HEALTHCARE FINANCING STRATEGY

2021 – 2025

Towards Universal Health Coverage and Health Security

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ACRONYMS

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
BADEA	Arab Bank for Economic Development in Africa
BOT	Build-operate-transfer
BPEHS	Basic Package of Essential Health Services
CDCs	Centres for Disease Control and Prevention
CHCs	Community Health Centres
CHPs	Community Health Posts
CHWs	Community Health Workers
COVID-19	Corona Virus Disease 2019
CSOs	Civil Society Organisations
DHMTs	District Health Management Teams
DHs	District Hospitals
DMO	District Medical Officer
DPPI	Directorate of Policy, Planning and Information
DRM	Domestic Resource Mobilisation
EHS	Essential Health Services
EPRF	Emergency Preparedness and Response Fund
EU	European Union
FCDO	Foreign, Commonwealth and Development Office (formerly DFID)
FHCI	Free Healthcare Initiative
GAVI	Global Alliance for Vaccines and Immunisation
GBV	Gender-based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
GIS	Geographic Information System
GIZ	German Agency for International Cooperation
GoSL	Government of Sierra Leone
HCF	Healthcare Facility
HE	Health Expenditure
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HW	Health Workforce
ICT	Information and Communications Technology
ICU	Intensive Care Unit
IGR	Internally Generated Revenue

IMF	International Monetary Fund
IMR	Infant Mortality Rate
ISDP	Institute for Security and Development Policy
IT	Information Technology
M&E	Monitoring and Evaluation
MCHPs	Maternal and Child Health Posts
MDAs	Ministries, Departments and Agencies
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MoF	Ministry of Finance
MoHS	Ministry of Health and Sanitation
MTEF	Medium-Term Expenditure Framework
MTNDP	Medium-term National Development Plan
NaCSA	National Commission for Social Action
NASSIT	National Social Security and Insurance Trust
NCDs	Non-communicable Diseases
NGOs	Non-government Organisations
NHA	National Health Account
NHSP	National Health and Sanitation Policy
NHSSP	National Health Sector Strategic Plan
NMR	Neonatal Mortality Rate
NMSA	National Medical Supplies Agency
NTDs	Neglected Tropical Diseases
OOP	Out-of-Pocket/Out-of-Pocket Payments
OTC	Over-the-counter
PBB	Programme-based Budgeting
PBF	Performance Based Financing
PFM	Public Financial Management
PHC	Primary Healthcare
PHUs	Peripheral Health Units
PPE	Personal Protective Equipment
PPP	Patient Protection Policy
PPP	Public–private Partnership
RAC	Resource Allocation Criteria
RCH	Reproductive and Child Health
SARA	Service Availability and Readiness Assessment
SDGs	Sustainable Development Goals
SLDHS	Sierra Leone Demographic and Health Survey

SLeSHI	Sierra Leone Social Health Insurance
SL-HCF	Sierra Leone Healthcare Facility
SLHFS	Sierra Leone Healthcare Financing Strategy
SLIHS	Sierra Leone Integrated Household
SMEs	Small and Medium-sized Enterprises
SSAHA	Special Semi-Autonomous Hospital Authority
SWAp	Sector-Wide Approach
TB	Tuberculosis
TELCOs	Tele-companies
THE	Total Health Expenditure
TWG	Technical Working Group
U5M	Under Five Mortality
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development [
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WRA	Women of Reproductive Age
XR	Extended Reality

FOREWARD

The development of this Sierra Leone Healthcare Financing Strategy (SLHFS) was driven by several factors. Primarily, the provisions of the *1991 Constitution of the Republic of Sierra Leone* guarantee the highest quality of healthcare services to every citizen within the resources available. The Human Capital Development component of the new Medium-term National Development Plan (MTNDP) 2019–2023 underpins government's obligation "*to provide adequate medical and healthcare facilities for all persons in Sierra Leone irrespective of colour, race, geographical location, religion and political affiliation, having due regard to the resources of the State".* Also, the Government of Sierra Leone (GoSL) has made commitments to achieving the Sustainable Development Goals (SDGs), particularly SDG 3, which calls for good healthcare and well-being, and Universal Health Coverage (UHC) that seeks to ensure that all people in the country can receive quality healthcare services without suffering financial hardship.

