ReBUILD Consortium

Research for stronger health systems post conflict

Queen Margaret University
INSTITUTE FOR GLOBAL HEALTH AND DEVELOPMENT
Critical thinking. Practice engagement. Social justice.

Health financing in fragile and conflict-affected states

Insights from a recent commission by WHO

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Background

- **Two billion people** now live in situations affected by fragility and conflict (World Bank 2018)
- Share of **extreme poor** living in conflict-affected situations is expected to rise to almost 60% by 2030
- More than **one third of maternal deaths** occur in fragile states, and **half of the children who die** before age five live in FCAS (Newbrander et al., 2011)
- A recent study found that **armed conflict substantially and persistently increases infant mortality** in Africa (Wagner et al., 2018)
- However, fragile states receive around **50% less aid than predicted**, despite their high needs (Graves et al., 2015)
- In this context, making progress towards **universal health coverage** (UHC) and meeting the Sustainable Development Goals (SDGs) is particularly challenging

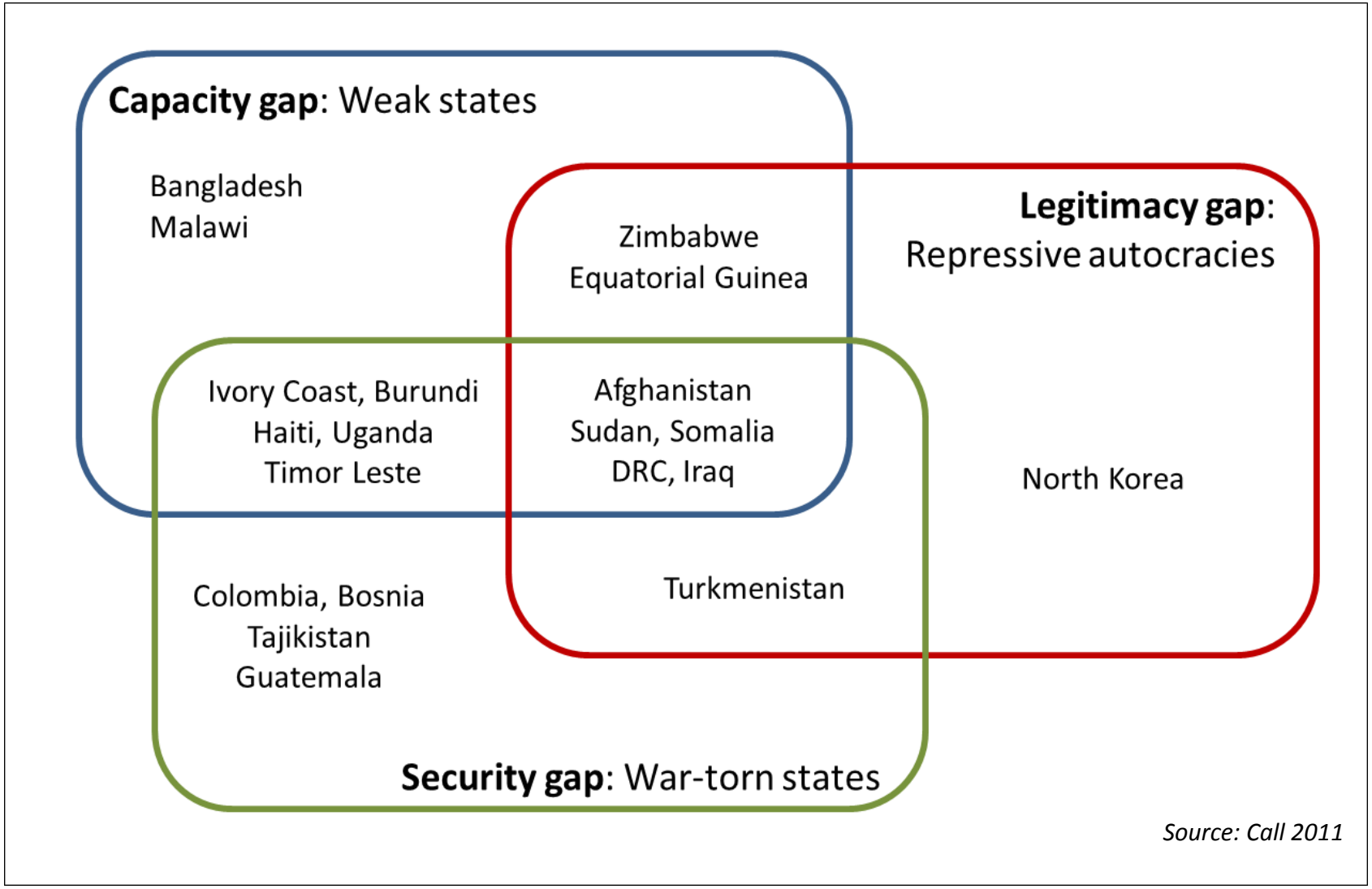
Rationale for work

- **Improving health financing systems** is critical to enable countries to raise more resources for health and make good choices about how to use them.
- **Technical guidance products** developed in recent years, including health financing diagnostic framework and guide to developing national HF strategies
- However, the evidence of what works in these circumstances is limited. There is **no clear guidance** on how to translate and apply the existing lessons and principles on health financing for universal health coverage to fragile situations.

