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The Agency of Recipient Countries in Transnational Policy-Related Knowledge Transfer

From Conditionality to Elaborated Autonomous Policy Learning

ABSTRACT Current research on transnational knowledge transfer has a strong bias toward (often conditionality-based) advice originating in the core OECD world and focuses nearly exclusively on the link from a source to a target of knowledge transfer. This contribution provides a broader and more nuanced picture by looking at the reverse logic of non-OECD countries proactively searching abroad for policy advice and assessing this advice based on their own requirements. Based on the role of conditionality and on the attitude of the recipient country toward cooperation with foreign sources of advice, five demand-side strategies in transnational policy-related knowledge transfer are distinguished, each of which is analyzed utilizing the example of health reform. The results highlight systematic differences in the attitude toward and employment of foreign advice.

KEYWORDS knowledge transfer, demand-side strategies, China, former Soviet Union, healthcare reform, international organizations

INTRODUCTION

The analysis of transnational policy-related knowledge transfer¹ mostly looks at policy adoption or policy learning through examples and advice originating from outside the

1. In our usage, “policy-related knowledge transfer” is an umbrella term that covers all forms of policy diffusion, often conceptualized based on Elkins and Simmons (2005), Simmons, Dobbin, and Garrett (2006), Dobbin, Simmons, and Garrett (2007) as coercion, competition, learning, and imitation. It also comprises all three orders of social learning identified by Hall (1993, p. 284), that is, a change in the arrangement and setting of policy instruments (first-order learning), the choice of new policy instruments and new techniques (second-order learning), and changes in “the hierarchy of goals and set of instruments employed to guide policy” (third-order learning). While the literature on policy diffusion looks mostly at the sources of the transfer, knowledge transfer is a broader concept including the recipient of this transfer (though it does not systematically include the recipient’s strategies of

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respective country, usually generated in “the West,” that is, the core region of the Organisation for Economic Co-operation and Development (OECD). Such policy advice consists mostly of already-established best practices, and the actors of knowledge transfer are often international organizations (IOs) such as the International Monetary Fund (IMF), the World Bank (WB), or the European Union (EU) as well as national donor agencies in development aid. This advice is then fed into national policy advisory systems (cf. e.g., Seymour-Ure, 1987; Halligan, 1995; Hustedt, 2019).

However, Howlett (2019) summarizes considerable gaps in the respective literature, namely, that research so far has focused on “OECD-type ‘developed’ nations” (p. 242), that “the emphasis on advice ‘supply’ has occurred at the neglect of the study of the ‘demand’ for advice” (p. 243), and that “these studies almost all focused exclusively on the national level and did not address . . . the international-domestic linkages which exist in many systems, especially in developing countries heavily influenced by advice from donor and international agencies” (p. 244; see also Manwaring, 2019).

In summary, current research has a strong bias toward (often conditionality-based) advice originating in the core OECD world and focuses nearly exclusively on the link from a source to a target of knowledge transfer. Therefore, we aim to provide a broader and more nuanced picture by looking at the reverse logic of non-OECD countries proactively searching abroad for policy advice and assessing this advice based on their own requirements. From this perspective, conditionality-based advice is just one subtype and agency is assigned to actors on both sides of the knowledge transfer. In order to systematically identify strategies employed by target countries, we first develop a classification of ideal–typical strategies of international knowledge transfer and analyze corresponding country cases.

As learning is an open process that can include the rejection of advice, the strategy for knowledge transfer does not predetermine the adoption of specific policies, although a specific strategy—for example, one developed by Washington-based IOs—may favor certain kinds of policy solutions. In any case, our aim is not to explain specific policy choices and policy outcomes, but to understand how international expertise is integrated when national governments search for solutions.

DEMAND-SIDE STRATEGIES

Howlett (2019) and Manwaring (2019) argue strongly for the integration of the “demand side,” that is, political decision-makers seeking or needing advice, into the analysis. Manwaring (2019) points out that the “net effect of marginalizing ‘demand’ factors is that it can de-politicize the extent and nature of advice-giving, and reduce it to a seeming technocratic exchange” (p. 270). We argue that a conceptual

dealing with international advice). We follow Stone’s (2012, p. 483) distinction between policy transfer and knowledge transfer, which necessitates the institutionalization of the transferred ideas, their implementation. Lawmaking can be considered a first step on the way to an institutionalization making such a transfer of knowledge observable.

approach to the demand side can start from an analysis of how specific actors, in our case national governments, deal with a specific kind of advice, here foreign advice. We term the ways in which national governments deal with advice they receive or want to receive “demand-side strategies.” We identify how these governments variously adopt, circumvent, evade, modify, or add to advice as knowledge transfer “is in reality a bargaining process between interdependent actors. . . . Even the most subordinate of actors have tactics and resources that can be deployed as part of a strategy of resistance. Moreover, there is the possibility of a two-stage game” (Bache & Taylor, 2003, p. 283). While in stage one the transfer is largely hegemonic, as recipients accept donor conditions in order to receive benefits, in stage two recipients can decide whether to resist or subvert the conditions agreed. Bache and Taylor (2003, p. 284) speak of “hidden transcripts” through which “there is outward agreement and cooperation that disguises strategies of non-compliance and obstruction” (p. 298). Thus, despite the widely accepted view of IOs as the dominant players in the creation of reform agendas, there is substantial scope for domestic policy-makers to affect the outcome of the reform process by deploying sophisticated resistance strategies that limit or modify the processes of learning and transfer (Arandarenko & Uvalic, 2014; Bache & Taylor, 2003).