As a key partner of the UHC 2030 Agenda, the country is keen to achieve national UHC goals, while guaranteeing equal access to preventative, curative, rehabilitative and palliative healthcare services without exposing anyone to excessive financial burdens.

The SLHFS has been developed using a consultative approach, involving all the key stakeholders in the healthcare sector, while taking cognisance of all new actors under the devolved system of governance. The plan provides a detailed description of healthcare financing outcomes to be sought, priority healthcare investments necessary to achieve the outcomes, financing strategies, and the organisational frameworks required to implement and monitor it.

The Ministry of Health and Sanitation (MoHS) is thankful to its staff, especially the Directorate of Policy, Planning and Information (DPPI), partners and other healthcare stakeholders who contributed to various efforts in shaping the development of this plan. The MoHS is also committed to the full realisation of this plan. We look forward to working collaboratively across national and local government, with healthcare partners and all other stakeholders and structures to ensure the successful implementation of this plan.

Austin Demby

Dr. Austin Demby
MINISTER OF HEALTH AND SANITATION

ACKNOWLEDGEMENTS

The Sierra Leone Healthcare Financing Strategy (SLHFS), *Towards Universal Health Coverage and Health Security*, recognises the strengths, challenges and some of the underlying weaknesses within the current social, economic and political environments under which this plan will be implemented. Being the first healthcare financing strategic plan in the healthcare sector, it is expected that all players rally around the strategic directions outlined in the plan to deliver the healthcare goals.

My acknowledgements go to all the stakeholders who contributed towards the development of this plan. In particular, I applaud the Directorate of Policy, Planning and Information (DPPI), particularly the Healthcare Financing Unit for their tireless efforts in stewarding this process. I commend them for the able manner in which they guided the process and the facilitation of the various working groups. Efforts from officers of other directorates and ministries, departments and agencies (MDAs) (e.g., The Ministry of Finance) towards this plan are also commendable; inputs and contributions from development and implementing partners are similarly commendable. The collective opinions and wisdom contributed greatly to the drafting and finalisation of the plan.

The development of the plan was made possible through the technical and financial assistance obtained from our development partners to whom we are very grateful. Particularly, it is important to appreciate the work of the Technical Working Group (TWG) members. I am aware that the World Bank, the World Health Organization (WHO) and the German Agency for International Cooperation (GIZ) contributed significantly to the development of the healthcare financing strategy; I would like to extend the Ministry's thanks and appreciation to these organisations and staff.

The successful implementation of this plan will require the coordinated efforts and actions of many sectors and the participation of all stakeholders in the healthcare sector. I am confident that this plan will inform the process of joint sector planning, coordination, partnerships and monitoring. I request and urge all stakeholders of the healthcare sector to put greater efforts into implementing this plan as a means of accelerating the attainment of the Universal Health Coverage (UHC) in the country and improving population healthcare outcomes and quality of life of people living in Sierra Leone.

Dr. Sartie M. Kenneh

AG. CHIEF MEDICAL OFFICER

EXECUTIVE SUMMARY

The following key factors impelled the formulation of this Sierra Leone Healthcare Financing Strategy (SLHFS) 2021–2025:

a) The country's Total Health Expenditure (THE) remains low compared to the National Health and Sanitation Policy (NHSP) aspirations (15% of Gross Domestic Product (GDP)) and international and regional standards required to provide Universal Health Coverage (UHC), leading to under-investment in healthcare, a development that could easily erode previous gains in healthcare
b) Despite the benefits brought by devolution, including improved planning and budgeting by the District Councils and other facilities, the healthcare financing system landscape remains fragmented, leading to coordination problems
c) The out-of-pocket payments (OOP) remain high, leading to inequities in the healthcare financing system, especially in the absence of a strong social financial protection system for the vulnerable, who face challenges in accessing healthcare
d) Past reform efforts have not adequately addressed these problems, calling for the need of this Sierra Leone Health Financing (SLHF) Strategy.

Ideally, the above challenges need to be addressed for the country to meet its obligations as per the 1991 Constitution of the Republic of Sierra Leone[1] that guarantees the highest quality healthcare services to every citizen within the resources available. In order to meet its commitments to achieving the Sustainable Development Goals (SDGs), particularly SDG 3 including UHC, an integrated Healthcare Facility (HCF) strategy is urgently needed.

