Reflections from FCAS settings

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FCDO health financing learning journey
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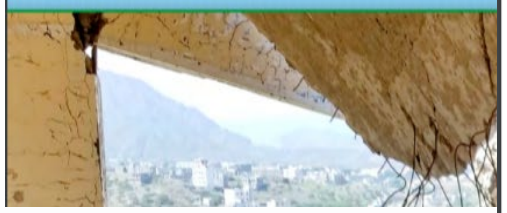
HEALTH FINANCING WORKING PAPER NO 13

HEALTH FINANCING IN FRAGILE AND CONFLICT-AFFECTED SITUATIONS: A REVIEW OF THE EVIDENCE



HEALTH FINANCING GUIDANCE NO 7

HEALTH FINANCING POLICY & IMPLEMENTATION IN FRAGILE & CONFLICT-AFFECTED SETTINGS:

A SYNTHESIS OF EVIDENCE AND POLICY RECOMMENDATIONS

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Review article

Health financing in fragile and conflict-affected settings: What do we know, seven years on?

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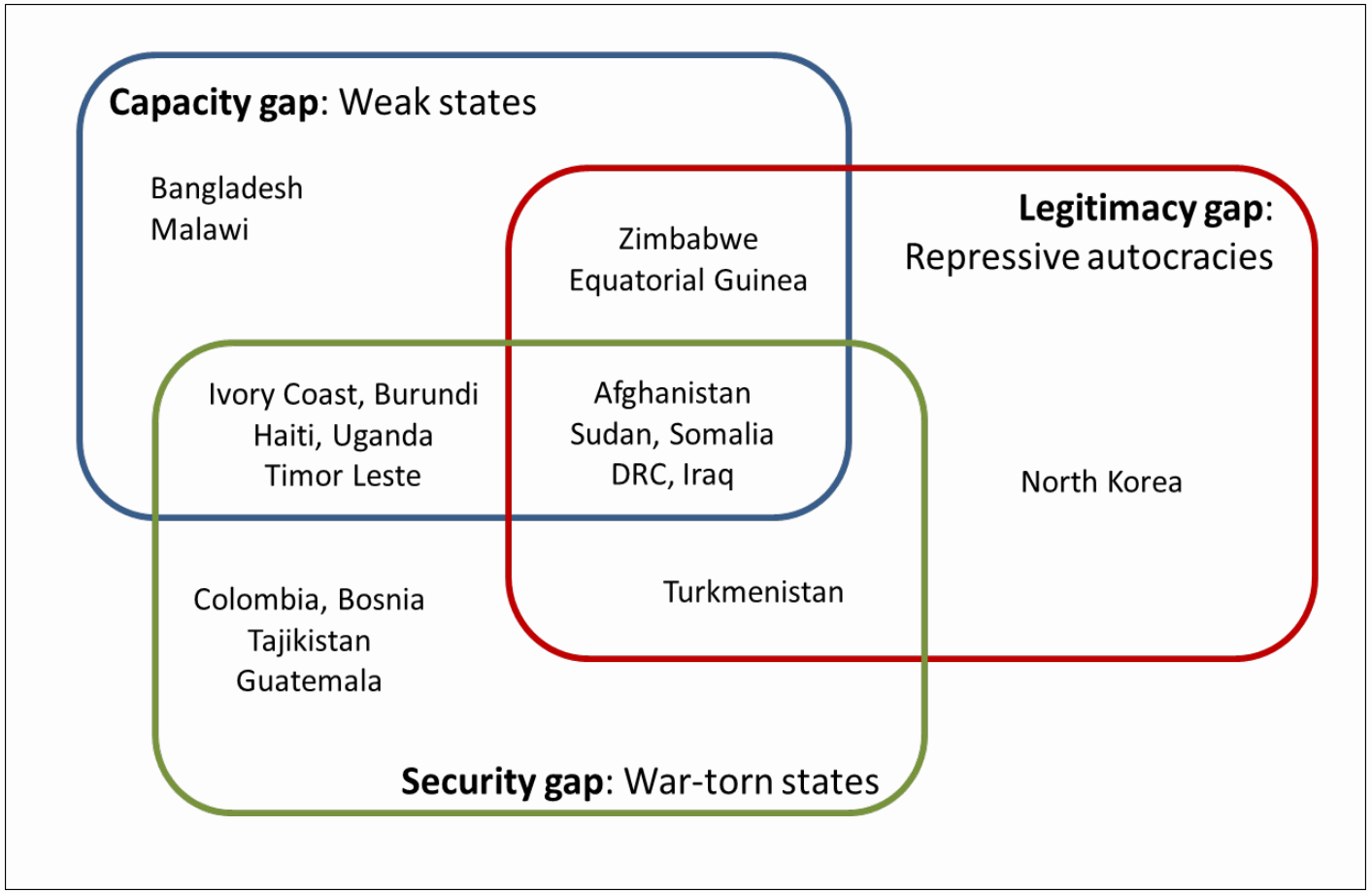
Approach