Approach

- **Initial meeting** in November 2017, including health financing staff from WHO Geneva, AFRO, EMRO; WHO health emergency programme and service delivery team; and external agencies (UHC 2030, P4H, World Bank, and ReBUILD)
- **In-depth consultation** led by the WHO EMRO office in May 2018, focussed on health financing in chronic and acute emergencies. More than 30 participants attended, including WHO regional, head office and country level experts, representatives from other partners such as the Global Fund, Ministry of Health representatives from the region, academic experts and consultants
- **Literature review** in which data from 168 published and grey documents were extracted, updating Witter 2012
  - Limitations: non-systematic; varying quality and independent of studies
- Paper in draft which also draws on **experience of team**

Definitions: FCAS



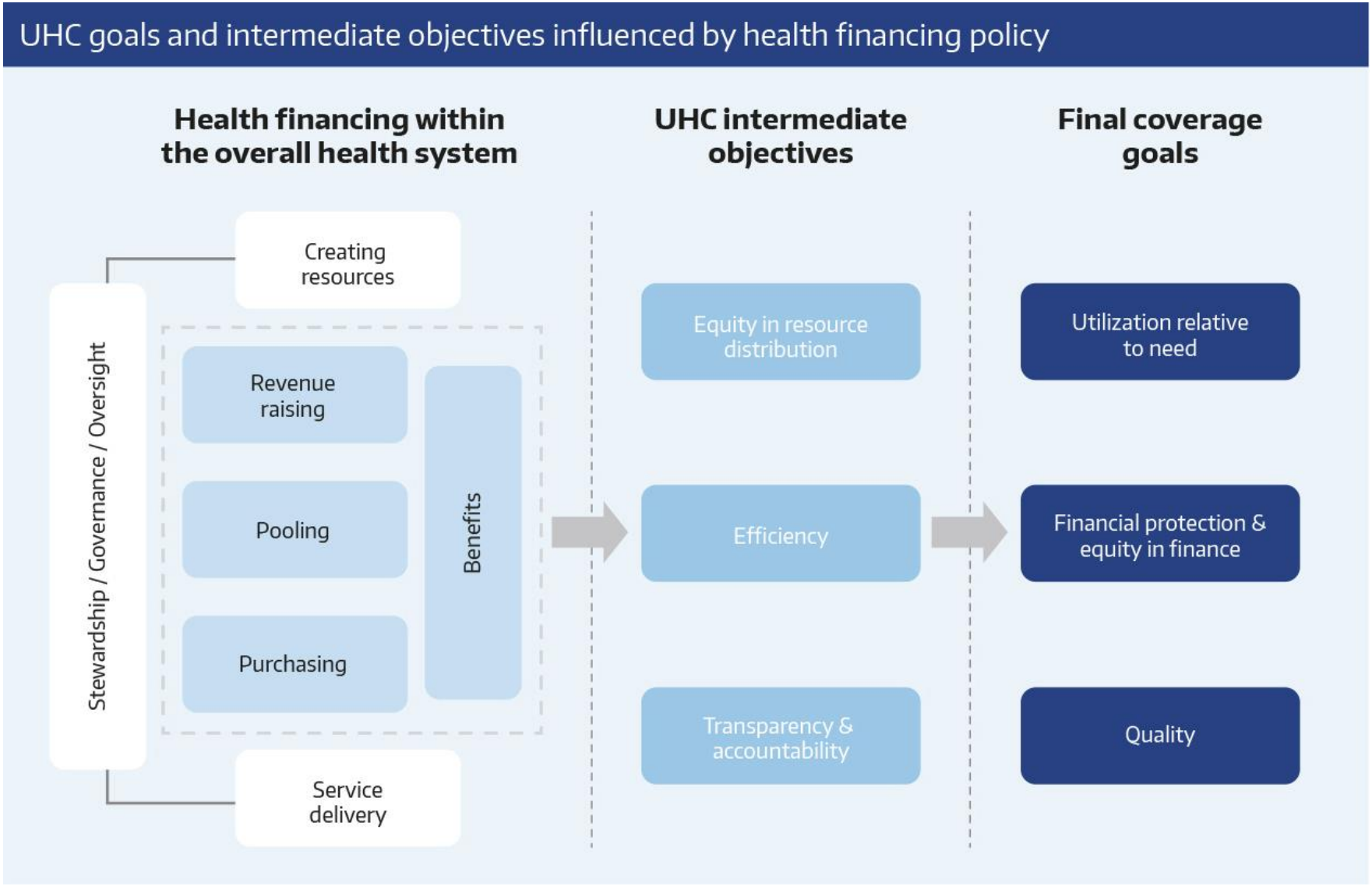
Source: Call 2011

What does being FCAS mean for the health sector?

