

Health Financing in Fragile, Conflict and Violence (FCV) Situations

Five key questions to be answered

SUMMARY

- *Levels and efficiency of health services financing in FCV countries are significantly low.*
- *FCV countries face more challenges in each of the health financing domains: resource mobilization and pooling, resource allocation, purchasing, and service provision.*
- *This note will discuss the issues and solutions around generating and pooling financial resources and maximizing the efficiency of existing money (purchasing).*



Source: Health policy project.

Q1 WHY is Health Financing a challenge in FCV situations?

FCV countries significantly underspend in health care. 21 of the 25 FCV countries with available data had [per capita health expenditure](#) below US\$100 in 2015, and 9 of them spent less than US\$40 per capita.

Residents in FCV countries had a higher proportion of their health care costs paid out-of-pocket (OOP), therefore facing high financial burdens. 8 of the 25 FCV countries had OOP costs of over 50 percent of total health care costs.

FCV countries have high dependence on external funding for health care and there is a big funding gap. [External funding](#) contributes to at least 20% of total health expenditure in 2/3 of FCV countries. FCV countries received [\\$3.93 less](#) external funding per person per year compared to stable low-income countries. There

was an estimated [41 percent funding gap](#) for UN-coordinated humanitarian assistance in 2017.

Conflicts are becoming more protracted (average of [19 years in 1990 to 37 years in 2013](#)). Over half of all refugees or internally displaced people can live in host communities for more than [4 years with](#) no immediate prospects of return, or resettlement. This is beyond the short time horizon of humanitarian assistance. For instance, UNHCR health funding for refugee health programs significantly reduces after two years. As most refugees do not have income or ability to pay for health care, they often overstretch the financial resources and service capacity of the host community. How to sustainably finance the long-term health needs of refugees, as well as their host community, is a challenge in hosting countries such as Lebanon, Jordan, and Chad.

Sustainable and coordinated financing is lacking to bridge humanitarian and development assistance. Many countries that experienced conflicts, violence, pandemics, or political crises receive humanitarian

assistance during a crisis or immediately post-crisis; however, in the medium term, countries transition from short-term humanitarian assistance to longer term development assistance. These two types of financial assistance are usually poorly coordinated, resulting in huge fluctuations in health financing or even a gap period, misalignment with country priorities, and threats to sustainability of health programs. The new trend is toward a [humanitarian- development nexus](#) to jointly conduct assessment, planning, investment, and health system strengthening during and post crisis.

With improved economy and governance, some FCV countries are transitioning from relying on donor funding to domestic resource mobilization. Côte d'Ivoire recently entered the preparatory transition

phase with GAVI, and in 2025, Côte d'Ivoire will start fully financing its own immunization program. How to effectively mobilize domestic resources, better coordinate the country system and donors, and ensure a smooth transition are priorities.

