Health systems during and after crisis: evidence for better policy and practice | Brief 4

How do different types of provider affect access to effective and affordable healthcare during and after crises?

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Health systems comprise a range of types of healthcare providers which differ widely in their motivations and services offered. Many thrive in the chronic absence of the state from healthcare provision, as is often the case in crisis-affected settings, although this comes at the expense of efficient and equitable healthcare provision.[1] This brief summarises the key characteristics of the different types of providers and the health services they offer, and discusses their involvement in health crises and possible interventions that can increase access to effective and affordable healthcare during and after crises.

The range of providers

The role of different types of providers in health systems varies widely between settings and depends heavily on contextual factors. Historical, political and social factors are all important. Some broad patterns for fragile and crisis-affected settings are highlighted in Table 1.

Responses during and after crises

Crises undermine the proper functioning of health systems through disruption to government revenue generation, destruction of healthcare infrastructure and the death and migration of health workers **(see accompanying brief on universal health coverage in crisis-affected settings)**. Well-resourced domestic and international armies, as well as some police forces, may have their own health facilities that can be drawn on during crises,[9] although in some cases this is done on a for-profit basis and therefore of limited benefit to poorer groups.[2]

In many settings disruption to the public healthcare system perpetuates and exacerbates existing reliance on informal providers.[1] In Sierra Leone, for example, people rarely rely exclusively on the public healthcare system,[10] while indigenous practitioners and traditional birth attendants in Cambodia played an important role in healthcare provision before, during and immediately after the conflict,

Key messages

- There is often a great diversity of healthcare providers in crisis-affected contexts, which is a challenge to regulation and financial protection but also one of the signs of resilience of pluralist health systems

- Governments often face severe capacity constraints in relation to financing and managing these providers and therefore have to adopt an agile approach to using the relative strengths of each sub-sector and mitigating their weaknesses. For example:

  - Directing more resources to the frontline providers in the public system, coupled with stronger supervision

  - Negotiating access for specific groups to use health facilities run by domestic or international military forces, or by other ministries

  - Supervising international NGOs to ensure capacity transfer to local partners using a structured transition plan that includes managers at all levels of the health system

  - Ensuring a level playing field for mission-based and other NGO providers in terms of inputs such as staffing, but also in relation to national standards and performance against national goals (also for private-for-profit facilities, where feasible)

  - Using community health workers to connect informal providers to training and supervision systems

- Roles will change over time and there is no 'ideal' distribution of roles. This is very contextual. However, it is important to maintain a strong dialogue with different provider groups and monitor for distortions in the health system which may subvert equitable access to appropriate and affordable quality healthcare for the population.

How do different types of provider affect access to effective and affordable healthcare during and after crises?

Table 1. Patterns for different types of providers in fragile and crisis-affected settings.
(Adapted from Pavignani and Colombo (2009).[2] Additional sources: [3,4,5,6,7,8])

Type of provider	Level of health system	Location	Relative strengths	Potential drawbacks
Public – health ministry	All levels	All areas, but infrastructure can be concentrated in urban areas	Supported by government; available to all	Underfunding often associated with informal fees and poor quality; mistrusted by marginalised communities
Public – domestic or international military; police and other ministries	Primary and secondary care	Near urban areas or public infrastructure such as army bases	Excess capacity; tends to be well funded	Focus on trauma and emergency care; formal and informal fees; use normally restricted to military or specified sectoral personnel
International NGOs	Primary and secondary care; health promotion	All areas, but may in some contexts be concentrated in displacement camps	Quick response; bring experience from similar work in other settings; well-funded	Lack of accountability; bypasses local capacity; short-term presence; lack contextual/cultural knowledge
Mission-based and other NGOs	Primary and secondary care; health promotion	Often more focused in rural areas	Trusted; history of providing services to communities	May have higher fees; not always as well staffed as government facilities
Private for-profit	Primary and secondary care; pharmaceutical supply	Predominantly urban	Excess capacity; may have higher perceived quality and flexibility (on hours and pay)	High formal fees; may not be well regulated; less invested in conflict zones (risk averse)
Informal providers	Basic primary care and pharmaceutical supply	Community-based	Trusted positions within communities; have good reach	Uncertain/temporary; low quality; offer limited services

although there has since been a gradual shift towards formal providers of healthcare.[11]

