point of data collection in 2014

NICE International also has both established and nascent or emerging partnerships with central government ministries in China. NICE has a long history of high level dialogue with government actors in China. The most obvious of these is the relationship with the NHFPC, with whom NI have been collaborating since 2009. Since then, NICE has hosted multiple delegations from the Chinese health ministry and in 2014, NI and representatives from the NHFPC reiterated their commitment to working together and highlighted priorities for collaboration with the goal of achieving sustainable universal coverage. Other partnerships, particularly with government actors, are nascent or emerging. This includes the Development Research Center, a think tank to China's State Council, and the Ministry of Human Resources and Social Security. Development of these should be a source of strength for future collaboration.

Key Finding 2: The pilot has successfully deployed a range of capacity building approaches.

NICE International and CNHDRC have deployed a range of effective capacity building activities as part of the implementation of the pilot. This has included bringing experts from the UK, conducting joint NI/CNHDRC training sessions, ongoing mentoring by NI and CNHDRC, training of trainers, secondment of CNHDRC staff to hospitals, and facilitating knowledge sharing and learning between pilot sites. There is evidence that the capacity building has been very effective in changing attitudes about evidence-informed priority setting in pilot sites. For example, some stakeholders described the training they had received as “*revolutionary*”, stating that it had changed the way they think about treatment – particularly in relation to the relative importance of clinical judgement and evidence.

The range of capacity building activities are perceived as having an important contribution, beyond simple training. Many of the capacity building activities involved knowledge sharing, hands on learning, or learning by doing, rather than training *per se* – and this was perceived as significant to the success of the pilot. Beyond the discrete training sessions, there has been a lot of contact between pilot counties and external stakeholders (including CNHDRC/NI) over time. For example:

- Capacity building has been centred on a training of trainers model – implemented at different levels;
- There are continued dialogue meetings between pilot sites;
- There have been visits by external experts – for example, a discussion of how stroke is managed in the UK, by a senior UK healthcare professional – which were noted as highly significant in supporting a significant change in thinking and management.

The scope of the training and capacity building activities has been significant in supporting implementation. The scope of the training has included use of management and information systems that are associated with the clinical pathways, not just the pathways themselves. Therefore, they support the implementation of the clinical pathways as a component of a complex reform, which was perceived as essential to change practice.

An update on evidence-informed priority setting in China in 2015

Overview

From 2016 onwards, NI's work in China is being brought under iDSI. This will continue NI's engagement with CNHDRC and NHFPC, and include developing national tools for institutionalizing evidence-informed priority-setting, including HTA, and support to a China-wide technical assistance hub for HTA and best practice guidelines from CNHDRC. These developments come at the request of CNHDRC and NHFPC, and signify CNHDRC's increasing importance and activity as a provider of expertise within China and other countries in the region.

Supporting capacity development in evidence-informed priority setting

NICE International delivered a study tour programme for a high-level delegation from China in September 2015,²⁵ in collaboration with the British Embassy in Beijing and the UK Department of Health.²⁶ The delegation comprised 25 high level officials, including seven division heads from the NHFPC and the Director General of the CNHDRC.

NICE International, iDSI and CNHDRC participated in a dissemination event in Beijing for the Clinical Pathways project in October 2015.²⁷ This included presentations of key interim results from the pilot, which from the early data suggested that the intervention was associated with greater use of services recommended in the clinical pathway. Results also suggested that to help secure cost control and financial protection for patients, it will be important to maintain a focus on payment reform. This will require a move away from the dominant 'fee-for-service' model, towards wider case payments implemented as part of this project. Much more can still be done in re-directing resources away from the hospital sector towards community care, at least in rural China. This will require sustained investment in primary care facilities and human resources. These sessions frequently reflected themes highlighted in the 2014 Itad interviews, with implementers from the pilot sites giving examples of how the CPs had built managerial and technical capacity, and fostered closer collaboration between different tiers of the health system. Physicians also highlighted the contribution the project had made to creating a more patient-centred approach, and the necessity of patient buy-in for the pilots to succeed.