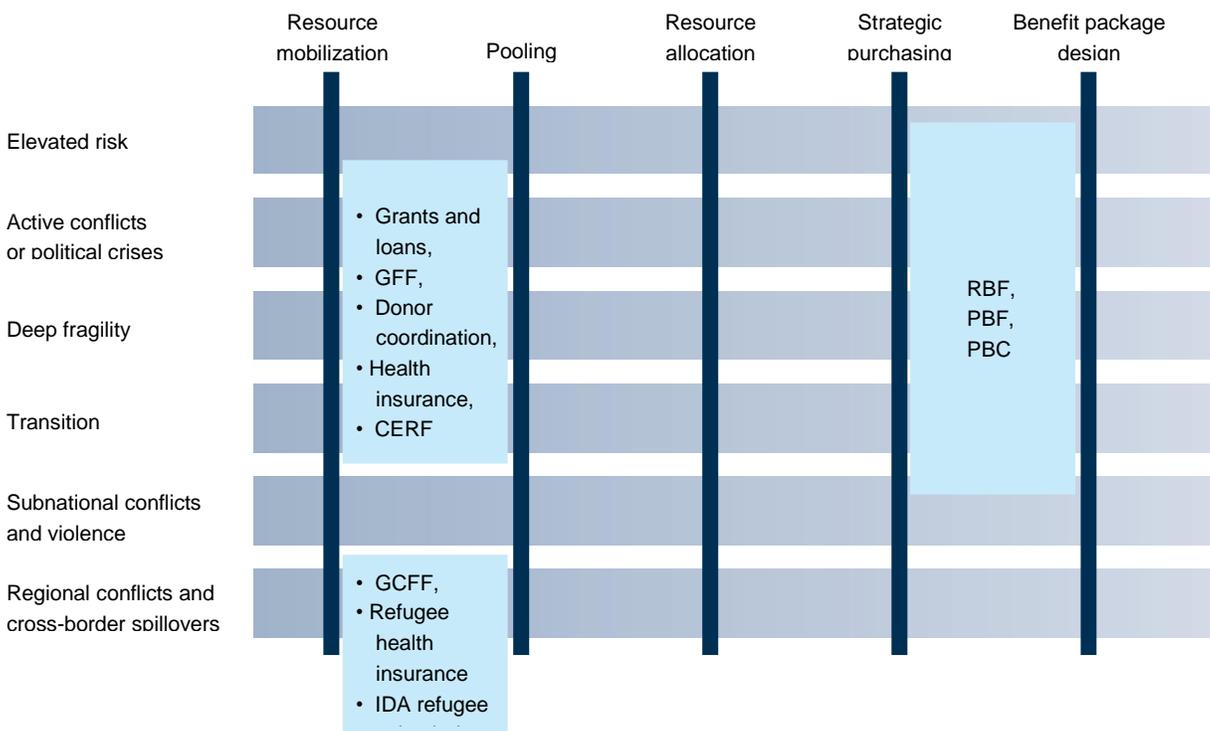
For donors, governments, and local and international health care providers, ensuring transparent and accountable financial mechanisms are important concerns, in the context of weak governance and institutional capacity.

Last but not least, the quality of assistance to FCV affected countries matters—in other words, upholding financial aid effectiveness and efficiency.

Q2 WHAT are the specific issues with FCV health financing?

Health financing in FCV contexts is a very broad and complex topic. There are six typologies of FCV contexts classified by the World Bank; each face different challenges in each of the five health financing domains: resource mobilization, pooling, resource allocation, purchasing, and benefit package design (Figure 1). Specific challenges can be understood in a matrix of interactions between FCV contexts and health financing domains. This note focuses on **resource generation, pooling, and purchasing** in various FCV contexts.

FIGURE 1 Framework of FCV health financing: the interactions between five health financing dimensions and six typologies of FCV





WHAT are the tools and instruments for resource mobilization and purchasing in FCV contexts?

BOX 1 Resources on Health Financing in Fragile States

- ✓ Resources from [ReBUILD's](#) work on health financing in conflict-affected and post-conflict settings
- ✓ A guidance note on [Health Insurance Schemes for Refugees](#) and other persons of concern to UNHCR
- ✓ Resources from [ReBUILD's](#) work on performance-based financing in fragile and post-conflict states
- ✓ World Bank's [Performance-Based Financing Toolkit](#)
- ✓ [RBF toolkits](#)
- ✓ World Bank's [Performance-Based Contracting for Health Services in Developing Countries: A Toolkit](#)

TABLE 1 Frequently used instruments and strategies for resource generation, pooling, and purchasing

	Resource generation and pooling	Purchasing
For FCV	<ul style="list-style-type: none"> Grants and loans Domestic financing Global Financing Facility (GFF) Health insurance (social, community-based) Central Emergency Response Fund (CERF) Donor coordination and pooling 	<ul style="list-style-type: none"> Result-Based Financing (RBF), including Performance-Based Financing (PBF) Contracting
For refugees	<ul style="list-style-type: none"> Grants Concessional loans <ul style="list-style-type: none"> • IDA refugee sub-window • Global Concessional Financing Facility (GCFF) Health insurance <ul style="list-style-type: none"> • Refugee health insurance 	

Instruments for resource generation and pooling

Health insurance

While health insurance is a commonly used instrument to pool resources and risks, it is not common in FCV countries. No study on social health insurance was found in FCV countries. [Zimbabwe](#) is in discussion on national health insurance as a policy option. Community-based health insurance also has limited success, with examples being post-conflict years of [Cambodia](#) and [Rwanda](#).