- **Inability to provide health services** to a large proportion of the population
- Lack of **equity** in who receives the available health services
- Ineffective or non-existent **referral systems** for the critically ill
- A **lack of infrastructure** (including facilities, human resources, equipment and supplies, and medicines) for delivering health services
- Non-operational **health information systems** for planning, management and disease surveillance
- Lack of **policy mechanisms** for developing, establishing and implementing national health policies
- Insufficient **coordination, oversight and monitoring** of health services by the emerging government, which may not have the capacity to manage
- Inadequate **management capacity** and systems (such as budgeting, accounting and human resource management systems) for raising and controlling resources

(Newbrander, Waldman, & Shepherd-Banigan 2011)

UHC goals and intermediate objectives influenced by health financing policy



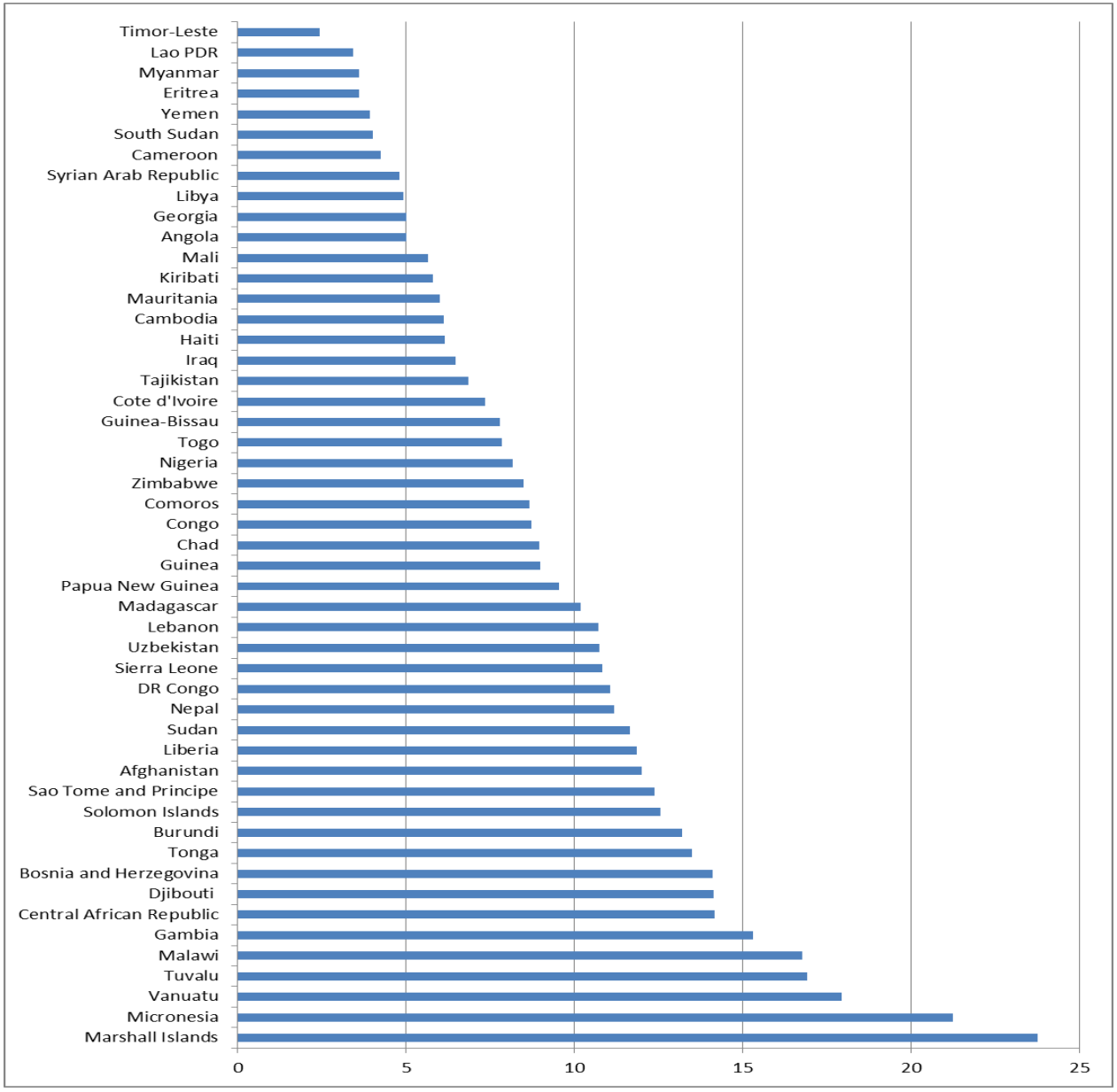
Source: (Kutzin et al., 2017)

