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Innovative Humanitarian Health Financing for Refugees

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1. Executive Summary

More than 65 million persons are currently forcibly displaced, of which more than 21 million are refugees. Conflicts are becoming more protracted, and a refugee remains a refugee on average for more than 10 years. Funding for refugee assistance comes primarily from Western donors after an emergency has occurred (e.g. discretionary post-emergency aid, such as in-kind and cash transfers). Given the current number of complex conflicts and the magnitude of displacement, new sources of funding and innovative financing instruments are needed. However, they should vary according to a wide range of different contexts.

This white paper, developed at the behest of the World Bank Group, examines innovative humanitarian health financing for refugees. Ultimately, the goal is to have a healthcare system for refugees that is integrated into a functioning national system; if implemented correctly, this integration will be beneficial to the refugees and the host populations. However, if national health systems are not functioning or those systems are overwhelmed, particularly at the beginning of an acute emergency, then parallel systems may need to be established.

The intended audience for this paper is multilateral and bilateral donors, UNHCR and other United Nations (UN) agencies, international non-governmental organizations (NGOs), and private sector actors.

The paper is premised on the following five declarations:

- i. Refugees, like all other persons in the world, have a right to universal health coverage (UHC).
- ii. The humanitarian system is currently overstretched and underfunded, and cannot meet the demands of multiple and increasingly protracted humanitarian emergencies.
- iii. Traditional funding for humanitarian emergencies is insufficient and unsustainable.
- iv. Current funding instruments are overwhelmingly post-emergency external assistance provided to United Nations agencies and international NGOs.
- v. Refugee crises are generally protracted, rather than short-term.

For this paper, refugee contexts are categorized according to i) phase; ii) location; iii) host country income level; and iv) functioning of district health system. The mechanisms outlined in this paper are assessed according to these different contexts.

Addressing the increasing level of humanitarian needs for refugees requires a wide range of resources and a sophisticated financing toolkit, ranging from insurance to concessional loans to acknowledgements from host governments that, as refugees may remain for a long time, they must implement medium and/or long term health financing solutions. Traditional refugee

assistance funding comes predominantly from ex-post (post-emergency) risk retention instruments, such as budget allocations (donations) from governments to the UN, international organizations and NGOs. Improving financing for humanitarian emergencies requires a paradigm shift: scaling up and shifting to include ex-ante (pre-emergency) planning.

We examine different financing mechanisms using the USAID Health Systems 2020 health financing framework, consisting of i) revenue; ii) pooling; iii) purchasing; and iv) provision, and make recommendations accordingly.

Recommendation 1 (revenue): The role of *remittances* in refugee settings needs to be better understood. Certain actions should be explored to make remittances flow more fluidly and efficiently in such settings. This will allow refugees to more easily pay for out-of-pocket medical expenses.

Recommendation 2 (purchasing): *Pay for Success* is most appropriate in protracted refugee settings, particularly camps, when addressing specific health interventions, but not for broad health systems issues.

Recommendation 3 (cuts across framework): Consider the creation of a pre-emergency '*Refugee Health Financing Emergency Facility*' to prepare for responding to acute emergencies. Similar to the pandemic emergency financing facility, resources could be mobilized through cash and insurance windows.

Recommendation 4 (cuts across framework): Assess possibilities of integrating refugees into *health insurance schemes* in protracted settings, and implement if feasible.

Recommendation 5 (cuts across framework): Consider using various financial mechanisms, such as the World Bank's IDA18 concessional loan program, to help refugee hosting countries *move from parallel health services to integrated health services* in protracted refugee camp settings.

2. Introduction

In 2015, there were 65.3 million forcibly displaced persons and 21.3 million refugees worldwide (Figure 1.4).¹ A refugee is defined as someone who has been forced to flee his or her country because of persecution, war, or violence, and who has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group.² Whether refugees live in camps or are integrated into host populations, and whether they are settled in low-income or middle-income countries (Figure 1.5),¹ governments often struggle to meet the health needs of these populations. Host countries' existing health systems are often weak, and the added burden of providing for refugees can make them even more fragile.

The ultimate goal is to have a healthcare system for refugees that is integrated into a functioning national system; if implemented correctly, this integration will be beneficial to the refugees and the host populations. However, if national health systems are not functioning or those systems are overwhelmed, particularly at the beginning of an acute emergency, then parallel systems may need to be established. Parallel systems provide healthcare specifically to refugees, and are not part of the existing national health system. These parallel systems are generally coordinated by the United Nations High Commissioner for Refugees (UNHCR) and provided by international and national non-governmental organizations (NGOs).

Providing **sustainable healthcare** to refugees (as well as internally displaced populations (IDPs) and other displaced populations) requires facilitating their access to existing health systems, improving the capacity and quality of such services to ease the strain on host countries, and addressing the financing of these services.

Health financing refers to (1) raising resources, through employment taxes, general taxes, fee-for-service payments, ad-valorem taxes, foreign savings, and so on; (2) the flow of money into the system; and (3) the allocation of resources by various means (e.g. user fees or funding for a specific emergency) from donors, refugees, the private sector, and other sources. **Innovative financing mechanisms** are defined as non-traditional applications of overseas development assistance (ODA), joint public-private mechanisms, and flows that fundraise by tapping new resources or that deliver new financial solutions to humanitarian and/or development problems on the ground.³

This document concerns itself primarily with **refugees**, but many of its conclusions may be applicable to non-refugee settings. We focus on innovative tools and methods that will require further exploration. Many aspects of financing are country and context dependent, thus where possible we provide examples.

The **objective** of this white paper, which was funded by the World Bank, is to explore different innovative humanitarian health financing mechanisms for refugees focusing primarily on varied source of funding and a broad range of instrument for those funds to provide health services to refugees in an integrated and sustainable manner.

The **intended audience** for this paper is multilateral and bilateral donors, UNHCR and other United Nations (UN) agencies, international NGOs, and the private sector.

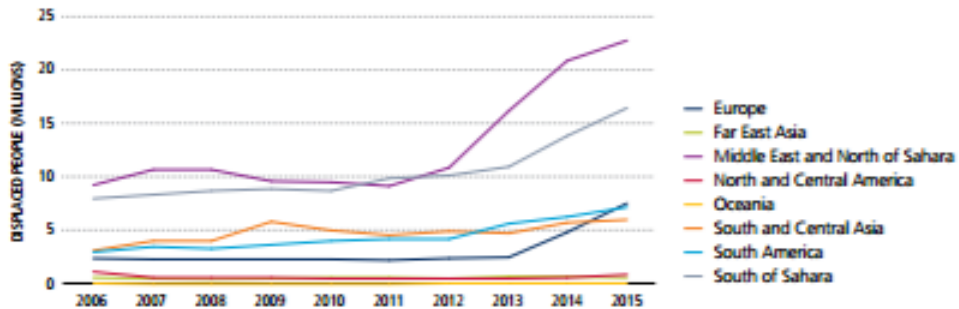
The paper is **premised** on the following five declarations:

1. Refugees, like all other persons in the world, have a right to universal health care coverage (UHC).
 - UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need. These services will be of sufficient quality to be effective, while also ensuring that their use does not expose the user to financial hardship.⁴
 - This definition embodies three related objectives:⁴
 - **Equity in access** to health services – everyone who needs services should get them, not just those who can pay for them;
 - **Quality** of health services – services should improve the health of those receiving them; and
 - **Protection against financial risk** – people should be protected against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.
2. The humanitarian system is currently overstretched and underfunded, and cannot meet the current demands of multiple and increasingly protracted humanitarian emergencies.⁵
3. Traditional funding for humanitarian emergencies is insufficient and unsustainable. It is overwhelmingly provided by Western governments after the emergency has occurred. Although these countries have been extremely generous, the amount of funding is insufficient and the manner in which it is provided is not sustainable. In 2015, the UN appealed for \$28 billion, the largest appeal ever; there was a 45% shortfall, the largest shortfall ever.¹
 - New and varied sources of funding are essential if the needs of persons affected by humanitarian emergencies are to be met.⁶ These sources should come from beyond Western governments to include non-Western governments, various multi-lateral organizations, the private sector, and refugees themselves, and can vary among solidarity levies, insurance, bonds or remittances.

4. Current funding instruments are overwhelmingly post-emergency external assistance provided to UN and international NGOs.
- When host governments and local NGOs have sufficient capacities, funds should be provided directly to them as long as humanitarian principles (i.e. humanity, neutrality, impartiality, and independence) are respected. This will be less expensive, more culturally appropriate, reduce inequity between refugees and host nationals, and will hopefully improve integrated services for host populations and refugees.
 - Pre-emergency (ex-ante) instruments should be focused on, as most humanitarian funding currently is provided post-emergency by Western donors. These ex-ante instruments require planning before emergencies occur. They include reserves, contingency funds, budget contingencies, contingent debt facilities, and risk-transfer products.
 - A variety of different and innovative funding instruments can be used according to context (Table 1) and risk. Such instruments will be discussed below.
5. Refugee crises are generally protracted, rather than short-term. The average refugee remains a refugee for more than 10 years.⁷
- Host governments should accept that refugees will likely be on their soil for many years and thus integrating into existing health services and establishing livelihoods for refugees should be pursued.
 - If planned and implemented well, and assuming the financial aspect has been addressed properly, then integration should improve health services for nationals and refugees alike by increasing the risk pool.
 - Refugees should be allowed to have livelihoods while they are residing in their host country, which may have a positive effect on the local economy,⁷ reduce their dependence on assistance, allow them to pay health premiums or other types of health payments, and provide them with new or continued skills when they return home.
 - Donors should provide multi-year funding in humanitarian settings to allow for predictable and sustainable programming. The current practice of one-year funding is detrimental to long-term planning.⁶

FIGURE 1.4

Number of displaced people by region of host country, 2006–2015



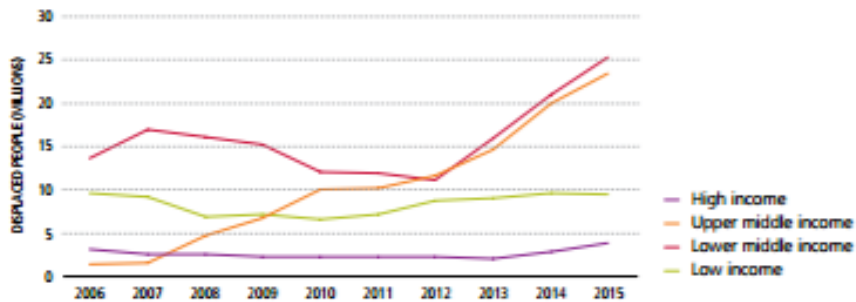
Source: Development Initiatives based on UN High Commissioner for Refugees (UNHCR) and UN Relief and Works Agency for Palestine Refugees in the Near East data

Notes: 'Displaced people' includes refugees and people in refugee-like situations, internally displaced persons (IDPs) and asylum seekers. IDP numbers include only people protected/assisted by the UNHCR. End of year data from UNHCR is used for all years except 2015, which uses mid-2015 data. Data is organised according to UNHCR's definitions of country/territory of asylum. Countries are organised according to the OECD's classification of regions, except for the Middle East and North of Sahara region, which have been combined.

Figure 1.4 is from the Global Humanitarian Assistance Report, 2016.

FIGURE 1.5

Number of displaced people by income group of host country, 2006–2015



Source: Development Initiatives based on UN High Commissioner for Refugees (UNHCR) and UN Relief and Works Agency for Palestine Refugees in the Near East data

Notes: 'Displaced people' includes refugees and people in refugee-like situations, internally displaced persons (IDPs) and asylum seekers. IDP numbers include only people protected/assisted by UNHCR. End of year data from UNHCR is used for all years except 2015, which uses mid-2015 data. Data is organised according to UNHCR's definitions of country/territory of asylum. Income groups are classified by the World Bank on an annual basis.