The Sierra Leone Healthcare Facility (SL-HCF) Strategy will be guided by the following principles.

The right to healthcare

The Constitution gives all Sierra Leoneans a right to the highest attainable standards of healthcare. The design of the healthcare financing system is an important step towards the realisation of this constitutional right.

Equity

Health financing and delivery models should ensure that contributions are made based on the ability to pay, while everyone benefits depending on their needs for healthcare. Equity must be improved, and financial risks protection provided to the poor, marginalised and other vulnerable groups who are unable to pay for healthcare services.

[1] The Constitution of Sierra Leone, 1991 (Act No. 6 of 1991) and subsequent Amendment Act, 2001

Solidarity in funding healthcare services

The cross-subsidy function of the Sierra Leone Social Health Insurance (SLeSHI), even at the pilot stage, must be enhanced. Solidarity is better obtained through membership of each Sierra Leonean in the SLeSHI and other pre-payment schemes.

Appropriateness and responsiveness

The adoption of innovative healthcare service delivery models, especially for Universal Health Coverage (UHC), that take into account the local context and acceptability and are tailored to local healthcare needs.

Effectiveness and efficiency

Effectiveness will be achieved through evidence-based interventions and strong healthcare management systems. Efficiency will be achieved by reducing fragmentation and the duplication of efforts across different levels, as well as promoting better performance of the healthcare systems.

Less choice, more protection

Despite the wealthy being used to a choice of services, and the freedom to choose among service providers as a basic right, such a choice can adversely affect the gatekeeping function, translating to the system's inefficiencies. To underscore the significance of the overall healthcare system efficiency as a goal, this principle will be applied and those who use the preferred provider system will obtain relatively higher protection compared to those who may want to retain the freedom to choose.

Accountability

This plan will ensure accountability for resources and results, with the focus on outputs, outcomes and impact, working with existing accountability innovations, policies, structures and systems.

Within the context of the critical factors in the Sierra Leone healthcare financing landscape, the principles to be followed, and the goal to be achieved are: "*Supporting adequate and sustainable healthcare financing and advocating for equitable and effective healthcare financing in Sierra Leone to obtain better population healthcare outcomes*". The 2021–2025 SL-HCF Strategy proposes several strategic directions. This is in recognition of the fact that success in the implementation of the SLHFS will depend on addressing a multitude of other factors besides healthcare financing reforms.

These include:

a) The acute shortage of Human Resources for Health (HRH)
b) A fragmented supply management system that relies heavily on external partner support[2] as well as commodity shortages
c) Low-quality service delivery with inequitable distribution of and under-developed healthcare infrastructure, with many healthcare facilities lacking the minimum medical equipment requirements and standards
d) Multiple fragmented systems for collecting healthcare-related data and revenue, with limited integration and interoperability among different software products
e) Ineffective healthcare sector governance structures as manifested by limited decision-making space and insufficient autonomy by the purchasers and limited autonomy among the service providers, including hospitals and Peripheral Health Units (PHUs), in such aspects as the transfer of funds between budget lines and strategic purchasing
f) Limited scope by the purchasers to influence the service delivery and provider performance.

The key strategies follow.

Table 1: 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

[2] Barr, A, Garrett, L. Marten, R and Kadandale, S., 2019, *Health Sector Fragmentation: Three Examples from Sierra Leone*, Globalization and Health 15:8 (https://doi.org/10.11.86/s12992.018-0447-5),

Table 2: 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 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)		

Table 3: 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)		

Table 4: 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		

Table 5: 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		

Table 6: 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

Table 7: 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

1. INTRODUCTION

The development of this Sierra Leone Healthcare Financing Strategy (SLHFS) is driven by several factors. To start with, the provisions of the *1991 Constitution of the Republic of Sierra Leone*[3] guarantee the highest quality healthcare services to every citizen within the resources available, and the Human Capital Development component of the new Medium-term National Development Plan (MTNDP) 2019–2023 *"to provide adequate medical and healthcare facilities for all persons in Sierra Leone irrespective of colour, race, geographical location, religion and political affiliation having due regard to the resources of the State*". Also, the Government of Sierra Leone (GoSL) has made commitments to achieving the Sustainable Development Goals (SDGs), particularly SDG 3 that calls for good healthcare and well-being, and Universal healthcare coverage (UHC) that seeks to ensure that all people in the country can receive quality healthcare services without suffering financial hardship. As a key partner of the UHC 2030 Agenda, the country is keen to achieve national UHC goals, while guaranteeing equal access to preventive, curative, rehabilitative and palliative healthcare services without exposing anyone to excessive financial burden.