Revenue raising and pooling	Summary of common challenges in FCAS settings	Strategies adopted to mitigate these (and gaps)

Desirable features:
- **Increase flows from public and mandatory sources**
- **Increase predictability and stability of funds**
- **Enhance redistribution of prepaid funds**
- **Ensure that funding sources are complementary**
- **Reduce fragmentation, duplication and overlaps**
- **Simplify financial flows**
	• **Low overall funding** (though can in cases be high but poorly distributed)
	• Public **funding is often low** (low GDP growth; low taxation; non-prioritisation of social sectors)
	  ○ May be multiple authorities collecting revenues
	  ○ Limited territorial control reduces government revenue base
	• Conflict tends to **depress health expenditure** (2%/year, in one study), while **raising needs** (disrupted services, displaced populations, etc.)
	• **High dependence on external funding** (donors, charities, remittances).
	  ○ **Problems**: instability; lack of predictability; and lack of alignment with public priorities (e.g. high volumes off-budget and off-plan)
	  ○ External support is **varied** by country: donors preferred to provide more funding to low-income fragile countries that have refugees or on-going external interventions but tended to avoid providing funding to countries with political gridlock, flawed elections, or economic decline.
	  ○ FCAS associated with **higher external finance for MICs**, not LICs (compared to non-FCAS LICs)
		• **Aid pooling and coordination** mechanisms, including shadow alignment
		• Policies to **increase financial access and decrease out of pocket payments**, including: user fee exemptions, health equity funds, health insurance, demand side financing
		• Greater use of **cash, card-based and mobile payments** in humanitarian settings

Revenue raising and pooling	Summary of common challenges in FCAS settings	Strategies adopted to mitigate these (and gaps)
	○ Assumption of **decreasing financial dependency post-shock** not well studied; dependency is also more than just financial ○ External finance can be too low for needs, while also being high relative to **absorptive capacity** (especially if there is a post-crisis funding influx), leading to low disbursement • High levels of **out of pocket payments**, in contexts where household incomes are often low and subject to shocks, with high levels of health need • **Low trust** undermines pooling – leads to lower levels of prepayment; more fragmented risk pools • **Segmented population**, especially where there are substantial refugee and displaced populations having varying protection	Gaps: • More attention could be paid to **domestic revenues**, as well as remittances, but challenge is to increase tax equitably • How to **harmonise/ integrate different strategies** to increase access, including across humanitarian and development programmes

