Commentary

Learning from Doing: How USAID’s Health Financing and Governance Project Supports Health System Reforms

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Abstract—This special issue of Health Systems & Reform presents a series of commentaries and articles that reflect the work of the Health Finance and Governance (HFG) project, a global flagship health project of the United States Agency for International Development (USAID). Over its six-year life, the 200 million USD project has worked with more than 40 partner countries to increase their domestic resources for health, manage those resources more effectively, and reduce system bottlenecks in order to increase access to and use of priority health services and strengthen health systems overall.

INTRODUCING HFG AND THE SPECIAL ISSUE

This special issue of Health Systems & Reform presents a series of commentaries and articles that reflect the work of the Health Finance and Governance (HFG) project, a global flagship health project of the United States Agency for International Development (USAID). Over its six-year life, the 200 million USD project has worked with more than 40 partner countries to increase their domestic resources for health, manage those resources more effectively, and reduce system bottlenecks in order to increase access to and use of priority health services and strengthen health systems overall. The majority of funding comes from USAID missions around the globe, making HFG a demand-driven project that provides state-of-the-art and country-specific technical assistance (TA). Much of this TA focuses on obstacles that impede health system functioning and slow essential reforms.

HFG’s work has focused less on formal research than earlier iterations of USAID health system projects, such as Partners for Health Reform (PHR) and PHRplus. Instead, the project honed its ability to work directly with partner countries in the creation or continuation of adaptable, contextually rooted, and sustained interventions that can be realistically...
implemented (and, if relevant, scaled) in environments that have substantial and country-specific constraints. The focus was frequently on facilitating country-led process changes that are essential to sustainable health system strengthening. Thus, a motivating factor for assembling this issue of *Health Systems & Reform* is to highlight lessons from country-focused and customized TA work of a kind that is not well represented in health policy journals. This is especially important because, by definition, TA is mainly focused on supporting a specific task defined in-country and as such does not draw out lessons for the larger policy community unless there is a specific request to do so. This issue seeks to share health systems lessons on critical health sector topics as well as put a spotlight on the process of providing TA to support country reform efforts.

The articles in this issue showcase HFG’s core belief that in order to meaningfully increase the use of life-saving health services—especially by women and children or other vulnerable populations—it is essential to have strong, functional health systems that are well managed and country financed. HFG hopes that the lessons presented in this issue on how to best grow and sustain health systems serve to promote discussion and advance the field of health systems strengthening.

**A SHORT HISTORY OF HEALTH SYSTEMS AND USAID**

USAID has worked to strengthen health systems by funding projects that expand access to high-quality, priority health services. This systems-focused work began in 1989 with the Health Financing and Sustainability Project. Subsequent USAID health systems projects (PHR, PHRplus, and Health Systems 20/20) were progressively larger and structured to be driven by the needs of country-based USAID missions. To achieve this, global projects receive a ceiling value up to which USAID missions can commission work, rather than a direct grant. Each of the previously mentioned projects reached its ceiling, reflecting the growing demand across USAID country missions for technical assistance to support country health sector reforms. USAID also funded numerous regional and bilateral health system projects, including the ZdravReform projects serving former Soviet Republics in Central Asia from 1994 to 2015 and featured in this special issue. In many countries, in-country technical assistance provided by the projects has, by design, complemented the health sector grants and loans of multilateral donors. The projects have also enriched the global health community’s understanding of the impact of reforms through evaluation research.

The importance of strengthening country health systems has gained acceptance in USAID, as evidenced by several positive trends. USAID has been designing bilateral projects that integrate health system performance and service delivery objectives, adding health systems to the scopes of other global health projects, placing a health systems advisor within missions, and investing in capacity building in health system approaches for country counterparts and USAID staff (e.g., regional Flagship Courses). This evolution was capped with the creation in 2012 of an Office of Health Systems in USAID’s Global Health Bureau where the HFG project sits.

**THIS SPECIAL ISSUE**

The articles and commentaries for this issue were selected to highlight topics that offer operational lessons for countries as well as the funders and technical agencies supporting them. They are the result of long-term TA work that afforded the project a close-up look at nuts and bolts of health system reform that are rarely analyzed in the research literature. Moreover, the editors sought to balance country-specific TA work with multicountry evidence. For country-specific papers, the emphasis was on why the TA was requested, including the problems to be overcome and the process of implementation. The multicountry papers focus on identifying operational and technical patterns across countries. The selection process favored long-term health sector challenges (maternal health, tuberculosis) that, because obvious answers have not worked, called out for health system innovation.