Figure 1.5 is from the Global Humanitarian Assistance Report, 2016.

3. Refugee Contexts

Refugee contexts and their various attributes can be categorized in numerous ways. For this paper, we use the following framework:

Table 1: Refugee Contexts

Phase	Location	Host Income Level	District health system
<ul style="list-style-type: none"> ● Preparedness (pre-emergency) ● Acute emergency ● Protracted ● Durable solutions <ul style="list-style-type: none"> ○ Voluntary repatriation ○ Local integration ○ Resettlement 	<ul style="list-style-type: none"> ● Camp, out of camp ● Urban, rural 	<ul style="list-style-type: none"> ● Low income country (LIC) ● Middle income country (MIC) 	<ul style="list-style-type: none"> ● Functioning ● Semi-functioning ● Non-functioning

How and what type of refugee healthcare is established depends upon some of the factors listed above. For example, types of services and their quality may differ between the acute emergency phase, where this is often limited capacity and security, compared with the protracted phase, where there is more stability. Parallel health systems are often established in camp settings compared with out of camp settings, where they are often integrated within existing national systems. Types of services and ability to refer may differ between urban and rural settings as well as LICs and MICs. Although it is difficult to clearly define functioning and non-functioning national or district health systems, the essential issue here relates to the ability of the district or regional health services to integrate refugees into an existing system that will provide sufficient access and quality of services. If such a system cannot do this, even with support from international organizations, then alternatives need to occur, such as providing parallel services by NGOs or private sector; but the latter should be avoided if possible.

4. Instruments for Financing Humanitarian Emergency Risk

Available **financing instruments** account for two dimensions – risk and timing:⁸

Risk is defined as the potential for or probability of a loss. It can be related to individuals or events. **Timing** refers to when the risky outcome occurs.

- **Risk-retention** tools hold *host countries responsible for risk*. Doing so provides more flexible payments, as they can spend at their discretion. These tools include contingency funds, budget allocations, contingent credit, budget reallocations, tax increases and post-emergency credit.
- **Risk-transfer** tools *allow host countries to transfer risk to another entity*. Doing so provides more security by having another party shoulder risk. These tools include insurance, indemnity reinsurance, indexed insurance, catastrophe bonds, catastrophe swaps, and donations.

In general:

- Risk retention instruments are preferred for smaller losses that are more frequent.
- Risk transfer instruments are preferred for larger losses that are less frequent.

Timing

- **Ex-ante instruments (pre-emergency)** depend on planning for emergencies, and include reserves, contingency funds, budget contingencies, contingent debt facilities, and risk-transfer products.
- **Ex-post instruments (post-emergency)** do not depend on planning for emergencies, and include donations, budget reallocation, loans, and tax increases.

There are a variety of financing instruments available for preparing and responding to humanitarian emergencies, which combine different features of timing and risk. Below are several examples (Table 2 modified from Dull Disasters)⁸.

Table 2: Financing Instruments according to Risk and Time

	Ex-ante (dependent on planning)	Ex-post (not dependent on planning)
Risk retention (host countries responsible for risk)	<ul style="list-style-type: none"> • Domestic contingency funds or budget allocations: money for emergency relief set aside prior to event • Taxes and subsidies to alter incentives for providing funding • Line of contingent credit: a loan disbursed under certain circumstances 	<ul style="list-style-type: none"> • Budget reallocation • Tax increases • Post-emergency credit • User fees • Taxes and subsidies to alter incentives for providing funding • Use tariffs to reduce prices of goods during emergencies (subsidies)
Risk transfer (host countries transfer risk to another entity)	<ul style="list-style-type: none"> • Traditional insurance or reinsurance: contract where insured pays insurer a premium, and insurer agrees to pay for pre-specified and post-verified losses • Indexed insurance: insurance contract where insurer makes payments based on certain external, measurable parameters or index (e.g. Sovereign Risk Insurance Pools, Pandemic Emergency Financing Facility) • Capital market instruments: financial instruments that can be bought or sold on capital markets, and investors shoulder risk (e.g. catastrophe bonds and swaps, Pandemic Emergency Financing Facility) • Contingency pooled UN funds (e.g. CERF and CBPFs) • Privatize and deregulate services 	<ul style="list-style-type: none"> • Discretionary post-emergency aid: includes in-kind and cash transfers <p style="text-align: center;">THIS IS THE MOST COMMON INSTRUMENT FOR AID DELIVERY IN HUMANITARIAN EMERGENCIES PROVIDED PRIMARILY BY WESTERN GOVERNMENTS</p>

As mentioned in the introduction, by far the most common financing instrument in humanitarian emergencies is discretionary post-emergency aid from Western governments (ex-post risk transfer). One important goal is to provide increased revenue beyond that provided by Western governments. Another is to increase the financing instruments, particularly ex-ante risk transfer instruments. This will be discussed in more detail below.

5. Traditional Humanitarian Funding

Traditional refugee funding comes predominantly from ex-post risk retention instruments such as budget allocations from governments to the UN, international organizations and NGOs.

Protecting and assisting refugees is primarily the responsibility of states. Domestic governments must respond to crises on their land and often invest significant amounts in preparedness and response. The majority of refugees are hosted in countries with low domestic capacity to support them. However, a lack of comparable data makes it difficult to measure the value of the contributions of developed and developing refugee hosting countries.¹

International humanitarian assistance has continued to grow, reaching a record high UN-coordinated appeal of USD 28 billion in 2015 (this number is for all humanitarian assistance, including conflict and natural disasters, refugees, internally displaced persons (IDPs) and non-displaced persons affected by disasters). Rises in humanitarian funding came from both government (the majority) and private donors, who respectively increased their contributions by an estimated 11% and 13% from the previous year. In 2015, twenty government donors contributed 97% of all international government contributions. While overall humanitarian funding increased in 2015, the gap between requested needs and contributions to UN-coordinated appeals increased. The amount requested through UN appeals stood at USD 19.8 billion in 2015, a slight decrease from the previous year, but contributions fell by considerably more, leaving the largest ever shortfall of 45% (USD 8.9 billion) with large differences among different countries.¹

Humanitarian funding in 2015 was increasingly concentrated in a relatively small group of emergencies. According to the UN Office for the Coordination of Humanitarian Affairs' Financial Tracking Service (FTS), five crises – in Syria, Yemen, South Sudan, Iraq and Sudan – accounted for more than half of all funding allocated to specific emergencies. This contrasts with 2011 and 2012, when the five largest crises received approximately one third of the total. The annual list of persistently underfunded or 'neglected emergencies' frequently features the same countries year after year. Long-term crises continue to absorb the largest volumes of international humanitarian assistance. In 2014, 91% of official humanitarian assistance for all sectors from the Organization for Economic Co-operation and Development (OECD) Development Assistance Committee donors went to long- and medium-term recipients, reinforcing the rationale for more multi-annual humanitarian planning and financing.¹

How funding reaches emergency-affected populations has implications for the efficiency and effectiveness of the assistance provided. In 2014, around two-thirds of funding from government donors was channeled via multilateral organizations, mostly to the six-major humanitarian-related UN agencies. Despite calls and commitments for more support to local actors, data from the FTS shows that funding channeled directly to local and national NGOs remains low, accounting for just 0.4% of international humanitarian assistance in 2015.¹

Pooled funding continues to play an important role in humanitarian financing. UN-led humanitarian pooled funds mobilized USD 1.3 billion in 2015, a 28% rise from the previous year. Funding pooled at the country level grew in particular, with an increase from the previous year of almost 50% in 2015. Flexible financing is understood to bring a number of benefits, including quicker responses, better accountability, lower administrative costs, and less reporting. However, the proportion of fully **unearmarked contributions** to UN agencies received from government donors decreased from 24% in 2012 to 16% in 2014; and unearmarked funding for NGOs represented just 8% of the overall funding they received in 2014.¹

To our knowledge, there have been no studies that have examined the cost effectiveness of providing health services to refugees in camps and out of camps. Such studies would be useful. However, there are other important factors that would also need to be examined, including but not limited to livelihoods of refugees and their contribution to the host economy, dignity and feelings of self-worth of refugees in these situations, and accessibility and quality of care.

FIGURE 3.1

International humanitarian response, 2011–2015

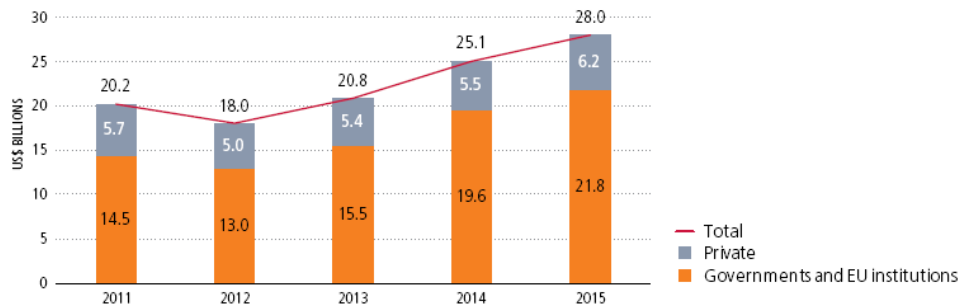


Figure 3.1 is from the Global Humanitarian Assistance Report, 2016.

FIGURE 4.1

International humanitarian assistance from governments by donor region, 2011–2015

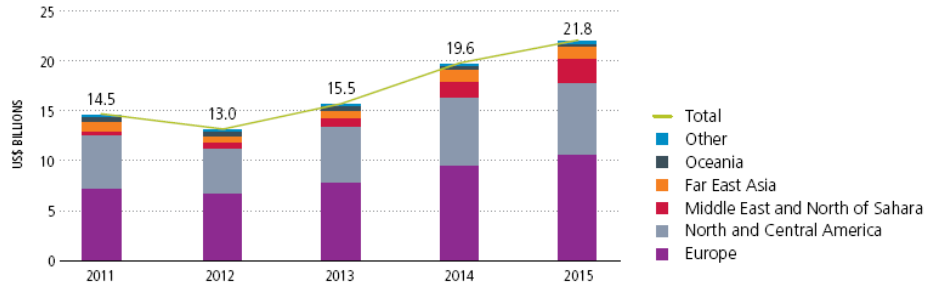


Figure 4.1 is from the Global Humanitarian Assistance Report, 2016.

FIGURE 6.2

International humanitarian assistance from governments to six UN agencies, 2010–2014

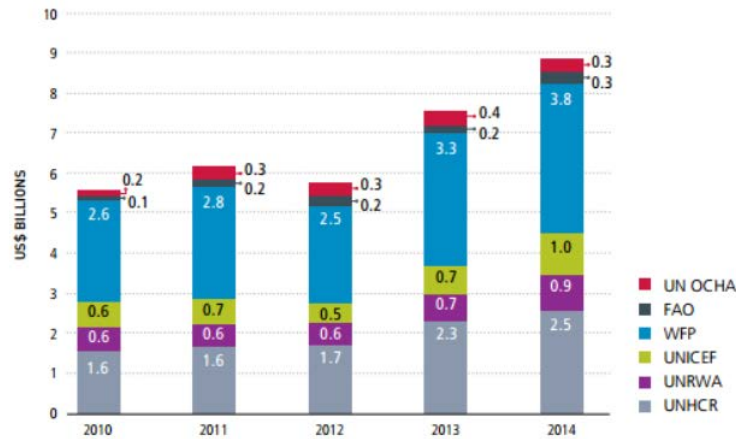


Figure 6.2 is from the Global Humanitarian Assistance Report, 2016.

