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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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ABSTRACT

Over the last few years, there has been growing attention to health systems research in fragile and conflict-affected setting (FCAS) from both researchers and donors. In 2012, an exploratory literature review was conducted to analyse the main themes and findings of recent literature focusing on health financing in FCAS. Seven years later, this paper presents an update of that review, reflecting on what has changed in terms of the knowledge base, and what are the on-going gaps and new challenges in our understanding of health financing in FCAS.

A total of 115 documents were reviewed following a purposeful, non-systematic search of grey and published literature. Data were analysed according to key health financing themes, ensuring comparability with the 2012 review. Bibliometric analysis suggests that the field has continued to grow, and is skewed towards countries with a large donor presence (such as Afghanistan). Aid coordination remains the largest single topic within the themes, likely reflecting the dominance of external players, not just substantively but also in relation to research. Many studies are commissioned by external agencies and in addition to concerns about independence of findings there is also likely a neglect of smaller, more home-grown reforms. In addition, we find that despite efforts to coordinate approaches across humanitarian and developmental settings, the literature remains distinct between them. We highlight research gaps, including empirical analysis of domestic and external financing trends across FCAS and non-FCAS over time, to understand better common health financing trajectories, what drives them and their implications. We highlight a dearth of evidence in relation to health financing goals and objectives for UHC (such as equity, efficiency, financial access), which is significant given the relevance of UHC, and the importance of the social and political values which different health financing arrangements can communicate, which also merit in-depth study.

1. Introduction

Over the last few years, there has been growing attention to health systems research in fragile and conflict-affected setting (FCAS) from both researchers and donors (Woodward et al., 2016). This is based on a number of considerations. First of all, fragility and conflict situations have increased since 2010, posing critical challenges to development globally (World Bank, 2018a). For example, it is estimated that the share of extreme poor living in FCAS will rise from 17% of the total today to 60% by 2030 (OECD, 2016). In addition, the link between fragility and conflict, and ill health is well established, with over 60% of the world's child and maternal deaths happening in situations characterised by fragility and conflict (OECD, 2018). Beyond health outcomes, health systems strengthening is often hypothesised to also promote peace, state-building and stability through its contribution to making the state more visible and legitimate and able to realise its primary function of service delivery (Kruk et al., 2010a). Motivated by these factors, donors have shown an increasing interest in investing in health systems in FCAS (Woodward et al., 2016). For example, the UK's Department for International Development (DFID) has committed to focus at least 50% of its budget on fragile states and regions (HMG, 2015). Despite the recognised importance of FCAS, there is still limited research and evidence to support health systems interventions in such contexts and several authors have highlighted the need for more work to define research priorities and conduct assessments of what works (AHSR, 2008; Woodward et al., 2016).

In 2012, an exploratory literature review was conducted to analyse the main themes and findings of the literature focusing on health

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financing in fragile and post-conflict (Witter, 2012). As one of the health system's building block (WHO, 2007), health financing was identified as a key component to re-establish health systems post-conflict and the review examined what was known on the topic with reference to FCAS, as well as identifying areas that needed further research. It found that the body of evidence available was growing but relatively limited. Much of the focus was on the role of donors in financing the health sector in FCAS, with some research also on contracting approaches (including through non-state actors) and basic packages of health care. Gaps in the literature were found in terms of analysis of access to care and equity during the post-conflict period, resource allocation, regulation, public financial management, payment systems and incentives, and also on health financing reforms, including an understanding of the policy-making trajectory and its influence in the long term developments (Witter, 2012).

Seven years later, this paper presents an update of that review, reflecting on what has changed in terms of the knowledge base, and what are the on-going gaps and new challenges in our understanding of health financing in FCAS settings.

1.1. Definitions and contexts

The first literature review reflected on the definitions of 'fragility' and 'post-conflict'. It highlighted how there is no universally accepted definition of 'fragile states', although many of the existing ones make reference to issues related to the capacity and willingness of the state to deliver core functions to its people, as well as their legitimacy and effectiveness in providing services and security (Newbrander, 2006; Witter, 2012). It also stressed that, while 'post-conflict' can be simply defined as a country or area where active conflict has ceased and there is a political transformation to a recognised government (Canavan et al., 2008), the transition to post-conflict is hardly ever linear, may take time and some countries can collapse back into conflict (Collier and Hoeffler, 2002; Witter, 2012).

Seven years later, the definition of FCAS still lacks clarity, and in fact there is ever growing acknowledgement that 'FCAS' are not a homogeneous group, that many types of fragility and conflict-affectedness exist (which cannot be simply seen as active versus post-conflict, but also include protracted crises and relapse into conflict and crisis) and that the FCAS classification is inherently a dynamic one. In line with this, the OECD, for example, has developed a new classification of fragile states, which focuses on five dimensions: violence, access to justice, accountable and inclusive institutions, economic inclusion and stability, and resilience (i.e., capacities to prevent and adapt to social, economic and environmental shocks and disasters) and applied it to all countries of the world to identify the 50 most vulnerable ones across all dimensions (OECD, 2016).

In recognition of the methodological and conceptual difficulties in the definition of 'fragility', 'conflict-affected', 'post-conflict' settings and the dynamic nature of this classification, the present literature review is expanded to include conflict-affected settings (rather than post-conflict only). This is not only related to the methodological difficulties of a clear-cut distinction, but, from a policy perspective, it recognises the importance of better understanding humanitarian contexts and the humanitarian-development nexus, which cannot be captured without broadening the focus to conflict-affected settings. In practice, the FCAS list that is used for this review is based on the combined World Bank's Harmonised List of Fragile Situations for the years between 2007 and 2017 (World Bank, 2017) (Supplementary data: Annex 1). In addition, other countries (such as Rwanda, Pakistan, Uganda, Ukraine) are included if the entire country or some areas within it were considered as fragile by the studies' authors when the research was carried out.