Based on the agency of the recipient country, transnational demand-side strategies can be placed on a continuum replacing the traditional dichotomy of acceptance and resistance (McDermott, Fitzgerald & Buchanan, 2013). On one end, there is conditionality-based international knowledge transfer² (e.g., bailout agreements with the IMF or membership negotiations with the EU). Close to that end is coordinated international knowledge transfer, where several foreign advice-givers (e.g., IOs or national donors in development aid) pool their advice and their resources, offering the recipient country some “ownership” of decision-making.

Toward the other end of the agency continuum, we find independent, self-organized international advice-seeking. In the absence of relevant conditionality, demand-side strategies can differ substantially depending on the attitude of the recipient toward cooperation with foreign sources of advice. Often a skeptical attitude dominates, which perceives international advice as ill-adjusted to country-specific needs and values or as a disguise for Western geopolitical ambitions. However, there can also be expectant cooperation based on the perception that learning from the West will promote development and modernization of the recipient country. In between there is pragmatic cooperation, which tries to learn from relevant successes and failures all over the world. Table 1 shows the resulting classification of ideal-typical strategies, together with the respective countries exemplifying them which are covered in the analysis below.

2. On the limits of conditionality, see Weyland (2006).

TABLE 1. Classification of Ideal–Typical Demand-Side Strategies in International Policy-Related Knowledge Transfer

	Conditionality-dominated		No relevant conditionality	
	Coordinated cooperation	Expectant cooperation	Pragmatic cooperation	Skeptical cooperation
Conditional cooperation	Coordinated cooperation	Expectant cooperation	Pragmatic cooperation	Skeptical cooperation
Conditionality-based international knowledge transfer	Coordinated international knowledge transfer	Sovereign international advice seeking	Elaborated autonomous international policy learning	Emphasis on domestic expertise
Case study: Ukraine since 2014	Case study: Kyrgyzstan since 2005	Case study: Kazakhstan since 2004	Case study: China since the 1980s	Case study: Russia since 2005

Note: Ideal types derived from Arandarenko and Uvalic (2014, pp. 239–244); Bache and Taylor (2003); McDermott, Fitzgerald, and Buchanan (2013); Van Swol, Paik, and Prahll (2018).

These types only address strategies related to genuine international knowledge transfer. However, there may exist a difference between rhetoric and substance. National governments can use misleading claims about international knowledge transfer as part of their legitimization strategy. On the one hand, a government can blame international advisors for unpopular domestic reforms, especially in the case of conditionality-dominated relations or—in a milder form—IOs can lend credibility to domestic actors in reforming countries (cf. Weyland, 2005; Jacoby, 2008).

On the other hand, a national government might downplay the role of international advice if it wants to demonstrate its independence from “foreign influences” or highlight its own policy competencies. Such rhetoric can be considered “skeptical cooperation” (cf. Van Swol, Paik & Prahll, 2018).

There is a further dimension of a government’s attitude toward international knowledge transfer, which Howlett and Joshi-Koop (2011) call “policy analytical capacity”: “Policy analytical capacity is an essential precondition for the adoption of transnational policy ideas and instruments; while policy capacity can be thought of as extending beyond analysis to include the actual administrative capacity of a government to undertake the day-to-day activities involved in policy implementation, policy analytical capacity is a more focused concept related to knowledge acquisition and utilization in policy formulation and decision-making processes. It refers to the amount of basic research a government can conduct or access, its ability to apply statistical methods, applied research methods, and advanced modeling techniques to this data and employ analytical techniques” (p. 86). We thus include policy analytical capacity as a second-order explanatory factor into our analysis.

RESEARCH DESIGN

This article systematically explores demand-side strategies in countries that were actively searching for fundamental reform models and, to a varying degree, utilizing the expertise

of IOs. The case studies presented below describe those cases that come closest to the ideal types summarized in Table 1. As IOs primarily advise governments, we focus on the demand-side strategy of national governments toward transnational policy-related knowledge transfer. Accordingly, the country studies below deal with policies in which governments play an important role and for which the core OECD region is perceived as standard setter.

For reasons of comparability, we focus on one policy field in which fundamental and systemic reforms occurred. We have opted for health reform as policy field, and selected countries that have been moving away from a socialist organization of their healthcare systems. Moreover, all countries have faced the need for a fundamental change of their healthcare systems, since they struggled with the erosion of old healthcare arrangements, rising costs, and/or socioeconomic instability. We examine some successor states of the Soviet Union and China, which chose to test reform approaches in regional pilot projects, influencing their reform initiatives in the following decades. While there are significant differences between the centralized and state-funded Semashko model in the Soviet Union and the more patchwork system of state-funded and collective protection in China, both systems depended on the institutional foundations of their command economies and were seen by the respective governments as requiring comprehensive restructuring in the process of economic reforms from the 1980s onward. Therefore, these cases are suitable for comparison in terms of demand-side strategies.