6. Innovative Humanitarian Health Financing

Addressing the increasing level of humanitarian needs for refugees requires a wide range of resources. A sophisticated financing toolkit ranges from insurance to concessional loans to acknowledgements from host governments that as refugees may remain for a long time they must implement medium and/or long term health financing solutions. Not all tools will work in all situations. In order to have the desired effect, solutions must combine finance streams and approaches that are appropriate, timed to anticipate and prevent crises or can react quickly to unpredictable crises, scalable, and targeted at the right people.

Improving financing for humanitarian emergencies requires a paradigm shift: scaling up and shifting the emphasis from ex-post (post-emergency) donations to include ex-ante (pre-emergency) planning. Donations are irregular, often result in ad-hoc and inadequate responses, and are subject to funding shortages. In contrast, an innovative health financing plan can set in place financing mechanisms with clear and flexible rules for dealing with emergencies prior to the emergency. It should specify actors and roles, triggers for payout, and allow for flexibility in response according to context (Table 1).

A coordinated emergency response for funding requires a plan of action that would:⁸

- Establish set decision-making rules prior to the emergency, have all stakeholders agree in advance, and be both feasible and credible.
 - There could be financial and other stakeholders who join after the emergency occurs to help with relief efforts or contribute financing.
- Document the roles and responsibilities of different actors.
- Define:
 - (1) Who is covered;
 - (2) What they are covered for;
 - (3) Clear inclusion or exclusion for pre-existing conditions;
 - (4) How and by whom the coverage is implemented; and
 - (5) Who pays for which components of coverage.
- Be adaptable to post-emergency conditions, while still operating within the agreed-upon rules.
- Be implemented using scalable information systems and delivery systems.

Key stakeholders would include financiers, implementers, academics and bureaucrats.⁸

- **Financiers** are crucial for determining the feasibility of any financial scheme.
- **Implementers** include service providers, such as government workers and NGOs, as well as local leaders, whose experience is crucial in determining what plans are actionable.
- **Academics** can determine the likelihood and impact of emergencies.
- **Bureaucrats** can help draft a plan appropriate for their country's political context and gain support for it.

Specifically, for refugee settings, the key stakeholders include but are not limited to:

- Refugees (and other displaced persons)
- Surrounding host populations
- Governments
- UN agencies
- NGOs
- Community-based/faith-based organizations
- Multilateral and bilateral donors
- Private sector (e.g. pharmacists, doctors, local businessmen, traditional and investment banks, IT companies, and insurance companies)

The new **Global Financing Facility**⁹ combines innovative financing mechanisms, public-private partnerships, and private sector capacity to end preventable maternal and child deaths. It is unique in many aspects, particularly because it combines coordination, expertise and a variety of finance mechanisms from many different revenue resources, and delivers according to context (Box 1).

Box 1: The Global Financing Facility (GFF)

The GFF, spearheaded by the UN and the World Bank, is a public-private partnership that funds efforts to end preventable maternal and child deaths by harnessing existing coordination structures, multi-sector expertise, and a variety of financing mechanisms. It estimates that reproductive, maternal, newborn, child, and adolescent health (RMNCAH) financing needs are \$33.3 billion. To meet this need, the GFF incorporates domestic funding, external donors, and innovative financing to raise resources, while emphasizing domestic ownership and sustainability.

The GFF focuses on 63 low and lower middle income countries, all with a high burden of maternal and child mortality. To apply for funding, a country sets priorities in an Investment Case, and then national and international financiers decide how to finance it with their respective means. Cases must provide a limited number of priorities and argue for a high impact, financially viable intervention, grounded in evidence. Financing mechanisms are then determined according to the case. Funds come from the GFF Trust Fund, international agencies, bilateral agencies and the private sector. With private sector partners, the GFF incorporates innovative financing mechanisms, fosters public-private partnerships, and uses private sector capacity. Depending on the case, the private sector may offer pay-for-performance loans, align with other investors to support RMNCAH priorities in specific countries, or help health providers access capital. Notably, the GFF also uses grants, guarantees, or concessions to reduce risk for investors, thus encouraging their participation.

As with the GFF, different sources of revenue and various financing mechanisms will need to be available for refugee emergencies according to context.

Using the USAID Health Systems 2020 **health financing framework**, consisting of **i) revenue; ii) pooling; iii) purchasing; and iv) provision**, we will provide some recommendations that could be used in refugee settings according to the contexts described in Table 1.

Health Financing Framework:

i. Revenue

Although not sufficiently researched, most revenue for refugee health financing comes from three sources: 1) the host governments; 2) Western governments; and 3) refugees (personal communication, Paul Spiegel).

The host governments often end up paying significant amounts of money from their own budgets to providing health care for refugees, particularly out of camp refugees. For example, in Jordan, the burden of Syrian refugees on the health care system and the amount of money the government was paying became too much to bear (estimated as 34 million Jordanian Dinars (JOD), at 1 JOD = USD 1.47). The government stopped providing free health care to Syrian refugees at the end of 2014.¹⁰

In 2016, UNHCR's approved budget was \$7.51 billion, but it received 3.94 billion (52%).¹¹ UNHCR's public health budget, which includes health, nutrition, food security, water and sanitation is approximately 12% of the overall UNHCR budget.

We know from various health access and utilization surveys (HAUS) that refugees pay out of pocket expenses for their health care, particularly those refugees outside of camps. A rather extreme example is in Jordan, where the non-Syrian refugees pay expensive non-Jordanian health care rates as opposed to the Syrian refugees. In December 2016, 44% of the interviewed non-Syrian refugee households spent an average of JOD 116.9 (43%) on health care during the last month of the interview although their combined monthly income is JOD 273.4.¹² In many countries, refugees are not officially allowed to work, and thus they get their money from unofficial work, borrowing, and remittances.

Other revenue for refugee health care comes from other UN agencies (i.e. WHO, UNICEF and UNFPA), international and national NGOs, and faith-based organizations.

Although not the focus of this paper, further exploration of bonds, solidarity levies and remittances will briefly be discussed here.

Bonds are a common capital market tool that can be used to finance responses to humanitarian emergencies. A creditor loans money to a public, corporate or other entity, which issues them a bond. The bond lasts until a preset date (maturity date), and once mature then the loaned funds (bond principal) are returned. Interest is usually paid out periodically until maturity. Bonds have either a set or variable interest rate (coupon). **Catastrophe bonds** are a public entity, insurance company or other organization issues a bond to an investor, with a high coupon rate, usually to reinsure another party. If a catastrophe (currently, most are for natural disasters) occurs, the investor defers or forfeits payment of the interest and/or principal. Instead the money is used to address the catastrophe. If there is no catastrophe, the bonds typically mature within three years, and investors are paid back the principal with interest.

A **solidarity levy or tax** is a government-imposed tax, levied on consumers or tax payers to provide funding towards set projects. The tax can be paid by individuals, business owners, or corporations.

The air ticket levy is one such example (Box 2).¹³

While a solidarity levy may be one mechanism to increase revenue for refugee health services, there is much competition. Many international agencies and causes would also like to use this mechanism.

Box 2: Example of a solidarity levy

Air-ticket levy (UNITAID): Ten countries charge an air ticket levy on passengers, at their chosen rate and ticket class. The ten countries are Cameroon, Chile, Congo, France, Guinea, Madagascar, Mali, Mauritius, Niger and the Republic of Korea. Norway allocates part of its tax on CO2 emissions. The air ticket levy promotes South-South cooperation by allowing new actors from Africa and Latin America to participate in financing international development.

All levy proceeds finance UNITAID, which combats HIV/AIDS, malaria and tuberculosis by addressing supply-side market inefficiencies.

Remittances are an important part of money flow and revenue globally. Migrants are now sending earnings to families and friends in developing countries at levels above USD 441 billion, which is three times the volume of official aid flows. Remittances constitute more than 10 percent of GDP in approximately 25 developing countries. They increase investments in health, education, and small businesses in various communities. Research on remittances during humanitarian emergencies is scarce, but it is assumed that it has a positive impact on the wellbeing of those receiving them. Remittances may help refugees pay user fees or for medicines, but they should not be relied on as a substitute for health financing. Rather, facilitating remittances can complement other initiatives. It is important to note that, in some cases, refugees may be the ones remitting back home.

A “remittance agency” refers to money transfer agencies or other financial service providers. Anti-money laundering laws require certain kinds of identification to send/receive money. In certain settings, refugees may not have sufficient identification, or the identification provided (e.g. from host government or UNHCR) may not be recognized by the remittance agency. In some circumstances, remittances may be transferred via telecommunications. Some refugees do not have access to mobile telephones, although this situation is rapidly changing.

Recommendation 1: The role of remittances in refugee settings needs to be better understood and certain actions should be explored to make remittances flow more fluidly and efficiently in such settings.

- **Ex-ante**
- **For protracted emergencies**

- Examine methods to reduce or eliminate surcharges specific to refugees;
- Work with certain remittance agencies to ensure that certain types of refugee identification is accepted;
- Provide simple mobile phones with sim cards to refugees, which may facilitate transfer of remittances in refugee settings;
- Work with host countries to develop national policies that facilitate receiving remittances. These include (1) special exchange rates, (2) state issued identity cards, (3) a national remittance service program.
- Work with countries that remit large amounts to populations in crises to develop national policies that facilitate the sending of remittances. These include (1) partnerships among governments, central banks, private banks and private agencies to develop an international, low cost system, (2) guaranteeing low cost transfers, (3) matching remittances, (4) providing up to date information on available remittance services, and 5) insure that the funds flow in compliance with national money laundering regulations.

ii. Pooling

Global contingency funds set aside money to cover possible humanitarian emergencies or disease outbreaks without requiring stakeholders themselves to pool risk.

Pooled funds can provide an important counterbalance to geographic or project donor preferences and ensure a flexible and responsive source of financing for emergencies.

The United Nations has a pooled fund called the **Central Emergency Response Fund (CERF)** that has increased over time (see Box 3 and Figure 6.3).¹ It is and will remain an important source of funds for the UN and UN-partners at the beginning of an emergency.

Box 3: UN Pooled Funds

The United Nations Central Emergency Response Fund sets aside donations to be immediately available for emergency responses to humanitarian crises. Funding is channeled through UN-managed humanitarian pooled funds, as the global **Central Emergency Response Fund (CERF)** and **Country-Based Pooled Funds (CBPFs)**. These received combined contributions of USD 1.3 billion in 2015.⁴ The CERF only disburses to UN agencies and the International Organization for Migration. Contributions to the CERF accounted for 34% of UN-managed pooled funding in 2015 (USD 462 million) – a slight increase from 2014 but consistent with its five-year average. In 2015, the CERF funded responses in 45 countries through either its rapid response or underfunded emergencies windows.¹ Recently, USD 100 million of CERF funding was released to help responses for refugee and other settings. However, it is limited and cannot sufficiently address the health needs of refugee settings.

FIGURE 6.3

Total funding to UN-managed humanitarian pooled funds, 2011–2015



iii. Purchasing

One unique example of purchasing occurred in Lebanon due to its highly privatized health care system. A **third-party auditor** was contracted by UNHCR to control costs incurred by UNHCR for secondary health care in Lebanon, while ensuring an appropriate level and quality of care was provided.

This was the first time UNHCR has undertaken such a process due to the unique circumstances of Lebanon. However, such a system may be considered in the future in countries that have a highly-privatized health care system (Box 4).