2. Methods

This article is based on a literature and document review carried out in mid-2018 on health financing in fragile and conflict-affected settings. The aim of our approach to the review was to allow comparability with the 2012 study, and at the same time capture new themes and topics of enquiry and research that have emerged during this period. In terms of inclusion criteria, the present review comprises documents (both in the published and grey literature) issued from 2012 onwards, which refer to FCAS countries or multi-country papers which describe at least one FCAS (see definitions above), and that refer directly, indirectly or in passing to the context as fragile/conflict-affected/post-conflict. Documents referring to humanitarian responses, conflict period, emergencies and transition are also included. In addition, documents needed to refer to at least one dimension of health financing, as defined in the functional framework of the WHO (Kutzin et al., 2017), therefore excluding publications focusing on health systems in general or on other 'building blocks', such as health service delivery, human resources or health information systems.

A purposeful, non-systematic literature search was carried out with an iterative approach. We started from a database search in PubMed and Scopus using key words *("conflict" OR "post-conflict" OR "reconstruction" OR "fragile") AND ("financing" OR "systems" OR "performance" OR "research" OR "user* fees" *OR "exemptions" OR "budgeting" OR "equity" OR "access" OR "performance-based" OR "output-based" OR "pay for performance" OR "incentives" OR "resource allocation" OR "public expenditure" OR "contracting" OR "public/private" OR "global health initiatives" OR "aid" OR* "funding" *OR "budgeting") AND "health*". The search yielded a very high number of results (35,294 entries from PubMed and more than 20,000 from Scopus). Since Scopus results can be ordered by relevance, only the first, most relevant 1000 entries from that database were screened by one researcher, using the title first and abstract if necessary. A total of 62 documents were considered relevant. The second step of the process involved running targeted searches in specialist journals and institutional websites (e.g., Conflict and Health, Disasters, ReBUILD research consortium, UHC 2030, WHO, World Bank, Royal Tropical Institute-KIT) on topics and FCAS countries for which there was less information available from the previous searches, as well as gathering suggestions from experts. After screening for relevance, this step led to the inclusion of a further 46 documents from which data were extracted. Finally, we used a snowball approach by reviewing the references of all documents to identify other, potentially relevant, ones. This led to the addition of another 7 documents. A total of 115 documents were reviewed.

Data were extracted in Excel using a series of pre-defined codes to track the type and topic of the document, and to extract the key information in relation to health financing and fragility (Supplementary data: Annex 2). These themes largely map against those identified in 2012 to allow comparison, although emerging themes were also included. Basic bibliometric analysis of the results was conducted, then the information extracted was analysed by theme to reflect on the main issues emerging in each theme, new findings and remaining gaps focusing on the key features and main challenges identified in FCAS, and options for policy and practice.

2.1. Findings

2.1.1. Bibliometric analysis

Despite the fact that the literature search was not systematic, some basic bibliometric analysis of the documents included has been carried out in order to provide a first overview of the findings and comparison with the previous review. Overall, we find that the number of publications on the topic has grown in recent years, from 42 in the 2001–2011 period to 115 in the 2012–2018 period (Fig. 1), although this also reflects our broader inclusion criteria.

We found documents referring to 30 FCAS countries specifically, while other documents (the majority) look at multiple countries of which one or more are included in our FCAS list (Fig. 2). The disaggregated analysis by country also shows that there is more research

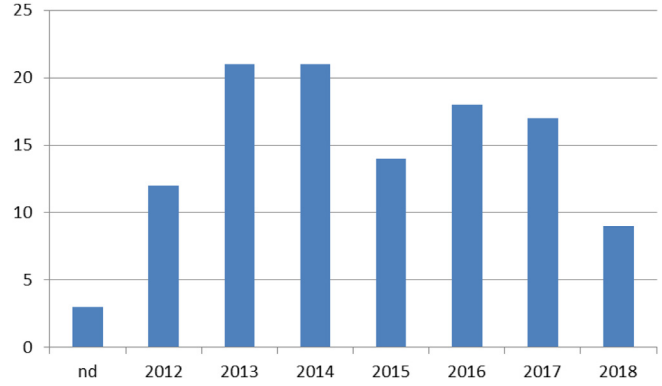

Fig. 1. Documents reviewed by year of publication.

carried out on some contexts such as Afghanistan than others. This may be related to language issues (e.g., less research on non-Anglophone countries, although the case of the Democratic Republic of the Congo (DRC) seems not to confirm this hypothesis) and/or to the presence of external funding and projects, that appears to play a role also in driving the funding available for research and the research carried out.

Finally, the analysis in terms of themes (based on the themes used at coding stage), we found that approximately half of the documents (n = 59, 51%) focussed on issues related to raising and pooling revenues as elements of health financing (Table 1). Within this category, similarly to what was found in 2012, the main topics of interest was aid coordination (n = 16) and external aid (n = 9), which again shows the prominence of the donors' perspective on health financing in FCAS.

2.2. Raising and pooling revenues

The challenges relating to funding sources and pooling of revenues in FCAS are described in a number of documents. Overall, the literature finds that these settings are characterised by a reduction in public funding and a parallel increase in private spending. Frequently, public funding covers only (and irregularly) salaries for health workers, while allocations to service delivery and drug procurement are limited. In context such as the DRC and Central African Republic (CAR), which faced protracted crises, even diminutive salaries have failed for years to reach the employees of an absent state (Pavignani et al., 2013). The gap left by public funding sources is often filled in by households, usually in the form of out-of-pocket payments (Buzuzi et al., 2016; Laokri et al., 2018; Mòdol, 2018). It has been noted that the households' contribution via out-of-pocket payments (often support also by remittances from abroad) can reach considerable levels despite the poverty of the involved population (Pavignani et al., 2013), increasing catastrophic

Table 1
Documents reviewed by theme.