Community-based providers such as publicly funded community health workers and traditional birth attendants can play important roles in maintaining primary healthcare services. They occupy positions in or near communities, which reduces travel distance (particularly important if restrictions are placed on travel) and allows them to maintain healthcare provision and disseminate information on any changes to healthcare provision arrangements.[2] The close social relations between health workers and communities provided a basis for maintaining motivation during the conflict in Uganda.[12] In Liberia, the presence of trained community health workers ensured that treatment for childhood pneumonia and diarrhoea was maintained during the 2014-16 Ebola epidemic.[13]

Mission-based, NGO and for-profit healthcare providers are commonly used in many settings and can be supported to maintain coverage of primary and secondary care during protracted crises. In Uganda, the services offered by a mission hospital were reportedly crucial to the containment of an Ebola outbreak.[14] Likewise international NGOs often play an important role in healthcare provision – usually through short-term international experts – although their involvement can raise expectations for public healthcare systems. For example international NGO services in refugee camps in Sierra Leone led to demands for similar public healthcare provision after the conflict.[5] Services can be incrementally incorporated with the government's health system as has been done in Zimbabwe, Uganda and Papua New Guinea,[3] however often the immediate post-crisis return to public healthcare is marked by increased costs of care at formal providers and therefore greater use of informal providers.[15]

There is however an important trade-off if responses to crises largely bypass public health systems as such approaches, although effective at protecting service provision in the short-term, may undermine state legitimacy in the longer-term.[3] This was particularly the case in Afghanistan where extensive contracting of non-public providers was poorly managed at the district level and undermined capacity-building in the public sector **(see associated brief on state-building and health in post-crisis settings)**.[16]

Governments may lack capacity or be reluctant to involve non-public providers, and there is a tendency for hostility towards international NGOs if their activities are seen as politically motivated.[17] In settings such as Afghanistan and Uganda, NGO and private for-profit providers have been subjected to regulations above and beyond those expected for publicly owned providers,[2] while international NGOs were refused permission to access many parts of Syria.[18] Similarly, non-public providers may hesitate to enter into contracts with the government if there is mistrust between them, lack of confidence in the government's ability to pay in a timely fashion, or if contracts are considered unappealing.[19, 20]

Supportive interventions

Community-based care

There are a range of public and non-public providers that are used within communities and which can be utilised when developing a response to crises.[10] Community health workers can be trained to provide important services, and can cascade training to informal providers. For example community health workers in Myanmar train traditional birth attendants to raise awareness on sexual violence and to refer survivors to the community health worker for care.[21] The wider functioning of the health system during crises is particularly important if community health workers are expected to provide diagnoses, treatments and referrals to health facilities. In Liberia, workers reported not referring people for important care if they knew a referral facility was not operational.[13]

Mobile healthcare services provided by the government or NGOs can help to provide care to the unstable populations that characterise many crises, particularly conflicts. In Democratic Republic of Congo mobile services have been used effectively to reach survivors of sexual violence with appropriate care.[22] However, mobile services can only provide limited types of healthcare and have substantial direct and indirect costs.[2]

Contracts and regulation

The introduction and expansion of service provision contracts for non-public providers can be a useful short-term response to maintain health service coverage during and following protracted crises. Successful examples include Cambodia, where use of specific healthcare services increased through provision by government-owned, NGO and for-profit private providers using health equity funds and voucher schemes.[23, 24] However, smaller, more informal arrangements between the government and non-public providers, as used in northern Nigeria,[3] may be more suitable where there is little capacity to manage contracts.