Box 4: Third Party Auditor for Healthcare Delivery in Lebanon to Syrian Refugees

The health care system in Lebanon is complex and highly privatized. As part of the 2013 partnership agreements with UNHCR, partners were tasked to assist refugees with access to secondary health care by providing the following sets of activities: 1) validating entitlements, getting pre-treatment approval, conducting peer reviews, and auditing hospital bills; 2) paying hospitals for hospitalization/treatment services based on the audited bills; and 3) ensuring hospitals bills for refugees would not exceed the Ministry of Public Health flat rates.

As a result of various challenges, including the complex hospital care system in Lebanon and the limited capacity of UNHCR Lebanon partners to provide secondary health care to refugees, a competitive bidding process was undertaken by UNHCR and a third-party auditor was selected. This company was a private for-profit company.

This company was used by many Lebanese to control their health care costs. In effect, it acted as an HMO to control costs incurred by UNHCR for secondary health care in Lebanon, while ensuring an appropriate level and quality of care was provided.

Pay for Success (Development Impact Bonds)

The Pay for Success (P4S) model is also referred to as “social impact bonds” or “development impact bonds” among other names, however the latter terms are confusing because P4S contracts are not truly bonds; they are more like loans.

Although P4S cuts across all four components of the health financing framework, we have decided to place it under purchasing, as its most predominant aspect.

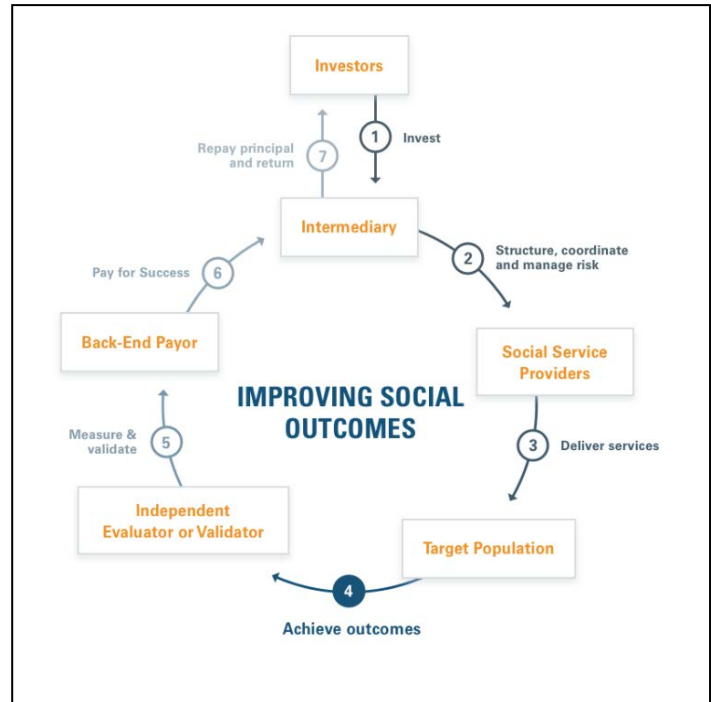
P4S contracts with investors, governments, bilateral or multilateral donors, and service providers to improve service delivery outcomes. Investors provide the capital for a program, and targets are set for service providers to achieve. Achieving these targets not only improves service delivery, but should also reduce the costs, and the savings generated are then used by the local government or donor to pay back investors over time. In theory, repayment only occurs if the program is successful, so investors assume the risk.

The basics of P4S can be found at this website: <http://www.payforsuccess.org/learn/basics/> where this P4S pathway (Figure 7) is found.¹⁴

Some of the essential points are:

- P4S links payments for service delivery to the achievement of impact indicators (not process indicators, which is what is often measured in such settings).
- Since the payer is not committed to paying for services if the desired outcomes are not achieved, donors or governments only repay investors if there is an improvement in health service delivery.
- Outcomes are measured according to pre-defined metrics and are verified by an independent agency.
- P4S contracts have financing agreements that provide upfront capital to support service delivery throughout the project period. Depending upon who provides the revenue, this could provide much needed funding from non-traditional donors, particularly the private sector.
- P4S requires time to undertake in-depth assessments requiring significant data, set up the financial arrangements, and negotiate among the various partners (Figure 7)

Figure 7: P4S Pathway



Recommendation 2: P4S is appropriate in protracted refugee settings, particularly camps, when addressing specific health interventions, but not broad health systems issues.

- **Ex-ante**
- **For protracted emergencies**

P4S requires a great deal of preparation, specific data, and measurement of impact indicators that are rarely available at the beginning and early stages of an emergency. Furthermore, during the acute phase of an emergency, one must address the whole health system in a comprehensive manner, which makes it difficult for P4S to be applied. For example, the causal pathways for the ultimate impact indicator of reducing mortality are often not easily attributable to specific interventions, but rather are due to a combination of complex and interdependent factors.

Consequently, we recommend that specific interventions that are relatively easy to measure and where evidence already exists of their efficacy and effectiveness use P4S. These include increasing vaccination coverage (measured as fewer measles or cholera outbreaks), improved birth outcomes (measured as deliveries with a skilled birth attendant), and reducing deaths due to a malaria (measured as spraying, bed nets, rapid diagnostic tests, following treatment protocols, etc..).

These specific interventions all are possible to implement and measure in protracted refugee settings, particularly in refugee camps. Measurement of numerators and denominators are more easily obtained than in out-of-camp settings, and partners are often international or national NGOs with clear roles and responsibilities. Refugees have fewer choices regarding services in camps than out of camp. **Therefore, P4S has an important but relatively limited role in the delivery of specific health interventions in protracted refugee settings, particularly camps.**

P4S would allow for private sector funds to finance these types of interventions, at a time when funding is often waning in protracted and forgotten refugee settings. Furthermore, the effectiveness of the service providers to deliver these interventions would increase and the costs may decrease.

iv. Provision

For a variety of reasons discussed above and elucidated further below, **the preferred provider of health services is the government, when there is sufficient capacity and when delivery is in an integrated manner to both refugees and nationals.** However, even if the government is the main provider of services, there is still a role for other providers, including international and national NGOs, faith-based organizations and the private sector.

The roles of these groups are context specific and examples are provided throughout the document.

v. Insurance

Traditional insurance, indexed insurance, and reinsurance cuts across all four components of the health financing framework.

Insurance can operate at several levels in emergency-prone contexts, offering payouts to

states, organizations, communities or individuals. Regional risk transfer and insurance mechanisms for **natural disasters** have existed for over a decade and are increasingly used for other catastrophes, such as pandemics. Mutualizing risk shares costs associated with loss and risk among many parties, so that no one entity is solely responsible. Governments, businesses, communities, or multilateral agencies can pool funds to protect populations against humanitarian crises, linking payment to emergencies, pandemics or natural disasters.^{1,8}

Some examples of indexed insurance and catastrophe bonds for natural disasters include the **African Risk Capacity group**¹⁵ and the **Caribbean Catastrophe Risk Insurance Facility**,¹⁶ described in Boxes 5 and 6.

Box 5: The African Risk Capacity (ARC) group

The ARC group holds governments accountable for mitigating crises and guaranteeing quick service delivery, especially through appropriate planning. The ARC is Africa's first sovereign catastrophe insurance pool. It is informed by data from the Africa RiskView, which combines weather and crop data with information on vulnerable populations and historic analysis of the costs of response. Payouts to ARC policy-holding governments are triggered when the estimated cost of responding crosses a certain pre-defined threshold.

Since its launch in May 2014, nine countries have joined the ARC and three participating countries (Mauritania, Niger and Senegal) have received their first payouts totaling a combined USD 26 million.

ARC aims to target between 20 and 30 countries for membership in the next four years, thus reducing the cost of overall insurance premiums for participating governments.

Box 6: The Caribbean Catastrophe Risk Insurance Facility (CCRIF)

CCRIF offers insurance coverage to Caribbean governments for natural disasters, combining it with capital market instruments and a parametric index. Initially a public-private partnership supported by the World Bank and other donors, the CCRIF covers 17 countries for earthquakes, tropical cyclones, and excessive rainfall. Countries purchase insurance through an annual premium, and are insured for up to \$100 million. If an event occurs, payouts disburse within two weeks. The CCRIF uses segregated portfolios to manage risk while maintaining a single operational structure. In addition to offering insurance, the CCRIF finances itself through the reinsurance market, catastrophe bonds, and catastrophe swaps.

To reinsure the CCRIF, the World Bank issued \$30 million in catastrophe bonds. The bonds rely on a parametric index that can be triggered annually, and they cover some of the risk from storm surges, wind from tropical cyclones, and damages from earthquakes. If the trigger occurs, then the principal is reduced (by preset terms) and paid to CCRIF. The investors are private funders and companies, which can trade these bonds on secondary markets. The bond coupon equals LIBOR (a common benchmark for short-term interest rates) plus 6.3% to 6.5%.

Following the recent Ebola epidemics in West Africa, the World Bank together with WHO and other partners are establishing a **Pandemic Emergency Financing Facility** that has specific triggers for specific pandemics. There is an insurance, bond, and cash window (Box 7).¹⁷

Box 7: Pandemic Emergency Financing Facility (PEF)

The World Bank is preparing the PEF to issue catastrophe bonds that cover pandemics. It is an innovative insurance-based mechanism that will provide surge funding in the form of grants to LICs to respond to rare, high severity disease outbreaks on the regional level to prevent them from becoming pandemics. PEF is needed because there is no fast-disbursing financing mechanism that can provide significant funds to resource-constrained countries early enough to help them fight an epidemic outbreak that is escalating. PEF was developed by World Bank Group in collaboration with WHO and other public-private sector partners. There are clear categories of what PEF will fund, how it will work, and how it will be governed.

It includes an insurance/bond window and a cash window.

Insurance/bond window: The insurance window covers a maximum amount of USD 500 million over 3 years through catastrophic (pandemic) bonds and pandemic insurance. Payment is triggered by an outbreak of specific diseases, or disease families with pandemic potential, and each disease has a maximum insurance coverage per event. To provide coverage, both premiums and bond coupons are paid by development partners. If there is a catastrophe, then funding is released according to parametric criteria. The parametric indices are based on outbreak size, severity, and spread, and have verified action criteria. The payout is based on layered activation criteria.

Cash window: The cash window covers a maximum amount of USD 100 million, replenished annually through donors. It complements the insurance window by:

- 1) Providing supplemental financing for addressing pathogens covered by insurance (e.g. before insurance activation or to supplement insurance payouts);
- 2) Covering severe outbreaks not included in the insurance scheme (e.g. new or different pathogens, or single-country outbreaks); and
- 3) Acting as a conduit for efficient and effective surge financing during crisis for development partners.

The cash window provides more flexibility to respond to emergency pathogens or situations that may not meet insurance activation criteria. The disbursements are also decided by activation criteria principles, but with more flexibility. A Steering Committee makes all decisions related to the cash window, which are also informed by technical experts' advice.