Main element		Theme	
Revenue raising/pooling	67	Overall review of financing	16
		Public spending	2
		Private spending	7
		External aid	9
		User fee exemptions	4
		Insurance/*mutuelles*	5
		Aid coordination	16
		Demand-side financing	8
Purchasing	19	Passive purchasing	1
		Efficiency	3
		Contracting	8
		PBF	7
Benefit packages & service provision	10	Service provision	3
		BPHS	4
		Role of NGOs in provision	3
Cross-cutting issues	23	Governance	2
		Equity	2
		UHC	1
		State-building/peace	9
		Humanitarian contexts	9
Total			**119**

Note: total of 119 instead of 115 as a few documents covered more than one theme.

expenditures and/or leading to diminished access to health services. However, we found a dearth of comparative analyses looking at patterns and trends among FCAS and differences between FCAS and non-FCAS in relation to government and private contribution to health expenditures.

Many FCAS rely on external aid to fund healthcare provision (WHO, 2018). In some cases, funding can be too much, such as in the aftermath of the tsunami in South Asia (Sondorp and Bornemisza, 2005), straining the absorptive capacity of the country. However, a cross-country analysis found that overall aid to FCAS (identified based on the Fragile States Index) for the 2005–2011 period was less than predicted ($7.22 per person in FCAS versus $11.15 per person in low-income, stable countries). In addition, relative to stable countries, donors preferred to provide funding to low-income fragile countries that have refugees or on-going external intervention but tended to avoid providing funding to countries with political gridlock, flawed elections, or economic decline (Graves et al., 2015).

Humanitarian funding represents 13% of overall overseas development assistance (Spiegel et al., 2018) and is focused on preparedness, as well as acute and protracted crises. In these settings, funding per capita tends to be highly variable and not necessarily related to needs, and challenges include persistent under-funding of the humanitarian response plans. For example, most recently in Yemen, WHO's response

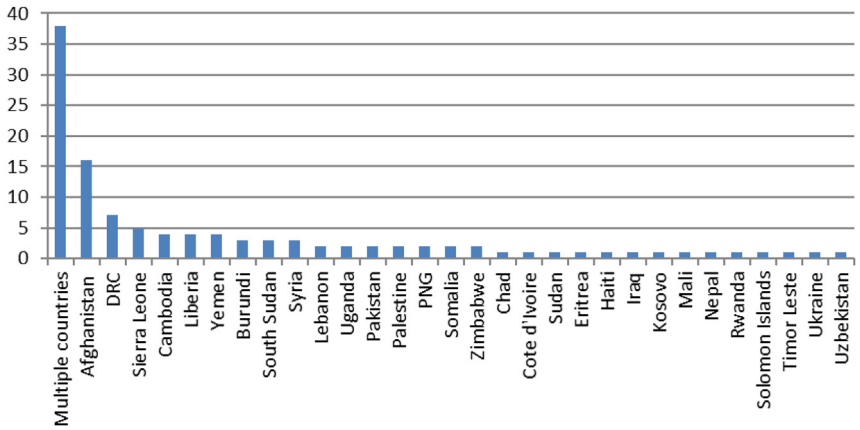

Fig. 2. Documents reviewed by country of focus.

plan for 2016 received 24% of total requested funding (Qirbi and Ismail, 2017).

The normative trajectory of donor funding, which is expected to increase during the conflict and immediate reconstruction phases and decrease in the longer term post-conflict phase, was already critiqued in Witter (2012), but is still often assumed. However, there is little empirical evidence to confirm it. Indeed, some studies actually point to the opposite pattern. For example, in Yemen it was noted that funding decreased at the beginning of the crisis because of diminished public expenditures accompanied by a fall in external aid as (non-humanitarian) international organisations scaled back their activities or withdrew from the country. The total external loan and grant funding for health fell from $51.3 m in 2014 to $1 m in 2015, and while later on the humanitarian response increased, its persistent under-funding has been a challenge (Qirbi and Ismail, 2017). Similarly, in Mali, following the coup in March 2012, donors suspended official development assistance and the on-going sector-wide approach in support of the health system came to a halt; it took months before alternative (and only partial) solutions to resume aid to the health sector were put in place (Paul et al., 2014).

The literature also highlights that dependence on external financing is about more than resource flows. High external aid is linked with unpredictability and volatility of funding levels and increased fragmentation of revenue sources and pools, as found for example in Palestine (Devi, 2013; Hamdan et al., 2003) and Somalia (Warsame, 2014). In addition, aid dependence brings external influence on health financing plans and policies, as well as on their implementation (Bertone et al., 2018c; Pavignani et al., 2013; Robert, 2012). Although FCAS in the middle-income country group tend to rely less on donors both for financial and technical support, it appears that in these contexts conflict and fragility have slowed down health financing reforms. In Ukraine, a reform programme started in 2010, but was abandoned in 2014 due to conflict and political instability (Lekhan et al., 2015), while a study in Tajikistan stresses that the progress of health financing reforms has been relatively slow compared with neighbouring Kazakhstan and Kyrgyzstan, largely due to the effects of civil war in the mid-1990s and significant out-migration of qualified experts (Mirzoev et al., 2007).

2.2.1. Aid coordination and effectiveness

Given the relevance of and the focus on external aid, it is not surprising that much of the documentation reviewed focuses on aid coordination and effectiveness. The principles that inform the engagement of the international community on these issues have been stated in the “New Deal for engagement in fragile states” which was endorsed at the Fourth High-Level Forum on Aid Effectiveness in Busan in 2011 (International Dialogue on Peacebuilding and Statebuilding, 2011). These are complemented, with reference to humanitarian settings, with the principles and commitments of the “Grand Bargain” signed at the World Humanitarian Forum in 2016 (IASC, 2016).