Developing partnerships

NICE International has deepened its interactions in 2015 with central government ministries, with a new Memorandum of Understanding (MoU) signed with CNHDRC during the September 2015 study tour. This builds on the collaboration between NI and CNHDRC in the area of clinical pathways. The MoU confirms that both organisations will continue to work together to develop frameworks for locally owned clinical guidelines and quality standards in additional priority conditions.²⁸ Creation of quality standards may potentially represent a more parsimonious and practical mechanism to support behaviour change, since in principle they would focus only key areas of concern across the whole pathway.

This collaboration was highlighted by Secretary of State Jeremy Hunt and by Chinese speakers at the UK-China Health Dialogue event as an example of important international partnership. During this event, DG Li Tao of CNHDRC and DG Zhang Zongjiu of NHFPC highlighted their key observations from the study tour. They referenced the role of NICE in the UK and their ambition to work with NICE International to establish a similar priority setting institution in China; DG Li Tao wished to deepen the existing collaboration with NICE International to develop health technology assessment in China. Work in China through the iDSI is designed to further this aim.

NI support to South-South collaboration and learning

International promotion by CNHDRC continued through HTAsiaLink, the Guidelines International Network (G-I-N) and the PMAC, to which CNHDRC and NICE International successfully submitted presentation abstracts.²⁹

As a result of dissemination activities, several representatives of international counterparts were able to come to China and conduct field visits in the pilot sites to better understand the project implementation and practical impact. Participation in 2015 included delegations from India and Indonesia to observe implementation.³⁰ NICE,

²⁵ Details on NICE website: <https://www.nice.org.uk/about/what-we-do/nice-international/nice-international-projects/nice-signs-mou-with-cnhdrc-during-uk-china-health-talks> Additional information on People to People Dialogue event: <https://www.gov.uk/government/news/uk-china-people-to-people-talks-set-vision-for-state-visit>

²⁶ The study tour was organised as part of the People to People Dialogue (P2P), one of the UK's key ministerial-level talks with China.

²⁷ Report on NICE website (English): <https://www.nice.org.uk/about/what-we-do/nice-international/nice-international-projects/nice-international-participates-in-clinical-pathways-dissemination-event-china>

²⁸ Excerpted text available here: <https://www.nice.org.uk/Media/Default/About/what-we-do/NICE-International/projects/CNHDRC-NICE-Appendices-A-I.pdf>

²⁹ A full list of dissemination activities is in the project report (October 2015): <https://www.nice.org.uk/Media/Default/About/what-we-do/NICE-International/projects/Introducing-evidence-based-clinical-pathways-for-stroke-and-COPD-rural-China.pdf>

³⁰ Information here: <https://www.nice.org.uk/about/what-we-do/nice-international/nice-international-projects/clinical-pathways-and-payment-reform-in-rural-china#Indian>

CNHDR and Thai colleagues from HITAP will deliver a workshop on experiences translating research into policy to the Indonesian Parliament members and senior policy-makers in 2016.

2.3. Reflections on the Methodology

As described in section 1.2, NI and Itad chose six indicators to measure progress at country level – and developed the associated data collection and analysis protocols. The indicators comprised a mixture of qualitative and quantitative measures, drawing from a range of data sources (both primary and secondary). This section of the report reflects on the lessons learned from the piloting and data collection processes in India and China, particularly with reference to the indicators and how the evidence generated can be interpreted and used.

Key Finding 1: SMART indicators may not be the most effective way to measure progress in achieving complex reforms.

While informative in some respects, it became clear during data collection that reporting against the indicators in isolation would not fully capture the scope of NICE International's engagement in the two countries. The changes that NI is hoping to support are very complex, and are occurring at different levels within an evolving country context with complicated political forces at play. Reporting against narrowly defined indicators generates only snapshots, and does not capture the wider contextual factors that enable or constrain progress. For example, while an indicator such as *"% of sampled participants that attend training events on QS who found that the training helped them implement the QS and improve their practice"* provides a quantitative measure of the effectiveness of the training, it provides very limited information about why and how, and therefore arguably has little value in terms of informing future training strategies.