Global Financing Facility (GFF)

Launched in 2015, the [Global Financing Facility \(GFF\) in support of Every Woman Every Child](#) helps governments in low- and lower-middle-income countries transform how they prioritize and finance the health and nutrition of their people. GFF has operated in [24 fragile countries and](#)

[states](#), including: Afghanistan, CAR, DRC, Côte d'Ivoire, Haiti, Mozambique, Liberia, Myanmar, Sierra Leone, Cameroon, Kenya, Nigeria, and Guinea.

Global Concessional Financing Facility (GCFF)

Launched in April 2016 through a partnership between the World Bank Group, United Nations, and Islamic Development Bank Group, the [Global Concessional Financing Facility](#) (GCFF) provides development support to middle-income countries affected by refugee crises around the world. Each \$1 in grant contributions leverages about \$4 in concessional financing. With funding from GCFF and IDA, the World Bank's [Jordan Emergency Health Project](#) commits US\$50 million to Jordan, of which US\$13.9 million is on concessional terms. The parallel loan for ISDB provides an additional US\$100 million. The GCFF has also provided US\$24.2 million concessional loans to the [Lebanon Health Resilience Project](#).

Refugee Health Insurance

UNHCR has implemented [refugee health insurance schemes in 11 countries](#), including several FCV countries, such as DRC, Togo, and Mali. A comprehensive [manual](#) has been generated on how to design and implement refugee health insurance. Most refugee insurance schemes started with UHNCR financing (as a subsidy for premium or insurer's administrative cost) for two years; then they were required to transit to user- or government-funded schemes in the form of community-based, social health insurance (Ghana), or private health insurance. Empirical evidence shows very limited success to scale up and sustain the scheme. Iran was the only example with a relatively large number of beneficiaries for hospital care and good sustainability.

Instruments for purchasing and more efficient use of funding

Results-based financing and performance-based financing

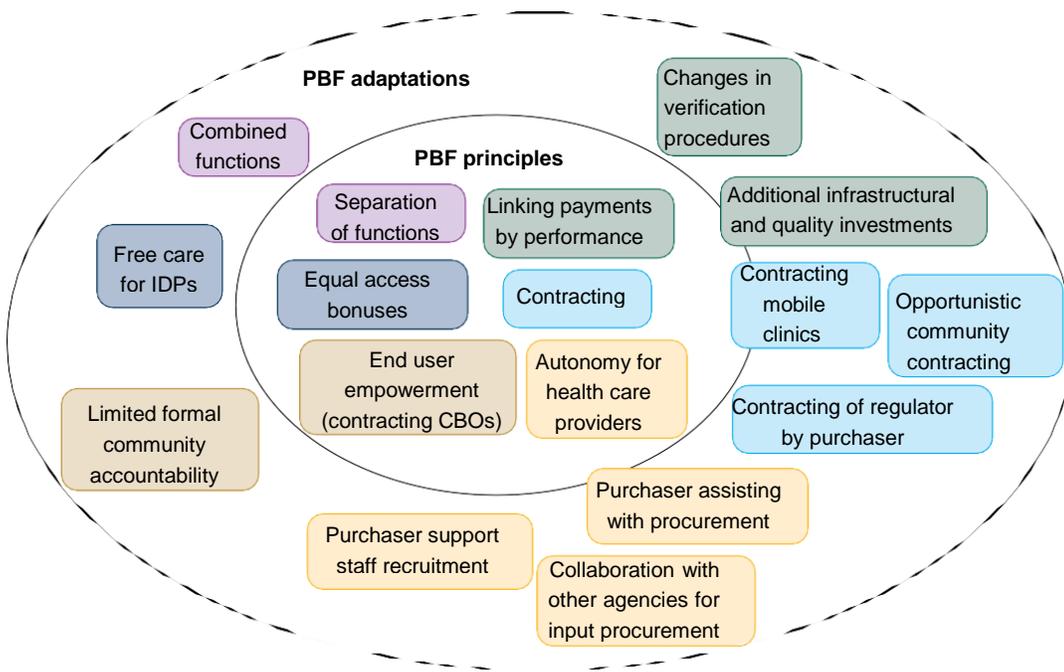
- **Results-based financing (RBF) is a category of financing instruments to incentivize results.** Performance-based financing (PBF) is a type of RBF that pays institutions or individual providers based on their performance, which is usually the quantity and quality of services delivered. In the classic purchasing

literature, schemes that pay for quantity of services include fee-for-service, capitation, and diagnosis related groups (DRG), etc.; whereas schemes that pay for quality are typically referred to as pay-for-performance.