Since the 1980s, these countries have started to initiate healthcare reforms with the explicit aim to create an alternative system. That means the national governments in all these countries perceived a need for reform in a policy field where the core OECD region was a clear reference point offering a number of different models. Thus, the need and the incentive for transnational knowledge transfer were clearly given (for more on the content of this advice, see Kaasch [2013]; Heinrich [2021]).

In our exploratory approach, examining all potential case countries,³ we find five countries that best represent five distinct demand-side strategies in international knowledge transfer. They were chosen to illustrate the ideal-typical demand-side strategies and to provide a better understanding of how international expertise is integrated into a government's decision-making processes. When we talk about the "demand-side strategy" of a specific country, we mean the strategy in the selected policy field for the period under study. This has no direct implications for other policy fields or other

3. Out of the 15 post-Soviet countries and China, 4 countries—Azerbaijan, Belarus, Uzbekistan, and Turkmenistan—made the conscious decision to keep the Soviet system largely intact. In Armenia, Latvia, Tajikistan, and Ukraine, several reform attempts failed because of political deadlock, thus leaving these countries with a partly reformed national health service. A third group has initiated major healthcare reforms—for example, the introduction of mandatory health insurance (MHI) schemes, namely, China, Estonia, Kyrgyzstan, Lithuania, Moldova, and Russia. Georgia and Kazakhstan also introduced such reforms but later canceled them. In the 2010s, Ukraine was discussing the introduction of an MHI as well. All of these nine countries have followed a similar trajectory. We look at only those in more detail that have (at least to some degree) developed a coherent demand-side strategy, and we use these countries to illustrate these ideal-typical strategies.

periods of time; our analysis also does not deal with inconsistencies in the strategy's actual application.

The country studies are based on a multi-method approach, which allows for data triangulation. Starting from a systematic review of academic and expert literature on our case countries, this includes an analysis of documents from state agencies and IOs, quantitative and qualitative content analyses of official statements, parliamentary debates and media reporting, quantitative indicators like the number of meetings between representatives of IMF and the national state executive⁴ as well as elite and expert interviews. As different strategies highlight different aspects of knowledge transfer and as the current state of research differs across the cases, each country study employs an adjusted selection of the aforementioned methods most fitting to the specific empirical circumstances. Accordingly, a strategy focusing on the projection of a desired international image, as in the case of Kazakhstan, requires a qualitative content analysis of government statements to identify key features of this image. However, a strategy based on self-reliance, as in the case of Russia, can be captured with a quantitative content analysis, whereby a simple word count demonstrates a lack of references to international advice. Thus, we conducted the case studies with our own specific, original data collection and analysis.

All country studies follow a similar structure. They start with a brief overview of relations with foreign sources of advice, mainly IOs, and consider coherence with the respective country's overall foreign policy stance. The actual demand-side strategy for healthcare reform is then analyzed based on official rhetoric and actual engagement with external expertise. As part of the analysis, the role of foreign advisors in the national advisory system is assessed. Each country study ends with a summary of the key features of the respective demand-side strategy.

UKRAINE: CONDITIONALITY-BASED INTERNATIONAL KNOWLEDGE TRANSFER

Ukraine since 2014 corresponds to the ideal type of a conditionality-based strategy. Due to its vulnerable financial position, Ukraine has been in regular negotiations with the IMF since independence. Consequently, Ukraine has become one of the biggest recipients of IMF support on record (International Monetary Fund [IMF], 2019). In 2010, the IMF approved a new US\$15bn loan for Ukraine highlighting that “the program's success crucially depends on strong political resolve to implement the planned policies

4. The respective text corpus was created using country names as search terms in the IMF archives (<http://archivcatalog.imf.org>), including both the institutional archive and the Executive Board documents, and on the IMF's website (www.imf.org). All documents have been analyzed with MaxQDA software and auto-coded using the keywords “conference,” “consultation,” “gather,” “joint mission,” “meeting,” “summit,” “working group,” and “workshop.” The results have been manually checked for relevance and coded for “level of meeting.” Top-level meetings include members of the IMF leadership in Washington, D.C., and the head of the IMF mission in the respective country on the one side and leading representatives of the state executive (president, prime minister, ministers, and their deputies) on the other side. If no information about the involvement of these actors (at least one on each side) was available, the meeting was not counted as top-level. The full dataset has been published open access as Pleines (2020).

and reforms” (Roudet, 2010). However, the Ukrainian government was not willing to enact the required reforms and, as a result, did not receive any financial support from the IMF after the first tranche had been paid (Connolly & Copsey, 2011; Kononczuk, 2013; Dragneva & Wolczuk, 2016; Kubicek, 2017).