A large literature reports on the different mechanisms which can be adopted to coordinate external funding in FCAS. This body of work compares different potential models and their implications (Bernardi et al., 2015; Commins et al., 2013; Hauck et al., 2013; Manuel et al., 2012) and also presents empirical cases from countries such as Afghanistan (Dalil et al., 2014), Liberia (Abramowitz, 2016; Hughes et al., 2012; Kruk et al., 2010b; Lee et al., 2011; Petit et al., 2013; Sondorp and Coolen, 2012), Zimbabwe (Salama et al., 2014), and South Sudan (Jones et al., 2015). The main findings are not substantially different from those of the 2012 review, stressing the importance of coordinating with (new) governments, using country systems, ensuring as much as possible alignment, harmonization and ownership, and mitigating the ‘transitional funding gap’ from humanitarian to development funders in countries where this is a risk (as was the case in Liberia). There is also recognised need for better interface between humanitarian and development actors on analysis, planning, coordination as well as raising and pooling funds for the health sector, internationally and at national level (Konyndyk, 2018; UN, 2016).

In relation to humanitarian crises, new mechanisms for raising external funding for refugee healthcare have been proposed. These include combined indexed insurance and catastrophe bonds, the establishment of a Refugee Health Financing Emergency Facility’ in the pre-emergency phase, and use of the World Bank's concessional loan program to support refugee hosting countries, although they are yet to be fully elaborated and tested (Spiegel et al., 2018).

2.2.2. Tax revenue mobilisation

Among the options for policy and practice to address the challenges faced by FCAS, one possibility is that of increasing the domestic or tax revenue mobilisation. It has been argued that the government ability to tax in the post-conflict period would also have broader governance implications related to state capacity building and the expansion of governmental responsiveness and accountability (van den Boogaard et al., 2018). However, in practice, conflict reduces revenue mobilisation because of reduced economic activity and tax base and, while there is some evidence of positive ‘revenue peace dividend’ following conflict, in most cases it is only a modest recovery compared to pre-war levels (van den Boogaard et al., 2018). Although a few specific analyses at country level exist which suggest that there may be space to expand domestic resource mobilisation (for example, in Sierra Leone (Witter et al., 2016)), overall we found a lack of studies and focus in this area across FCAS.

2.2.3. User fees abolition and exemptions

Although inequitable out-of-pocket payments from households are usually higher or increasing in FCAS, the literature highlights a number of country examples where user fees were abolished or exemptions introduced in order to protect the most vulnerable patients and communities. Empirical evidence of fee abolition or exemption with specific reference to the fragility of the context is however limited and results are varied across settings. A study by Medecins sans Frontieres in Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti and Mali found that user fees resulted in low utilisation rates, exclusion from healthcare and exacerbation of impoverishment, while targeted exemptions for vulnerable individuals proved ineffective and payments of modest or ‘flat’ fees also did not adequately improve coverage. Conversely, user fee abolition for large population groups led to rapid increases in utilisation of health services (Ponsar et al., 2011). Similarly, a quasi-experimental study in Afghanistan showed that abolishing user fees for the Basic Package of Health Services (BPHS) did improve utilisation without affecting quality of care (Steinhardt et al., 2013). In Sierra Leone, an evaluation of the Free Health Care Initiative for expectant and lactating mothers and children under five concluded that it was one factor contributing to improvements in coverage and equity of coverage, despite weaknesses in implementation in a number of core areas, such as drugs supply (Witter et al., 2016). However, it is also shown that maintaining effectiveness of fee exemptions over time in weak health systems is challenging, particularly where public funding for health facilities is low (see, for example, in DRC - (Maini et al., 2014)). In addition, many countries have multiple approaches to increasing financial access for vulnerable populations, which are not harmonised. Where this has been done, longer term sustainability is likely to be enhanced – for example, in Sudan, where a free-standing policy of free care for caesareans and under-five care was brought under the umbrella of the National Health Insurance Fund (Witter et al., 2013).

There has been a long-standing debate about user fees for health care during the acute phase of conflict and in humanitarian contexts. Many authors, especially among humanitarian NGOs have strongly advocated in favour of providing free care to communities and in particular to refugees, internally displaced people (IDPs) and vulnerable groups (Derderian and Schockaert, 2010; Poletti and Sondorp, 2004). However, in many weak and underfunded health systems patient fees

are still considered as an acceptable 'survival strategy' for the health system. While until 2008–2010 some donors (including humanitarian ones) supported cost-recovery policies (Hands, 2004), a shift has since happened and consensus has been reached that user fees for primary health care services should not be applied during humanitarian situations (DG ECHO, 2009; IASC, 2010; UNHCR, 2012). However, Medecins sans Frontieres has recently warned about the trend of user fee reintroduction (linked to aid retrenchment) despite the evidence on their inequitable effects, in particular for populations affected by conflict, epidemics and crises (MSF, 2017).

Further challenges emerge in specific situations – for example, during protracted emergencies or in contexts that keep moving between the emergency and post/pre-emergency phase, where both humanitarian and development NGOs are present and services are not provided for free to the entire population. Such situations have been described along the Liberia-Cote d'Ivoire border (Derderian, 2014), and in the eastern DRC and CAR, where ideological and operational clashes have occurred between humanitarian and development NGOs (Bertone et al., 2018b; Derderian and Schockaert, 2010; Dijkzeul and Lynch, 2006). Another challenging situation is the provision of care to IDPs and refugees in countries or host communities that have a (more) established health system but do not allow integrated access for IDPs and refugees. Traditionally, this has been resolved by creating a parallel, externally funded and free at the point of delivery health system for refugees, separate from that of the host communities. However, this has increased fragmentation and disparities and put pressure on national health financing, as noted in Lebanon and Jordan (Axelson, 2018; Blanchet et al., 2016; Spiegel et al., 2018; WHO EMRO, 2018).