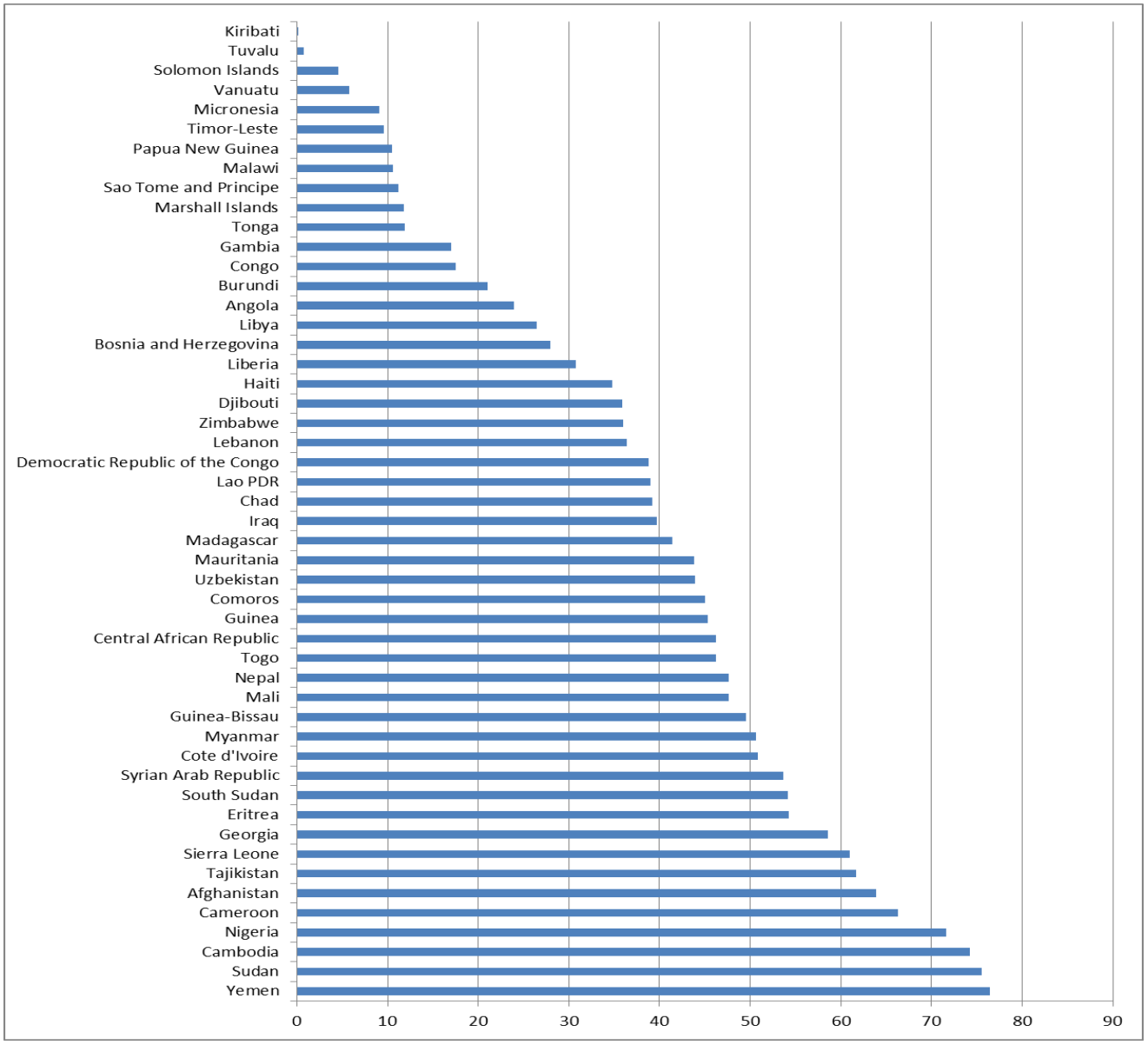
Proportion of general government expenditure devoted to health, FCAS countries, 2014



- **Small but significant difference in government commitment to health**, with FCAS countries as whole averaging 9% of government expenditure on health, compared to 12.5% for non-FCAS countries
- This is largely driven by differences in **middle-income countries**

Source: authors' calculation based on (WHO, 2018)

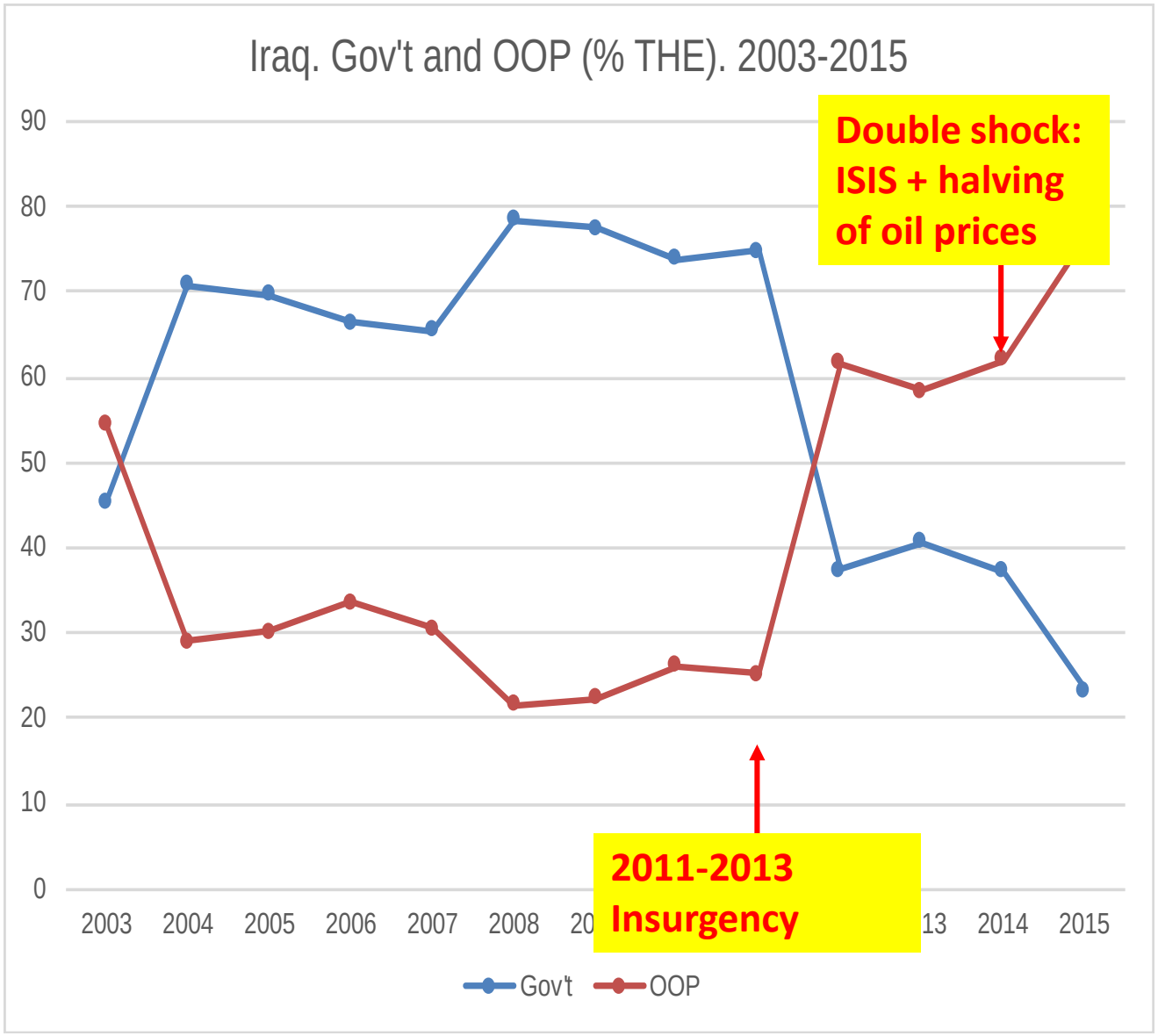
Out of pocket payments (% of current health expenditure), FCAS countries, 2014