In addition, the PEF funds are given to two types of responders:

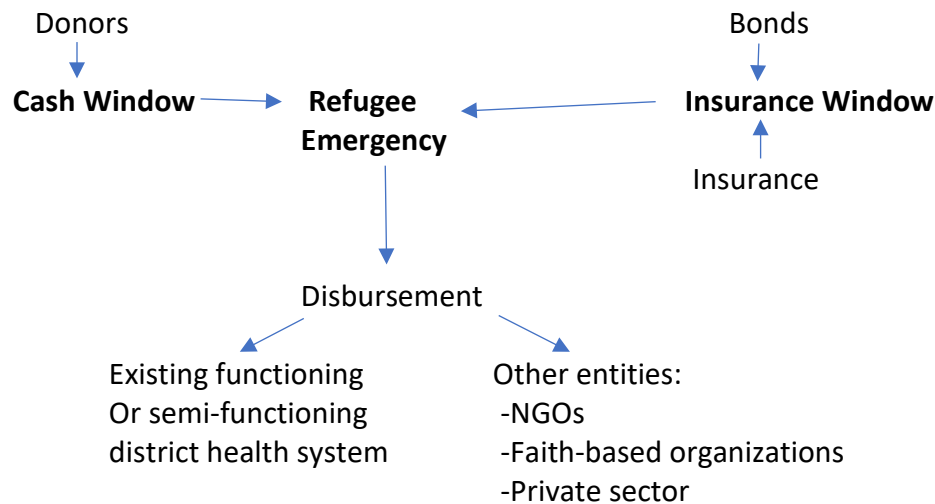
- 1) National entities (e.g. Ministries of Health); and
- 2) Accredited international organizations and NGOs

Recommendation 3: Consider the creation of a ‘Refugee Health Financing Emergency Facility’

- Ex-ante, risk transfer
- For acute emergencies

Similar to PEF, resources could be mobilized through cash and insurance windows.

Figure 8: Refugee Health Financing Model (modified from PEF)



Objective: Provide funding from diverse sources using a variety of financing mechanisms, to health systems for refugees during the acute phase of an emergency.

- Cash window will be **UN pooled funds**; a mechanism that exists already.
 - Existing rules of disbursement need to be re-examined and decisions more evidence-based and transparent.
- Insurance window will consist of **bonds** financed from the private sector with clear parametric indices.
 - For bonds, there are at least two alternatives:
 - **Short-term bonds** that are meant to bridge a gap due to insufficient funds at the beginning of an emergency. Guarantees from donors or UN agencies to repay the bond at specific time could be provided to reduce risk. However, with this mechanism, funds from different sources, likely more traditional ones, would have to be found to eventually pay back the bond holders.

Longer-term bonds with their implicit risk could be issued with no guarantee of repayment of principle. These bonds may have higher yields than the ‘short-term’ bonds discussed above.

- Insurance window will consist of **insurance** financed from the private sector, donors, and UN agencies (e.g. UNHCR) with clear parametric indices.
 - Note that UNHCR expends hundreds of millions of dollars each year on health services for refugees. Some of these funds could be ‘set aside’ for health insurance pre-emergency.
- Indices considered could include:
 - The Fragile States Index (FSI) produced by the Fund for Peace (FFP). It is a critical tool in highlighting not only the normal pressures that all states experience, but also in identifying when those pressures are pushing a state towards the brink of failure (see Annex 1).¹⁸
 - A certain number of refugees crossing a border
- However, it is important to note that academics and actuaries would need to undertake considerable analysis to decide if the risk is measurable and predicable
- When possible, funds should go to national/regional/district level offices that manage national health systems and are responsible for integrating refugees.
 - Existing health systems, whether functional or semi-functional, will likely need increased capacity and support from UN and international NGOs (INGOs).
- If national health systems at the regional or district level are not functional or cannot sufficiently address the emergency needs of refugees, then other entities should receive the funds. These entities include the UN, INGOs, faith-based organizations, and in some rare circumstances the private sector (e.g. mostly privatized health systems, such as Lebanon).
 - Since the objective is to have refugees integrated into the national health system with funds used to improve the system for nationals and refugees, incentives and agreements should be put into place with the non-governmental entities to ensure that once the situation is more stable, refugees will move from these ‘parallel’ systems to national systems. Doing so will require capacity building the latter.
- It is acknowledged that any private sector participants would have to earn a profit to cover operational costs, and that adverse selection is a problem.

Traditional Insurance

Insurance companies pool risk by having the insured pay premiums to the insurer. Should any insured entity suffer a loss, the insurance company will cover them. Insurance companies must demonstrate credibility prior to contracting, or that they can pay claims if an emergency occurs. Typically, a certified actuary reviews their financing plan and decides if it is adequate.

Insurers also often buy reinsurance from a third party. Reinsurance shares risk (and gain), and reduces loss in the case of an extreme event that the insurer cannot pay for.

A government or organization insuring humanitarian emergencies needs to determine how much risk it retains and how much it transfers, or whether it would just buy an insurance policy from a private company. There are various types of insurance schemes (Table 3).¹⁹

Table 3: Types of Insurance Schemes¹⁹

	Privately funded (private insurance)						Publicly funded through some form of taxation (public insurance)			
Type of enrolment (Voluntary–mandatory)	Voluntary	Voluntary	Voluntary	Voluntary	Mandatory	Voluntary	Mandatory	Voluntary	Mandatory	Mandatory
Type of contributions (Risk-rated–community-rated–income-based)	Risk-rated	Risk-rated	Community-rated	Community-rated	Community-rated	Income-based	Community-rated	Income-based	Income-based	Income-based
Type of management (Private for-profit–non-profit–public)	For-profit commercial	Non-profit	Non-profit community	Public	Non-profit	Non-profit	For-profit commercial	Public	Non-profit	Public
Examples	Tata AIG in India	BUPA in United Kingdom	Self-employed Women’s Association health insurance in India	Medibank in Australia	Collective Health Care Institutions (CHCI) in Uruguay	Some private health insurance plans (known as ISAPRES) in Chile	Various in Switzerland	Seguro Popular in Mexico	Various in the Netherlands	Slovakia

Health Insurance for Refugees

In protracted settings, when the health situation is relatively stable, health insurance for refugees should be considered. Protracted settings are defined as a refugee situation of more than 5 years. Examples include Jordan, Lebanon, and Turkey, which have a stable health situation and host Syrian refugees, although not Syria itself. UNHCR developed a guidance note on health insurance schemes for refugees and other persons of concern to UNHCR that provides strong direction.²⁰

There are numerous direct and indirect benefits in providing health insurance to refugees. Improved access to health services and financial protection are clearly the two largest benefits. Indirect benefits include an official piece of documentation (the health insurance card) that may protect refugees from harassment by authorities and provide refugees with a sense of belonging and security – or allow them to send and receive remittances (Box 8). More data about refugees may be provided to UNHCR and its partners to allow for an objective decision as to who is vulnerable. Other data can be collected from health insurance companies about who uses which services where and for what reason. The protection benefits and data from different sources may also allow for improvement in other sectors and programs. Although equity is an important component in health care, it must be one of many factors to be considered in making a decision regarding health insurance. While a scheme may exclude a group of especially vulnerable refugees or those with specific illnesses, it may still be cost effective for some or the majority of refugees to be able to voluntarily have the opportunity to have health insurance.²⁰

Box 8: Refugee Health Insurance in the Islamic Republic of Iran

The Islamic Republic of Iran and UNHCR launched the health insurance scheme for Afghan refugees in 2011 through a semi-private insurance company (HISE). HISE was made available to registered refugees on an individual and voluntary basis with the overall goal of improving equity and financial access to in-patient services, with a special focus on vulnerable populations. Launching of HISE also aimed at generating additional opportunities for further improvement of refugees' access to healthcare and creating a positive impact on their health status. Through minimizing the financial burden of vulnerable refugees, HISE also aimed at indirectly generating positive impacts on the prevention of gender-based violence, school drop-outs, and other issues. The scheme provided complementary health insurance coverage to 331,003 Afghan refugees, including 214,652 vulnerable persons and 116,351 non-vulnerable refugees. Registered refugees in Iran have the possibility to have work permits and thus livelihoods. This allows some of them to pay for their premiums and co-payments themselves. For those who could not but fit the vulnerability criteria, UNHCR covered their costs. In 2015, negotiations were concluded with the government to allow refugees access to the national health insurance scheme.

The main objective of health insurance should be for refugees to integrate into existing national systems if they exist and are functioning. If they are 'semi-functional', external financial assistance and expertise may help some national systems improve sufficiently to provide health services for their citizens and refugees. Numerous countries in Africa have integrated UHC into their national frameworks, but progress towards implementation has been uneven.²¹ In the future, as more countries in Africa have UHC, the more feasible it will be for refugees to integrate into such systems.

For health insurance for refugees to be feasible and sustainable, however, refugees must earn **livelihoods** to pay for their premiums and co-share costs. The issue of livelihoods is complex and will not be discussed in detail here. However, they are essential to reduce refugee

dependency as well as the amount of donor assistance. The World Bank's 2016 report entitled 'Forcibly displaced: toward a development approach that supports refugees, the internally displaced, and their hosts' shows that refugee influxes often benefit the local economy, although who benefits within that community is more nuanced.

There will always be vulnerable populations in all societies that cannot afford to pay for health insurance. Decisions as to who is vulnerable and who will help to pay (fully or partially) for these vulnerable persons will need to be made. Depending upon the number of refugees contributing to the national system, the risk pool may have sufficiently grown to allow for subsidizing the insurance premiums and co-payments for these refugees as occurs with nationals. Other sources of revenue could come from UNHCR, which is currently funding hundreds of millions of dollars in health care services via government and NGOs, many of which are parallel services.

Recommendation 4: Assess the possibility of integrating refugees into health insurance schemes in protracted settings and implement if feasible.

- **Post-ante, risk transfer**
- **For protracted emergencies**

In summary, health insurance for refugees in protracted settings should be explored. In those countries where national systems are functioning or can be supported to become functional, the preference is for refugees to be integrated into such national systems. An infusion of funds from donors, UNHCR and other organizations will likely be needed together with technical support to capacitate the existing system. Allowing refugees to work will provide them with a means to cover their costs. If health insurance is mandatory for refugees as well as nationals, the risk pool should increase sufficiently to support the system. Subsidies for vulnerable refugees should be along the same lines as those for nationals.

If national health systems are not functioning and cannot provide sufficient access and quality of services to both nationals and refugees, then other forms of insurance can be explored.

The provision of **private health insurance** is one possibility, but it is generally significantly more expensive than national health insurance. In general, refugees should be provided with the similar level of services to that of the 'average' national.²² In most countries where refugees are located, it is unlikely that the 'average' national can afford private health insurance. Thus, it is unlikely that refugees will be able to afford private health insurance.

Table 4: UNHCR’s Health Insurance Schemes for Refugees, 2015²³

Country	Type of health insurance	No of beneficiaries	Since when?
Malaysia (KL)	Group voluntary health insurance	~600	2014
Iran	HISE 3 (planning for HISE 4)	220,000	2011
DRC (Kinshasa)	NGO run/ UNHCR funded mutuelle (no exclusions but very expensive ...)	8,000	2009
Ghana	National Health Insurance Scheme	Potentially all refugees	2013
Togo	National Mutuelle framework		2015
Russian Federation	voluntary health insurance (commercial) UNHCR funded	800	2010
Jordan	Government, commercial (?)		
Rwanda	Mutuelle (implemented by MoH)		
Senegal	Mutuelle	3,850	2012
Guinea	NGO-run/UNHCR-funded mutuelle to be transformed into community-based mutuelle		
Mali	Mutuelle	700	2013

Microinsurance and Community-Based Health Insurance Schemes²⁴

The terms microinsurance and community-based health insurance are often used interchangeably; however, microinsurance is a broader concept that includes community-based health insurance (CBHI) schemes. Microinsurance refers to public, private, not-for-profit or community-based insurance schemes whose services are tailored to the needs of the poor, and which operate on a local level. Microinsurance targets those who would normally be excluded from mainstream insurance coverage. It protects the vulnerable from risks specific to their situation (e.g. flooding, catastrophic health expenditure), based on the risk likelihood and cost. Individuals pay low premiums to a small pool, and the fund provides limited coverage with a small but still meaningful payout. Microinsurance schemes are often integrated into already existing social protection systems.

Problems arise when trying to enroll the extremely poor, as they cannot pay into the pool and so they may need to be subsidized. Microinsurance schemes can also be difficult to maintain, especially for health, as they require individuals to consistently pay into the pool and may collapse if too many people withdraw at once.