Key Finding 2: It is important to capture short term progress towards longer term goals.

The indicators also had varying utility for tracking progress in early stages of NICE International's activities – particularly given the fairly nascent stage of evidence-informed priority setting in the two countries. For example, while an indicator to measure the publication of legislation to enforce the uptake of evidence-informed decisions (e.g. on services or technologies) would be a critical milestone to record, the indicator does nothing to capture steps towards that goal before it has been achieved and therefore, taking a narrow definition of the indicator may miss some important areas of progress. This limits its utility as a tool for reflecting on progress and informing future strategy.

Key Finding 3: Composite scoring scales were a useful way for plotting progress and informing strategy.

Two of the indicators used composite scales as a way of reporting against the indicators (see Annexes C and D).

- *Extent of adoption of similar processes for QS/CP development in other locations*
- *Number and depth of new partnerships developed by NICE International*

The scales were designed to be completed initially by NI, and the findings then verified and expanded through country level data collection. They were found to be useful tools for systematically classifying the different activities that NI and other stakeholders are engaged in – for example, allowing NI to map its network of partnerships at country level. Critically, these tools can be applied periodically and, as composites, they can incorporate assessment of a greater number of factors than would be possible within one indicator. Both of these characteristics arguably make them a more useful tool for reflecting on progress, or lack of, over time and informing the development of future strategies for engagement.

3. Conclusions and Implications for NICE International and iDSI

Conclusions from India and China

Across both India and China, NICE International's choice of country level partners – both individual and institutional – has been critical to the success of its work to-date. In India, the commitment of representatives from KFOG and the Government of Kerala was a fundamental driver of the success of the QS development process and has supported the increasing profile of evidence-informed priority setting at the central level. Many of its partnerships are based on links built with individuals, in line with the approach to relationship building in India which to-date has been successful. However, it is not without its challenges given turnover of individuals and it is clear that NI will not always be able to rely on champions to shape future relationships with organisations and ministries, given the need to promote institutionalisation of methods and processes.

In China, CNHDRC's position in the health system, networks and local knowledge have been significant in driving the implementation of the clinical pathways and reforms. This has been particularly relevant given the need to build on earlier experiences around the implementation of CP as a package of reforms, rather than in isolation. CNHDRC's presence 'on the ground' and ability to support different types of ongoing capacity building appear to have been critical to the implementation of the reforms. Happily, the partnership appears to have been synergistic, given the increased capacity and profile CNHDRC has built as a result.

Capitalising on momentum around evidence informed priority setting has required a combined strategy of effective communication around the pilots as demonstration of proof of concept, and leveraging influence at central level. In China, there was evidence of the pilot having national influence, as a model for development of national policy and one which will be replicated in 1,000 counties and 100 cities nationwide - this is a substantial achievement. At a central level, CNHDRC have been very effective at leveraging the dialogue around the pilot and getting central people involved in the discussions, using their direct policy channel. In India, NI's relationships with stakeholders at national level have been critical for raising the profile of evidence-informed priority setting and creating a dialogue among some key stakeholders. However, what is also clear is that there is a need to maximise opportunities to leverage the pilot experience through a more systematic communication approach around its demonstration of proof of concept. More tailored communication approaches that focus on the *process* and its replicability, rather than solely the value of the product as a tool for reducing MMR in a specific context, might do more to encourage scale-up of similar processes.

The NICE brand and methodology are valued, but approaches to evidence-informed priority setting need to be country-owned. In terms of technical expertise, the NICE brand is associated with high quality and robust methodologies, but the fact that NICE International are not prescriptive in determining what evidence-informed priority setting should look like in different countries is highly valued. NICE International has rightly identified the need to respond to specific contexts with bespoke and tailored strategies and this is recognised and valued by stakeholders.

