HEALTH SYSTEMS AFTER CONFLICT - EVIDENCE FOR BETTER POLICY AND PRACTICE | BRIEFING PAPER 2

# Health financing policy in conflict affected settings: lessons from ReBUILD research

## Background

Health financing policies that support universal access to health care without causing impoverishment are critical for health and economic development in any setting. Vulnerable populations that are affected by a history of conflict require particular attention to ensure that their households, communities and societies are not permanently scarred by the legacy of that conflict. While a significant body of work addresses the impacts of different health financing policies for health care access, and to a lesser extent poverty and impoverishment, little of this is in conflict affected settings and even less specifically examines the interaction between health systems, financing policies, poverty and conflict[1]. ReBuild has undertaken a complex research project addressing these interactions spanning four countries.

## Research approach

ReBUILD's health financing project had two major components.

A reanalysis of household survey data aimed to identify the impact of health financing policy changes on households' access to health care and expenditure patterns pre-conflict, during conflict and post-conflict[2].

A life history study of older heads of poor households and their health care use before, during and after conflict, focusing on the relationships between health seeking behaviour, expenditures on health care, conflict, and health and poverty experiences[3].

## Key points:

Out of pocket health expenditures play important roles in the processes that drive households into poverty and maintain them there, so health financing policies that seek to reduce this expenditure are important.

However, post-conflict health financing policies have had limited effects in addressing poverty because of a range of factors that arise in their implementation, many of which could be predicted.

Health financing policies in conflict-affected settings should be designed using a systemic rather than piecemeal understanding of intervention, and recognising capacity and staff experience limitations.

Health financing policy change takes time to evolve, with no discrete before/after effect. Policy intentions need to be reinforced during longer-term support for health system management.

| Research components | Cambodia | Sierra Leone | Uganda | Zimbabwe |
|---|---|---|---|---|
| 1. Reanalysis of household surveys | √ | √ | √ | |
| 2. Life histories of older heads of poor households | √ | √ | √ | √ |

[1] See Health financing in fragile and post-conflict states: What do we know and what are the gaps? [http://www.sciencedirect.com/science/article/pii/S0277953612006752] Sophie Witter (2012) *Social Science and Medicine Volume 75, Issue 12, December 2012, Pages 2370–2377*

[2] This component was undertaken in Cambodia, Sierra Leone and Uganda, but could not be completed in Zimbabwe owing to data access issues. Pre-, during and post-conflict periods were studied if covered by available household surveys.

[3] This component was undertaken in all four countries.

# Findings

## Impacts of health financing policies on household expenditure patterns

In Sierra Leone, we examined the impact of the Free Health Care Initiative (FHCI) introduced in 2010, post conflict, on health care use and expenditures for children, and expectant and recent mothers, the target populations for the initiative[4]. The findings suggest that the policy had relatively small effects. The proportion of children who accessed care without payment increased, but not children's utilisation of care overall, and use of informal sources of care may have decreased. Many eligible children still paid for care, and overall level of payment was unaffected. While use of maternal health services did increase substantially, the effect diminished over time, emphasising the importance of resourcing the supply of services to meet increased demand.

> *"It was better when both my children were alive. They would make contributions to pay for my medications. At the moment my surviving son is really struggling to pay as his family is now big."*
>
> Female, Zimbabwe

In Cambodia[5], we examined the combined effects of a complex mix of financing policies, comparing districts with different combinations of the policies[6]. These policies were:

- the formalisation of user fees in public health facilities
- the introduction of health equity funds (HEFs), both government and donor funded, which fund the exemption of poor households from fees
- vouchers for pregnant women to cover costs of maternal care in public health facilities
- community based health insurance
- contracting arrangements by which public subsidies are allocated by a contract rather than budgetary process.

The widespread roll-out of financing schemes across the country is associated with a general reduction in out of pocket spending by the poor.

Both types of health equity funds are associated with reduced out of pocket spending, although the effect of donor schemes is larger. The overall effect for vouchers, aimed only at reproductive health services, is more modest though enhanced when combined with other schemes. Our analysis suggests that policies take a number of years to have a substantial effect.

In Uganda, the major health financing policy change occurred in 2001 when user fees were withdrawn from all public health facilities[7]. In northern Uganda at that time, over 90% of the population was living in internal displacement camps because of the conflict, and it was not possible to evaluate this change for the conflict-affected population[8]. We studied the impact of the population's return from the camps after 2006 on their household budget and health expenditure patterns, and found that food consumption increased in the post camp period, particularly in rural areas. Whilst overall utilisation of health services did not change significantly, there was a significant shift from use of formal private services to use of informal private services and public services, particularly for the poorest.