- **PBF is a popular payment mechanism in post-conflict countries and fragile states** (Burundi, DRC, CAR, Djibouti, Afghanistan, Haiti, Liberia, Zimbabwe), possibly because the weak health care system gives opportunities to innovate and establish new systems and institutional reform. It is also more feasible in [settings](#) where external actors and donors have a strong influence, or where there is a low level of trust within the public system.

PBF has six design principles. However, adaption to contexts and flexibility in implementation are important for the survival of the PBF. Typical adaptations made from field experiences in FCV countries are summarized in Figure 2. Notably, some adaptations violate the “design principles” for pragmatic reasons. For example, PBF requires payment against performance; yet many programs in fragile states often do not have the resources to achieve the results. Therefore, PBF programs in DRC, CAR, and Nigeria provided [flexible and nonperformance-based funding](#) in advance for construction and rehabilitation of destroyed facilities, recruitment of health professionals, and procurement of drugs and essential supplies. While PBF requires payments to be made after results verification, it is sometimes risky to verify (e.g., Ebola

FIGURE 2 Design Principles and Practical Adaptations of Performance-Based Financing (BPF)



Source: [Bertone et al. 2018](#)

crisis in Liberia). Therefore, some FCV PBF programs may have to allow payment without verification. Most FCV settings do not have a functional banking infrastructure, and cash payments to facilities and individual providers are often used.

- **There are positive results from PBF, but there is limited understanding of its impact** (intended and unintended). [PBF programs in Afghanistan have demonstrated positive gains in service utilization](#). However, there is no conclusive evidence if PBF is superior to other payment arrangements. [PBF in Zimbabwe](#) helped to increase resource mobilization. It introduced a contractual relationship for some providers, and improved their payment system, data quality, and autonomy. [Haiti's previous experiences of RBF](#) demonstrated a substantial increase in rates of completely vaccinated children and prenatal care among women, as well as an increase in the quantities of primary health care services. Based on the positive results, the Ministry of Public Health and Population (MSPP) made RBF mechanisms one of the key pillars of the 2012 National Health Strategy.

Contracting

Since 1999, [contracting international NGOs](#) to provide health services has been identified as a primary mechanism to support health sectors in FCV countries. Experiences in Cambodia, Haiti, Afghanistan, DRC, Liberia, and southern Sudan have shown contracting to be effective in improving access to basic care, and often better than government at reducing inequalities.

[Afghanistan](#) showed good results with large-scale contracting. Since 2002, a joint mission of funders, in collaboration with the Ministry of Public Health, started to fund contracts with 27 NGOs (17 international and 10 Afghan) that cover most of the population in 34 provinces for a standardized package of care. Contract periods averaged at 26 months (12–36 months). On the other hand, contracting can lead to a tendency to depend on donors, and undermine the capacity building and involvement of government, making it difficult to eventually transfer the function to government. Moreover, NGOs usually pay higher salaries than the government, and may even lead to a brain drain.

BOX 2. Opportunities to Explore [Innovative Health Financing](#) Instruments for FCV

Various innovative financing instruments have been shown feasible for stable middle- and low-income countries. Despite the limited experiences in FCV countries, their potential in FCV contexts could be further explored through:

- Social impact bonds
- PPPs
- Earned income business models
- Combined indexed insurance and catastrophe bonds
- Multi-donor trust funds

BOX 3. Costing Tools and Resources for Basic Packages of Services in FCV Contexts

- [WHO costing tool for maternal and child health](#)
- [One-Health Tool](#) for costing and planning of services and capacity
- [WHO CHOICE Tool](#) for selecting cost-effective interventions
- Costed packaged in [Syria, Lebanon, Sub-Saharan Africa, 49 low-income countries](#)
- [UNHCR reproductive health package costing](#)



WHAT has been done at the World Bank?

