Reflections from FCAS settings

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FCDO health financing learning journey
12th October 2020

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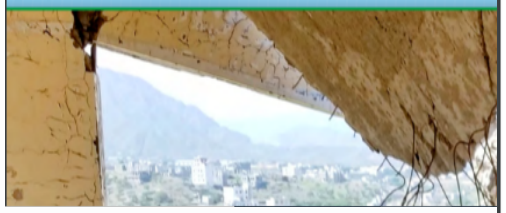
HEALTH FINANCING WORKING PAPER NO 13

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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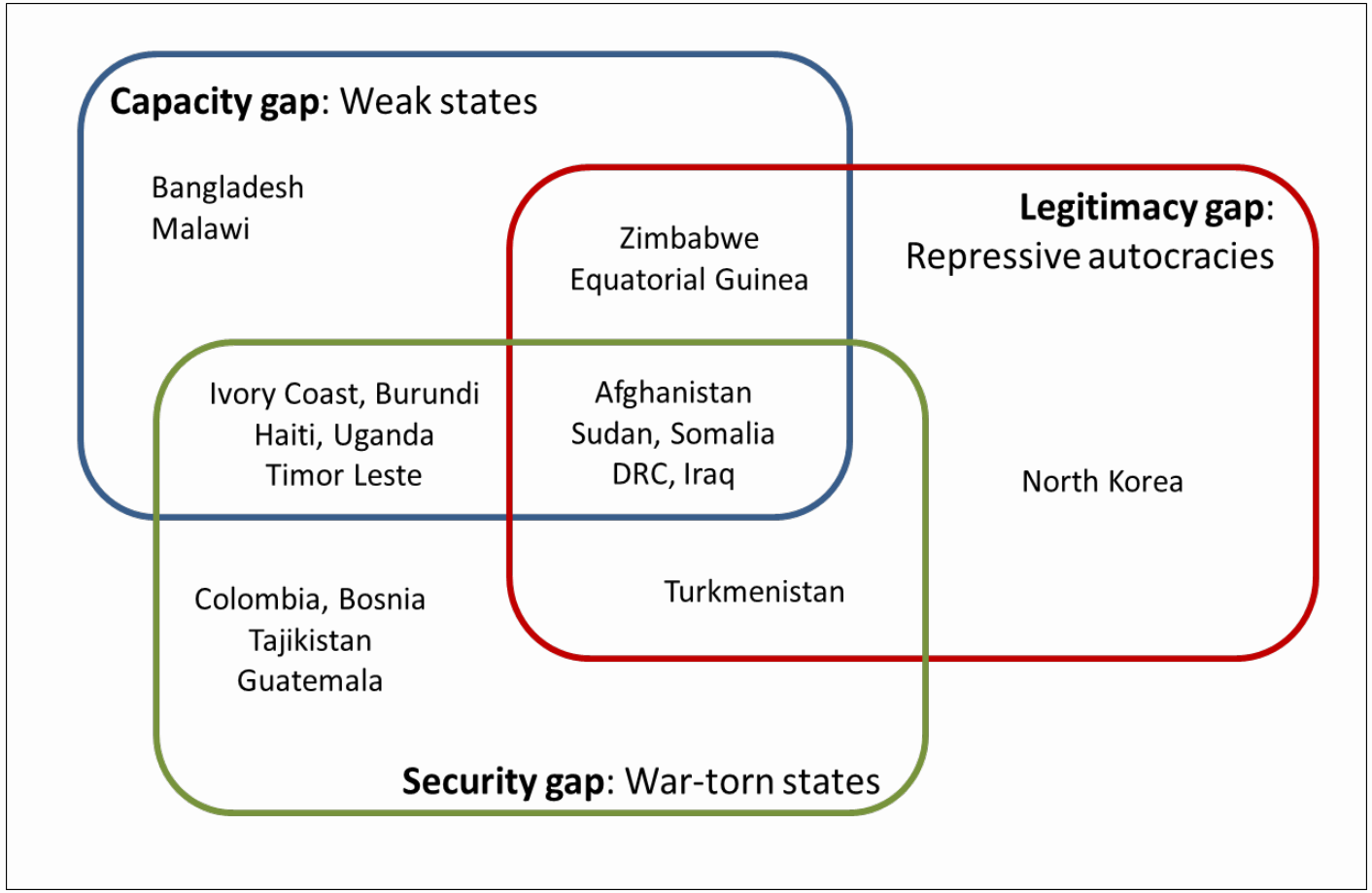
Approach

- 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
  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.