2.2.4. Health insurance

Similarly to the 2012 finding, studies on social health insurance or indeed experiences of introducing health insurance in FCAS are few. Evidence on the effectiveness of this approach is limited and issues of lack of trust and lack of capacity affect ability to collect contributions. In Palestine, a Governmental Health Insurance (GHI) was initially compulsory for public sector employees and then expanded to the informal and private sectors on a voluntary basis, with reduced/waived premiums for some vulnerable groups (Hamdan et al., 2003). However, the GHI was found not to have improved vertical equity (Abu-Zaineh et al., 2008). In Yemen, options for social health insurance are being considered for the (yet to come) post-conflict phase (Holst and Gericke, 2012). Given the existing lack of trust at the community level, any future scheme should build on pre-existing programmes already trusted in the community (Fuss, 2016). Insecurity, low quality of healthcare, poor awareness among the population and limited willingness to pay, as well as low technical capacity, were identified as barriers to expansion of health insurance in Afghanistan (Zeng et al., 2017).

Overall, there is limited evidence on health insurance in humanitarian contexts. However, some studies show that, where insurance systems are already established, purchasing insurance coverage on behalf of vulnerable, displaced and refugee populations is a possible strategy, as illustrated in the case of Afghan refugees in Iran and IDPs in Darfur (Spiegel, 2018; UNHCR, 2012; Witter, 2015).

In line with the broader literature emphasizing potential adverse selection and small risk-pools, the experience of community-based health insurance (CBHI) in FCAS has been limited and mixed. While the example of Rwanda's somewhat exceptional CBHI (described in the 2012 review) is still being discussed, a CBHI pilot in five provinces of Afghanistan showed that enrolment and cost-recovery were modest and there was no evidence of reduced out-of-pocket expenditures, though CBHI members had higher utilisation of health services (Rao et al., 2009).

2.2.5. Health equity funds

The introduction and relatively successful implementation of health equity funds (HEFs), where third-party organisations (often NGOs) are in charge of identifying the poorest and funding their access to care, have been well documented in Cambodia and the experience was reported in the 2012 review. Interestingly, however, HEFs have not 'spread' to other FCAS. We found limited, mostly anecdotal descriptions of HEFs (often under different names and slightly modified design) being piloted in Laos (Thomé and Pholsena, 2009), DRC (Dijkzeul and Lynch, 2006; Gerstl et al., 2013), Rwanda, Mali and Togo (Gerbier and Botokro, 2009) and Syria (WHO, 2017) as part of broader NGO-led health interventions, as well as in the DRC and Cameroon where they are part of NGO-led PBF schemes (Flink et al., 2016; Mayaka et al., 2011). However, studies systematically reporting on HEFs' design and functioning mechanisms and evidence of their impact is limited, if non-existent, outside Cambodia, with the exception of a Cameroon pilot, whose analysis revealed challenges in the identification of the poorest, as well as other barriers to access for the very poor (Flink et al., 2016).

2.2.6. Demand-side financing

Experiences of demand-side financing, such as vouchers and conditional cash transfers (CCT), in FCAS remain limited but compared to the 2012 review we did find more evidence. Vouchers have been used with some success to increase access to family planning for poor households in Yemen and Pakistan (Boddam-Whetham et al., 2016; Grainger et al., 2017), as well as in Syria (Balan, 2015). In Afghanistan, a CCT programme implemented in 2009–2011 was evaluated as successful in stimulating demand for, and increasing utilisation of maternal and child health services, in particular when both families and community health workers were targeted (Lin and Salehi, 2013). However, there was also evidence of non-economic barriers to care which impeded women's access to services (Witvorapong and Foshanji, 2016).

Our review found evidence that cash transfers have been growing in use in humanitarian contexts and across sectors including food security, livelihoods, shelter, water and sanitation, protection, health, nutrition and education, but still account for no more than 6% of humanitarian assistance (World Bank, 2016). However, the debate on the merits and challenges is still open, with proponents arguing that they can be cost-effective and timely, allow recipients greater choice and dignity, and have beneficial knock-on effects on local economic activity, and sceptics pointing to the risks of insecurity and corruption, the possibility of excluding some groups such as women, or of misuse and their unsuitability in cases where functioning markets and services do not exist (Harvey, 2005). It has been suggested that in humanitarian contexts, cash transfers are most effective and efficient when provided as 'multipurpose cash' – one grant to address multiple needs across sectors (Doocy and Tappis, 2017; Fabre and Aggiss, 2017). However, it has also been argued that, with relation to health care, unconditional or multipurpose cash transfers may not work as well as they do for food, as health needs are not distributed equally across populations and out-of-pocket payments for health costs are not predictable (WHO & Global Health Cluster, 2018).

2.3. Purchasing

Compared to raising and pooling funds, less evidence is available on purchasing in FCAS. The challenges identified are generally similar to those of low-income settings, and include passive purchasing mechanisms, such as allocation of public funds by budget line and via historical budgets, with a bias in favour of secondary care and often no clear rationale for geographical distribution and unpredictable execution (see for example, in DRC and Papua New Guinea (Barroy et al., 2014; Wiltshire and Mako, 2014)). Purchasing is also often fragmented, with complex accountability relations. For example, in DRC, Provincial Health Authorities have up to 30 contracts with external partners [personal communication, 2014]. In terms of expenditures, public providers are often restricted by rigid funding rules but also ineffectually regulated (Bertone and Witter, 2015a; Ensor and Witter, 2001). Insurance systems are more common in middle-income FCAS

and generally pay fee-for-service, which does not control prices effectively, while contracted-out NGOs usually operate with line-item budgets, negotiated during the bidding process for aid funding.