There is still 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 the National Health Sector Strategic Plan (NHSSP) 2021–2025 and the UHC Roadmap 2021–2030. 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. Lastly, 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 above notwithstanding, even with additional resources for healthcare, the GoSL would have to ensure the utmost prudence in domestic revenue generation and in resource use in order to achieve the SDGs and UHC objectives and must pay attention to the volatility of the country's fiscal space in its domestic resource mobilisation (DRM) and in healthcare system reform endeavours. The limited fiscal space in Sierra Leone is occasioned by severe triple exogenous shocks, namely, the Ebola epidemic of 2014–2016, the decline in the international price of iron-ore exports, and the COVID-19 pandemic. The effects of these shocks are still being felt and should be considered in the design of mechanisms to safeguard the healthcare of citizens.

[3] The Constitution of Sierra Leone, 1991 (Act No. 6 of 1991) and subsequent Amendment Act, 2001

Against this background, there is a need for an integrated strategy that addresses healthcare financing issues in a holistic manner to meet and sustain targeted healthcare outcomes. The healthcare financing strategy was developed by the Directorate of Policy, Planning and Information (DPPI), Ministry of Health and Sanitation (MoHS), with technical support from the World Bank. The Strategy benefited from inputs obtained from various groups: namely, Health Donor Working Group, the World Bank/GFF, Foreign, Commonwealth and Development Office (FCDO), WHO and the United Nations Children's Fund UNICEF. Overall coordination of the process was facilitated by the DPPI and the MoHS.

Target beneficiaries of the HCF strategy include:

a) MoHS
b) SLeSHI
c) MoF
d) Local councils
e) Government agencies involved in healthcare and healthcare financing
f) Other development partners in the public and private healthcare sector
g) The whole population.

The present HCF strategy paper consists of four sections:

1. Section one comprises the background, rationale, and objectives of the healthcare financing reform, as well as other motivating factors, all of which form the basis for the development of this strategic document.
2. Section two contains healthcare financing goals and principles.
3. The third section presents the strategic interventions for the healthcare sector.
4. In Section four, the implementation, monitoring and evaluation issues surrounding this Strategy are discussed, including its implementation, and healthcare outcome indicators.

2. RATIONALE

2.1 Country and Sector Context

Sierra Leone lies in the West African region, bordering Guinea, Liberia, and the Atlantic Ocean. The country has a population of 7.65 million, has a high poverty rate – (56.8%)[4] in 2018 – and is classified among the least developed countries in the world (SLIHS). The growing youth population has led to high dependency ratio (76%) providing an economic burden to the economically active population.

Following a decade-long civil war that ended in 2002, Sierra Leone's economy grew at an average annual rate of 7.8% (2003–2014) before slowing down following the twin shocks between 2014 and 2015 – the Ebola epidemic and the low international price of iron ore, a key export for the country. Following these shocks, 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 2019[5] and a high budget deficit of 5.7% of GDP (2019). With a per capita GDP of US$534 and GDP totalling US$4.1 billion in 2019, the country accounts for less than 0.01% of the world economy. According to the 2021 Index of Economic Freedom Report, Sierra Leone, as one of the world's most impoverished and least developed countries, must overcome daunting challenges to expand its economic freedom. From the Report, the most pressing areas for action are judicial effectiveness, financial freedom, government integrity, and labour freedom, all while continuing to improve fiscal healthcare. The IMF Country Report No. 20/116, April 2020 paints a positive picture for the future of Sierra Leone's economy, projecting moderate growth up until 2025, as shown in *Table 8: Sierra Leone Selected Economic Indicators* overleaf.