- **No clear guidance** on how to translate and apply the existing lessons and principles on health financing for universal health coverage to fragile situations
- Based on series on consultations organized by WHO and ReBUILD in Geneva, Cairo, Liverpool, 2017-19
- 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
- **Framed around the idea of government deficits**, particularly in terms of government legitimacy, security and capacity to ensure the provision of basic services
  - Existing policy recommendations in support of UHC stresses the importance of government, particularly in terms of financing
- The paper's perspective is that of public policy and the role of government, given its central importance to the long-term development of health systems
  - the agenda of the Humanitarian Development Nexus is of particular relevance



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**.

Summary messages (I)

- Reflections focus on three areas:
  a) **Ensuring financing of core public /common goods** e.g. surveillance, testing/labs
  b) **Importance of working through & strengthening the public systems** required to finance and deliver health services; or alternatively working through substitute mechanisms which shadow them
  c) **Strategic use of cash** to complement b), alleviate indirect costs etc.
- In general, existing policy messages for health financing policy remain relevant in FCAS, although the specific interventions & modalities which are feasible, and appropriate emphasis and timing, will often differ
- As reliance on external funding increases, there is a high risk of increased fragmentation in revenue sources and fund flows, with potential negative knock-on effects for uncoordinated policies on benefits, provider payment etc.