What are the challenges and lessons learned?

Selected World Bank [Publications](#) on Health Financing for Fragile States:

- [Financing for Fragile and Conflict-Affected Countries website](#)
- [Performance-Based Contracting for Health Services in Developing Countries: A Toolkit](#)
- [Cost-Effectiveness Analysis of Results-Based Financing Programs: A Toolkit](#)
- [Incentivizing Nutrition: Incentive Mechanisms to Accelerate Improved Nutrition Outcomes](#)
- [Performance-Based Contracting for Health Services in Developing Countries: A Toolkit](#)
- [Delivering Services to the Afghan People](#)
- [Results-Based Financing for Health](#)
- [Contracting for the Delivery of Community Health Services: A Review of Global Experience](#)

BOX 4. Voices From the Field

Common challenges emerging from TTL interviews on Performance-Based Financing (PBF) in FCV settings

- Focus primarily on supply of services but not demand side
- Possible resistance
- Potential cost increase
- Verification may be difficult
- Limited capacity of providers
- Ensuring equitable distribution of incentives
- Workload of community health workers

Common challenges emerging from TTL interviews on contracting in FCV settings

- Sustainability
- Difficulty in measuring performance
- Lack of government capacity building and stewardship
- Lack of competition
- Fragmentation of care
- High management cost

Common challenges emerging from TTL interviews on FCV country health financing system Key Lessons

Learned

- Even in FCV settings or a fiscally constrained situations, it is possible for government to increase financing toward RBF/health system improvements
- Implementing major health financing changes (e.g., RBF) requires progressive and sustained engagement
- It is crucial to have clear priority setting, and design a unified basic package of health services

- Be flexible and innovative to adapt PBF design to contexts
- Provide substantial flexibility and autonomy to service providers
- Conduct independent, frequent, and robust Monitoring and Evaluation (M&E)
- Analytical work should go hand-in-hand with operations and implementation of projects
- Avoid fragmentation of health systems
- Strengthening health financing functions serves both to strengthen health system and enhance efficiency of donor support
- There is sufficient private capital looking for social investments, but there is a lack of intermediaries presenting these opportunities to investors in a language and with metrics understandable and relevant to them
- Blended/donor capital is critical to accelerating the adoption of these instruments over the coming years

