

Conversation with Amanda Glassman on August 27, 2013

Participants

- Amanda Glassman – Director of Global Health Policy and Senior Fellow, Center for Global Development
- Ben Rachbach – Research Analyst, GiveWell
- Alexander Berger – Senior Research Analyst, GiveWell

Note: This set of notes was compiled by GiveWell and gives an overview of the major points made by Amanda Glassman.

Summary

GiveWell spoke to Amanda Glassman as part of its shallow investigation into philanthropic opportunities to strengthen health systems in the developing world. Amanda Glassman is Director of Global Health Policy and a senior fellow at the Center for Global Development. Conversation topics included the history, present trends, and major organizations in the field of health systems strengthening. Health policy interventions and the process by which national health policy changes were also discussed.

The field of health systems strengthening

History

In the 70s and 80s, the World Bank and regional development banks focused on funding health systems "hardware," such as hospitals, clinics, and latrines. When they didn't get desired results from hardware alone, they shifted their focus to "software," such as training for healthcare providers.

After the 1993 "World Development Report: Investing in Health," the focus turned towards funding the most cost-effective interventions. Some investment in health systems continued, because these systems were needed to deliver the interventions, but the focus was on the results of the interventions, not on the performance of the health systems.

More recently, much funding has been focused on specific diseases, particularly for antiretrovirals for AIDS, which have a dramatic and visible impact on patients who receive them. Funders are attracted to the clear impact from these drugs.

In 2006-7, GAVI and the Global Fund began to spend significant sums on health systems strengthening to support their disease-specific programs. However, they mostly funded health systems inputs, and they were unable to clearly track the results of that spending.

Recently, the field has returned to the idea of focusing on the most cost-effective interventions, but with more of a focus on measurable results than previously.

In general, the popularity of the field has ebbed and flowed over the decades because health systems are fundamental to achieving health goals but are harder to understand and measure than simple disease-specific interventions. Nordic countries (except Norway) and the UK tend to be enthusiastic about health systems strengthening. The UK highly values its own single-payer, universal coverage National Health Service. In the US, on the other hand, strengthening health systems in developing countries has been a hard sell because efforts to provide universal coverage domestically are politically contentious. There is also a general belief that health systems strengthening has not worked in the past, in part because past projects have not been rigorously evaluated.

As the complex history suggests, "health systems strengthening" does not always mean the same thing to different actors. In particular, it can be used to describe diverse efforts to increase funding for general-purpose health infrastructure (such as supply chains), to improve health policy (such as by more closely tying financing to results), or to achieve universal healthcare.

Evidence for health systems strengthening

There is considerable evidence that simply investing money in health systems inputs does not produce good health results. Focusing on inputs leads to poor outcomes such as building hospitals in areas where they are not needed. Instead of focusing on inputs, funders should focus on the results that the system produces and provide flexible funding. In-country actors will be better positioned to determine how funds should be used to produce the desired results.

Organizations working in health systems strengthening

Both organizations with a broad focus on health and disease-focused groups work on health systems. Key funders of health systems in developing countries include:

- Development banks (the World Bank and regional banks)
- Bilateral funders such as the United States Agency for International Development (USAID)
- The Global Alliance for Vaccines and Immunisation (GAVI)
- The Global Fund to Fight Aids, Tuberculosis, and Malaria
- The United States President's Emergency Plan for AIDS Relief (PEPFAR)
- The Gates Foundation

Development banks are the most engaged at the highest levels of policy, directly advising health ministries. The banks fund infrastructure, facilities, and, sometimes, recurring costs such as salaries for healthcare workers. The World Bank works on health in almost every country in the developing world. In the past, the World Bank focused more heavily on

health policy and health systems reform than it now does. Development banks tend to have a higher concentration of health economists and health policy experts, while other funders have more doctors and public health experts on staff.

USAID has had a health systems strengthening project for many years, under a variety of names, including Partnerships for Health Reform, Partners for Health Reform Plus, Health Systems 20/20 (2006-2012), and now Health Financing and Governance (2013-2017, \$209 million). It has contracted with Abt Associates to carry out the projects. Its projects typically provide technical assistance rather than direct aid. In general, USAID does a lot of work through contractors and has most of its budget tied to particular earmarks. USAID health systems strengthening has tended to be in support of the major health causes targeted by the US: AIDS primarily, and, to a lesser extent, family planning and maternal and child health.

The Gates Foundation had traditionally focused on specific diseases, but it recently added a small health delivery group to work on health systems as a way to achieve disease-specific goals.

PEPFAR and the Global Fund are disease-focused groups that fund health systems to achieve disease-specific goals.