The situation changed in 2014: after the Euromaidan protests, Ukraine’s new government under President Petro Poroshenko opted for increased integration with the “West” and IOs, while the economic crisis in the aftermath of the loss of Crimea and the war in eastern Ukraine brought the country close to financial default. Between 2014 and 2015, the IMF and EU provided a total support of US\$40bn. Thus, Ukraine’s relations with the IMF (and consequently the WB) and the EU were clearly dominated by conditionality (cf. e.g., Kirchner, Giucci & Kolb, 2015; Wolczuk, 2018).

Accordingly, the Ukrainian government accepted the need to implement the program agreed with the IMF. For example, when urging deputies to pass the necessary laws, President Poroshenko explained in a speech to parliament that “we need to implement the IMF program, without which Ukraine is extremely vulnerable” (Zinets, 2017). Simultaneously, some reforms—mainly those aimed at fighting corruption and rent-seeking—threatened strong vested interests and met stiff opposition, including from within the government itself (Pleines, 2016). The IMF remained very skeptical about the government’s will to reform and checked the implementation of agreed policies carefully on the ground. This led to delays in disbursements from the IMF on several occasions (IMF, 2017).

Partly in order to overcome the related deadlock, the integration of foreign advice in the political reform process was encouraged by the IMF: “Partnerships and coalitions on policy dialogue and ASA [advisory services and analytical work] with other development partners . . . and other bilateral donors will continue and be expanded as much as possible” (IMF, 2017, p. 7). Moreover, Ukraine’s policy advisory system features a large number of independent think tanks and civil society organizations, which often have strong links to Western and international organizations not just for funding but also for knowledge transfer. Many analysts have argued that the combination of foreign and domestic expertise and pressure has “sandwiched” the Ukrainian government, enforcing reforms from two sides (Cleary, 2016; Twigg, 2017).

In the case of healthcare reform, experts broadly agree that this “sandwich”-approach has worked. Faced with a largely dysfunctional and underfunded healthcare system, Ukraine adopted a “Health Strategy for 2015–20” (Lekhan et al., 2015a; Lekhan et al., 2015b). It also negotiated with the IMF about a reform of healthcare financing (IMF, 2015; International Labour Organization, 2016, pp. 26–27; Engler et al., 2016). Ulyana Suprun, who acted as health minister from 2016 to 2019, initiated substantial reforms, adopted by the Ukrainian government in November 2016, and made broad efforts to integrate foreign expertise. A Strategic Advisory Group on healthcare reform was set up in 2017, which included renowned domestic and international experts. Moreover, World Health Organization (WHO), United States Agency for International Development (USAID), and United Nations (UN) programs and national donor organizations from

several Western countries supported healthcare reforms (Stepurko, 2017, p. 3; Twigg, 2017).

At the same time, a reform aimed at reigning in costs could not easily count on broad popular support (Fond “Demokratichni Initsiativi,” 2017, pp. 26–28; Stepurko, 2017; Twigg, 2017; Komarovskiy, 2018). Healthcare reform also met stiff resistance in the health committee of the Ukrainian parliament, which in January 2017 scheduled a motion of no confidence. Moreover, experts highlight that healthcare reform suffered from high turnover at the Ministry of Health (MOH). Suprun, in turn, complained about “light acts of sabotage” conducted by about half of the employees of the MOH (Shkarpova, 2017). This adds to Howlett and Joshi-Koop’s (2011) concept of policy analytical capacity, namely, regarding whether a government is able to actually use that capacity in a reliable way.

In summary, Ukraine is an example of the standard case of loan-based conditionality. In order to avoid default, there is a strong incentive to accept advice from IOs—namely, the IMF and the EU. Since Ukraine’s national policy advisory system was largely in favor of IMF-backed reforms, this combination of foreign and domestic pressure promoted the continuation of reforms against opposition from vested interests.

KYRGYZSTAN: COORDINATED INTERNATIONAL KNOWLEDGE TRANSFER

Kyrgyzstan became a champion of international development aid after the end of the Soviet Union. The small country was relatively poor and welcomed foreign aid. Notably, official development aid accounted for an estimated 42% of national government expenditure in 2015.⁵ With many donors active in the country, Kyrgyzstan became one of the few countries worldwide to adopt the “Sector-Wide Approach” to healthcare (SWAp). Since 1997, the country has been running several projects related to healthcare reform with support from the WHO, USAID, WB, and other technical partners and donor organizations (World Bank [WB], 2005; Birdsall, 2012).

The idea of the SWAp, which was formalized in Kyrgyzstan in 2005, is to pool resources in order to improve coordination⁶ and increase ownership by the recipient country. Under this framework, development partners in Kyrgyzstan “agreed to coordinate their financial and technical contributions . . . , and committed to ever greater reliance on the Kyrgyz government’s own planning, management, and accountability systems” (Birdsall, 2012, p. 8).

The SWAp in Kyrgyzstan is composed of development partners pooling their finances into the country’s budget; this group of partners includes both “basket financiers,” namely, the WB, the German Development Bank, and the Swiss Agency for Development and Cooperation, and “parallel financiers,” such as USAID, the German Corporation for International Cooperation (GIZ), the Global Fund to Fight AIDS,

5. World Bank DataBank (<https://data.worldbank.org/indicator/DT.ODA.ODAT.XP.ZS?locations=KG>).

6. The underlying assumption is that coordinated assistance decreases transaction costs and improves effectiveness of the assistance (Bigsten & Tengstam, 2015).