## The role of health care use and health expenditures in the life histories of older heads of poor households

Figure 1 shows key relationships between conflict, poverty, health and health care[9], and illustrates the role played by health spending in vicious cycles of poverty and health that in many cases have roots in, or have been exacerbated by conflict and crisis. In respondents' accounts, conflict may be directly implicated in poverty (e.g. through loss of assets), health (e.g. after conflict-related injuries), health care (e.g.

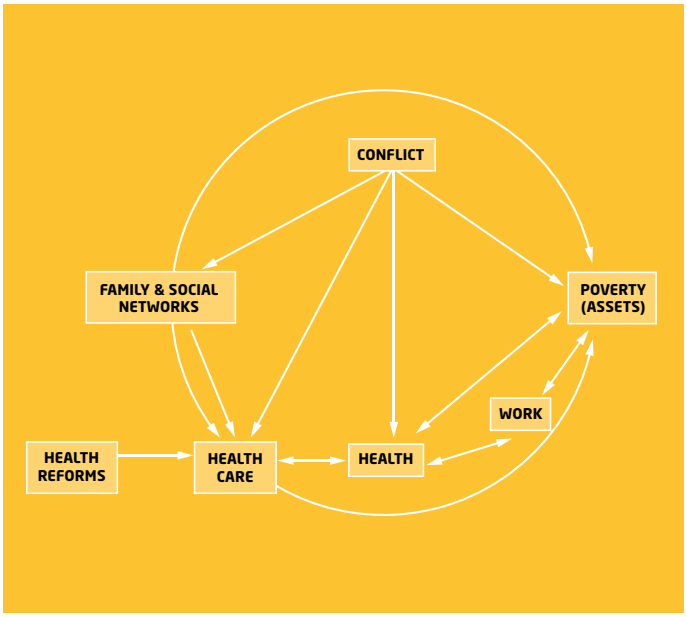


**Figure 1: Key relationships between conflict, poverty, health and health care**

[4] See Edoku et al., 2016 Health Economics Review2016 6:19 [http://healtheconomicsreview.springeropen.com/articles/10.1186/s13561-016-0096-4]

[5] A paper from this research by Chhun et al, is currently under review. It will be available on ReBUILD website

[6] Multiple rounds of the Cambodia Socio-Economic Survey between 1997 & 2011 were used – all in the post conflict period – using difference-in-difference methods & panel estimation.

[7] A paper from this research by Tseng et al, is currently under review. It will be available on ReBUILD website

[8] Public health facilities were mostly not operational, with available health services largely provided by humanitarian agencies without charge

[9] This is based on the accounts of Cambodian interviewees, but illustrates findings applicable in all four countries.

through reduced access to timely care when health services are destroyed) and family and social networks (e.g. after deaths of family members). Older respondents were almost all suffering from multiple chronic conditions that partly reflect their age but are also often traced to events or processes of the conflict period. These restrict their ability to work, and require repeated health care use, both of which drive them into poverty and keep them there. Family and social networks are the major source of resilience, but for many people these networks have been depleted by the conflict, particularly through loss of male breadwinners and/or the younger generation.

> *"...She died in three months. […] Yes, I had [the ID poor card], but I had no money for transport and who would lend me the money […] so I just let fate decide. If I took the baby to hospital, the other children would die too. No mother would want their baby or children to die, but I could do nothing."*
>
> 40-year-old female, Cambodia

Hence, health financing policies that focus on reducing the costs of health care are well targeted at addressing key processes that drive and maintain poverty at the household level and in some cases, they succeed in mitigating problems. In Cambodia for example, whilst health equity funds and community based health insurance are often helpful in mitigating the problems, the findings give clear insights into how they could have a greater impact. They could cover a wider range of the costs of accessing health care than just facility fees[10], and they could ensure that users are not discriminated against when they try to access health care[11] .

In Zimbabwe, the crisis period of hyper-inflation led to increased levels of expenditure by households who were less able to cover costs[12]. Three main causes are identified:

(1) facility fees, now charged in hard currency are unaffordable for many respondents, who were all older adults and suffering from multiple chronic conditions

(2) policies which aim to exempt the poor are inadequately funded and have ceased to operate and

(3) under-funded public services have become unreliable, increasing private sector use, most often small drug shops, stretching household budgets.

Coping strategies such as delaying treatment, taking on additional jobs, selling assets and reducing drug doses below those recommended are all likely to play a role in maintaining households in poverty and respondents in poor health.

In Uganda[13], respondents' accounts suggest limited availability of formal health care in the camps during the conflict period, and a reliance on informal and traditional health care. Since returning home, the poorly functioning public system with frequent drug stock-outs, and physical access challenges, means frequent use of drug shops and small private clinics, contingent on having resources for these. Older and widowed female household heads were most likely to be poor, and face challenges in raising resources for health care, and often delayed care seeking. Consequently, the policy of free health care (user charge removal) fails to achieve its aims of ensuring access to effective health care and protecting households from its costs.

