HEALTHCARE FINANCING STRATEGY ABRIDGED VERSION

Towards Universal Health Coverage and Health Security

1. MESSAGE FROM THE MINISTER OF HEALTH AND SANITATION

We are delighted to unveil our ambitious and continentally transforming first healthcare financing strategic plan. This plan is a product of deep reflections from feedback received from our beneficiaries, partners and various stakeholders; and internal reflections from lessons learned and successes over decades in the health sector.

The Ministry of Health and Sanitation (MoHS) remains an ever-evolving institution that adopts approaches, which respond to the needs of her beneficiaries and stakeholders at large.

This Strategy is developed as a response to the WHO/AFRO – AFR/RC56/10 (2006) Africa regional committee resolution that urges member countries, such as Sierra Leone, to adapt sustainable healthcare financing strategies, including prepayment schemes aimed at sharing risks among different population groups to curtail cases of catastrophic healthcare expenditures and avert the impoverishment of healthcare system clients.

The international and national partners in the health sector are advancing in the implementation of the strategic plan that is aligned with NHSSP 2021 – 2025. This therefore calls for renewed commitment and engagement with current partnerships in the health sector.

We believe that the strategic plan will serve a strong entry point in the advancement of the new direction of the government and build the momentum to achieve the constitutional mandate of the Ministry.

Austin Demby

Dr. Austin Demby
Minister of Health and Sanitation

2. WHY THE STRATEGIC PLAN?

Following these shocks, for instance: decade civil war in 2002, Ebola epidemic in 2014 to 2015, COVID-19 epidemic in 2019; the country's economic growth declined from 4.6% in 2014 to 2.1% in 2015, before assuming an upturn in 2018 (3.5%), 2019 (5.1%) and 2020 (4.7%). The economy is yet to recover, as evidenced by the adverse macroeconomic indicators, including a high debt burden of 62.3%t of GDP 20191 and a high budget deficit of 5.7% of GDP (2019). With a per capita GDP of US$534 and GDP totaling US$4.1 billion in 2019, the country accounts for less than 0.01% of the world economy.

Therefore, there is a need for sustainable healthcare financing and efficiency as articulated in the National Health and Sanitation Policy (NHSP) 2021–2030 and subsequent policy documents, such as UHC Roadmap 2021–2030 and the National Health Sector Strategic Plan (NHSSP) 2021–2025. Further, there is the recognition of healthcare financing as one of the ten pillars of the UHC Roadmap 2021–2030 that calls for sustainable healthcare financing, and the development of a strategy to garner adequate resources for the healthcare sector, ensure the efficient and effective utilisation of available resources, and to streamline different social healthcare protection schemes.

Sierra Leone Selected Economic Indicators

	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
National account and prices Growth									
GDP at constant prices	3.8	3.5	5.1	4.7	4.6	4.6	4.5	4.5	4.6
GDP excluding iron ore	3.6	5.4	4.5	4.4	4.5	4.4	4.4	4.4	4.4
Inflation									
Consumer prices (end-of-period)	15.3	14.2	13.9	13.0	11.0	9.6	8.8	8.0	7.5
Consumer prices (average)	18.2	16.0	14.8	13.4	12.0	10.3	9.2	8.4	7.8

Source: IMF Country Report No. 20/116, April 2020

In the healthcare sector, the country has made significant progress in improving healthcare outcomes over the past two decades. According to SLDHS 2019, the country has experienced the following improvements:

a) A reduction in the infant mortality rate (IMR) (75 deaths per 1,000 live births) from 92 per 1,000 in 2013
b) A reduction in the under-five mortality (U5M) rate (122 deaths per 1,000 live births) from 156 per 1,000 in 2013
c) A reduction in the neonatal mortality rate (NMR) (31.2 per 1,000 live births) from 39 per 1,000 in 2013
d) A reduction in the maternal mortality ratio (MMR) 717 per 100,000 live births from 1,165 per 100,000 in 2013
e) Life expectancy has improved to 54 years in 2019 from 39 years in 2000 (World Bank, 2020)
f) National HIV prevalence increased from 1.5% in 2013 to 1.7% in 2019 and remains low at 2.2% for women and 1.1% for men.