Portfolio Summary

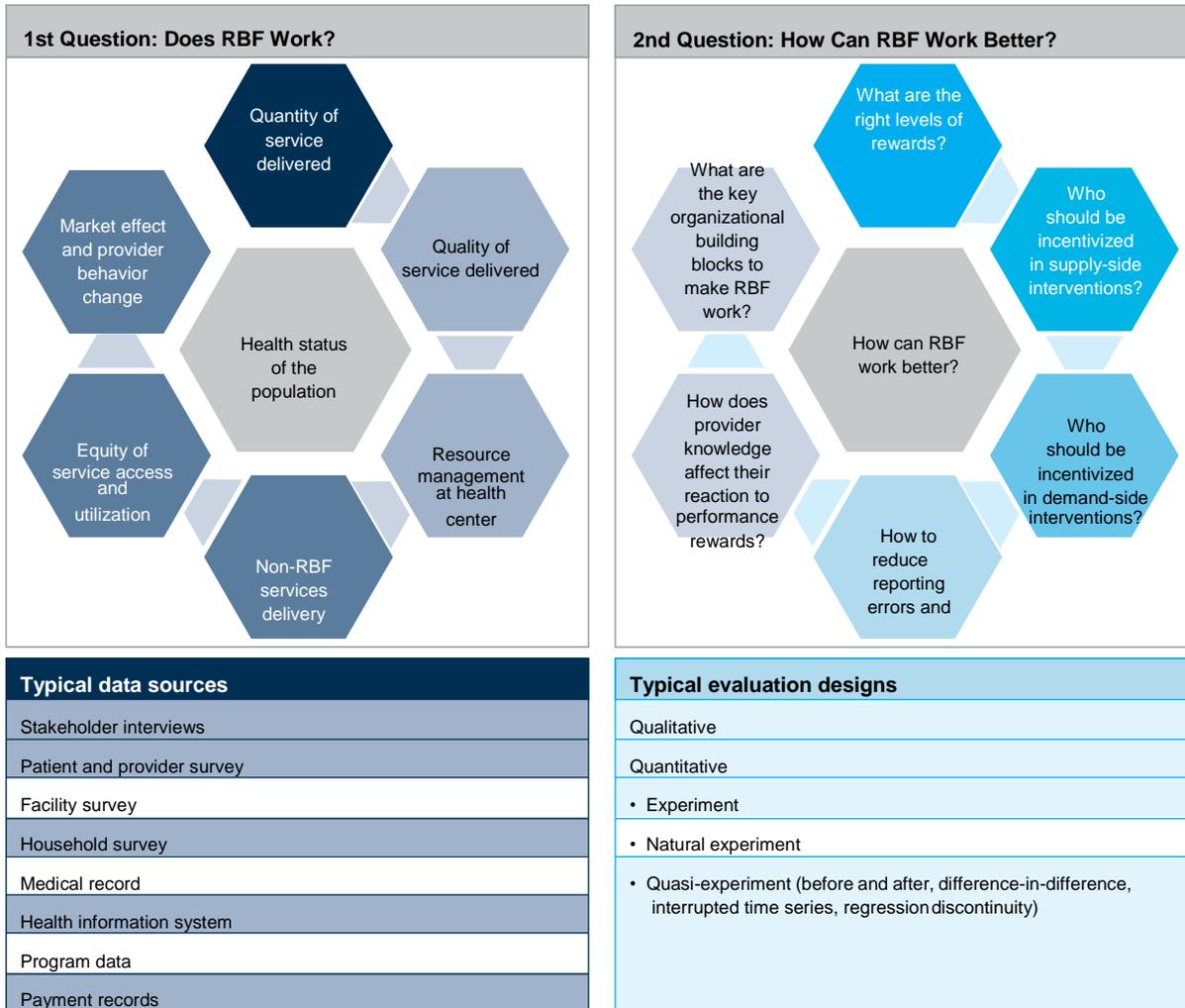
Country	RBF	Contracting	Other health financing topics	Project title
Afghanistan	Yes	Yes	RBF impact evaluation	Strengthening Health Activities for the Rural Poor (SHARP) (P112446) Afghanistan: System Enhancement for Health Action in Transition Project (P129663)
Burundi	Yes	No		P156012—Health System Support Project (“KIRA”)
DRC	Yes	No		P147555—Health System Strengthening for Better Maternal and Child Health Results Project (PDSS)
Congo	Yes	No		P143849—CG Rep. Health Sector Project
Haiti	Yes	No	UHC	P123706—Improving Maternal and Child Health through Integrated Social Services P167512—Strengthening Primary Health Care and Surveillance in Haiti P164060—ASA on Universal Health Coverage and Pandemic Preparedness in Haiti
Liberia	Yes	No		P128909—Liberia Health Systems Strengthening
CAR	Yes	No		P164953—Health System Support and Strengthening Project P119815—CF-Health System Support Project
South Sudan	No	Yes		South Sudan Health Rapid Results Project AF (P156917)
Zimbabwe	Yes	No	UHC	Health Sector Development Support Project (P125229) Zimbabwe Health Sector Development Support Project AF II (P156879) Zimbabwe Health Sector Development Support Project III—AF (P163976)

Q5

HOW should we evaluate instruments and strategies for purchasing?

- Many health financing instruments and interventions for purchasing are systematic and complex, therefore intrinsically different to evaluate.
- A World Bank study to evaluate the different financing instruments and strategies and identify the best instruments and lessons for different FCV contexts is forthcoming.
- Results-based financing has been evaluated in some FCV countries, and [toolkits and step-by-step hands-on guides](#) are available.

FIGURE 3 Evaluation of Results-Based Financing



This FCV Health Knowledge Note highlights operational tips to resolve health issues in FCV situations. The notes are supported by the Middle East and North Africa Multi Donor Trust Fund and The State and Peacebuilding Fund (SPF). The SPF is a global fund to finance critical development operations and analysis in situations of fragility, conflict, and violence. The SPF is kindly supported by: Australia, Denmark, Germany, The Netherlands, Norway, Sweden, Switzerland, The United Kingdom, as well as IBRD.

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