NICE International currently has significant convening power, but this requires ongoing strategic engagement at multiple levels. NICE International appears to be highly respected in both India and China, and has significant convening power. This is a key area of its added value – NI is able to support collaboration and dialogue between in-country stakeholders around the evidence-informed priority setting agenda, as well as supporting South-South collaboration. In order to play this role, NI has drawn on both the NICE brand and its relationships at country level which has been an effective approach. However, the corollary of this is that, to continue to operate in a position of influence, NICE International needs to have enough of a country presence to be able to maintain an understanding of the contexts and stakeholder dynamics, in environments in which these can change rapidly and significantly.

Implications for iDSI and NICE International

NICE International's support is valued for the fact that it is not prescriptive – but rather focuses on bespoke, tailored, and country-specific strategies. **This suggests that iDSI's emphasis on demand-driven practical support is therefore likely to be welcomed, and should continue to remain at the heart of its Theory of Change.**

The NICE brand has significant convening power, and this is seen as an important role for NICE International at country level. Given that much of its future work will fall under the banner of iDSI, **there is arguably a need to consider how the NICE brand can best be leveraged while also building the profile of the iDSI network as a leader in evidence-informed priority setting.**

The choice of country level partners has proved fundamental to the success of NICE International's work. To-date, the commitment to evidence-informed priority setting, political influence, and links to the health system have arguably been more significant than extensive technical expertise. **Robust situational analyses and stakeholder mapping are priorities for iDSI and NICE International as they move forward with expanding their country level portfolios, in order to inform strategic partner selection.**

It is clear that so-called evidence 'champions' have provided an important conduit for NI's engagement, particularly in India; however, there is also a need to balance this with a focus on embedding institutional partnerships, given the risks associated with an over-emphasis on individual relationships. In order for iDSI to be able to capitalise on the momentum around evidence-informed priority setting and leverage the work that NI has done to-date, **it should reflect on its individual and institutional relationships strategically and invest in collaborations to contribute to longer term objectives.**

Engaging strategically requires an in-depth understanding of the country context, including the political economy and stakeholder dynamics, as well as the ability to build and maintain relationships in those spaces. To-date, NICE International has been very successful in doing this – **however, this requires a substantial commitment of time and resources, suggesting the need for ongoing prioritisation of country level engagement.**

Communication around pilot projects as a proof of concept has been done, but appears somewhat ad hoc and opportunistic, rather than as part of a strategic and systematic communication plan. Perhaps as a result, there are mixed perceptions of value on the replicability and wider relevance of some of the projects. **Communication around pilots as demonstration of proof of concept, with a greater focus on generalisability, might represent a workstream that could be strengthened in future.**