[4] Sierra Leone Integrated Household Survey Report

[5] https://www.worldbank.org/en/country/sierraleone/overview

Table 8: Sierra Leone Selected Economic Indicators

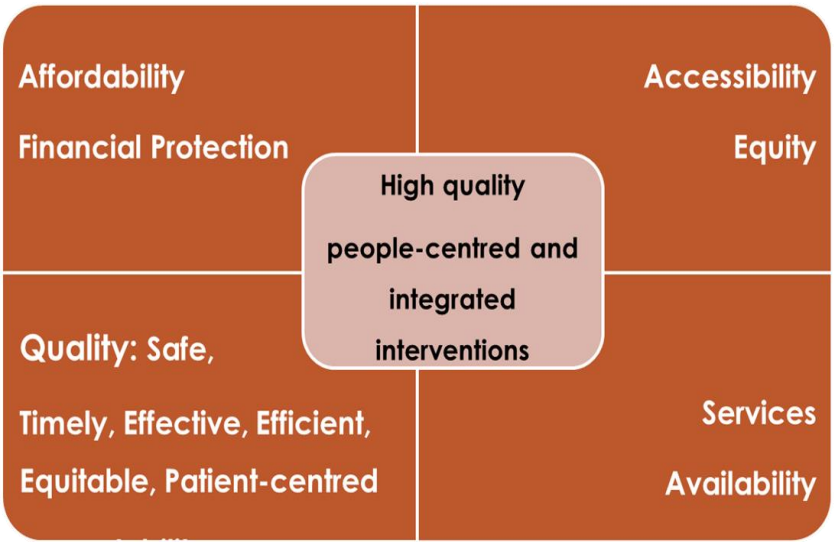
	2017	2018	2019	2020	2021	2022	2023	2024	2025
National account and prices Growth									
GDP at constant prices	3.8	3.5	5.1	4.7	4.6	4.6	4.5	4.5	4.6
GDP excluding iron ore	3.6	5.4	4.5	4.4	4.5	4.4	4.4	4.4	4.4
Inflation									
Consumer prices (end-of-period)	15.3	14.2	13.9	13.0	11.0	9.6	8.8	8.0	7.5
Consumer 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*
https://www.google.com/search?q=trends+in+siera+leone+revenue+performance&oq=trends+in+siera+leone+revenue+performance&aqs=chrome.0.69i59.8476j0j7&sourceid=chrome&ie=UTF-8

In the healthcare sector, the country has made significant progress in improving healthcare outcomes over the past two decades. According to the Sierra Leone Demographic and Health Survey (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 rate (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.

Figure 1: GoSL Aspiration for UHC



Notwithstanding these improvements, the country still lags behind its neighbours for many of the healthcare indicators, including IMR, U5M and NMR[6/7]. Total fertility rate also remains high at 4.2 children per woman. Communicable diseases provide a major challenge accounting for 70% of the total disease burden, while non-communicable diseases (NCDs) and injuries account for 22% and 8% respectively. Further, preterm, intrapartum conditions and neonatal sepsis account for 80% of all neonatal deaths. A significant share of the current disease burden is avertable. More than half of the childhood deaths are due to curable diseases, such as malaria (20%), pneumonia (12%) and diarrhoea (10%). For children surviving beyond 28 days of life, the three leading causes of death are malaria, pneumonia and diarrhoea.

Against the above background, the GoSL is committed to achieving the SDGs to reverse the above healthcare indicators. Through the MoHS, the GoSL articulates its commitment to maintaining UHC and the SDG 3 that call for good healthcare and well-being as articulated in various policy documents (NHSSP 2021–2025, NHSP 2021–2030, UHC Roadmap 2030). This commitment is further reiterated by the President of the Republic of Sierra Leone (HE Dr Julius Maada Bio) during the launch of the National Action Plan for Health Security and the Road Map for UHC. At the event, the President noted that: *"Our National Action Plan for Health Security and the Road Map for Universal Health Coverage in Sierra Leone that we will launch today are consistent with one of our key national priorities – healthcare. To our mind, quality healthcare is foundational to productivity and overall well-being."* As a key partner of the UHC 2030 Agenda, the country is keen to achieve national UHC goals, guaranteeing equal access to preventive, curative, rehabilitative and palliative healthcare services without exposing anyone to excessive

[6]For instance, IMR for Ghana stand at (35) while, Senegal (32) and Liberia (54]). U5M for Ghana is (48), Senegal (44) and Liberia (71). NMR for Ghana is (24), Senegal (21) and Liberia (25)]