CBHI is a microinsurance scheme focused on mitigating health risks that is managed on the community level by a community organization, rather than a public, private or not-for-profit group. The community organization collects premiums and pools funds to protect enrolled community members from risks. Enrollment is voluntary, and usually these schemes emerge when the social protection system or private sector cannot reach affected individuals. CBHI generally has low transaction costs and high trust but, like microinsurance, struggles with maintaining enrollment and creating a large enough pool to adequately cover multiple claims at once.

Along with traditional insurance, microinsurance and CBHI for refugees in protracted settings should also be explored. It can substitute, complement, link with, supplement, or provide an alternative for other healthcare mechanisms.

The **Global Concessional Financing Facility (GCFF)**, launched in 2016, provides financial support to middle income countries addressing humanitarian crises. While relying on grants from donor countries, it leverages every dollar to yield four times the amount for concessional financing (long-term loans with low interest). The GCFF will expand to a global scale a facility launched earlier to support Jordan and Lebanon, to ensure there is a coordinated international response to refugee crises in middle income countries. (Box 9).²⁵ This GCFF should be able to facilitate refugees integrating into national health systems by injecting much needed capital to address capacity issues that may exist in refugee hosting countries.

Box 9: The Global Concessional Financing Facility

The Global Concessional Financing Facility (GCFF) provides financial support to middle income countries impacted by refugee crises across the globe. It bridges the gap between humanitarian and development assistance and strengthens the resilience of countries impacted by refugee crises by assisting both host communities and refugees. It supports policy reforms and programs in areas such as education, health, and job creation to create sustainable development outcomes.

The GCFF builds upon the Concessional Financing Facility for the Middle East and North Africa (MENA CFF), expanding it globally to middle income countries. Both are part of the World Bank's Global Crisis Response Platform, which responds to crises by combining knowledge, resources, and financial tools in a manner that emphasizes systematic, scaled-up support.

The GCFF relies on grants from donor countries, but leverages every dollar to yield four times the amount for concessional financing (long-term loans with low interest). The project facilitates the coordination among humanitarian agencies and development banks, so that they respond to refugee emergencies together. Its current goal is to raise USD 1 billion in grants for Jordan and Lebanon, as well as USD 500 million in grants for other middle income countries, during the next five years. In doing so, the GCFF would actually generate USD 6 billion as concessional financing.

Agreements between the European Union and Turkey, as well as Jordan, include economic incentives and duty-free zones that should aid Turkish and Jordanian economies. Hopefully, further research continues to show that refugees together with the assistance that comes with them may improve the host economies. If this situation is combined with economic incentives for host countries that will incentivize them to allow refugees to work, then the costs of external funding for health care in these settings should decline.

In 2016, the World Bank shareholders established a **USD 2 billion window under IDA18 to support refugee hosting countries**, with the justification that developing countries will not use their scarce resources to cover non-nationals. IDA (lowest income) countries who host more than 25,000 refugees, or have a population that is more than 0.1% refugees, can access these funds. They will be distributed according to how many refugees they are hosting. Eighty-three percent (83%) of the funds will come from this window and 17% from their regular IDA allocation. In order to access the funds, the countries will have to submit a policy note on their approach to refugees, which has to be accompanied by an eligibility note from the Bank when going to the Board for approval. To help county teams and Governments use these funds, and use them strategically, the World Bank has been undertaking “Forced Displacement Strategy Notes” in collaboration with UNHCR.

There are many refugee camps throughout the world that continue to provide parallel health services to refugees. Some are located in remote areas, while others are near more populated locales. UNHCR continues to provide funding for those parallel health services, primarily to NGOs. For the most part, refugees have limited or no livelihoods in these camps, and thus health services remain free of charge. In long-term protracted refugee camps, compared to host country nationals, mortality rates are generally lower and maternal-child health outcomes are generally better.^{26,27} In many of these camps, between 5% and 20% of patients are nationals themselves (Spiegel, personal communication).

Missions have been undertaken in various African countries to turn these camps into ‘villages’. The objective is to integrate services for refugees into national health and educational systems, which in turn should improve those services for nationals. There is the possibility that the quality of services for refugees would fall as the parallel services provided by NGOs and funded by UNHCR are stopped. However, as mentioned previously, the principle is to provide a similar level of services to refugees to those received by nationals in that area.²² There have been many complications in moving from parallel to integrated services in these long-term refugee camps. Beyond political complications, experience suggests that in some settings an initial injection of funds is necessary; although there is insufficient documentation as to the cost of undertaking such a process. This would generally not be undertaken in isolation, but rather in conjunction with education and the development plans for that region of the country.

Recommendation 5: Consider various financial mechanisms to move from parallel health services to integrated health services in protracted refugee camp settings

- **Post-ante, risk transfer**
- **For protracted emergencies**

As the IDA18 progresses and begins to provide concessional loans to countries, particularly in Africa where many of these long-term camps exist, these concessional loans may prove an appropriate vehicle to allow for such a transition from camps to ‘villages’ with integrated services for nationals and refugees. As mentioned above, depending upon the existing health system, health insurance may be an option if refugees have the possibility to work.

7. Conclusion

There are some innovative health financing instruments that currently exist for development and natural disaster settings that could be adapted to refugee health settings according to different contexts. Recent developments such as the pandemic emergency financing facility following the Ebola epidemic in West Africa as well as the newly established Global Financing Facility show that innovative health financing mechanisms are feasible and there is strong interest by donors and the private sector. Furthermore, primarily due to the Syrian crisis, the World Bank Group and other bilateral and multi-lateral organizations are re-thinking how humanitarian aid and development assistance are provided. All of this provides a fertile environment to proactively consider how innovative humanitarian health financing can be explored and implemented in refugee settings taking into account different contexts.

There remain, however, many unanswered questions that need to be explored, with data that are not currently available.

- Except for health insurance, many of the other financial instruments discussed here could be used beyond the health sector for refugee settings (particularly the education sector). *Should a global ‘Refugee Financing Facility’ be created that covers all sectors?*
- Unlike for natural disasters where parametric indices are predicable to measure risk, such indicators do not yet exist for refugee settings. *Can measurable and predictable parametric indices be developed pre-emergency for refugee settings?*
- Data are not yet available in most refugee contexts to compare the costs of refugee health care (and other sectors) in camps compared to out of camp settings. However, it is likely that such data could be collected and modeled to address this issue. Such data would be important for acute emergencies as well as transforming parallel health systems in camps to integrated models. *How can we gather this data?*

- Pay for Success (P4S) can be administratively heavy to establish and robust data are needed. P4S has not yet been implemented in the acute emergency phase, and thus we do not know if it can be successfully applied. For this reason, P4S has been recommended in the protracted refugee camp settings for specific interventions. *Can P4S succeed in different refugee contexts at scale?*
- Health insurance for refugees is complex to implement at the country level, but it has been shown to be possible depending upon context.
 - *However, could a multi-national insurance company or some sort of consortium of such global insurance companies band together to provide a global health insurance policy for refugees?*
 - *Could such a scheme be established at different phases, including pre-emergency to potential refugees and acute emergency to new refugees? Is coordinating among insurance companies, the international humanitarian system, and governments logistically possible?*
 - *Would the costs of developing such a system be prohibitive?*
 - *Would we want to explore such a private scheme for the acute emergency phase when the ultimate goal is to integrate refugees into national health systems?*

This white paper provides many possibilities of different and innovative mechanisms to provide health funding and services in refugee settings. We hope that it will serve as the basis for numerous and diverse organizations in the public and private sector to explore these possibilities.

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20. Anant Udpa, Social Finance

Bibliography

1. African Risk Capacity. (2016). Vision and Mission. Retrieved from <http://www.africanriskcapacity.org/about/vision-and-mission>
2. Beck L, Schwab C, & Pinedo A. (2016). Social impact bonds: What's in a name? *Stanford Social Innovation Review*. Retrieved from https://ssir.org/articles/entry/social_impact_bonds_whats_in_a_name
3. Belinsky M, Eddy M, Lohmann J, & George M. (2014). The application of social impact bonds to universal health-care initiatives in south-east Asia. *WHO South-East Asia Journal of Public Health*, 3, 3-4
4. Billo A, & Boyer K. (2016). Investing in communities affected by conflict and crises. *Stanford Social Innovation Review*. Retrieved from https://ssir.org/articles/entry/investing_in_communities_affected_by_conflict_and_crises1
5. Blanchet K, et al. (2016). Syrian refugees in Lebanon: The search for universal health coverage. *Conflict and Health*, 10(12)
6. Caribbean Catastrophe Risk Insurance Facility. (2017). Homepage. Retrieved from <http://www.ccrif.org>
7. Caribbean Catastrophe Risk Insurance Facility. (2017). Understanding CCRIF - A collection of questions and answers. Retrieved from <http://www.ccrif.org/publications/understanding-ccrif-collection-questions-and-answers-revised-february-2016>
8. The Case Foundation. (2015). A short guide to impact investing. Retrieved from <http://casefoundation.org/wp-content/uploads/2014/09/Short-Guide-Oct2015-Digital-FINAL.pdf>
9. Catholic Agency for Overseas Development, Food and Agriculture Organization of the United Nations, & World Vision. (2015). *Future humanitarian financing: Looking beyond the crisis*
10. Center for Global Development. (2016). Payouts for perils: Insurance contracts for better emergency and humanitarian aid. Retrieved from <https://www.cgdev.org/working-group/payouts-for-perils>
11. Clarke D, Dercon S. (2016). *Dull disasters: How planning ahead will make a difference*. New York, NY: Oxford University Press.
12. Ericsson. (2016). Ericsson announces emergency wallet to support humanitarian response. Retrieved from <https://www.ericsson.com/news/2014566>
13. Evans S. (2017). Catastrophe bond & insurance-linked securities deal directory. Retrieved from http://www.artemis.bm/deal_directory/
14. Financial Industry Regulatory Authority. (2017). Investor alerts: Catastrophe bonds and other event-linked securities. Retrieved from

- <http://www.finra.org/investors/alerts/catastrophe-bonds-and-other-event-linked-securities>
15. The Financial Times. (2017). Definition of sukuk (Islamic bonds). Retrieved from [http://lexicon.ft.com/Term?term=sukuk-\(Islamic-bonds\)](http://lexicon.ft.com/Term?term=sukuk-(Islamic-bonds))
 16. Fund for Peace. (2016). *Fragile States Index 2016*. Retrieved from <http://library.fundforpeace.org/fsi16-report>
 17. Gavi the Vaccine Alliance. (2015). *The 2015 pneumococcal vaccine report*. Retrieved from <http://www.gavi.org/funding/pneumococcal-amc/>
 18. The Global Financing Facility. (2016). FAQ. Retrieved from www.globalfinancingfacility.org/faq
 19. The Global Financing Facility. (2016). Introduction. Retrieved from www.globalfinancingfacility.org/introduction
 20. The Global Financing Facility. (2016). Our approach. Retrieved from www.globalfinancingfacility.org/our-approach
 21. The Global Financing Facility. (2016). Private sector engagement strategy. Retrieved from https://www.globalfinancingfacility.org/sites/gff_new/files/Private%20Sector%20Engagement%20Strategy.pdf
 22. Global Humanitarian Assistance. (2015). *Global Humanitarian Assistance Report 2015*. Retrieved from <http://www.globalhumanitarianassistance.org/report/gha-report-2015/>
 23. Global Humanitarian Assistance. (2016). *Global Humanitarian Assistance Report 2016*. Retrieved from <http://www.globalhumanitarianassistance.org/wp-content/uploads/2016/07/GHA-report-2016-full-report.pdf>
 24. Hafeez A, Riaz R, Shah S, Pervaiz J, & Southall D. (2004). Integrating health care for mothers and children in refugee camps and at district level. *British Medical Journal*, 328(7443), 834-6
 25. Hynes M, Sheik M, Wilson HG, Spiegel P. (2002). Reproductive health indicators and outcomes among refugee and internally displaced persons in post-emergency phase camps. *JAMA*, 288(5), 595-603
 26. International Committee of the Red Cross. (2015). Impact finance and capital market: A trend for humanitarians? Retrieved from <http://blogs.icrc.org/gphi2/2015/07/20/impact-finance-and-capital-market-a-trend-for-humanitarians/>
 27. The International Finance Facility for Immunisation. (2015). Global finance magazine recognises IFFIm sukuk. Retrieved from <http://www.iffim.org/Library/News/Announcements/Global-Finance-magazine-recognises-IFFIm-sukuk/>
 28. The International Finance Facility for Immunisation. (2016). IFFIm awarded prize for 'innovation in Islamic finance 2015'. Retrieved from