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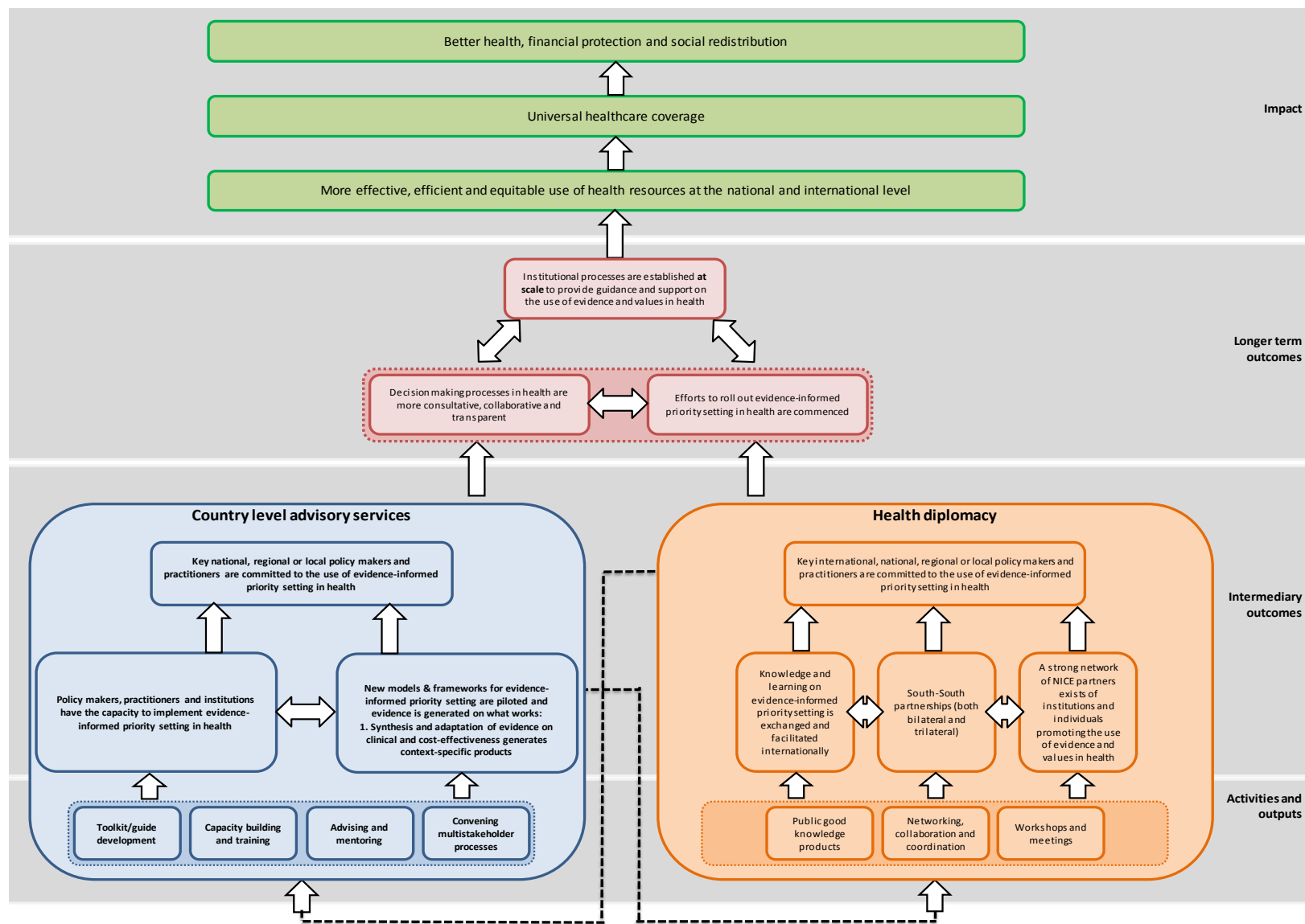
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Annex A. Theory of Change for NICE International



Annex B. Further details on methodology for country visits

B.1 India

Overview

The team spent ten days in India, conducting interviews in Delhi and in Kerala, as well as visiting four of the pilot facilities³¹ and attending a QS review meeting. A period of analysis followed the country visit, which included review of additional documentation, write-up and analysis of the qualitative data from interviews, and some liaison with the China team.

Data Collection

Desk review

A process of document review commenced prior to the country visit and continued into the later phases of the assignment. The study drew upon the documents provided by NICE International, and collected further documents from key informants interviewed as well as through systematic internet searches.

The documents reviewed consisted of:

- Media reports, blogs, and journal articles;
- Letters from NRHM to stakeholders in Kerala;
- Documents related to the different elements of NICE International's work in India, such as study visit reports, Memoranda of Understanding, minutes of meetings, and emails
- Additional documents identified by the review team or provided by key informants (for example, reports on related work ongoing elsewhere in India)

Key informant interviews

The primary mode of data collection for this phase of work was key informant interviews with stakeholders at the central level and in Kerala. The preliminary list of informants to be interviewed was selected based on consultations with NICE International, ensuring that there was representation from the various stakeholder groups:

- Stakeholders involved in the pilot project in Kerala, either in development or implementation of the quality standard;
- NRHM and other government officials in Kerala;
- Representatives of Government of India and other associated organisations that NICE International is working with at a central level;
- Representatives from other states who have been involved in study visits or are engaging in similar quality standard or guideline development processes;
- Development partners and other organisations with whom NICE International are engaging (namely, DFID, ACCESS and the World Bank).