2.3.1. Contracting

Contracting, and in particular contracting-out to NGOs to provide services to the population on behalf of the government, often with donor funding, has been long seen as a potentially successful option for purchasing and providing services in FCAS. There is a large literature on it, which was already identified and discussed in the 2012 review. Relevant experiences include those of Haiti, Afghanistan, DRC, Guatemala, Liberia, Cambodia, South Sudan (Abramson, 2009; Alonge et al., 2015; Blaakman et al., 2013; Eichler et al., 2009; Michael et al., 2013; Morgan, 2005; Siddiqi et al., 2006; Vong et al., 2018; World Bank, 2018b; Zeng et al., 2013). A common feature in contexts where contracting-out of services to NGOs was adopted is the limited public service delivery capacity or donors which are unable or unwilling to fund public services directly. These contracts are sometimes funded out of pooled funds, and linked to the development of basic packages of services, as the case in Afghanistan. However, in challenging environments, such as South Sudan, logistical and security constraints have created severe implementation challenges for contracting programmes (Morgan, 2005).

Contracting can also occur with public facilities – internal contracting or contracting-in – and indeed some countries have moved over time from contracting-out to a hybrid model, followed by internal contracting. This is the case for example of Cambodia, where contracting has been used to accelerate the recovery of the rural health system. Contracting out was piloted between 1999 and 2002-3, followed by "hybrid contracting" and, from 2009, Special Operating Agencies (SOAs), which test a form of internal contracting (Jacobs et al., 2010; Khim et al., 2017; Khim and Annear, 2013; Vong et al., 2018). There are reported increases in utilisation of services by the general population and the poor under the SOAs (Vong et al., 2018), although robust evaluation is challenging given the selection approach to SOAs and the additional resources provided to them. More interesting is the iterative learning process and gradual resumption of national leadership despite continued financial and technical reliance on the plethora of international agencies which have contributed to the health sector over the past two decades. Afghanistan and Liberia also experimented with hybrid approaches, mixing contracting-out and contracting-in arrangements, but have not yet moved to contracting-in only (Blaakman et al., 2013; Sondorp and Coolen, 2012).

2.3.2. Performance based financing

Performance based financing (PBF) – in which health facilities are paid according to the volume of verified and specific services that they produce, modified by quality scores - has been increasingly implemented in low and middle income countries over the last decade (Soucat et al., 2017). This topic was already identified as a key one on purchasing for FCAS in the 2012 review. Since then a small but growing body of literature has been developing which looks specifically at PBF in relation to fragile contexts. A recent literature review (Bertone et al., 2018a) allowed empirically testing of some of the hypotheses proposed by Witter (2012) in relation to PBF in FCAS. It found that PBF is currently implemented in 23 FCAS, which were often the early implementers. The review highlights that, rather than emerging despite fragility, conditions of fragility (such as, greater role of external actors, openness to institutional reform, lower levels of trust within the public system and between government and donors) may favour PBF adoption. Case studies on Sierra Leone, Zimbabwe and Chad analysing the politics and political economy of PBF highlight the importance of the role of external actors, interacting with national capacity, in shaping how PBF is adopted, adapted and scaled up or discontinued (Bertone et al., 2018b; Kiendrébéogo et al., 2017; Witter et al. n.d.). Less clear are the effects of FCAS contexts and features on PBF implementation and on PBF effectiveness, which vary across settings and indicators (Bertone et al., 2018a).

A specific issue, which have not been analysed in the literature with reference to PBF in non-FCAS and FCAS, is its role as mechanism for strengthening strategic purchasing (Soucat et al., 2017). However, a recent study (Witter et al., 2019) looked at the effects of PBF on strategic purchasing in three FCAS settings (Zimbabwe, northern Uganda, and DRC) and concluded that these PBF programmes have not brought about systematic transformation of purchasing in the health sector. Still, partial improvements were noted in some domains, such as creating more incentives for service delivery and quality for some services, bringing focus to data quality and enabling national policies to improve equity (such as user fee removal or reduction). The link between PBF and governance has also been analysed in Burundi, where PBF was found to contribute to good governance through separation of functions, transparency in management and a meticulous description of administrative procedures (Peerenboom et al., 2014). Finally, a study on DRC concludes that while there may be a role for PBF in fragile contexts, to be effective it needs to be rooted in wider financing and human resource policy reforms (Fox et al., 2014). These are largely in line with findings from non-FCAS settings.

Few studies of PBF in humanitarian contexts exist (Banga-Mingo et al., 2014; Soeters et al., 2011). A recent comparative analysis of PBF implemented in humanitarian settings in South Kivu (DRC), Adamawa State (Nigeria) and Central African Republic points to the need for adaptation in design and implementation (instead of a "copy-and-paste" approach). Factors that may facilitate adaptation include organisational flexibility, local staff and knowledge, and embedded long-term partners (Bertone et al., 2018b).

2.4. Benefit packages and service provision

In general, most FCAS (and, indeed, many non-FCAS) lack clearly defined healthcare benefit packages as well as data on their resourcing needs, although the definition of basic packages of health services (BPHS) is an area which has received support and investment (as highlighted below). There is often a gap, as in DRC, between nationally defined list of services by level of care and actual services available to the population. Frequently, population entitlements vary based on donor funding and preferences and across areas of the country (Jacobs et al. n.d.; Mathew and Abiodun, 2017).

Given resource constraints, governments face difficult decisions on essential benefit packages. In conflict-affected settings, emergency packages typically focus on primary healthcare interventions relating to maternal, newborn and child health, immunisation, nutrition, mental health services and the diagnosis and treatment for some communicable and non-communicable diseases (Witter and Hunter, 2017). Those packages can then provide a basis for expansion of coverage (WHO, 2014). Services for trauma and for sexual and gender-based violence are important in conflict-affected settings, though not always included in essential health packages.