Universal healthcare

Many international actors in health systems strengthening currently favor universal health care. However, different stakeholders have different definitions of universal health care. Ms. Glassman believes that, in countries that currently only spend \$30 per capita on health, it is unrealistic to achieve universal health care if it is defined as any citizen's ability to access any healthcare they need without regard to cost; a more basic definition may be more achievable.

One strength of universal healthcare is that if the government pays for healthcare, seriously ill people will not bankrupt themselves by paying out-of-pocket.

Health policy

Health policy vs. other kinds of health systems strengthening

Ms. Glassman believes that health policy reform efforts are likely to be higher-leverage than inputs-oriented health systems strengthening.

Policy instruments could have major and measureable impacts on health by improving incentives for health systems to achieve particular health goals. Making concrete health goals public is likely to improve accountability and public participation.

Policy interventions

Promising policy interventions include:

- Guaranteeing access for all citizens to an essential package of health interventions. Health budgets would need to be structured to ensure that those interventions are funded.
- Pay for performance on health outcomes. In this system, the government or external funders pay contractors only if they achieve the desired results. This should provide stronger incentives for contractors and greater rigor around assessment than paying up front. There is currently a lot of experimentation with various kinds of pay for performance schemes and there have been good results (e.g. with an anti-recidivism program for inmates leaving prison). Social impact bonds are an example of this type of scheme, which are funded by private groups and individuals. In the case where external funders pay governments for performance, it provides the governments with flexible funding, which they have little of and which allows them to test innovative programs.
- Health report cards for local clinics. Publicizing the performance of front-line providers improves accountability. A report card experiment in Uganda found positive effects. Report cards allow for clinics to have both greater autonomy and better incentives. There is evidence that making results visible causes health providers to put peer pressure on each other, which improves outcomes.
- Contracting out some health services to private providers. There have been quasi-experimental studies that suggest this idea has some promise.
- Increasing supervision for health providers. This has been shown to improve performance.
- Health insurance schemes. There are results available on the impact of health insurance in Ghana.
- Changing the funding system of international organizations such as GAVI and the Global Fund so that funders set goals, rather than governments proposing projects, and countries' progress on these goals is made public.

National vs. local policy

Ms. Glassman's research includes studying the role of state-level health policy in large decentralized countries such as India, Pakistan, and Nigeria. States in these countries control most health funding and decision-making. However, the World Bank and other international organizations primarily work at the national level. Her policy ideas for these decentralized countries include:

- Allocate funding from the federal to the state level based on current population sizes and health risks. In some countries, funding is based on historical allocations that no longer make sense.
- Create insurance schemes for citizens at the state level and publicize state-level health results to create a reputational incentive for states to do better.

- Encourage involvement from international organizations at the subnational level, particular providing advisers to state governments.

Process of policy change

Policy change usually occurs as a process of successive approximations, where a country tries something, works out the bugs, and then tries a new version. Sometimes there are reforms that have a large positive impact right away, but these are less common.

Funders can have a role in this process by funding pilot studies that, if successful, get scaled up across the country. The World Bank's Health Results Innovation Trust Fund (created in 2007) is a promising example of this kind of funding. The Trust Fund funding accompanies the Bank's main International Development Association (IDA) loans to developing countries. The Bank uses the Trust Fund money to run randomized controlled trials on the use of the IDA loans that provide data to the country about how best to spend the IDA loans going forward. That data might help actors within the country make the case for scaling up successful programs.

The World Health Organization and the Pan-American Health Organization tend to advocate particular solutions to national governments. Ms. Glassman believes that policy research and advising is more likely to achieve good results than advocacy.

The major bottleneck to a more policy-focused approach to health systems strengthening is convincing major funders to adopt such an approach. More funding for policy projects would send a signal about the importance of those projects.

Peru is an example of a country that has made progress on strengthening its health systems but has run into problems. When the authoritarian President Alberto Fujimori took control of the country after years of internal conflict, government health service provision had essentially ceased in much of the country. Fujimori instituted a fee for service program for maternal and child health services. The program was very successful at jump-starting services, but it encouraged providers to undertake far more services than necessary. To date, Peru has yet to fix the problem.

On the other hand, many upper middle-income countries have made tremendous progress in strengthening their health systems.

People and organizations for GiveWell to talk to

- Gorik Ooms, human rights lawyer, proponent of universal healthcare, and former CEO of Doctors Without Borders Belgium
- Catherine Connor, Principal Associate, Abt Associates
- Monique Vledder, Manager, Health Results Innovation Trust Fund
- Ariel Pablos Mendez, Assistant Administrator for Global Health, USAID
- Joseph Kutzin Health Economist, WHO

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