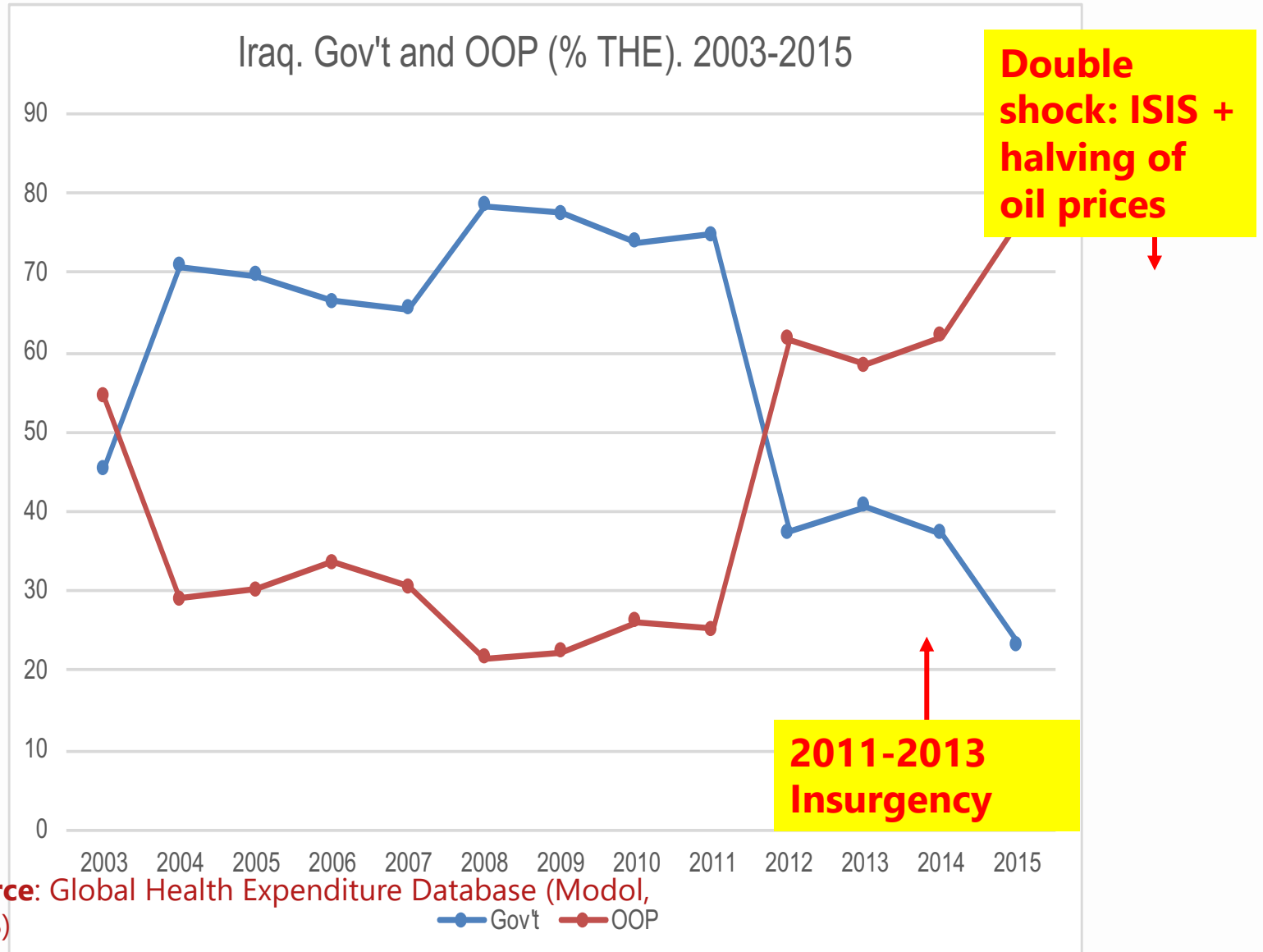
Summary messages (II)