Tuberculosis and Malaria, and the WHO. While the first group directly finances the healthcare SWAp, the second supports it by aligning their programs to it. According to the WB, the SWAp project “was explicitly designed to implement a Government-generated health care reform strategy, with the Bank taking the lead in an active and cohesive donor environment” (WB, 2008, p. xi).⁷ The public consensus with a broad range of donors strengthened the role of the MOH in domestic policy debates and helped to keep reforms on track despite frequent changes in government (Birdsall, 2012, p. 21).

Mainly as a result of the SWAp, Kyrgyzstan earned the reputation of a “pioneer” of healthcare reforms (Falkingham, Akkazieva & Baschieri, 2010), adopting one of the most “liberal” regulatory frameworks in the post-Soviet region (Wolfe et al., 2009). The WB (2013) presents Kyrgyzstan as a best-practice model for moving toward universal health insurance coverage, where “the positive outcomes were achieved thanks to a comprehensive approach rather than reliance on a single instrument” (p. 137). Dominis, Yazbeck, and Hartel (2018) also see the country as an example of the effective coordination of international assistance in pursuit of healthcare reform.

The SWAp also contributes to the recipient country’s leadership over the assistance (Cassels, 1997). As was suggested in expert interviews, the SWAp “gives” the MOH “more power . . . versus the donors” (Development Partner 2, 2017, personal communication, 8 December, paragraph 137), while, overall, the framework is believed to be “mutually beneficial” to all parties (State Partner 1, 2016, personal communication, 4 July, paragraph 27). There have been no cases of development partners threatening to stop their assistance (State Partner 1, 2016, personal communication, July, paragraph 85).

Nevertheless, there is some conditionality in the financing provided by the “basket financiers,” although the presence of multiple development partners helps to even this out. International reports imply that “mutually beneficial” cooperation works only when there is a broad consensus about the direction to be taken. The WB (2003) stated that the “problems faced by the health reforms have been discussed . . . , at a Roundtable organized by the MOH with the help of the WB, WHO and other donors, the president of the Kyrgyz Republic expressed his strong support for the reforms. The resolution based on this Roundtable has been adopted by the Government of the Kyrgyz Republic” (p. 57).

However, a high rate of staff turnover in the MOH jeopardized the leadership of the ministry (Development Partner 3, 2016, personal communication, 4 July, paragraph 24) and the healthcare reform coordination process (Development Partner 4, 2016, personal communication, 6 July, paragraph 33). On the side of the recipient state, a multitude of

7. It should be noted, however, that despite the “leading” role of the WB among the “basket financiers,” other partners remain equally significant in the reform process. The WHO, for instance, takes an active role in organizing the coordination meetings among the donors (Development Partner 1, 2018, personal communication, 16 January, paragraph 28) and is known as the “lead partner” among all the development partners working in healthcare in Kyrgyzstan (Development Partner 5, 2016, personal communication, 24 June, paragraph 3).

agencies have to be coordinated, including the MOH, the Ministry of Finance, the Ministry of Education, the Ministry of Social Affairs and Development, the Mandatory Health Insurance Fund, the prime minister and government apparatus as well as members of parliament (cf. Ministerstvo Zdravookhraneniia Kyrgyzkoi Respubliki, 2015).

In summary, the example of Kyrgyzstan corresponds to our ideal type of a coordination-based strategy. Compared to Ukraine, a coordinated donor approach gives the recipient country more leeway because the larger number of foreign partners make roundtables and consensus-seeking the standard and leadership of the recipient country and related stakeholders the norm. Thus, this strategy provides an opportunity to the government for policy learning from multiple sources. Simultaneously, a high fluctuation of politicians and administrative staff involved on the side of the recipient does restrict both policy analytical capacity and the establishing of institutional memory.

RUSSIA: EMPHASIS ON DOMESTIC EXPERTISE

Although Russia received IMF grants shortly after independence, international reform pressure was not as strong as in the case of Ukraine due to Russia's geopolitical standing as successor of the Soviet Union. Additionally, the country reformed its healthcare system independently by introducing a mandatory health insurance (MHI) scheme in the early 1990s, resorting to Soviet-era pilot projects, at a time when IOs focused entirely on stabilizing the Russian economy. IOs did not propose major reforms in the Russian healthcare sector, but rather tried to improve the sector's efficiency instead (Cook, 2007).

When Vladimir Putin became president in 2000, his agenda included the restoration of Russia as a great power, the realization of which strongly relied on a long-lasting economic recovery based on exports of natural resources. The country's gross domestic product (GDP) rose more than eight-fold between 2000 and 2013.

As part of this larger strategy, Russia had fully repaid its debt to the IMF by 2005. In a next step, Russia requested to be withdrawn from the OECD list of recipients of development aid and started to provide development aid itself. "Political reasons for being a donor are numerous, but the key for Russia is to strengthen its geopolitical position, pursue its national interests and maximize the return on provided aid" (Beletskaya, 2015, p. 2). Russia's official development assistance increased from US\$0.05bn in 2004 (President of the Russian Federation, 2007, p. 9) to US\$1.2bn in 2015 (Organisation for Economic Co-operation and Development, 2017, p. 295).