[7] WDI 2018

financial burden. As shown in Figure 1, GoSL's aspiration is that, through UHC, all Sierra Leoneans have access to essential quality healthcare services without suffering financial hardship and leaving no one behind. Ideally, UHC can only be achieved through the implementation of evidence-based healthcare financing policies that promote mobilisation and the allocation of financial resources in ways that best meet the healthcare needs of the population and improve equity in healthcare service utilisation. Central to achieving UHC is the requirement for the GoSL to implement a range of reforms that strengthen healthcare financing functions, notably, those that ensure that both internal and external resources are generated, pooled and managed effectively, and the purchasing and allocation functions are carried out equitably and efficiently.

Sierra Leone's healthcare system provides the avenue through which the above reform efforts are to be achieved. The system is organised around the Primary Healthcare (PHC) concept that was introduced in the 1980s based on the 1978 Alma Ata Declaration. The healthcare service delivery is provided through a network of more than 1,284 healthcare facilities, of which 1,203 are public and 81 are private organised into three levels of care[8/9]. The basic package of essential healthcare services (BPEHS) is delivered through two levels.

The first is the primary healthcare level, which comprises:

a) Peripheral healthcare units (PHUs)
b) Maternal and child healthcare posts (MCHP)
c) Community healthcare posts (CHPs)
d) Community healthcare centres (CHCs)
e) Community healthcare workers (CHWs).

The second level consists of district hospitals (secondary healthcare) and regional hospitals (tertiary healthcare) that receive referrals from the periphery units). At the apex of the national healthcare system are six teaching government hospitals[10] that provide specialised healthcare services.

[8] GoSL 2017, Summary Report of the 2017 Service Availability and Readiness Assessment (SARA) Plus in Sierra Leone, Quality of Care, Survey and Data Quality Review, Ministry of Health and Sanitation

[9] MoHS 2020, Sierra Leone Private Health Sector Assessment (Version 2.0), July (Obita, W, Marani, L, Gitonga, N)

[10] These include: Connaught Hospital, Ola During Children's Hospital, Princess Christian Maternity Hospital, Lakka, Kissy Mental, and Jui

In addition to the introduction of healthcare financing reforms, this SLHFS recognises that successful implementation will depend on a multitude of factors. These include:

1. Acute shortage of HRH, with the country having 6.4 skilled healthcare workers per 10,000 population, falling short of the regional average for Africa (13.3) and the WHO's threshold of 23 per 10,000 and 44.5 for UHC [11.]
2. Fragmented supply management system that relies heavily on external partner support[12] as well as commodity shortages with the availability of essential medicines with the tracer items estimated at 31% (SARA+, 2017)
3. Low quality service delivery, with inequitable distribution and under-developed healthcare infrastructure, and many healthcare facilities lacking the minimum standards for medical equipment requirements, as well as being over-utilised at the tertiary level and under-utilised at the periphery points (SARA 2017)
4. Multiple fragmented systems for collecting healthcare-related data, with limited integration and interoperability among different software products such as NHIS, LMIS and HRIS
5. Ineffective healthcare sector governance structures manifested by: limited decision-making space and insufficient autonomy by the purchasers; limited autonomy among the service providers, including hospitals and PHUs, in such aspects as transfer of funds between budget lines and strategic purchasing; and limited scope by the purchasers to influence the service delivery and provider performance.

In as much as previous and on-going reform efforts have attempted to address these challenges, they are still evidenced in the healthcare financing landscape. In the country's quest to achieve middle-income status by 2039, as articulated in the MTNDP, a comprehensive and integrated healthcare financing strategy is required to support the GoSL's efforts to achieve UHC.

2.2 Underspending in Health

Table 9: Health Expenditures of Selected West African Countries, including Sierra Leone (overleaf) shows selected healthcare finance indicators for Sierra Leone compared to other countries in the region.