In Sierra Leone, there were differences in patterns of health care use between districts and between urban and rural respondents, and consequently in the extent of health related costs. For example, before the war, some respondents frequently report only minor costs and even free public health services (e.g. token payments for consumables for delivery services) while others reported significant payments (e.g. around US$65 for delivery of a male child[14]). While many respondents report recourse to family, friends and church to help with health costs, this was not always successful. In some cases, respondents reported deaths owing to the absence of funds to access hospital care, and deaths following sometimes costly but ultimately ineffective care. Assets were sold to raise funds for health care, or used as collateral against loans from community members.

> *"… after the war, life was not easy, it was very hard, we did not even have land to cultivate on so we worked in the stone quarry for other people and also weed their gardens. [….] In that way we would get some money..."*
>
> 62 year old female, Uganda

Consistent with the household survey analysis, respondents report limited impact of the FHCI, with informal charges and drug stock outs that mean paying for medicines for both maternal and child health care.

[10] Some health equity funds do this.

[11] Some health workers seem to perceive such patients as free-riding and providing insufficient financial incentive for good service.

[12] A paper from this research by Buzuzi et al, is under review. It will be available on ReBUILD website

[13] See Ssali, S. et al (2016) Building post-conflict health systems: a gender analysis from Northern Uganda, in Gideon, J, ed. Handbook on gender and Health. London: Edward Elgar.

[14] Reported as Le10,000 around 1990 although the specific date of this pre-war birth is not clear from the interview. (An exchange rate of 151.5 Leones to the USD is reported by World Bank Indicators in 1990 http://www.tradingeconomics.com/sierra-leone/official-exchange-rate-lcu-per-us-dollar-period-average-wb-data.html.)

# Conclusions and recommendations

The life histories explain and contextualise the household survey analysis. Both sets of findings were largely consistent with each other, and suggest a number of conclusions and recommendations:

1. Health financing policies targeted at removing or reducing out of pocket health expenditure are essential interventions in processes that drive and maintain poverty at household level, many of which originate or were exacerbated by conflict.

2. The health financing policies present in the four countries have, in general, a limited effectiveness in addressing processes of poverty for a range of reasons:

   a. In some cases, they are not fully implemented – e.g. formal fees, whether removed for all, or for targeted groups, have been replaced by informal ones.

   b. There has been inadequate funding and in particular inadequate drug supply to support effective service delivery. Consequently, health utilisation and expenditure is redirected to private and informal health providers, including drug shops, and this may have the overall effect of increasing health expenditure.

   c. There is insufficient coverage of the ancillary costs of seeking health care such as transport and child care costs. Ensuring services are free once accessed is insufficient for the poorest households.

   d. The incentives for the health workforce to ensure access to effective services and non-discriminatory treatment of exempted populations are inadequate[15].

   e. Unfunded exemptions, in a context of a high prevalence of poverty, and qualification for exemption result in an impossible choice for service providers between honouring exemptions and maintaining service provision.

3. Health financing policies should be designed using a systemic rather than piecemeal understanding of intervention. Points 2a. to e. illustrate that failures to comprehensively address the requirements of effective access to health care for poor populations have affected all four countries to different extents. In conflict affected settings, recognition of relevant capacity and staff experience limitations are particularly important aspects to be considered in design of these policies.

4. It is important to consider the longer term implications of health financing policy change which generally does not generate a discrete before/after effect but one that evolves. Evidence from Sierra Leone suggested that the effectiveness of the FHCI waned after the first few months; yet in Cambodia, the health financing policies appeared to be most effective 2-3 years after their initial implementation. This may reflect Cambodia's greater distance from its conflict, and stronger institutions. Attention needs to be paid to how to reinforce policy intentions in the processes of health system management and support over the long term.

**The ReBUILD Consortium is an international research partnership working on health systems strengthening in post-conflict and post-crisis settings.**

## Resources

- For more information on ReBUILD's research and outputs, visit the website at www.rebuildconsortium.com
- All reports and articles from ReBUILD's health financing research can be accessed at http://bit.ly/2eB2Muz

## Contact

**ReBUILD Consortium**
**Liverpool School of Tropical Medicine**
**Pembroke Place**
**Liverpool, L3 5QA**

**T:** +44(0)151 705 3100

**E:** rebuildconsortium@lstmed.ac.uk

**W:** rebuildconsortium.com

@ReBUILDRPC

This is an output of a project funded by UK aid from the UK government. However the views expressed do not necessarily reflect the UK government's official policies.

UKaid from the British people

[15] See also Establishing a responsive and equitable health workforce post-conflict and post-crisis: lessons from ReBUILD research, ReBUILD briefing paper, 2016.