There are questions regarding sustainability in the longer-term due to significant administrative burdens for contract design and monitoring, and for competitive tender processes,[2,25] and those were important drivers in the switch away from using contracts with NGO and for-profit providers in Cambodia after 2009.[26] Further, regulation of the quality of care in the non-public sectors is often difficult for governments due to lack of capacity and contested state legitimacy, and it becomes more difficult over time as the sectors become more organised and politically powerful.[2] In the absence of capacity to regulate effectively, governments can use public resources to support providers that meet certain standards, for example the provision of training and equipment to some traditional birth attendants in Nigeria, or can promote social franchising arrangements.[3]

Health workforce policies

It is important to maintain coherent staffing policies during and after crises. There is a risk that protracted crises exacerbate variations in the remuneration packages and other terms and conditions between types of provider, which will exacerbate imbalances in the distribution of workers between sectors and geographic locations.[27] For example in northern Uganda the post-conflict period saw a shift in staff from mission to government facilities, partly because of changes in their relative terms and conditions.[28]

Task shifting can help to utilise the presence of community health workers so they can perform some procedures previously restricted to other cadres of health worker.[29] However formal policies and training are required to implement task-shifting effectively. In the absence of such policies in Liberia and Uganda, informal and ad hoc task-shifting emerged and led to concerns regarding the quality of care provided.[30, 31] Further, there is a risk that task-shifting may increase the workload of community health workers and undermine already-fragile morale. The introduction of policies to incorporate informal healthcare providers within the formal health system can offer further opportunities for task shifting, or at least raising awareness of where to seek care, but again requires appropriate support.

Long-term recovery

Response to crises should not only include government systems where possible, but should seek to build government capacity to manage and provide health services. In Timor-Leste, there was an emphasis on provision and management of healthcare through NGOs during the crisis and the immediate post-crisis period, but a transition strategy set out a process and timeline for developing government capacity to resume provision and management of services.[32] Importantly, that capacity building process prioritised mid-level managers, who are often overlooked during rebuilding processes.[8]

There is a trade-off between short-term recovery and longer-term health systems strengthening, which is politically and technically difficult. Long-term planning is essential during crises and should include an assessment of distortions taking place in the health system,[2] and adopting models of service provision that are feasible to scale-up in the long-term. Planning for recovery can be top-down or bottom-up but should be inclusive of different types of provider and should involve assessments of future funding for health, the size and composition of different types of providers, and the gaps that need to be filled in order to achieve sustainable and equitable coverage of basic healthcare services.

References

1. Hill, P.S. et al., 2014. The "empty void" is a crowded space. Conflict and Health, 8(1) http://bit.ly/2qqesEk   Pavignani, E. & Colombo, A., 2009. Analysing Disrupted Health Sectors: A Modular Manual, Geneva: WHO http://bit.ly/2qqhTuy

2. Batley, R. & Mcloughlin, C., 2010. Engagement with Non-State Service Providers in Fragile States. Development Policy Review, 28(2) http://bit.ly/2qmtFZc

3. Bornemisza, O. et al., 2010. Promoting health equity in conflict-affected fragile states. Social Science & Medicine, 70(1) http://bit.ly/1jSJFZQ

4. Eldon, J. et al., 2008. Health Systems Reconstruction and State-building. London: HLSP Institute http://bit.ly/2qqi0eN

5. Pavignani, E., 2005. Health Service Delivery in Post-Conflict States. In High Level Forum on the Health MDGs: Selected Papers 2003-2005. WHO, Geneva http://bit.ly/1KzYecB

6. Ssali, S., 2016. Maintaining an effective health workforce during and after conflict http://bit.ly/2qmzAgD

7. Witter, S. et al., 2015. State-building and human resources for health in fragile and conflict-affected states: exploring the linkages. Human Resources for Health, 13(1) http://bit.ly/2qLLYYv

8. Gordon, S., 2013. Health, Conflict, Stability and Statebuilding: A House Built on Sand? Journal of Intervention and Statebuilding, 7(1) http://bit.ly/2raWMiU

9. Denny, L., Mallett, R., 2014. Mapping Sierra Leone's plural health system and how people navigate it. London: ODI http://bit.ly/1oGZPUt

10. Ros, B. et al., 2015. Health care seeking behaviour and impact of health financing policy on household financial protection in post conflict Cambodia. Liverpool: ReBUILD Consortium. http://bit.ly/2qqgTGZ