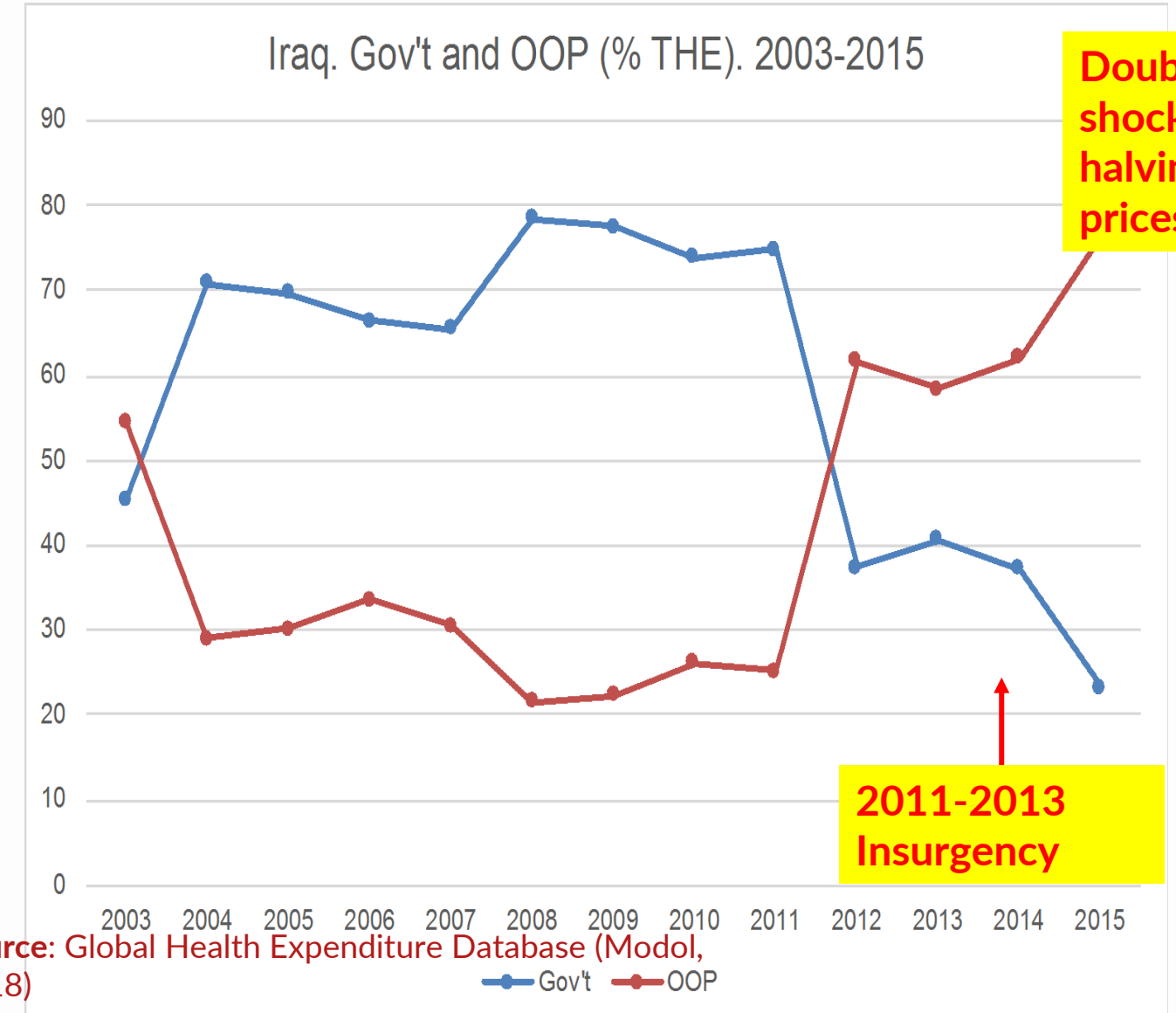
Summary messages (II)

- Where separate funding streams, and related pooling / purchasing arrangements are inevitable, **harmonizing underlying policies** is critical both in the short and longer term
- Greater external funding typically comes with greater influence over policies; **experimentation** with results-based financing, explicit benefit packages etc. have become common in FCAS.
  - It is important that these initiatives can be sustained - in some cases, RBF schemes show extremely high costs e.g. for performance validation.
- Where it is not possible/desirable to work through government, substitute arrangements e.g. multi-donor trust funds may work and also lay important foundations for the future development of the health system.

Summary messages (III)

- **Ensuring a well-functioning basic provider payment system** (e.g. input-based methods, ensuring that salaries are paid on time and basic inputs delivered), should take precedence over more advanced/ information-intensive systems.
- There is considerable evidence that **cash transfer programming** (CTP) can improve access to and utilization of health services in humanitarian settings; when unconditional or unrestricted they need to be part of a range of policies which also **aim to strengthen the role of the public sector** (even if through substitute mechanisms) in terms of financing, oversight and provision (to a lesser extent).
  - Note that a central objective of UHC is financial protection, the implication of which is to minimize reliance on out-of-pocket payments (cash) at the point of service use.

The dance of public financing and OOP…



Source: Global Health Expenditure Database (Modol, 2018)

- 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
- Interesting to compare for pattern with COVID

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
- Support the opening / contribute to take advantage of **windows of opportunity**
- **Preventing collapse**
  - through to supporting, strengthening, and sustainable systems, depending on the circumstances
- Working **across formal borders**, as relevant (e.g. regional programmes)

Policy areas to pursue

- Tailored **domestic revenue generation strategies**, including advocacy for prioritization of social sector spending and use of earmarked funding streams
- 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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Thank you

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