Members of the Itad team visited India for ten days during October 2014, conducting interviews in Delhi (centred on a forum convened by NICE International and the World Bank³²) and in Kerala. Some follow-up interviews were also conducted by Skype. In addition to the list agreed between Itad and NICE International, a degree of snowball sampling occurred during the country visit, as further relevant informants were identified or it became clear that certain informants would not be available (for example, people who had moved facilities or could not be accessed for logistical reasons).

The interviews followed one of several semi-structured interview guides which were based around the indicators. The questions were framed according to the indicators; and specific priority issues were highlighted

³¹ W&C Hospital, SAT Hospital, SUT Hospital, and CHC Kanyakulangara

³² Better Decisions for Better Health: Priority-setting and Health Technology Assessment for Universal Health Coverage in India

for each stakeholder group, given the anticipated constraints in terms of time available for interviews (particularly for government officials). All interviews were conducted by two members of the review team, and were written up comprehensively by one member.

Analysis

Following the country visit and desk review, evidence was collated against each of the six indicators – bringing together the findings of the document review with the qualitative data collected during the country visit.

The interviews were analysed according to the principles of framework analysis, which is a qualitative method appropriate to research with “specific questions, a limited time frame, a pre-designed sample (e.g. professional participants) and a priori issues (e.g. organisational and integration issues) that need to be dealt with.”³³ The interviews were coded thematically against the six indicators. Coding of the interviews in this way allowed collation of qualitative evidence against the relevant indicators – themes could then be drawn out to generate a robust synthesis of views.

B.2 China

Overview

Site visits were carried out in November 2014. In autumn 2014, in preparation for site visits, short discussions were held with CNHDRC staff in Beijing. Document review, and discussions with CNHDRC preceding site visits, made clear the degree to which the China pilot is an integrated reform of ‘clinical pathways +’, in which, clinical pathways are bundled with other supporting systems, as above.

Lewis Husain carried out the site visits and visits were supported by CNHDRC. Sites visited were Huangdao District (Qingdao City) and Qianjiang District (Chongqing Municipality), with each visit lasting 1 to 1.5 days. In both site visits, meetings were arranged with stakeholders from all key groups. For the most part, meetings were held in Huangdao People’s Hospital and Qianjiang Central Hospital. The format of the visits was not identical. In Qianjiang, hospital management convened a highly useful initial multi-stakeholder meeting and gave a very comprehensive overall presentation on the state of implementation of the pilot. This was a very successful strategy.

Data collection

During site visits, the main mode of data collection during site visits was key informant interviews with stakeholders from groups identified as key to the implementation of the pilot. These were identified in discussions with CNHDRC and included:

- Local government bureaus (bureaus of health and bureaus of health insurance);
- Hospital management;
- Clinical staff, including nursing staff;
- Other support staff in hospital;

November 2014 data collection was limited to the two site visits and did not include central-level experts involved in development of clinical pathways. The site visits totaled 2.5 days. A total of nine interviews were carried out in Huangdao, and eighteen in Qianjiang. Interviews were conducted according to semi-structured protocols developed in advance of the visits and translated into Chinese.

Analysis


Interview records were coded for relevant themes and these provided the basis for analysis and write up. As with the India case, interviewing and subsequent analysis of findings of the China site visits uncovered a large

³³ Srivastava, A. & Thomson, S. B. 2009. Framework Analysis: A Qualitative Methodology for Applied Policy Research. Research Note JOAAG, Vol. 4. No. 2.

amount of rich information relating to project implementation, not all of which was captured by the existing indicator framework.