[11] Barbara McPake, B, Dayal, P., and Herbst, C.H (2019), *Never again? Challenges in transforming the healthcare workforce landscape in post-Ebola West Africa*, Human Resources for Health Vol. 17, Article Number 19 (2019)

[12] Barr, A, Garrett, L. Marten, R and Kadandale, S., 2019, *Health Sector Fragmentation: Three Examples from Sierra Leone*, Globalization and Health 15:8 (https://doi.org/10.11.86/s12992.018-0447-5)

The table provides various pointers:

1. The country has the lowest GDP per capita in the region, a development that could be attributed to the slow economic growth attributed to the adverse effects of the civil war and the Ebola pandemic
2. Relatively better performance in terms of both government healthcare expenditure as a percentage of government expenditure (7.2%), though falling short of the Abuja target of 15% and the THE as a percentage of the GDP (16%). The latter should be interpreted with caution as the figure is a combination of funds from the government, OOP, donors and private insurance
3. Government healthcare expenditure as a percentage of GDP is relatively low, which could point to the need to increase government investments in healthcare. Though the country has a moderate OOP (44.8% of THE) according to Table 9 below, the latest National Health Account (NHA) (2017–2018) report shows slow decline from a high of 62% in 2013 to 61% in 2018; the figure remains high with adverse consequences depending on the socioeconomic settings.

Table 9: Health Expenditure of Selected West African Countries, including Sierra Leone

Country	GDP PC (Constant 2018 US$)	Govt HE as a % of govt exp.	THE as % of GDP	Per capita THE	Govt Health exp as % of GDP	OOP Exp. as a % of THE	Catastrophic Headcount	
							at 10% threshold	at 25% threshold
Benin	1,245	3.3	2.664	30.94	19.7	44.5	10.92	5.38
Guinea	975	4.1	3.93	38.32	16.4	60.6	6.97	1.25
Senegal	1,481	4.3	3.978	58.9	23.8	55.9	3.33	0.19
Cameroon	1,534	1.1	3.58	54.14	6	75.6	10.78	2.98
Burkina Faso	715	8.8	5.63	40.25	42.5	35.8	3.13	0.42
Togo	679	4.3	6.17	41.84	17	56.3	10.25	0.02
Ghana	2,202	6.4	3.5	77.91	38.98	37.7	1.11	0.09
Liberia	674	5.2	6.74	45.42	25.1	41.9	n/a	n/a
Mali	900	5.4	3.885	34.95	28.2	33.9	6.48	1.11
Sierra Leone	534	7.2	16.063	85.5	9.7	44.8	54.2	22.16
Nigeria	2,153	4.4	3.89	83.75	14.9	76.6	15.05	4.06

Source: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=SN

Households, through OOP provide the major source of financing for the healthcare sector accounting for 44.8% of the THE, followed by the development partners (22.2%), government 9.7%, and others combined (19.44%). The significant external support sustainability questions the fiscal space for healthcare. This source has been and will still be critical in fully financing or subsidising the provision of basic healthcare services at primary and district hospital levels. Even then, dependence on it may not guarantee the sustainability of fiscal space for healthcare in the long term. External donor support is not only highly dependent on, understandably, self-interests but also has a high potential for conditionalities that may not be aligned to the country's development priorities. Moreover, it is not feasible for Sierra Leone to expect to receive donor support forever. Many donors are known to graduate countries from their healthcare programmes when they cross an eligibility threshold, without regard to the state of the countries' fiscal space. Though still at the nascent stages, the private sector has started to emerge in healthcare financing, and this opportunity needs to be exploited in the future.

2.3 Allocation of Resources

Purchasing provides the link between the resources mobilised for UHC and the effective delivery of quality healthcare services. It involves the allocation of funds to healthcare providers to obtain services for specific groups and, for this reason, it is important to have clear lines of engagement between the demand and supply sides to achieve the desired healthcare impacts. In determining alternative options to obtain allocative efficiency, two questions need to be addressed:

1. Who pays for what outputs?
2. Who should pay for what inputs?

With multiple sources of financing (i.e., government, partners, and households) many different resource allocation types have evolved. With the decentralisation in Sierra Leone, the situation has become even more complex with the Local Councils also becoming significant payers for healthcare services and managers of local public healthcare facilities. This is especially so with the provisions of the Local Government Act 2004, 51 (2) that allow primary and secondary healthcare funds to be transferred directly from the MoF to the Local Councils[13] (Tables 12 and 13).

[13] The Local Government Act, 2004, Section Number 51(2)

Table 10: Current and Potential Role of the Key Financing Agents with Respect to: "Who Pays for What Outputs?"