3. HEALTH FINANCING PRINCIPLES AND GOALS

The principles that underpin the development of this Sierra Leone Healthcare Financing Strategy (SLHFS) include the following:

- The right to healthcare
- Equity
- Solidarity in funding healthcare services
- Appropriateness and responsiveness
- Effectiveness and efficiency
- Less choice, more protection
- Accountability

Strategic Goals

Common Challenges

- Low investment in healthcare
- High out-of-pocket spending
- Limited access to healthcare services
- Low insurance coverage/limited pre-payment schemes
- Limited social safety nets
- Inefficiency in resource use

Main Causes

- Macroeconomic constraints that limit fiscal space
- High dependence on external donor support
- Weak public financial management capacity
- Weak inter-sectoral coordination and collaboration
- Limited evidence, data and information

Major Consequences

- Inadequate funding for healthcare programmes
- Poor healthcare infrastructure
- Low compensation of healthcare workers leading to low morale
- Low healthcare status
- Widening socio-economic status gap
- Increased poverty

MAIN POLICY GOAL

Supporting adequate and sustainable healthcare financing and advocating for equitable and effective healthcare care financing in Sierra Leone to obtain better Population healthcare outcomes.

Core HCF Strategies

- Achieving UHC
- Increasing investment in healthcare
- Strengthening social safety nets
- Enhancing technical and allocative efficiency
- Graduated approach to establish SLeSHI

Health and Development Strategies

- Scaling up SDGs and UHC
- Eliminating healthcare related poverty
- Improving national and international partnerships

Functional Strategies

- Policy and regulatory development for:
- Revenue Collection
- Risk pooling
- Purchasing
- Implementing new provider payment methods
- Implementing healthcare sector and financing reforms
- Building capacity

Evaluation Strategies

- Analysing key success factors
- Setting measurable targets and progress indicators to maximise healthcare outcomes and reduce inequalities
- Producing evidence-based policy e.g. supporting National Health Accounts, Public Expenditure Review and Resource Mapping and Expenditure Tracking
- Monitoring progress of implementation and evaluating all strategic actions

4. KEY STRATEGIES

Strategy 1 – Increase Resources for Health

2021	2023	2025
Initiate discussions with MoF on new taxes to support healthcare	Establish policy and legal framework for implementation of new taxes	Agree with MoF on revenue disbursement modalities to healthcare
OOP as a major source of healthcare financing, 61% of THE as of 2018 NHA	Reduce OOP spending to 51% of THE	OOP spending at 40% of THE

Strategy 2 – Equitable Resource Allocation for Efficiency Gains

2021	2023	2025
Initiate negotiations with key actors on the need to review the resource allocation criteria (RAC) to be skewed towards preventive and primary healthcare	New resources allocation formulae to be endorsed and approved for implementation	New weighted RAC to be implemented
Use of weighted variables that include: Poverty rate, Bed use, Outpatient case load, Accident area, Fuel costs, Infrastructure, U5 population, Disease burden, Population of WRA (15–49)		

Strategy 3 – Strategic Purchasing

2021	2023	2025
Introduce policy and regulatory framework to shift from input-based budgeting towards strategic purchasing	Strategic purchasing tools to be developed and piloted in several facilities	MoHS to roll out strategic purchasing as a major healthcare reform agenda
Capacity strengthening of the actors, especially those with fiduciary responsibilities on programme-based budgeting, performance-based financing and public financial management (with MoF)		

Strategy 4 – Establish a National Health Insurance Scheme

2021	2023	2025
Absence of an established pooling mechanism for healthcare	Establish policy and legal framework for UHC Fund	Establish UHC Fund
Steering committee established for SLeSHI	Pilot testing SLeSHI in selected districts/facilities and recommend national rollout available	Full roll out of SLeSHI
Established systems and structures for SLeSHI (MoHS/NASSIT)	Develop a comprehensive benefits package and accreditation, registration, quality, coordination mechanisms and structures	
Strengthen the capacity of key actors in Public Financial Management (PFM), provision of UHC at all stages		

Strategy 5 – Digitise Revenue-collection Platforms

2021	2023	2025
Initiate policy and regulatory frameworks for digitisation of revenue collection	Pilot testing of digitisation of revenue collection in selected healthcare facilities	Roll out and monitor digitisation of revenue collection
Plan for capacity strengthening of key actors		

Strategy 6 – Private Sector Health Financing

2021	2023	2025
Establish frameworks/ guidelines for collaboration between the government and for-profit and not-for-profit private sector building on Sector-Wide Approach (SWAp)	Establish national and district level multisectoral Public–Private Partnership (PPP) coordination frameworks for roll out of UHC	Roll out/scale up PPP nationwide to support UHC

Strategy 7 – Financing Health-related Epidemics and Outbreaks

2021	2023	2025
Establish policy and regulatory frameworks for Emergency Preparedness and Response Fund (EPRF) with Government contribution of 0.1%	Increase total government allocation to the EPRF to 0.5%	Increase government allocation to 1% and establish regional surveillance and response hubs