11. Namakula, J. & Witter, S., 2014. Living through conflict and post-conflict: experiences of health workers in northern Uganda. Health Policy and Planning, 29(suppl 2) http://bit.ly/2pERjAl

12. Siekmans, K. et al., 2017. Community-based health care is an essential component of a resilient health system. BMC Public Health, 17(1) http://bit.ly/2qqfMak

13. McPake, B. et al., 2015. Ebola in the context of conflict affected states and health systems. Conflict and Health, 9(1) http://bit.ly/2pRbua1

14. ReBUILD, 2016. Health financing policy in conflict affected settings: lessons from ReBUILD research. Liverpool, ReBUILD Consortium http://bit.ly/2rkQv01

15. Sabril, B. et al., 2007. Towards sustainable delivery of health services in Afghanistan: options for the future. Bulletin of the WHO, 85(9) http://bit.ly/2pPDYlp

16. Ndaruhutse et al., 2011. State-Building, Peace-Building and Service Delivery in Fragile and Conflict-Affected States: Literature Review. London: UK DFID http://bit.ly/2rl0aF1

17. Whittall, J., 2014. The 'new humanitarian aid landscape': Case study: MSF interaction with non-traditional and emerging aid actors in Syria 2013-14. Geneva: MSF International http://bit.ly/2pPHA6Y

18. Carlson, C., 2007. Health service delivery in fragile states for US$5 per person per year: Myth or reality? London: Merlin/LSHTM http://bit.ly/2pEPled

19. McLoughlin, C., 2008. Annotated bibliography on contracting NGOs to deliver services. Birmingham: University of Birmingham http://bit.ly/2qLLgdN

20. Tanabe, M. et al., 2013. Piloting community-based medical care for survivors of sexual assault in conflict-affected Karen State of eastern Burma. Conflict and Health, 7(1) http://bit.ly/2rlbTDB

21. Kohli, A. et al., 2012. A Congolese community-based health program for survivors of sexual violence. Conflict and Health, 6(1) http://bit.ly/2rkODEN

22. Witter, S., 2012. Health financing in fragile and post-conflict states: What do we know and what are the gaps? Social Science & Medicine, 75(12) http://bit.ly/2rkzFi7

23. Ensor, T. et al., 2017. Impact of health financing policies in Cambodia: A 20 year experience. Social Science & Medicine, 177 http://bit.ly/2qmvYv0

24. Ssengooba, F., McPake, B., Palmer, N., 2012. Why performance-based contracting failed in Uganda. Social Science & Medicine, 75(2) http://bit.ly/2qNMVj4

25. Vong, S. et al., 2015. Understanding contracting in Cambodia: findings from interviews with key informants and health service managers and providers. Liverpool: ReBUILD Consortium. http://bit.ly/2rl3Ne1

26. Chirwa, Y. et al., 2015. Understanding health worker incentives in post-crisis settings: lessons from health worker in-depth interviews and life histories in Zimbabwe, Liverpool: ReBUILD Consortium http://bit.ly/2eTxz5T

27. Namakula, J. et al., 2016. Health worker experiences of and movement between public and private not-for-profit sectors. Human Resources for Health, 14 http://bit.ly/2qmCMIS

28. Roome, E. at al., 2014. Human resource management in post-conflict health systems: review of research and knowledge gaps. Conflict and Health, 8(1) http://bit.ly/2qmiZd1

29. Varpilah, S.T. et al., 2011. Rebuilding human resources for health: a case study from Liberia. Human Resources for Health, 9(1) http://bit.ly/2pF59Dg

30. Dambisya, Y.M. & Matinhure, S., 2012. Policy and programmatic implications of task shifting in Uganda: a case study. BMC Health Services Research, 12(1) http://bit.ly/2rbbiHr

31. Rohland, K., Cliffe, S., 2002. The East Timor Reconstruction Program: Successes, Problems and Tradeoffs. Washington DC: World Bank Group http://bit.ly/2rkKrVJ

Villagers wait to be seen by Djiboutian and U.S. health care providers during a Medical Civic Action Program clinic in Chebelley, Djibouti. Photo US Air Force, Christopher Ruano.