Prefacing the articles are commentaries on two health governance issues: the role of legislatures and public financial management. In “Health and the Legislature: The Case of Nigeria” on governance and health in Nigeria, Tejuoso, Alawode, and Baruwa tackle the longstanding challenges faced by the health sector. They explore the important role of legislators and legislatures in influencing the functioning of the health sector though oversight and funding decisions. The commentary highlights positive results from a recent intervention designed to empower legislators but notes that Nigeria has a long way to go. In “Health Financing in Bangladesh: Why Changes in Public Financial Management Rules Will Be Important,” Islam, Akhter, and Islam highlight the importance of building a strong and adaptive public financial management system in support of health finance reform in Bangladesh. The authors review the health financing challenges faced in the country and outline reforms, such as revenue retention and recycling at the facility level, that require a supporting operational environment on the health sector.
The commentary “Health System Reforms to Accelerate Universal Health Coverage in Côte D’Ivoire” by Dagnan focuses on in-depth health sector reforms, particularly results-based financing and accountability. Hospedales and Tarantino’s regional commentary from the Caribbean, “Fighting Health Security Threats Requires a Cross-Border Approach,” highlights the need for close collaboration across many different national institutions in order for small countries within a region to collectively deal with future outbreaks and regional health emergencies.

Though the articles in this issue provide a broad view of the work of the HFG project, they represent only the tip of the iceberg in a project that included hundreds of assignments in more than 40 countries. The selected articles feature lessons from targeted and long-term policy TA that has relevance beyond the countries it was originally targeted for.

In “A Review of Initiatives that Link Provider Payment with Quality Measurement of Maternal Health Services in Low- and Middle-Income Countries,” Wright and Eichler summarize a growing literature on the links between provider payment mechanisms and improvements in the quality of maternal health services. The authors found 26 recent programs in 16 low- and middle-income countries that attempt to use payment incentives to influence the quality of services. The authors uncover a range of operational findings that have relevance for countries considering using provider payments to influence service quality. The incentives in provider payments are linked to improvements in facility management, and the enhancement of care processes is associated with higher quality care. For example, incentives can be structured to both reward facilities and stimulate teamwork, and regular and structured supervision with feedback strengthens the quality of care. The authors note limitations with the work, mainly that a majority of the studies were funded though one trust fund managed by the World Bank and therefore included similar design elements. Another limitation was that the study could not cover many private-sector initiatives due to a lack of published or publicly available studies.

In “Responding to Health System Failure on Tuberculosis in Southern Africa,” Hartel, Yazbeck, and Osewe examine the immense challenge of tuberculosis (TB) in the Southern Africa mining industry through a health system lens. Using the Flagship Framework for health systems, the authors systematically review each of the five control knobs (financing, payment, organization, regulation, and behavior) and point out where traditional interventions in each of these areas have failed in TB control and prevention. The authors argue that health systems need to incorporate a more patient-centered approach to avoid a repetition of these failures. The authors also argue that an all-of-government response will be needed to tackle TB given the multisectoral drivers that are outside the control or influence of the health sector.

In “Association Between User Fees and Dropout from Methadone Maintenance Therapy: Results of a Cohort Study in Vietnam,” Johns et al. tackle transitioning donor funding to domestic resources. They examine Vietnam’s recent introduction of user fees into its methadone maintenance therapy (MMT) program, designed to increase domestic spending, and assess whether or not the fees are associated with increased MMT dropout rates. Following patients paying user fees for one year, the authors find no association between provincial policies on user fees and dropout from or nonretention in MMT. They do, however, note an increase of catastrophic payments that is burdensome for up to half of MMT patients. This study is important not only for future work in Vietnam but also because it represents an example of the critical role of monitoring the health system implications of a financial transition away from external funding.

Todini, Hamnett, and Fryatt’s article, “Integrating HIV/AIDS in Vietnam’s Social Health Insurance Scheme: Experience and Lessons from the Health Finance and Governance Project, 2014–2017,” describes how donor financing of a national HIV/AIDS response can be transitioned to domestic funding as part of a country’s broader health financing reform efforts. The HIV/AIDS response in Vietnam has been financed mainly by external donors (85%). Due to Vietnam’s rapidly growing economy and its “graduation” to lower-middle income status, development partners have been collaborating with the government of Vietnam to advocate for increased domestic funding for HIV/AIDS prevention and treatment services. The article identifies lessons from HFG’s three-year field-based technical support that are potentially relevant for other lower-middle-income countries facing similar transition complexities in HIV/AIDS. Though providing an example of what seems like the start of a successful transition away from donor financing, the article also shows the many challenges and the need for continued advocacy and outreach. Vulnerable groups, mainly intravenous drug users, are often stigmatized and frequently unable to access essential services. Getting these groups enrolled in social health insurance was a major bottleneck and will likely remain so.