Annex C. NICE International's partnerships at country level

C.1 Scale for classifying partnerships

Date completed				
Name and type of partner(s)				
Scale of implementation	<input type="checkbox"/> State/Regional <input type="checkbox"/> National <input type="checkbox"/> Global			
Type of partnership	<input type="checkbox"/> Bilateral <input type="checkbox"/> Trilateral <input type="checkbox"/> Other (please specify) _____			
				
Phase reached	Nascent <input type="checkbox"/>	Emerging <input type="checkbox"/>	Established <input type="checkbox"/>	Mature <input type="checkbox"/>
Description	<p>This is an early phase of engagement, characterised by a period of scoping and exploration. For example, activities may include:</p> <ul style="list-style-type: none"> • Networking and initial contact with a potential partner, for example at conferences • An initial scoping meeting between NICE International and partner(s) to discuss ideas for possible engagement 	<p>Following initial engagement activities, an emerging partnership may be characterised by:</p> <ul style="list-style-type: none"> • Signed Memorandum of Understanding • Multiple meetings between partner and NICE International with the specific aim of discussing possible engagement • Two-way, mutual communication, with both partners proactive in driving partnership forward • Identification and agreement on focus of collaboration – i.e. shared vision • Joint output(s), for example a concept note, draft MoU or joint funding application 	<p>An established partnership is defined by formalisation of the partnership, and the beginning of implementation on joint projects, for example:</p> <ul style="list-style-type: none"> • Successful application for joint funding • Governance and working arrangements for partnership defined • Commencement of implementation of a joint project • Good working relationship, with regular communication 	<p>A mature partnership may be characterised by the following features:</p> <ul style="list-style-type: none"> • Long standing partnership, with at least one project or phase completed • Reviews and assessment of partnership of done, to improve joint working • New collaborations, or renewal or expansion of existing collaboration • High levels of institutional trust between NICE International and partner, for example, sharing of financial data

C.2 NICE International's partnerships in India (2014)

Nascent	Emerging	Established	Mature
<ul style="list-style-type: none"> TAST and Government of Bihar Andhra Pradesh Aarogyasri Trust TMST and Government of Odisha 	<ul style="list-style-type: none"> SAST, Government of Karnataka³⁴ National Health Systems Resource Centre,³⁵ Gol Department of Health Research / ICMR, Gol 	<ul style="list-style-type: none"> FRICH and FMR ACCESS and Joint Learning Network 	<ul style="list-style-type: none"> Government of Kerala KFOG Rashtriya Swasthya Bima Yojna (RSBY), Ministry of Labour, Gol World Bank

	Nascent	Emerging	Established	Mature
State/Regional	3	1	0	2
National	0	2	1	1
Global	0	0	1	1

Updates to partnerships in 2015

These partnerships are as classified at the time of data collection in 2014 – NICE International note that a number of these relationships have developed since then. For example, the relationship with **NHSRC** has matured – NI has worked closely with NHSRC over the past year, particularly on the STG Task Forces. As the conveners of the HTA steering group, **DHR/ICMR** have also had a more established working relationship with NI in 2015.

A strong relationship has also been well established with **MoHFW** during 2014-15; this has endured even through changes in ministers, and so also displays characteristics of an established relationship at the level of central government. The current minister has invited one of NI's Technical Advisors to be part of the national primary care taskforce, which serves as direct evidence of that relationship.

NI have also been building links with **Gates India** and contributed technical material to pieces of work led by Gates, with regular communication between the organisations on activities of interest. There have been nascent partnerships formed in 2015 with other organisations, such as **BMJ India** and **WHO India**, improving the network NI and iDSI have at the central level.

³⁴ NI note that this relationship might now be considered more **nascent**, as there has been no further joint activity during 2015.