5. STRATEGIC INTERVENTIONS

The most viable strategic interventions to address the healthcare financing challenges for the next five years are provided below:

5.1.Enhance Resource Mobilisation

The GoSL has committed to "… *progressively increase in public healthcare expenditure to 15 percent of the GDP*. (NHSP 2019, p. 6). This Strategy envisages that resource allocation to the public healthcare sector in the plan period will be linked with national development indicators, absorptive capacity and financial indicators and healthcare will get its due share. The government will be incentivised for incremental State resources for public healthcare expenditure.

Projection of Government Budgetary Allocation (as a percentage of GDP), 2019–2025

	2019	**2021**	**2023**	**2025**
GDP growth at constant prices (%)	5.1%	4.6	4.5	4.6
GDP Current US$ (billion)	4.12 billion	4.53 billion	4.96 billion	5.41 billion
Projected XR (SLL:US$)	9,072.84	10,632.00	12,275.00	13,918.00
GDP Current SLL (billion)	37,398.26	48,162.96	60,884.00	75,296.38
Govt Exp % GDP (percent)	9.7	10.70	11.70	12.75
Projected Govt Exp (US$ million)	399.83	484.71	580.32	689.7209
Population (million), growth rate of 2.1%	7.81	8.14	8.48	8.84
Govt Exp % GDP (per capita)	51.18	60	68	78

Source: Own calculations[2]

5.2. Improve Resource Allocation

This Strategy proposes that public spending on healthcare be allocated to high impact interventions with the greatest impact on healthcare outcomes. The present resource allocation criteria will be reviewed to obtain equity in line with these objectives. Table below provides few indicators to be considered, in addition to the current ones, in coming up with a more equitable weighted resource allocation criteria.

[2] Exchange rates obtained from https://fxtop.com/en/historical-exchange-rates, Other obtained from - https://data.worldbank.org/indicator/SP.POP.GROW?locations=SL