In terms of service provision, where there is lack of capacity for public service delivery or lack of confidence by donors, or simply external preference for non-state actors, funding is often channelled to (international) NGOs through contracting-out approaches described above or project funding, which can increase effective coverage in the short term but also carries risks of patchy provision, higher costs and may have a system-weakening legacy in the long term (Bertone and Witter, 2015b). Another challenge, in particular for multilateral organisations, is to work in settings where the state and therefore the government is unrecognized (Garber et al., 2018). At the same time, the capacity of governments to regulate the pluralistic market of formal and informal, public and private (and hybrid) providers may be constrained, leading to variations in quality and content of healthcare services. Private (for profit or not) providers of services, training and pharmaceuticals markets are often left to evolve and proliferate by the

absent state, without regulation (Hill et al., 2014; Pavignani et al., 2013).

2.4.1. Basic packages of health services

Basic packages of health services (BPHS) were already identified as a relevant topic in the 2012 review and discussed in relation to non-state providers and contracting-out approaches in FCAS. Indeed, explicit BPHS have been introduced in a number of FCAS (including Afghanistan, Liberia, South Sudan, Somalia, DRC and Cambodia), in particular in the post-conflict, reconstruction phase, often to facilitate contracting-out of services to NGOs.

Afghanistan is the longest-running example of BPHS contracting in FCAS and it is extensively documented (Howard et al., 2014). While some highlight how it led to general improvements (increase in access to and utilisation of primary health care services in rural areas, number of BPHS facilities, access for women to basic healthcare and more attended deliveries, better supply of essential medicines and more functional health information system) (Newbrander et al., 2014), others find that the BPHS approach has not addressed barriers to accessing services and that overall service coverage remained low (Frost et al., 2016). Similarly, in Liberia, while the BPHS represented a key step in the progress to recovery of the health sector, an analysis of stakeholder perceptions found limited understanding of the BPHS by health workers which led to sub-optimal delivery of certain services (such as facility-based deliveries), parallel private services, and health workers leaving their posts (Petit et al., 2013).

2.4.2. Accreditation and regulation of providers

As highlighted in the 2012 review, there is a general lack of published evidence on accreditation experiences and on how to effectively engage all providers, including non-state and informal providers in FCAS. On the topic of accreditation of providers, we found one study (run by the external project implementers) which described the experience of Liberia in creating an accreditation system as part of the BPHS development to identify facilities that had the clinical and management standards to provide the BPHS (Cleveland et al., 2011). However, the literature is limited and has not fully explored the role of non-public providers and the challenges they pose to service delivery.

2.4.3. Public financial management

In line with the 2012 review, few documents were found on public financial management (PFM), although this is a key bottleneck to effective health financing (Cashin et al., 2017). Importantly, some literature suggests that, similarly to taxation, high-quality and legitimate PFM systems could also support the transition to post-conflict reconstruction (Porter et al., 2011). The challenges found are similar to those of low-income countries with weak PFM systems: such as for example, rigid input-based budgeting approaches, misalignment between planning and budgeting, fragmented and parallel cash flows and procurement systems by donors, NGOs, and global initiatives. Studies in DRC revealed that critical bottlenecks included excessive use of off-budget procedures, limited capacity, political interference, dependence on donors' disbursements schedules, lack of budget implementation tracking (Le Gargasson et al., 2014), and weak budget preparation procedures (Barroy et al., 2014).

2.5. UHC goals and objectives in relation to health financing

2.5.1. Equity and efficiency in resource allocation

Literature on resource allocation in FCAS was found to be limited, confirming the finding of the previous review. Often FCAS are contexts where decision-making has become ad hoc and data on population needs is lacking, so that the risks of poor allocation and capture of resources to serve the well-connected minority is high. External funding also leaves important gaps. For example, an analysis of humanitarian funding for reproductive health between 2002 and 2013 found comparatively limited attention and programming for family planning and abortion care in particular (Tanabe et al., 2015). In addition, research suggests that global health initiatives (such as GAVI and the GFATM) are increasingly investing in conflict-affected countries. This has helped to rapidly scale up health services, strengthen human resources, improve procurement, and develop guidelines and protocols, but negative influences included distorting priorities, inequitable financing of disease-specific over other health services, diversion of staff and limited flexibility and responsiveness to the contextual challenges of conflict-affected countries (Patel et al., 2015).

2.5.2. Transparency and accountability

In FCAS there is typically limited reporting, transparency and accountability for health financing decisions and resources. In addition, where there is substantial external influence, these can become non-transparent (Bertone et al., 2018c) and institutionally fragmented (Beaston-Blaakman et al., 2011). This is despite the fact that, although the literature on health system linkages to state-building is contested and empirical evidence is hard to establish (Eldon et al., 2008; Percival, 2017; Witter et al., 2015), there is emerging evidence that public health measures, including equitable access to basic health care, may contribute to peace-building- for example, reconciling warring sides - in the aftermath of conflict (Christensen and Edward, 2015; Sen and Faisal, 2015).

2.5.3. Utilisation relative to needs

Patterns of equity across FCAS have not been systematically studied and there is a lack of recent benefits incidence analyses which allow for comparisons, but individual case studies exist. For example, an analysis of Cote d'Ivoire from 1893 to 2013 highlights how armed conflict exacerbated historically inherited challenges to the health system, including unequal distribution of health services (Gaber and Patel, 2013). A study in Palestine suggests that the worse-off have disproportionately greater needs for all levels of care. However, with the exception of primary-level, utilisation of all levels of care appears to be significantly higher for the better-off (Abu-Zaineh et al., 2011) – a finding which is common to other settings, but may be more pronounced in FCAS. Another study analysing the equity of the utilisation of health services for 2010 in Afghanistan found that, while utilisation of inpatient and outpatient care and antenatal care was equally distributed among income groups, the poor used more public facilities while the wealthy used more private facilities. In addition, there was a substantial inequality in the use of institutional delivery services (Kim et al., 2016).