³⁵ National Health Systems Resource Centre (NHSRC) was set up in 2007, under the National Rural Health Mission (NRHM) of Government of India. Its function is to serve as an "apex body for technical assistance". The website states that "the goal of this institution is to improve health outcomes by facilitating governance reform, health systems innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models." http://nhsrindia.org/index.php?option=com_content&view=article&id=300:organisation&catid=84:about-us&Itemid=730

C.3 NICE International's partnerships in China³⁶

Nascent	Emerging	Established	Mature
<ul style="list-style-type: none"> National and provincial government actors 	<ul style="list-style-type: none"> Qingdao 	<ul style="list-style-type: none"> National Health and Family Planning Commission National Development and Reform Center 	<ul style="list-style-type: none"> CNHDRC Renmin University

	Nascent	Emerging	Established	Mature
Sub-national	?	1	0	0
National	0	0	2	2

³⁶ As classified at the time of data collection in 2014

Annex D. Scale for plotting scale-up of evidence-informed priority setting

Phase	Interest	Early engagement	Scoping	Initiation of development	Product finalisation	Product implementation
Description	<p>This is an early phase of the process, characterised by some level of expressed interest by stakeholders in other locations:</p> <ul style="list-style-type: none"> Interest is expressed casually/informally Likely to result from ad hoc contact (for example, at meetings or social events) or engagement with publications/presentations by stakeholders from focal project. Interest may be superficial or genuine, and may or may not be followed up 	<p>Following an initial expression of interest, this phase is characterised by proactive learning on the part of the stakeholder(s), indicative of genuine interest; for example:</p> <ul style="list-style-type: none"> Study visit to location of focal product implementation Attendance at meeting convened by stakeholders from focal project Request to NI or stakeholders engaged with focal product for more information Sustained contact between stakeholders in new location and those engaged with focal product (or NICE International) 	<p>The planning phase is characterised by actions that illustrate an intention to implement a process of QS/CP development, such as:</p> <ul style="list-style-type: none"> Plans for development of QS/CP approved Funds for development process secured Local human resources committed Key stakeholders identified 	<p>This phase represents the start of the development process:</p> <ul style="list-style-type: none"> Working group (or other committee of key stakeholders) convened Review of existing guidance and background research conducted First meeting of QS/CP development group held 	<p>This phase is characterised by the completion of the QS/CP product:</p> <ul style="list-style-type: none"> Development process completed Consultation with wider group of stakeholders may be conducted QS/CP published Associated publicity, for example media reports, and government statements, letters or circulars 	<p>This phase is focused specifically on the implementation of the product:</p> <ul style="list-style-type: none"> QS/CP implemented in at least one healthcare facility Instigation of reforms/management systems associated with QS/CP

Type of scale-up	Phase reached and supporting evidence					
Development of new QS/CP for focal condition within focal location ³⁷	Interest <input type="checkbox"/> Evidence:	Early engagement <input type="checkbox"/> Evidence:	Scoping <input type="checkbox"/> Evidence:	Initiation of development <input type="checkbox"/> Evidence:	Product finalisation <input type="checkbox"/> Evidence:	Product implementation <input type="checkbox"/> Evidence:
Development of QS/CP for new condition within focal location ³⁸	Interest <input type="checkbox"/> Evidence:	Early engagement <input type="checkbox"/> Evidence:	Scoping <input type="checkbox"/> Evidence:	Initiation of development <input type="checkbox"/> Evidence:	Product finalisation <input type="checkbox"/> Evidence:	Product implementation <input type="checkbox"/> Evidence:
Development of QS/CP for focal condition in new location ³⁹	Interest <input type="checkbox"/> Evidence:	Early engagement <input type="checkbox"/> Evidence:	Scoping <input type="checkbox"/> Evidence:	Initiation of development <input type="checkbox"/> Evidence:	Product finalisation <input type="checkbox"/> Evidence:	Product implementation <input type="checkbox"/> Evidence:
Development of QS/CP for new condition in new location ⁴⁰	Interest <input type="checkbox"/> Evidence:	Early engagement <input type="checkbox"/> Evidence:	Scoping <input type="checkbox"/> Evidence:	Initiation of development <input type="checkbox"/> Evidence:	Product finalisation <input type="checkbox"/> Evidence:	Product implementation <input type="checkbox"/> Evidence:

³⁷ For example, QS linked to maternity care/PPH, in Kerala

³⁸ For example a QS for a condition other than PPH, in Kerala

³⁹ For example, QS linked to maternity care/PPH in a new location

⁴⁰ For example a QS for a condition other than PPH, in a new location