A similar approach to emancipation from foreign support was embraced in relation to international knowledge transfer. Russia declared itself a "sovereign democracy" and introduced legislation to limit the inflow of foreign grants. "This led to the ousting of Western donors, whose place was taken by Russian government structures" (Belyaeva, 2019, p. 402). However, even before these changes, external financing was not "a major contribution to healthcare financing"; most assistance was provided as technical expertise (World Health Organization, Regional Office for Europe, 1998, p. 37; Tragakes & Lessof, 2003, p. 107). The WB and WHO, for instance, provided technical assistance

in healthcare financing reform, child and maternal health, and the organization of primary care (Popovich et al., 2011, p. 89).

Russia's reservation toward foreign advice became obvious during the WB's Social Protection Implementation Project (SPIL) in 2004, which included short-term insurance for sickness and maternity. Russia "practiced limited involvement of international consultants in SPIL implementation. Learning from foreign experience . . . mostly took place through foreign study tours arranged for Russian legislative and executive government specialists" (WB, 2004, p. 28).

This limited engagement manifests itself in many forms. The number of high-level meetings of IMF representatives with the Russian government (as documented by the IMF), which added up to 20 in the three years prior to Putin's first presidency, stood at only one per year after 2004. Simultaneously, references to policy advice from IOs all but disappeared from national debates. From late 2005 until early 2008, then-prime minister (and future president) Dmitry Medvedev was responsible for four National Priority Projects of the Russian government, one of which was devoted to healthcare. A databank search⁸ of official documents of the Russian federal state executive and the national parliament with references to the IMF, the WB, or the WHO in the context of the priority project "health" returned only five hits related to actual activities in or relations with Russia. The same search yielded 73 hits for "Putin."

By 2009, the IMF (2009) reported as a mere passive observer: "The authorities explained to the mission that, among the key reforms still ahead, they would want to give priority to health and education. However, we also sensed a clear realism on the part of senior officials that there is still no strong political momentum behind such reforms" (p. 53). According to Yakovlev, Freikman, and Zolotov (2016), "the tendency toward restriction of international cooperation is particularly disconcerting as it is fraught with the risk of self-isolation" (p. 23).

However, the major advisory centers on economic policy—three of them being responsible for all Russian economic development strategies since 2000—as well as a majority of the 72 Russian economic think tanks analyzed by Yakovlev, Freikman, and Zolotov (2016, p. 12) still had direct links to the international expert community. Thus, one can argue that international expertise was integrated into Russian policy-making via domestic experts, of whom the most prominent—at least in the realm of economic and social policy—had strong links to the global epistemic community and had absorbed policy advice from IOs like the IMF and the WB.

An example indicating that international expertise is not completely disregarded in Russia is the development of a new state program for healthcare in the early 2010s. A draft version by the MOH included a reference to the relevance of cooperation with IOs where UN-bodies and the WHO were mentioned first (Ministerstvo Zdravookhraneniia Rossiiskoi Federatsii, n.d., p. 44). Altogether, the draft makes 30 references to the WHO alone. However, the final version, passed in 2014, does not mention the WHO once.

8. Using the Integrum Profi database at integrum.ru. The search included 87 sources for the period from 1 October 2006 to 30 March 2008.

The section titled “Increasing the Role of the Russian Federation in Global Health Care” instead declares cooperation with neighboring countries the highest priority (Pravitel’stvo Rossiiskoi Federatsii, 2014, p. 51).

Nevertheless, Russia has retained working-level relations with IOs. For example, at the 72nd World Health Assembly, the MOH expressed “the readiness of the Russian Federation to continue providing a complex financial, technical and expert assistance to the WHO” (Ministerstvo Zdravookhraneniia Rossiiskoi Federatsii, 2019). The government provided over US\$20mn to the WHO European Office for the Prevention and Control of Noncommunicable Diseases located in Moscow (World Health Organization [WHO], 2018, p. 282). According to Minister Veronika Skvortsova: “A great advantage of the activities of an office like this one is that it actively involves both international and Russian experts from leading research institutes in its work, which facilitates the exchange of experience and the continued application of the best practices inside the country” (WHO, 2018, p. 282).

In summary, Russia’s reliance on domestic expertise is part of a shift toward a more assertive foreign policy stance. It combines a hostile rhetoric toward foreign sources of policy advice with reduced direct engagement. The national policy advisory system changes accordingly, giving more influence to domestic experts and loosening international links. At the same time, working relations with IOs continue and—at least in the sphere of economic and social policies—domestic experts regularly absorb policy advice from abroad.

KAZAKHSTAN: SOVEREIGN INTERNATIONAL ADVICE-SEEKING

Though it received its first IMF grant shortly after independence, in the late 1990s, Kazakhstan started to export its natural resources on a large scale and thereby gradually emancipated itself from financial donors. Debts to the IMF were fully repaid by 2000. The following oil boom, which saw the country’s GDP rise more than thirteen-fold between 2000 and 2013, ensured financial independence. Accordingly, there was no relevant conditionality that could influence social policy-making during this period.