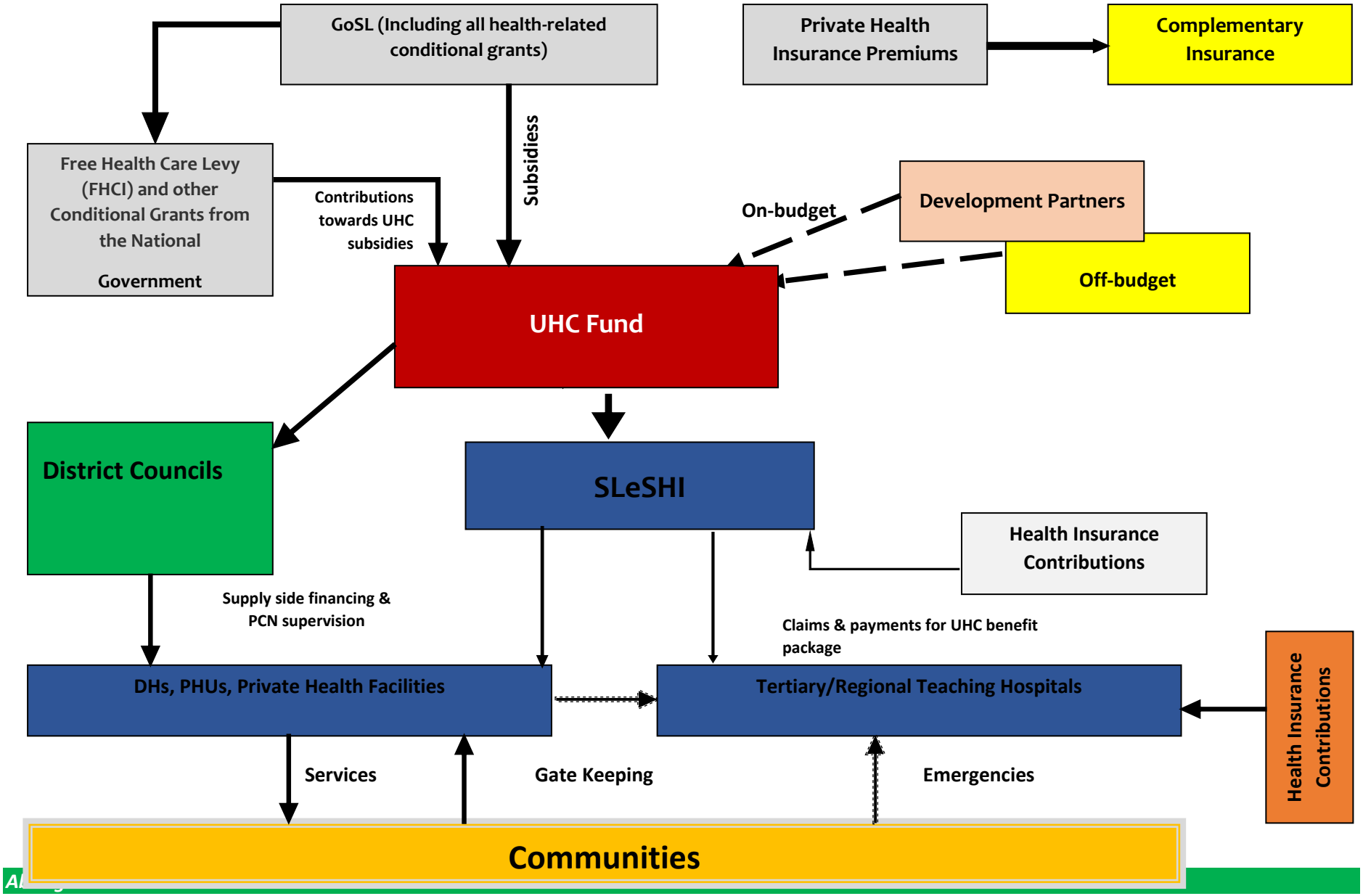
Resource Allocation Criteria

Current	Proposed
Secondary	
Bed capacity 20%	Poverty Rate
Population 30%	Bed use
Utilisation rate 20%	Outpatient case load
Lumpsum 30%	Infrastructure
Primary	U5 Population
Needs Adjusted Pop 70%	Disease Burden
Lumpsum 30%	Population of WRA 15–49
Adjustment factors	Prone to Accidents
Zone 1	
Zone 2	
Zone 3	
Zone 1: Cities: Kenema, Makeni, Freetown, Koidu New Sembehun, Bo, Prot Loko **Zone 2: Districts: Bombali, Bo, Kenema, Moyamba, Port Loko, Ward C, Tonkolili** **Zone 3: Districts: Bonthe, Kambia, Pujehun, Kailahun, Koinadudu, Karene, Falaba, Kono and Bonthe Municipal**	

5.3. Establish a UHC Fund to be Integrated into SLeSHI, once Operationalised

This Strategy proposes the pooling of all healthcare resources at the national level to create a UHC Fund to be hosted by the government (Treasury), Office of the President or other constitutional body as preparation gets underway to establish SLeSHI. The resources will be drawn from, among others, the FHCI Levy normally meant to cover all services provided at PHUs, 'off' and 'on' budgetary contributions from the development partners, GoSL healthcare-related conditional grants to support the indigent and other population groups. The pooled funds will be available for the provision of services at the District Hospitals (DHs), PHUs, private healthcare facilities and tertiary/regional teaching hospitals, on a reimbursable basis.

Establishment of a UHC Fund



5.4.Document and Account for Health Spending

This Strategy calls for the provision of tailored PFM training programmes to the accountants, finance officers and leadership at the MoHS, Local Councils, healthcare facilities and DHMTs, and finance officers at the hospitals to be able to adequately plan and manage funds in a decentralised environment. Based on the findings by Tengbeh A. F. et al. (2020), the focus will be on various aspects of the PFM that are identified for attention.

These include:

a) Understanding of the PFM Act and related financial management rules and regulations
b) Planning and budgeting (e.g., development of annual health plans, monitoring and coordination of budget execution, documentation)
c) Receipts, payments, management of cash and commitments
d) Procurement and contracts management
e) Payroll management and financial reporting and generation
f) Management of internally generated revenue
g) Monitoring and evaluation of healthcare projects.

In line with the country's commitment to transparency and accountability, this Strategy proposes the establishment of appropriate and responsive fiscal responsibility through coaching, mentoring, on-the-job training and workshop-type on-site and off-site training sessions led by the MoF.

5.4.1. Key interventions in the operationalisation of SLeSHI include the following.

5.4.1.1.Pilot testing of SLeSHI

This Strategy proposes the implementation of SLeSHI through a phased approach, whereby a few districts will be selected on the basis of geographical and disease burden considerations and/or certain population groups to participate in a first phase (two years). The lessons learned in Phase 1 will be used to scale up to the whole country. With limited fiscal space and the array of administrative, operational and institutional issues discussed earlier, the government may not be ready for the implementation of a fully blown and sustainable social healthcare insurance for the next five years.