- Comparing out of pocket payments by income level, there is a **significant difference between FCAS and non-FCAS countries in the low income group**, with a mean of 43% out of pocket payments in the former, as against 31% for the latter.
- However, **for middle income groups, there is no significant difference between FCAS and non-FCAS** countries, suggesting that they are either able to protect through continued pooling or only experience shorter term disruption.

Source: authors' calculation based on (WHO, 2018)

The dance of public financing and OOP…



- Overall expenditure on health as a proportion of GDP ranged widely from less than 2% to 17% in 2014 for FCAS countries, with **means of between 6-8%,** depending on the income group.
- There was **no significant difference between FCAS and non-FCAS** countries
- However, **internal composition changes over time** – OOP increasing when public finances are affected by shocks, e.g. in Iraq

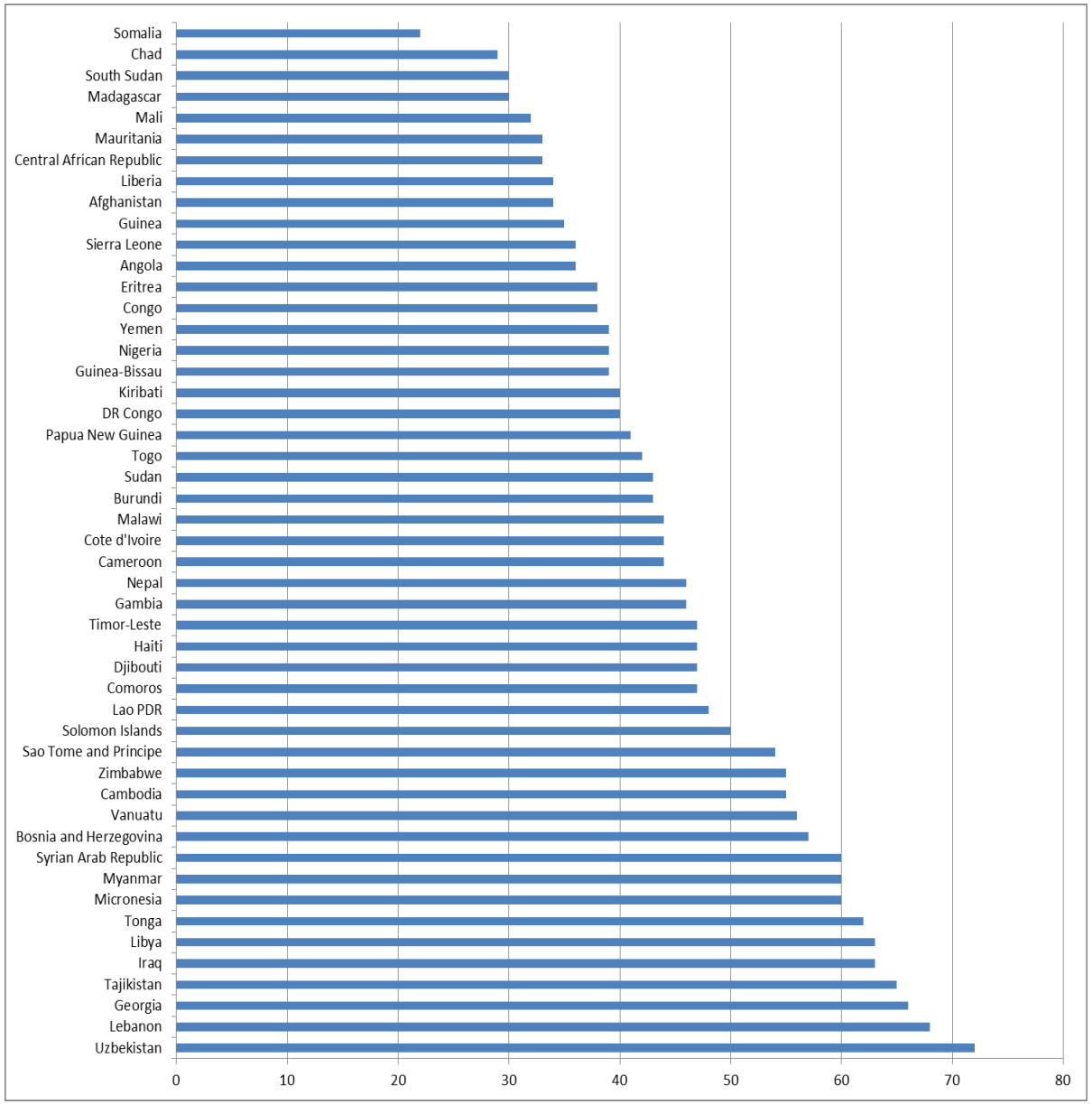
Source: Global Health Expenditure Database (Modol, 2018)