- 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

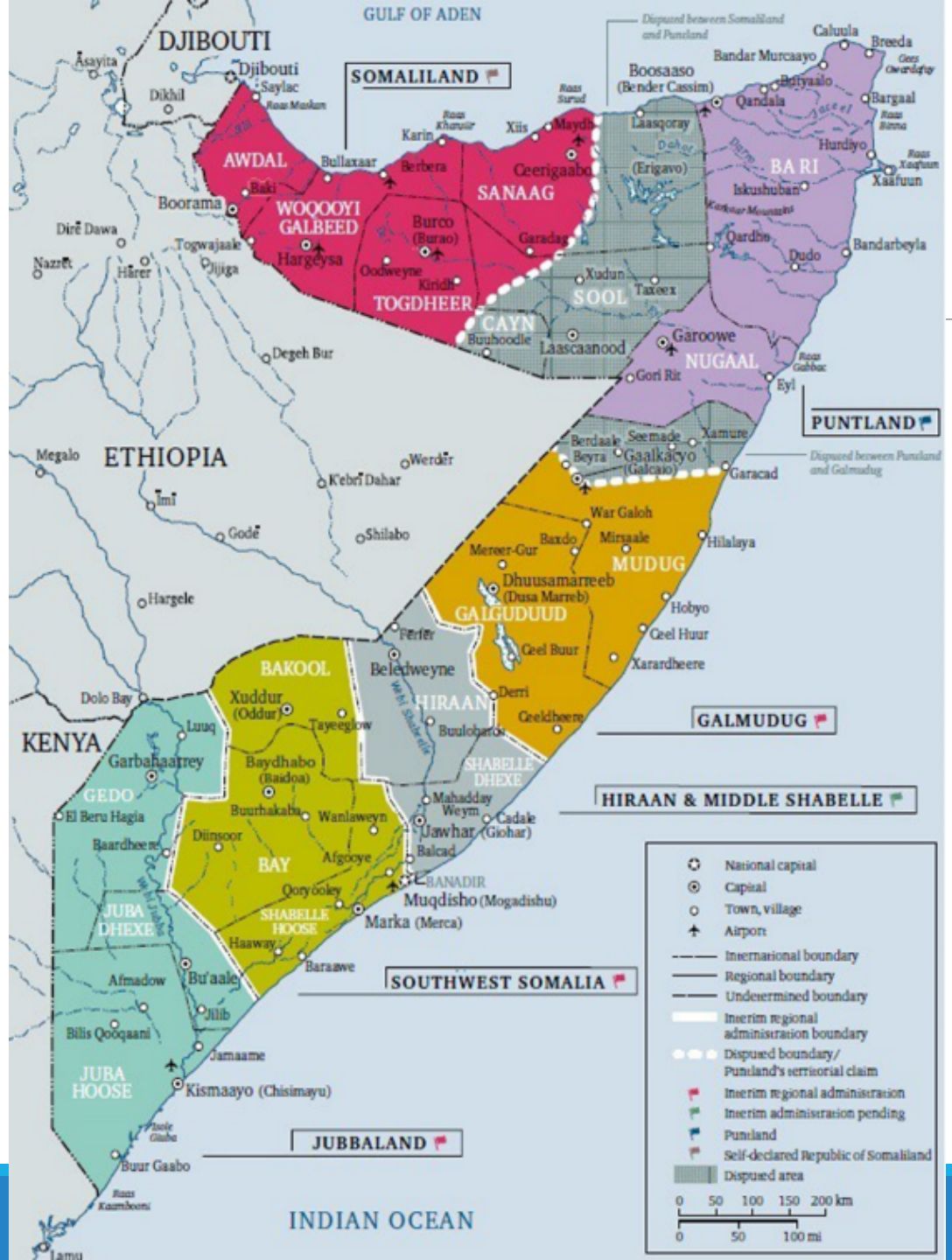
- Tailored **domestic revenue generation strategies**, including advocacy for prioritization of social sector spending and use of earmarked funding streams
- Further **pooling of donor support**, including harmonizing financial management, human resource and other procedures across donors, implementing 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