5.4.1.2.Establish appropriate systems and structures for the implementation of SLeSHI

The MoHS will work with NASSIT to develop the capacity of the Secretariat mandated to establish SLeSHI to invest in the effective and efficient administrative and management systems, especially at the PHUs levels in the pilot districts. This is to effectively manage both claims and associated resources to improve the quality of care and collect the respective contributions.

5.4.1.3.Design of SLeSHI to obtain modest coverage

This Strategy recommends that, in the initial phase, government considers having one scheme that comprises formal sector employees, informal sector individuals, and the poor who will be funded by employee payroll deductions, employer matching payments and tax funding.

5.4.1.4.Enrolment of the beneficiaries

During the Pilot phase, SLeSHI will be supported to enrol members into the scheme, initially targeting FHCI target groups, and channel donor funds for those programmes differently than currently being done. SLeSHI is intended to be a national programme with one pool and one benefit package, initially targeting the populations below the poverty line on a non-contributory basis, and the formal sector employees (on a contributory basis). There will be opportunities for the informal sector workers to join the contributory scheme on a voluntary basis. Partial subsidies can be offered to people in the informal sector and near the poverty line.

5.5.Strengthen Health Systems Governance

User fees will be digitised in selected secondary care level facilities, including district and regional hospitals, and tertiary level units on a pilot basis.

The preferred financial information system to be used will be selected on the basis of:

a) Its capabilities in financial accounting to improve service delivery, manage data efficiently and integrate billing and financial data
b) System support in terms of acceptance and user training, being able to troubleshoot basic user issues, training and assigning tasks, and ensuring data backups
c) Usability for fee collection and other uses, such as improved efficiency in service delivery, faster triaging of patients hence time saving, user friendly and report-generation and data issues (that is, easy access to data leading to quick report generation, easy file retrieval, fewer prescription errors).

The fees will be collected in ways that cause no inconvenience to patients and staff and ensure maximum collection that can easily be accounted for. A graduated fee structure between the different tiers implementing the user fees will encourage the use of low-cost primary healthcare services rather than expensive referral facilities and improve the targeting of resources by reducing unnecessary utilisation. Revenues generated from user fees will be deposited into the respective hospital or healthcare facility accounts and retained separately by the hospitals. These revenues will be considered as additional to budgetary allocations from the MoF and purposefully used for service delivery improvements.

An appropriate legislative framework will be put in place to prevent the autonomous hospitals from becoming profit-driven and providing inequitable services. This will require significant investments in preparation for autonomy and complementary reforms to drive hospital performance towards the UHC objectives.

5.5.1. The journey to managerial and autonomous status will involve the following:

- Governance
- Legal and Regulatory Framework
- Increase hospital management authority over healthcare workforce
- Administrative and financial management

- Consistent and coordinated approach between the different institutions involved in hospital-related policies
- Develop healthcare information systems for increased accountability
- Monitoring and supervision framework

5.5.2. Through a Memorandum of Understanding or other mutually agreed arrangements, the private sector will:

- Provide appropriate medical technologies
- Improvement of skills level of healthcare professionals
- Increased scope in service delivery to reduce overseas medical treatment expenditures of GoSL
- Increase private sector participation in multisectoral engagements

6. MONITORING AND EVALUATION

The monitoring and evaluation (M&E) framework in this Strategy aims to determine whether government's healthcare reforms progressively contribute to the achievement of the goals of equity and effectiveness, as shown below. It defines performance in terms of the hierarchy of the three levels of achievement. At the highest level is the final outcome of financial risk protection as reflected in the health status, healthcare financing and client satisfaction and responsiveness.

Sierra Leone Healthcare Finance Strategy: Final Outcome, Intermediate Outcomes, and Final Outputs

<table>
<tr><td rowspan="4">EQUITY</td><td colspan="3">Health Status <<< Financing >>> Client Satisfaction and Responsiveness
FINAL OUTCOME: Financial Risk Protection</td></tr>
<tr><td>Intermediate Outcome
Access</td><td>Intermediate Outcome
Quality</td><td>Intermediate Outcome
Efficiency</td></tr>
<tr><td>Financial Access
Physical Access</td><td>* Structural aspects of quality
* Procedural aspects of quality</td><td>Allocative efficiency
Technical efficiency</td></tr>
<tr><td colspan="3">Financing, service delivery, regulation, and governance</td></tr>
</table>

Estimated cost of implementing the plan (See NHSSP 2021-2025)