2.5.4. Financial protection and equity in finance

Our review found that financing incidence in FCAS has also received limited attention, with no cross-country analyses. However, where reliance on out of pocket payments is high, is it likely that there is a marked increase in regressive healthcare financing. A study in the Occupied Palestinian Territory, for example, shows the pro-rich character of out-of-pocket payments, compared to the progressivity of the government health insurance scheme (Abu-Zaineh et al., 2008). In Sierra Leone, the incidence of catastrophic health expenditure decreased significantly from approximately 50% in 2003 to 32% in 2011, as it moved away from the immediate post-conflict period (Edoka et al., 2017) – a result of changing endowments and health system factors, including the Free Health Care Initiative of 2010.

3. Discussion and conclusion

This literature review has some important methodological limitations. Most importantly our literature search was not systematic or exhaustive, due to the broad nature of the topic. We remained purposefully comprehensive in the definition of the inclusion criteria in order to be able to capture as much as possible of on-going debates. Although we acknowledge that a number of documents may have been

overlooked despite several iterations in the search and expert advice, we believe that the review has captured the key debates and issues on health financing in fragile and conflict affected settings, in particular providing a useful comparison with the review published seven years ago. Also it should be noted that, although 'quality' is included among the UHC goals and objectives in relation to health financing (Kutzin et al., 2017), no specific searches were run on that topic and no studies were found to directly refer to it so that studies discussing quality among other issues would be reported under other topics.

Overall, the number and focus of the documents retrieved and included suggests that the available literature on health financing in FCAS focuses quite heavily on some countries, while others are neglected, and on themes which highlight the prominence of the donors' perspective on health financing in FCAS. Topics such as the issue of domestic health financing (both in terms of taxation and PFM) were found to be overlooked in the literature. It is also important to note the variable quality of studies reviewed, as noted previously in Witter (2012). Many are hampered by poor data quality, given the challenging settings (Woodward et al., 2016), and a significant proportion are conducted by designers and implementers of health financing reforms and are therefore not independent. Many are commissioned by external agencies and there is therefore likely a neglect of smaller, local and more home-grown reforms. These issues as well as the varying quality of the studies may in some cases be the cause of different findings on a same topic. Finally, although we attempted to cover humanitarian settings as much as fragile and post-conflict ones, we found that the literature tends to be distinct, mirroring organisational and funding differences.

In terms of health financing functions, the review highlights that, while revenue raising and pooling continue to be covered in the literature, there is a lack of empirical analyses of trends in aid and internal financing (government allocations) for health at country-level in FCAS and in comparison with non-FCAS, also looking at what drives these trends and what are the consequences, including in terms of equity (progressivity) of domestic revenue raising in the form of general taxation, social health insurance or other options. While a trajectory of increased donor funding during conflict and in the immediate aftermath and reduced donor funding in the longer term is often assumed, this expectation does not seem realistic, as mobilising domestic resources is complex and may take longer than expected. Indeed, an important topic to explore could rather be how funding is used. Some countries, such as Cambodia and Rwanda, have made impressive progress in expanding coverage of healthcare in the post-conflict period, and both have relied heavily on international funding for a long period of time. Therefore, it may be worth focusing on maximising external aid, making it more predictable and stable and using it more effectively.

The review also finds that while some issues like user fees exemptions and abolition are well documented and at the centre of the debate, others remain under-studied. These include demand-side financing mechanisms (with the exception of humanitarian contexts), as well as health equity funds, for which evidence outside Cambodia is extremely limited.

Similarly, while contracting arrangements and performance-based financing (key 'purchasing' topics already identified in the 2012 review) continue to be studied, with the body of literature recently expanding to cover the specificities of PBF in fragile and humanitarian settings, not all aspects are well covered. Outstanding questions on contracting relate to the longer term impact of this approach, for example on institution-building, governance and accountability, and its cost-effectiveness. Some of the questions include:

- Is contracting out by-passing weak public institutions or building capacity?
- How can it phase into longer term system strengthening?
- What are the implications in terms of accountability, sustainability and regulation of conflicts of interests?
- How cost effective is it in relation to alternative approaches?

In addition, further studies could document reforms to strengthen and defragment health care purchasing arrangements in FCAS and humanitarian settings, including for the provision of services to displaced and refugee populations.

In terms of benefit packages and service delivery, the BPHS model remains a preferred approach in FCAS and the focus of many studies, usually referring to a selected number of countries (Afghanistan, in particular). However, some potentially relevant issues remain unexplored, such as the development of dynamic costing models to support service delivery in rapidly changing (humanitarian) contexts. Another topic, which continues to be understudied, is the challenges and options for regulation of the mixed provider landscape in FCAS, in the context of weak governance. While this may be seen as less urgent in fragile settings, it is arguably equally if not more critical to health financing and systems performance here.

Finally, we found a dearth of evidence in relation to health financing goals and objectives for UHC, including on issues such as equity and efficiency in resource allocation, equitable access, financial protection and quality of health services, for which few specific FCAS studies and no comparative analyses between FCAS and non-FCAS exist. Although this is under-studied, health financing reforms aspiring to achieve these objectives and goals have the potential not only to allow progress towards UHC, but also to communicate political and social values, such as social solidarity (through cross-subsidies and pooling); inclusion (e.g. targeting poorer areas); equity (e.g. reducing financial barriers); reconciliation (e.g. resources allocated to opposition areas); human rights (e.g. establishing constitutional rights to health care); participation (e.g. civil society involvement); and confidence in public stewardship (e.g. donor resources channelled through public systems). This is particularly important in fragile, post-conflict recovery settings where they potentially link to broader confidence-building processes.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.socscimed.2019.04.019.

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