Purchasing	Summary of common challenges in FCAS settings	Strategies adopted to mitigate these (and gaps)
Desirable features: - **Increase allocation of resources to providers linked to population health needs, information on performance, or a combination** - **Move away from either rigid, input-based line item budgets or completely unmanaged fee-for-service reimbursement** - **Manage expenditure growth** - **Move towards a unified data platform on patient activity**	• **Multiple** (uncoordinated and unaligned) **purchasers**, with households often dominant • Data on and assessment of **population needs and provider performance** is limited and often fragmented • **Fee for service** payment dominates in private, informal sectors; public sector commonly a mix of fixed (under-funded) **budgets** and user fees; various forms of **contracting** in humanitarian sector • Lack of confidence in government by donors → **funding is often channelled to (I)NGOs**, leading to patchy provision and often higher costs (inefficient provision) • **Data** on payments and outcomes not unified or linked • **Complex remuneration** and weak regulation undermines accountability of providers	• **Contracting** and performance-based contracting, often with NGOs • **Performance-based financing** **Gaps**: • Overall purchasing assessments and how to **defragment it** and improve its performance, also working across humanitarian and development silos • Development of **context-specific regulatory models** for different sectors

Benefits packages	Summary of common challenges in FCAS settings	Strategies adopted to mitigate these (and gaps)
Desirable features: - **Clarify the population's entitlements and obligations** - **Improve population's awareness of their legal entitlements and obligations** - **Align promised benefits/ entitlements with provider payment mechanisms**	• **Entitlements** unclear and not linked to funding • Population **awareness** of entitlements is low • Healthcare packages may be missing or ill defined → care seeking can be irrational • Fragmented funding influences service provision – e.g**. vertical programmes** can give resourcing preference to some disease areas • **Service provision capacity may be disrupted** (especially during acute crisis and when boundaries shifting and contested), with patchy coverage and low quality of care • **Parallel provision for refugees** in many settings and challenges transitioning away from this	• Development and implementation of **essential health care packages** **Gaps**: • More work is needed on **quality of care** in FCAS settings • **Dynamic costing** of packages to allow for changing contexts • **Greater integration** of humanitarian purchasing and provision