- <http://www.iffim.org/Library/News/Announcements/IFFIm-awarded-prize-for--Innovation-in-Islamic-Finance-2015-/>
29. The International Finance Facility for Immunisation. (2016). Investor presentation. Retrieved from <http://www.iffim.org/library/audio-visual/presentations/iffim-investor-presentation/>
 30. The International Finance Facility for Immunisation. (2016). Overview. Retrieved from <http://www.iffim.org/about/overview/>
 31. Investopedia. (2017). Catastrophe bond. Retrieved from <http://www.investopedia.com/terms/c/catastrophebond.asp>
 32. Investopedia. (2017). Libor. Retrieved from <http://www.investopedia.com/terms/l/libor.asp>
 33. Jensen R. (2013). "Social impact bond" buzz heads west. *The Bond Buyer*. Retrieved from <https://www.bondbuyer.com/news/social-impact-bond-buzz-heads-west>
 34. Kutzin J. (2016). *WHO pre-conference workshop - why and how to approach UHC in Africa from a public finance perspective?* Presentation. Retrieved from http://apps.who.int/health_financing/events/JosephKutzin-why-and-how-to-approach-uhc-in-africa-from-a-public-finance-perspective.pdf
 35. Malkawi K. (2014). Gov't had no other choice but to stop providing free healthcare to Syrians. *Jordan Times*. Retrieved from <http://www.jordantimes.com/news/local/govt-had-no-other-choice-stop-providing-free-healthcare-syrians-%E2%80%94-hiasat>
 36. McCoy D, Chand S, & Sridhar D. (2009). Global health funding: How much, where it comes from and where it goes. *Health Policy and Planning*, 24, 407–417
 37. Meghani A, & Basu S. (2015). A review of innovative international financing mechanisms to address noncommunicable diseases. *Health Affairs*, 34(9), 1546–1553
 38. Mendoza N. (2015). The next wave of development finance innovation. *Devex*. Retrieved from <https://www.devex.com/news/the-next-wave-of-development-finance-innovation-87139>
 39. Nonprofit Finance Funds. (2017). What is pay for success? <http://www.payforsuccess.org/learn/basics/>
 40. Orach C, Dubourg D, & De Brouwere V. (2007). Costs and coverage of reproductive health interventions in three rural refugee-affected districts, Uganda. *Tropical Medicine and International Health*, 12(3), 459–469
 41. Overseas Development Institute. (2007). *Remittances during crises implications for humanitarian response*. Retrieved from <https://www.odi.org/publications/228-remittances-crisis-humanitarian-response>
 42. Overseas Development Institute. (2016). *Time to let go: remaking humanitarian action for the modern era*. Retrieved from <https://www.odi.org/sites/odi.org.uk/files/resource-documents/10422.pdf>

43. Pauly M, & Swanson A. (2013). *Social impact bonds in nonprofit health care: New product or new package? Working paper 18991*. National Bureau of Economic Research. Retrieved from <http://www.nber.org/papers/w18991>
44. Plaza S, Navarrete M, & Ratha D. (2011). *Migration and remittances household surveys in Sub-Saharan Africa: Methodological aspects and main findings*. Retrieved from http://siteresources.worldbank.org/EXTDECPROSPECTS/Resources/476882-1157133580628/Plaza_Navarrete_Ratha_MethodologicalPaper.pdf
45. The Rockefeller Foundation. (2017). Innovative finance and impact investing. Retrieved from <https://www.rockefellerfoundation.org/our-work/initiatives/innovative-finance/>
46. Rowley E, Burnham G, & Drabe R. (2006). Protracted refugee situations: Parallel health systems and planning for the integration of services. *Journal of Refugee Studies*, 19(2)
47. Sekhri N, Savedoff W. (2005). Private health insurance: Implications for developing countries. *Bulletin for the World Health Organization*. 83(2), 127-34
48. Sommers L. (2015). Pandemic bonds have potential to be win-win-win. Retrieved from <http://larrysummers.com/2015/10/13/pandemic-emergency-financing-has-the-potential-to-be-a-win-win-win/>
49. Spiegel P, Sheik M, Gotway-Crawford C, Salama P. (2002). Health programmes and policies associated with decreased mortality in displaced people in post-emergency phase camps: a retrospective study. *Lancet*, 360(9349), 1927-34
50. UN News Centre. (2017). UN releases \$100 million to sustain relief operations in world's most neglected crises. Retrieved from <http://www.un.org/apps/news/story.asp?NewsID=56064>
51. UNITAID. (2017). Innovative financing: the air ticket levy. Retrieved from <http://www.unitaid.eu/en/how/innovative-financing>
52. United Nations High Commissioner for Refugees. (2011). A guidance note on health insurance schemes for refugees and other persons of concern to UNHCR. Retrieved from <http://www.unhcr.org/4f7d4cb1342.pdf>
53. United Nations High Commissioner for Refugees. (2014). Global Strategy for Public Health Public Health - HIV and Reproductive Health - Food Security and Nutrition- Water, Sanitation and Hygiene (WASH), 2014-2018. Retrieved from <http://www.unhcr.org/530f12d26.pdf>
54. United Nations High Commissioner for Refugees. (2015). Jordan refugee response - vulnerability assessment framework. Retrieved from <http://www.alnap.org/resource/20534>
55. United Nations High Commissioner for Refugees. (2015). Meeting on health insurance for refugees.
56. United Nations High Commissioner for Refugees. (2015). UNHCR - figures at a glance. Retrieved from <http://www.unhcr.org/en-us/figures-at-a-glance.html>

57. United Nations High Commissioner for Refugees. (2015). World at war - Global trends in forced displacement in 2014. Retrieved from <http://www.unhcr.org/556725e69.pdf>
58. United Nations High Commissioner for Refugees. (2016). Health access and utilization survey: access to health services in Jordan among refugees from other nationalities. Retrieved from <https://data2.unhcr.org/en/documents/download/54666>
59. United Nations High Commissioner for Refugees. (2017). Figures at a glance. Retrieved from <http://www.unhcr.org/en-us/figures-at-a-glance.html>
60. United Nations High Commissioner for Refugees, & Social Performance Task Force. (2016). *Serving refugee populations: The next financial inclusion frontier guidelines for financial service providers*. Retrieved from <https://sptf.info/images/Guidelines-for-FSPs-on-serving-refugee-populations-Nov2016.pdf>
61. United Nations Office for the Coordination of Humanitarian Affairs. (2016). About CERF. Retrieved from http://www.unocha.org/cerf/sites/default/files/CERF/About%20CERF/AboutCERF_EN_20161111.pdf
62. United Nations Office for the Coordination of Humanitarian Affairs. (2017). Who we are. Retrieved from <http://www.unocha.org/cerf/about-us/who-we-are>
63. Vargas-Silva, C. (2016). *Literature review: Remittances sent to and from refugees and internally displaced persons*. Retrieved from http://www.knomad.org/docs/working_papers/KNOMAD%20WP%202012%20Lit%20Review%20Remittances%20tofrom%20Refugees%20and%20IDPs.pdf
64. Wiechers, T. (2013). *Microinsurance and social protection*. Microinsurance Network. Retrieved from http://www.microinsurancenetw.org/sites/default/files/Microinsurance_and_Social_Protection_FINAL_0.pdf
65. The World Bank Group. (2014). World bank issues its first ever catastrophe bond linked to natural hazard risks in sixteen Caribbean countries. *Press Releases*. Retrieved from <http://treasury.worldbank.org/cmd/htm/FirstCatBondLinkedToNaturalHazards.html>
66. The World Bank Group. (2016). Following the refugees: New global concessional financing facility. *News*. Retrieved from <http://www.worldbank.org/en/news/feature/2016/10/04/following-the-refugees-new-global-concessional-financing-facility>
67. The World Bank Group. (2016). Global concessional financing facility flyer. Retrieved from <http://pubdocs.worldbank.org/en/222001475547774765/FlyerGlobalCFF.pdf>

68. The World Bank Group. (2016). Pandemic emergency facility: Frequently asked questions. *Brief*. Retrieved from <http://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-facility-frequently-asked-questions>
69. World Economic Forum. (2016). Impact investing across asset classes. Retrieved from <http://reports.weforum.org/impact-investment/3-impact-investment-sector-assessment/3-4-impact-investing-across-asset-classes/>
70. World Health Organization. (2008). Sharing the burden of sickness: Mutual health insurance in Rwanda. *Bulletin for the World Health Organization*. Retrieved from <http://www.who.int/bulletin/volumes/86/11/08-021108/en/>
71. World Health Organization. (2009). *Taskforce for Innovative International Financing for Health Systems. Working Group 2: Raising and Channelling Funds. Progress report to Taskforce*. Retrieved from http://www.who.int/pmnch/media/membernews/2009/20090319_tfwg2.pdf
72. World Health Organization. (2015). *Contingency fund for emergencies*. Presentation. Retrieved from http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/Contingency-Fund-Emergencies.pdf
73. World Health Organization. (2016). Emergency capacities. Retrieved from http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/en/
74. World Health Organization. (2016). *UHC in Africa: A framework for action*. Retrieved from <http://documents.worldbank.org/curated/en/735071472096342073/pdf/108008-v1-REVISED-PUBLIC-Main-report-TICAD-UHC-Framework-FINAL.pdf>
75. World Health Organization. (2017). Health financing for universal coverage. http://www.who.int/health_financing/universal_coverage_definition/en/
76. World Humanitarian Summit. (2015). *High-level panel on humanitarian financing report to the secretary-general: Too important to fail — addressing the humanitarian financing gap*. Retrieved from <http://reliefweb.int/sites/reliefweb.int/files/resources/%5BHLP%20Report%5D%20Too%20important%20to%20fail%E2%80%94addressing%20the%20humanitarian%20financing%20gap.pdf>
77. Xavier D. (2016). *Forcibly displaced: toward a development approach that supports refugees, the internally displaced, and their hosts*. Retrieved from <https://openknowledge.worldbank.org/handle/10986/25016>

Annex 1: Fragile State Index¹⁸

Social Indicators

Demographic Pressures

Pressures on the population such as disease and natural disasters make it difficult for the government to protect its citizens or demonstrate a lack of capacity or will.

Includes pressures and measures related to:

- Natural Disasters
- Disease
- Environment
- Pollution
- Food Scarcity
- Malnutrition
- Water Scarcity
- Population Growth
- Youth Bulge
- Mortality

Group Grievance

When tension and violence exists between groups, the state's ability to provide security is undermined and fear and further violence may ensue.