In the article by Bhat, Holtz, and Avila, “Reaching the Missing Middle: Ensuring Health Coverage for India’s Urban Poor,” the authors review policy options for one of the major challenges facing India: the lack of access to public facilities and qualified primary health care providers for the majority of the urban poor. This population mostly belongs to the informal sector, which encompasses workers whose
jobs are not recognized formally and from whom no taxes are collected. Given the current limited levels of government investment in health, the options are not straightforward. Current public health insurance plans provide only hospital coverage and are unsustainable. The article explores the feasibility of targeting the urban poor with health insurance schemes that include primary health services. The authors conclude that affordable health care for the urban poor could come from a two-pronged approach of programmatic (supply-side) interventions and demand-side financing initiatives, primarily insurance. For new insurance mechanisms to work, however, there needs to be stronger involvement from the National Regulatory and Development Authority but also greater outreach to target populations. The government still has a major role to play, however, and the article describes the use of TA to support a landscape analysis that informed health policy options for the urban poor.

Cali, Makinen, and Derrienic’s article, “Emerging Lessons from the Development of National Health Financing Strategies in Eight Developing Countries,” reviews the experience of countries working with the HFG project to develop national health financing strategies in response to the World Health Organization’s call and in service of supporting universal health coverage. The authors develop a framework based on recent World Health Organization guidelines to assess the implementation efforts. The authors find that all countries complied with the guidelines in a number of areas, including basing the strategy on evidence, clarifying strategy objectives, and providing full population coverage. Another finding relates to the different ways each country links the development of the strategy to ongoing developmental processes and engages different groups of stakeholders. These examples of how countries went about developing and identifying good practices and alternative approaches are all the more relevant as more countries pursue the development of health financing strategies.

An accurate understanding of how financial resources flow through the health system is considered fundamental information for reforms. “How Do Countries Use Resource Tracking Data to Inform Policy Change: Shining Light into the Black Box,” by Bhuwanee, Cogswell, and Ashagari, looks at why countries do not routinely use the resource tracking data that they produce with TA from the HFG project and others. The authors reviewed the literature and conducted a survey of 67 government officials from 42 countries to identify factors that increase use of resource tracking data for policy. They propose a framework that groups the factors and apply it to 16 countries that produced resource tracking data. Higher country competency across the factors was associated with a higher likelihood of resource tracking data having a measurable impact. The authors acknowledge several limitations, including the small sample of countries and the fact that all factors were given equal weight.

In “Keys to Health System Strengthening Success: Lessons from 25 Years of Health System Reforms and External Technical Support in Central Asia,” a cross-country review that examines the Central Asia Region over the last 25 years, Dominis, Yazbeck, and Hartel tease out lessons in health system reform efforts for other low- and middle-income countries. They take advantage of the relatively similar starting points of Kazakhstan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan after the dissolution of the Soviet Union in 1991 and, through a literature review and virtual focus groups, investigate factors that led to the broadest and most sustained health system reforms in the ensuing years. Overall, the authors find three characteristics of reforms that they deem critical to success: the high level of collaboration between donors who were involved in the Central Asia Region, an early emphasis on national ownership by all parties, and the actors’ pragmatic as opposed to ideological approach in implementing reforms. The article provides a helpful narrative of the Central Asia Region’s evolving health system reform efforts since the region’s independence and examines both country and donor dynamics. The authors conclude by pointing out the need for countries to recognize and prioritize their most pressing challenges and for donors to support these priorities in a coordinated and realistic manner.

CONCLUSIONS

A recurrent theme in these articles and the HFG project is that health system strengthening for results must be nationally owned and nationally led rather than donor driven. The role of donors, however, can be instrumental. An important role, in addition to funding, is to facilitate country access to global good practice knowledge, and this again can be done in several ways. Long-term, supportive, in-country TA allows for global knowledge to be tailored to national needs over time and presents a flexible instrument capable of supporting both design elements of health systems reform as well as operational implementation support for health system strengthening. Donors also add value by comparing multiple countries’ efforts to strengthen their health systems and by sharing similarities and variations. This in turn expands global knowledge and allows individual countries to tap global experiences that are most relevant to their constraints and needs.
Another important function of donor support is technical evaluation of what works and what does not. This can be done at the country level by assessing the impact of reforms and policy actions or through reviews of global experiences with specific instruments. What stands out most clearly, however, and is at the heart of the HFG project, is the role that donors can play in synthesizing lessons from operational experiences in health system strengthening in many countries. Frequently, global studies focus on the “health system architecture”—the different ways in which interventions are delivered and financed—and do not cover the “how to’s” of system strengthening processes and implementation, namely, “health system engineering.” This means that health system architecture is more likely to be represented in global policy discussions and journals, but the experience of HFG and other USAID projects shows that health system engineering—improving the functioning of the system—is central to realizing the promise of architectural reforms and deserves greater attention for the lessons from across low- and middle-income countries.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

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