Simultaneously, Kazakhstan’s foreign policy was highly focused on creating the image of being a reliable and equal partner of major players in international politics. The country’s long-term President Nursultan Nazarbayev stated in one of his national addresses that Kazakhstan must act as a “responsible member of the international community,” one of only two central tasks he sees for his country in international relations (Ambrosio & Lange, 2014, p. 551). Similarly, Anceschi (2014) concludes that “the regime, in different ways at different junctures, came to assess its own international legitimacy on the basis of the degree of support that the international community extended to Kazakhstan’s international activity” (p. 5).

At the same time, the national advisory system in this authoritarian country did not boast genuinely independent expertise. When the international Extractive Industries Transparency Initiative, which Kazakhstan was eager to join, demanded the participation of civil society organizations, Kazakhstan’s acceptance was delayed for several years; the

country's government did not agree to include organizations beyond state control into the monitoring of state finances (Pleines & Wöstheinrich, 2016, p. 304).

Thus, there is a built-in tension between strong relations with IOs and Western governments on the one hand and the rejection of any interference into the country's increasingly authoritarian domestic affairs on the other. This tension was very strong in relations with countries and organizations advocating human rights standards; however, it did not pose a real obstacle in international knowledge transfer related to economic and social policies. As the Soviet-era welfare system was considered too expensive even in times of an oil boom and healthcare was not perceived as a priority for the state's expenditure, there was a genuine interest in substantial reforms that would reduce spending (Franke-Schwenk, 2012, pp. 247, 252).

To finance its healthcare system, Kazakhstan had established an MHI fund in 1996 in order to reduce state budget transfers. However, in the aftermath of the Russian financial crisis of 1998, the IMF (1999, p. 55) and WB recommended closing all nonbudgetary funds, including the MHI Fund, and shifting back to budgetary financing. The WB (2007, p. 40) remained highly skeptical of the MHI, resulting in a deterioration in relations: in 2002, Kazakhstan's government canceled the WB's health project. The WB (2007, p. 7) described the following two years as "a brief hiatus."

In 2004, Kazakhstan's "National Programme of Health Care Reform and Development for 2005–2010" included a "participatory process" with representatives of the WB, the WHO and donor organizations. The WB (2007) diplomatically summed up that "by early 2006, after several years of deepening relations, it became apparent to all parties that the Government needed assistance primarily on implementation rather than policy dialogue. Accordingly, in mid-2006 the Government formally requested the Bank to help prepare an institutional reform and capacity-building project for the health sector and allocated a budget for project preparation" (p. 7).

Thus, the IMF, WB, and WHO—even in their own assessment—contributed more to administrative capacity-building than to the development of reform concepts. This is also demonstrated by the meetings of IMF officials with state representatives in Kazakhstan. While the number of top-level meetings between 2005 and 2018 equals just one per year, "Kazakhstan has received technical assistance and training by the Fund in virtually every area of economic policy, including through over 90 technical assistance missions provided during 1993–2014" (IMF, 2014, p. 4).

Our content analysis of official statements and semi-official expert statements and news reports for the period from 2007 to 2016⁹ shows that in relation to international involvement in healthcare reform, Kazakhstan regularly highlights three aspects: first, that the country is an equal partner to the major IOs and receives broad support; second,

9. A search for "health care" [zdravookhranen*] AND "Kazakhstan" was used in Google and Yandex (a Russian-language search engine). The results were checked manually, restricting the text corpus to statements by state officials and by experts employed at state-run institutions plus news reports from state-controlled mass media. A total of 54 documents with references to international involvement in the country's healthcare reform have been included in this analysis.

that the country takes “international experiences” (usually using this or similar wording) into consideration; and third, that one of the most important reform efforts is to improve the education of domestic medical professionals and experts (i.e., capacity-building).

In a similar vein, the national healthcare program (2016–19) stresses “close collaboration” with IOs, including the WHO and other UN structures, to facilitate “promotion and exchange of experience for Kazakh specialists” in these organizations (President Respubliki Kazakhstan, 2016, pp. 32–33). The country’s strategic plan for development through 2025 also emphasizes “support of international financial institutions” as well as “transfer of technologies, knowledge and best practices through intensive cooperation with international partners” (President Respubliki Kazakhstan, 2018, pp. 16–17). In short, the government wants to improve its policy analytical capacity.

In summary, sovereign national advice-seeking as practiced by Kazakhstan focuses more on symbols than on substance. The major aim—in line with broader foreign policy goals—is to establish the country as an equal and valued actor on the international scene. This leads to official openness toward IOs, especially major ones, and attempts to improve domestic expertise. At the same time, the authoritarian regime limits diversity in the national policy advisory system and restricts international advice accordingly.