Includes pressures and measures related to:

- Discrimination
- Powerlessness
- Ethnic Violence
- Communal Violence
- Sectarian Violence
- Religious Violence

Refugees and IDPs

Pressures associated with population displacement. This strains public services and has the potential to pose a security threat.

Includes pressures and measures related to:

- Displacement
- Refugee Camps
- IDP Camps
- Disease related to Displacement
- Refugees per capita
- IDPs per capita
- Capacity to absorb

Human Flight & Brain Drain

When there is little opportunity, people migrate, leaving a vacuum of human capital. Those with resources also often leave before, or just as, conflict erupts.

Includes pressures and measures related to:

- Migration per capita
- Human Capital
- Emigration of Educated Citizens

Economic Indicators

Uneven Economic Development

When there are ethnic, religious, or regional disparities, governments tend to be uneven in their commitment to the social contract.

Includes pressures and measures related to:

- GINI Coefficient
- Income Share of Highest 10%
- Income Share of Lowest 10%
- Rural v. Urban Distribution of Services
- Improved Service Access
- Slum Population

Poverty & Economic Decline

Poverty and economic decline strain the ability of the state to provide for its citizens if they cannot provide for themselves and can create friction between "haves" and "have nots".

Includes pressures and measures related to:

- Economic Deficit
- Government Debt
- Unemployment
- Youth Employment
- Purchasing Power
- GDP per capita
- GDP Growth
- Inflation

Political and Military Indicators

State Legitimacy

Corruption and lack of representativeness in the government directly undermine social contract.

Includes pressures and measures related to:

- Corruption
- Government Effectiveness
- Political Participation
- Electoral Process
- Level of Democracy
- Illicit Economy
- Drug Trade
- Protests and Demonstrations
- Power Struggles

Security Apparatus

The security apparatus should have a monopoly on use of legitimate force. The social contract is weakened where affected by competing groups.

Includes pressures and measures related to:

- Internal Conflict
- Small Arms Proliferation
- Riots and Protests
- Fatalities from Conflict
- Military Coups
- Rebel Activity
- Militancy
- Bombings
- Political Prisoners

Public Services

The provision of health, education, and sanitation services, among others, are key roles of the state.

Includes pressures and measures related to:

- Policing
- Criminality
- Education Provision
- Literacy
- Water & Sanitation
- Infrastructure
- Quality Healthcare
- Telephony
- Internet Access
- Energy Reliability
- Roads

Factionalized Elites

When local and national leaders engage in deadlock and brinkmanship for political gain, this undermines the social contract.

Includes pressures and measures related to:

- Power Struggles
- Defectors
- Flawed Elections
- Political Competition

Human Rights & Rule of Law

When human rights are violated or unevenly protected, the state is failing in its ultimate responsibility.

Includes pressures and measures related to:

- Press Freedom
- Civil Liberties
- Political Freedoms
- Human Trafficking
- Political Prisoners
- Incarceration
- Religious Persecution
- Torture
- Executions

External Intervention

When the state fails to meet its international or domestic obligations, external actors may intervene to provide services or to manipulate internal affairs.

Includes pressures and measures related to:

- Foreign Assistance
- Presence of Peacekeepers
- Presence of UN Missions
- Foreign Military Intervention
- Sanctions
- Credit Rating

Annex 2: Examples of Other Existing Instruments

The **MultiCat Mexico Ltd. (Series 2012-1)** cat bonds insure **The Fund for Natural Disasters of Mexico (FONDEN)**, through a network of private insurers and reinsurers. USD 315 million in notes was issued, broken into three classes. Class A notes account for USD 140 million, insure against damage from earthquakes, are rated “B,” and have an 8% coupon. Class B notes account for \$75 million, insure the Atlantic coast of Mexico against hurricanes, are rated “B+,” and have a 7.75% coupon. Class C notes account for \$100 million, insure the Pacific coast of Mexico against hurricanes, are rate “B-,” and have a coupon of 7.5%. All three bonds use parametric triggers and mature in three years.²⁸

The **WHO Contingency Fund for Emergencies (CFE)** finances WHO emergency and disease outbreak response efforts through donor contributions. It supports WHO emergency responses for up to three months, incorporating financing, leadership, human resources and coordination. Disbursement occurs at the discretion of the Director-General, and all donor contributions are unearmarked and pooled. An initial amount is disbursed immediately, the second amount must be accompanied by a budget within 48 hours, and the third amount must be accompanied by a joint agency action plan within 72 hours.²⁹

International Finance Facility for Immunization (Iffim) Bonds: Iffim issues traditional bonds and sukuk (a financial certificate that complies with Islamic law) on international capital markets, making cash immediately available for Global Alliance for Vaccines and Immunization (GAVI) programs. Governments make long-term monetary pledges to Iffim, which finances bond repayment. No event is required for pay out; rather bonds can be issued when immediate capital is needed and then paid back by donors using the government pledges.^{30,31}

Advanced Market Commitment (Gavi, the Vaccine Alliance): Gavi commits to purchasing vaccines for developing countries in advance, thus promoting new vaccine research, vaccine manufacturing and vaccine distribution. It shapes and guarantees demand. In 2009, USD 1.5 billion was pledged for a pilot program for pneumococcal vaccines. Among its other goals, the AMC program accelerates the vaccine development process; guarantees the initial purchase price for a set amount of new vaccines and incentivizes manufacturers to scale up production; and ensures predictable supply to recipients through binding commitments with manufacturers that set low, long-term prices.³²

References

1. Global Humanitarian Assistance. Global Humanitarian Assistance Report 2016, <http://www.globalhumanitarianassistance.org/wp-content/uploads/2016/07/GHA-report-2016-full-report.pdf> Accessed March 10, 2017, 2016.
2. United Nations High Commissioner for Refugees. What is a refugee? <http://www.unrefugees.org/what-is-a-refugee/> Accessed April 10, 2017.
3. World Health Organization. Taskforce for Innovative International Financing for Health Systems. Working Group 2: Raising and Channelling Funds. Progress report to Taskforce. http://www.who.int/pmnch/media/membernews/2009/20090319_tfwg2.pdf Accessed March 15, 2017, 2009.
4. World Health Organization. Health financing for universal coverage. http://www.who.int/health_financing/universal_coverage_definition/en/ Accessed March 13, 2017.
5. Overseas Development Institute. Time to let go: remaking humanitarian action for the modern era. <https://www.odi.org/sites/odi.org.uk/files/resource-documents/10422.pdf> Accessed March 10, 2017. London, 2016.
6. High-Level Panel on Humanitarian Financing. Too important to fail - addressing the humanitarian financing gap. <https://consultations.worldhumanitariansummit.org/bitcache/eb90a59ea8f1c6a87f2c410c1102e286544dabbb?vid=566924&disposition=inline&op=view> Accessed March 10, 2017. New York, 2016.
7. Xavier D. Forcibly displaced: toward a development approach that supports refugees, the internally displaced, and their hosts. <https://openknowledge.worldbank.org/handle/10986/25016> Accessed March 10, 2017: The World Bank Group, 2016.
8. Clarke D, Dercon S. Dull disasters: how planning ahead will make a difference: Oxford University Press; 2016.
9. World Bank Group. Global Financing Facility. <http://globalfinancingfacility.org/> Accessed March 10, 2017. 2016 (accessed August 28 2016).
10. Malkawi K. Gov't had no other choice but to stop providing free healthcare to Syrians. <http://www.jordantimes.com/news/local/govt-had-no-other-choice-stop-providing-free-healthcare-syrians-%E2%80%94-hiasat> Accessed Mar 22, 2017. The Jordan Times, . 2014.
11. United Nations High Commissioner for Refugees. Global Focus <http://reporting.unhcr.org/financial> Accessed March 20, 2017.
12. United Nations High Commissioner for Refugees. Health access and utilization survey: access to health services in Jordan among refugees from other nationalities. <https://data2.unhcr.org/en/documents/download/54666> Accessed Mar 23, 2017, 2016.
13. UNITAID. Innovative financing: the air ticket levy

- <http://www.unitaid.eu/en/how/innovative-financing> Accessed March 23, 2017.
14. Nonprofit Finance Funds. What is pay for success?
<http://www.payforsuccess.org/learn/basics/> Accessed March 20, 2017.
 15. African Risk Capacity. <http://www.africanriskcapacity.org/> Accessed March 20, 2017. (accessed August 28 2016).
 16. Caribbean Catastrophe Risk Insurance Facility. <http://www.ccrif.org/> Accessed March 20, 2017. (accessed August 28 2016).
 17. World Bank Group. Pandemic Emergency Facility: Frequently Asked Questions, <http://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-facility-frequently-asked-questions> Accessed March 22, 2017.
 18. Fund for Peace. Fragile States Index 2016, <http://library.fundforpeace.org/fsi16-report> Accessed March 22, 2017. 2016.
 19. Sekhri N, Savedoff W. Private health insurance: implications for developing countries. *Bull World Health Organ* 2005; **83**(2): 127-34.
 20. United Nations High Commissioner for Refugees. A Guidance Note on Health Insurance Schemes for Refugees and other Persons of Concern to UNHCR. <http://www.unhcr.org/4f7d4cb1342.pdf> Accessed March 10, 2017. Geneva, 2011.
 21. World Health Organization. UHC in Africa: a framework for action. <http://documents.worldbank.org/curated/en/735071472096342073/pdf/108008-v1-REVISED-PUBLIC-Main-report-TICAD-UHC-Framework-FINAL.pdf> Accessed March 23, 2017 2016.
 22. United Nations High Commissioner for Refugees. Global Strategy for Public Health Public Health - HIV and Reproductive Health - Food Security and Nutrition- Water, Sanitation and Hygiene (WASH), 2014-2018. <http://www.unhcr.org/530f12d26.pdf> Accessed March 15, 2017 2014.
 23. United Nations High Commissioner for Refugees. Meeting on health insurance for refugees 2015.
 24. Wiechers T. Microinsurance and social protection. http://www.microinsurancenet.org/sites/default/files/Microinsurance_and_Social_Protection_FINAL_0.pdf Accessed March 31, 2017, 2013.
 25. World Bank Group. Global concessional financing facility. <http://pubdocs.worldbank.org/en/222001475547774765/FlyerGlobalCFF.pdf> Accessed March 20 2017. 2016.
 26. Hynes M, Sheik M, Wilson HG, Spiegel P. Reproductive health indicators and outcomes among refugee and internally displaced persons in postemergency phase camps. *JAMA : the journal of the American Medical Association* 2002; **288**(5): 595-603.
 27. Spiegel P, Sheik M, Gotway-Crawford C, Salama P. Health programmes and policies associated with decreased mortality in displaced people in postemergency phase camps: a retrospective study. *Lancet* 2002; **360**(9349): 1927-34.
 28. Evans S. Catastrophe bond & insurance-linked securities deal directory. http://www.artemis.bm/deal_directory/ Accessed April 5, 2017, 2017.

29. World Health Organization. Contingency fund for emergencies. http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/Contingency-Fund-Emergencies.pdf Accessed March 31, 2017, 2015.
30. The International Finance Facility for Immunisation. Global finance magazine recognises IFFIm sukuk. <http://www.iffim.org/Library/News/Announcements/Global-Finance-magazine-recognises-IFFIm-sukuk/> Accessed April 5, 2017, 2015.
31. The International Finance Facility for Immunisation. Investor presentation. <http://www.iffim.org/library/audio-visual/presentations/iffim-investor-presentation/> Accessed April 5, 2017, 2016.
32. GAVI the Vaccine Alliance. Advance market commitment for pneumococcal vaccines. <http://www.gavi.org/funding/pneumococcal-amc/> Accessed April 5, 2017, 2015.