UHC objectives	• **Resources captured**; not flowing to populations with highest need • Gaps in critical resources can make even limited resource **inefficient** (e.g. public budgets often focussed on salaries, leaving lack of funds for drugs, outreach, supplies, supervision, especially for frontline PHC services) • **Non-priority care** can gain bulk of resources (e.g. prevention and lower cost, more equitable services neglected) • Governance and reporting weak: **limited transparency and accountability**, often exacerbated by external dependence
UHC goals	• Financial and non-financial barriers: **inequitable access** • **Under-consumption of care by poor** and marginalised, exacerbated by physical access barriers, especially with shifting populations & in slum areas • **Regressive financing** of health care, especially when out of pocket payments predominate • FCAS associated with **lower financial protection** in middle income countries • **Catastrophic payments**, especially for chronic illness • **Quality** of care often poorly regulated and low
Other cross-cutting themes	• Weak **public financial management** systems contribute to many of the challenges above, and are also themselves undermined by plethora of aid funding channels • Health financing institutions have **low capacity**, which is hard to build in a context of chronic or intermittent shocks • Conflict and institutional weakness can block **systemic reforms**, although there is also some evidence for **windows of opportunity** opening post-crisis (in some circumstances)

UHC coverage index



- Overall **coverage for essential health care** (UHC index for 2015) shows a wide range of performance (from around 20% for Somalia to >70% in Uzbekistan)
- Differences between FCAS and non-FCAS settings are **not significant for low income countries**
- However, for **lower middle income** countries (50% for FCAS, 59% for non-FCAS) and **upper middle countries** (58% for FCAS, 68% for non-FCAS), the differences are highly significant

Good practices for external actors in FCAS

- **Long-term commitments** (financial and relational – e.g., limit turnover) and consideration of long-term effects (including for humanitarian aid)
- Speed, flexibility and **context-sensitivity**
  - best fit, not necessarily best practice
- Reinforce government **stewardship and capacity**
  - avoid bad practices, e.g., triggering brain drain and distortion through per diems
- Alignment and **harmonisation**, including for humanitarian development nexus
- Service **integration** where possible
- Local level engagement, linking **systems and communities**
- **Agile monitoring and evaluation** in dynamic and data-limited contexts
- Working in a **political economy-sensitive** way
- Working **across formal borders**, as relevant (e.g. regional programmes)
- Support the opening / contribute to take advantage of **windows of opportunity**
- **Preventing collapse**
  - through to supporting, strengthening, and sustainable systems, depending on the circumstances

Comment on the literature

- High focus on **some countries** (e.g. Afghanistan); others neglected
- Equally lumpy on topics: **aid coordination** dominates, and some topics such as purchasing, quality of care, provider regulation, resource allocation, efficiency, and data and financial management systems are either totally or relatively neglected
- Many studies are hampered by **poor data quality**, given the challenging settings
- A significant proportion are conducted by designers and implementers of health financing reforms and are therefore **not independent**
- Many are commissioned by external agencies and there is therefore likely a **neglect of smaller, local and more home-grown reforms**
- The literature on FCAS also tends to be **distinct** from that on humanitarian settings, mirroring organisational and funding differences

Areas for more research exploration (cross-cutting topics)

- **Equity analysis of health coverage** in FCAS settings specifically
- Analysis through case studies of how **health financing design and implementation can convey social values** and contribute to social resilience in FCAS settings
- Investigation of **how to strengthen PFM and health financing data systems** in FCAS settings
- Analysis of **successful experiences in bridging humanitarian and development** health financing modalities
- Analysis of the impact of **health financing reforms on efficiency**
- Understanding and **managing the political economy of health financing reforms** in FCAS settings
- Longitudinal studies of **health financing institutional development** and its determinants in FCAS settings

Conclusions

- **Heterogeneity** of FCAS settings and need to focus on each context as unique, with its particular challenges, opportunities and history.
- Analysis shows **variation in performance** on health financing indicators (with some common features)
  - many FCAS countries share features with low income countries generally.
- The WHO's **guiding principles for health financing reforms** in support of UHC still apply in FCAS settings
  - in fact, even more so, given the greater severity of the challenges that they often face, such as fragmentation, complexity and volatility of funds, for example.
- Although FCAS settings go through different phases, many face **chronic problems and complex emergencies**, in which strategies for humanitarian response and development converge.
  - lessons on contracting health care provision and insurance models are just some examples of areas where this convergence is occurring and can be further pursued. This is important to managing transitions.

Policy areas to pursue

- Tailored **domestic revenue generation strategies**, including advocacy for prioritization of social sector spending
- Further **pooling of donor support**, including harmonizing financial management, human resource and other procedures across donors, implementing agencies and districts, including through shadow alignment where needed
- Focusing on strategies to **improve quality and protect users** in the formal and informal sectors
- **Tailored health sector assessments** to understand causes of inefficiency and ways to address these, including low budget absorption capacity
- More **politically astute intervention**,
  - based on understanding the internal and external agency incentives,
  - looking for politically feasible improvements, even where not optimal,
  - enabling work across politically contested areas
- Being **better prepared for crisis**
  - for example, having basic packages established and costed, so that governments and donors can react quickly to shocks;
  - Or having simple but functional systems for tracking expenditures and resource flows

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