CHINA: ELABORATED AUTONOMOUS INTERNATIONAL POLICY LEARNING

China’s engagement with Western and other foreign expertise rose after the 1970s, when a new generation of political leaders came to power in the wake of severe socioeconomic instability and the ensuing erosion of Maoist social security arrangements. From the very beginning of its international engagement, China sought advice strategically based on an autonomous decision by the central leadership, albeit with still-limited economic power (see Kim, 1992). From the 1980s onward, the Chinese government and academic experts began to proactively search for new rural (and urban) healthcare schemes. This was part of the “reform and opening” process, which deeply integrated China into the global economy, world politics, and the global community. While this process had enormous domestic repercussions, the power elite was mostly interested in controlled and selective integration (McNally, 2012).

The government was eager to learn from abroad, with pragmatic reference to both Western and non-Western (e.g., Singaporean) healthcare systems. Nonetheless, rather than copying foreign models, the strategy was to selectively incorporate them into the national ensemble of institutions and norms as well as into original policy cycles. Adaptive learning competences on the part of the power elites and increasing policy analytical capacity played a central role here (Wang, 2009).

Interestingly, before the 1980s, the People’s Republic of China (PRC) had gained some recognition for its effective rural healthcare policies. Based on collective agriculture, its Cooperative Medical System (CMS) utilized resources from the collective economy to provide basic health services and support paramedics (“barefoot doctors”) in the villages,

providing preventive and primary care. Furthermore, during the Cultural Revolution, qualified doctors from the cities were sent to work in rural areas, which enhanced the effectiveness of rural healthcare (Hussain, 1990). After 1979, however, China gradually dissolved collective agriculture, and the core institutions of rural healthcare vanished along with it. Qualified doctors returned to the cities, and barefoot doctors began to operate on a for-profit basis (Klotzbücher, 2006). Running a CMS now required rural cadres to collect premiums from rural households on a voluntary basis; eventually the schemes collapsed in most of rural China (Duckett, 2011).

After the PRC replaced Taiwan as a WB member in 1980, the WB subsequently sent missions to explore the situation of healthcare, provided policy advice, and engaged in various funded projects (WB, 1982)—including a series of healthcare projects. In 1986, China vowed to achieve universal access to basic healthcare by 2000 (Wang, 2009, p. 387). Consequently, the WB's second health project (1986–99) involved a rural health insurance experiment (WB, 1986). The WB arranged for cooperation between the Chinese MOH and the RAND Corporation, which organized the experiment in rural Sichuan in the late 1980s (Cretin, Williams & Sine, 2006). One focus of the experiment was to determine the contribution level that would create the strongest incentives for farmers to join the CMS. In other local experiments, farmers often refused to join the CMS, so pressure from local cadres was needed, but that did not have full political backing in Beijing (Müller, 2016). Another focus was to determine reimbursement rates that would create incentives for farmers to seek medical care.¹⁰

Overall, the experiments introduced ideas and methods of “Western” health economics to rural health protection and had a lasting impact on the development of rural health insurance, which expanded into widespread local experiments in the 1990s. With regard to expenditures, varying reimbursement rates for different types of drugs and services became a lasting feature of rural health insurance. While some limitations to CMS benefits had already existed under the planned economy, the complex and detailed reimbursement catalogues developed in the 1990s have been the outcome of learning from IOs (Carrin et al., 1999). In 1999, the WB lauded the timely and professional organization of the Health II project. It allowed for successful technology transfer, the influence of which was further enhanced by the concurrent emergence of health economics as an academic discipline in China—a process also supported by WB projects (WB, 1999).

Notably, in this process, foreign expertise was never adopted fully and throughout the country. On the one hand, policymakers were aware that the different institutional context in China limited the fungibility and effectiveness of foreign models. They therefore proceeded in a gradual and experimental fashion. On the other, policymakers often utilized foreign knowledge strategically, in order to underline their particular aims. Dependent on changing political tides in Beijing and on different ideological camps on

10. Due to the profit-seeking behavior of doctors in the reform period, farmers had begun to delay treatment, which often worsened their condition, and facilitated medical bankruptcies or the loss of the ability to work (Cailliez, 1998).

While our ideal types describe the strategy of a national government toward foreign advice, the impact of that advice on domestic policy-making can be understood only in the context of the national policy advisory system, that is, in relation to alternative and rival sources of advice. In the case of Russia and (to an extent) Kazakhstan, domestic expertise is seen as a substitute for foreign advice. In the case of Ukraine and (to an extent) Kyrgyzstan, it is only secondary to international advice and can support or hamper it, whereas in China domestic expertise has a supervisory role, deciding how to deal with foreign advice.

As our country studies show, the demand-side strategy relates to a country's overall perception of its role in international relations. This perception concerns each country's favored cooperation partners—Western organizations in the case of Ukraine, important IOs in the cases of Kazakhstan and Kyrgyzstan, any potentially relevant source in the case of China, or no foreign source at all in the case of Russia. It also concerns the attitude toward foreign expertise. Conditionality, as found in Ukraine and, to a lesser degree, Kyrgyzstan, implies acceptance of unequal relationships. Kazakhstan aims at an equal and constructive partnership, which China takes for granted, whereas Russia wants to demonstrate its disinterest in any relationship related to transnational knowledge transfer. However, more research into the explaining factors for the adoption of specific strategies is clearly needed, for instance, regarding changes in strategy over time and results of a particular choice of foreign advice through a detailed analysis of domestic political processes. ■

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