Financing of essential health services in Somali states

NIGEL PEARSON,

FCDO HEALTH FINANCING LEARNING JOURNEY

12TH OCTOBER 2020



Somali states

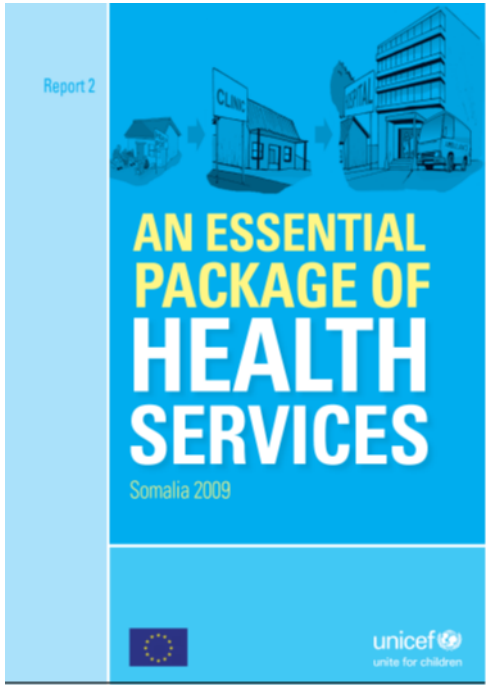
- Unique country context, highly fragmented & conflictual
- government(s) trying to expand legitimacy, security & capacity to deliver services
- weak health sector coordination
- lack of harmonised health financing

Resource mapping & expenditure tracking in Somalia (preliminary findings)

21% of donor funding humanitarian

40 – 45% donor funding FCDO & Global Fund

69% funding for service delivery; 48% for EPHS



FDO funding for EPHS delivery

***IN 2020,* EPHS in 45 (out of 90) districts in 9 (out of 18) regions**

SHINE – CHANGE PSI led consortium: EPHS in 10 districts in Sahil, Karkaar and Gedo regions and has led the way in developing systems & tools at the regional and district levels which have been adopted in SHINE programmes

SHINE – Mott McD led consortium: EPHS in 17 districts in Banadir, Galgadud, Awdal and Toghdeer regions

SHINE - UNICEF: EPHS funding to 8 districts

(SHINE & CHANGE recorded 111,358 skilled assisted deliveries in 2018)

Potential Somali funding sources

From health ministries, municipalities, communities and diaspora contributing to EPHS costs.

In Burao and Odweyne for example the donor contribution 75%, diaspora 10% , private sector 0.5% and local and central government 14.5%

Regional Health Office in Berbera, Sahil. The office was built with 50% co-financed by Berbera Municipality and DFID: the regional medical stores (on the right) was built from private funds donated via the Regional Health Board

Revising & costing the package

1. Evidence based interventions in line with Disease Control Priorities 3 (DCP 3) and based on burden of disease.

2. Estimate total financing envelope for EPHS (*from all potential sources*) and cost per capita.

2. Examine the trade-offs, based on: population estimates, realistic scale and scope (includes if all districts are included and % population coverage), disease burden estimates, predicted human resources, commodities,

3. Use of WHO's (Avenir Health's) One Health Costing Tool to apply in this activity.

4. Compare costs for 65% coverage vs 85% or 100% coverage.

The World Bank

Improving Healthcare Services in Somalia ("Damal Caafimad" Project) (P172031)

EPHS – next steps

- MoHs and donors need to look at affordability.

- EPHS programme delivery design (around different trade-offs).

- Decide contracting mechanisms & provider payment systems

- Resource tracking, aim to harmonise funding flows (? Use of WB GFF), and increase financial protection.

- Harmonise data & data dashboarding