Outputs	MoHS	Local Councils	Households	Development Partners
Public Health Interventions	MoHS provides the policy and regulatory framework, technical guidance, and capacity building for the implementation of public healthcare interventions	Local councils managed facilities provide these services with a linkage to the communities	Have responsibility for community mobilisation, maintenance through community-based committees/groups, e.g., water, sanitation and Hygiene (WASH) activities and the provision of local labour for public healthcare services.	Provide complementary funding for technical assistance and essential public healthcare services.
Basic Package of Essential Health Services (EHS)	Provide conducive policy and regulatory environment, technical guidance, and capacity building for the basic package of EHS	Local councils pay for and provide this basic package of EHS. Their administrative level is closest to service provision	Have responsibility to participate in the discussions regarding what is included in the basic package of services. Have responsibility to provide feedback on the implementation of the basic package of services	Provide complementary funding for technical assistance on the basic package of services
Hospital Services	MoHS provides these services through its retained higher-level hospitals, mostly centres of training and excellence but also include district hospitals in Freetown (Western Area Urban and Western Area Rural districts)	Local councils pay for and provide primary healthcare services through resources from the council budgets. MoHS and partners provide conditional grants	Responsibility as community representatives in the governance of the hospitals. Giving community feedback on the quality of services provided at the hospitals.	Provision of complementary funding, technical assistance on hospital governance and service provision. Provision of supplementary funding for essential but scarce hospital equipment and human resources.

Outpatient Drugs	MoHS has a mandate for policies and strategies on pharmaceuticals and the supply chain in the country. Coordinate, at national level, international procurements in coordination with other actors to ensure economies of scale	Local councils have an oversight role to ensure the availability of outpatient drugs in their respective council areas	Through OOP, the households normally contribute to the purchase of drugs when there are stockouts in facilities	Provision of supplementary funding for technical assistance on pharmaceuticals and supplies for outpatients

Table 11: Current and Potential Role of the Key Financing Agents with Respect to: "Who Pays for What Inputs?"

Inputs	**MoHS**	**Local Councils**	**Households**	**Development Partners**
Personnel Services	Salaries of staff	Salaries for staff providing oversight for healthcare in the local councils	Through OOP payments the facilities can pay for salaries, especially for contracted staff, particularly the lower-level cadres	Partners pay for top-ups for specific cadres (e.g., District Information Officers)
Maintenance, Operations and Other Expenses	Allocation through current budget mechanism does not provide incentives for performance and also makes it difficult to track healthcare service costs	Have the capacity to mobilise own resources revenue, though the budget does not provide adequate incentives for the providers.	OOP payments contribute significantly to the operations and maintenance of facilities	Have no direct responsibilities but, can support through direct support to government or vertical programs through conditional grants
Drugs	MoHS has regulatory authority with respect to quality and drug prices	MoHS has regulatory authority with respect to quality and drug prices	Through OOP payments, the households pay for items such as over-the-counter (OTC) drugs, syringes and cotton wool that may not be available in the facilities	Programme-based procurements and take advantage of economies of scale based on global procurements.

Capital Outlay	MoHS performs sector capital investments, including infrastructure support, medical equipment, transport equipment, Information Technology (IT) equipment, using MoHS funds	Local councils provide inputs into the planning of capital investments in the local councils	Minor role, except for in-kind contributions towards the construction of lower-level facilities	Complement MoHS capital investments, including infrastructure support, medical equipment, transport equipment, IT equipment as needed

Tables 11 and 12 explore the current and potential role of the key financing agents with respect to the first question. The MoHS and the Local Councils, with funding from the MoF, emerge as the main funders of most of the healthcare services.

The MoHS and the Local Councils continue to be the key funders of key healthcare outputs. Local Councils should continue their role as payers for primary and secondary healthcare services. The second question, which examines who should pay for what inputs, considers the two main financing agents (i.e., MoHS and Local Councils). Both emerge to be in a more strategic position now to introduce purchasing mechanisms that will promote equity, efficiency and productivity. Both the MoHS and Local Councils appear to have the required tools at their disposal to enhance efficiency and productivity, although they are constrained by civil service salary structures and have inadequate healthcare information systems. Despite the MoHS and the Local Councils being the main funders of most of the healthcare services, development partners are actors to ensure economies of scale.

2.4 Fragmented Health Financing System

The country's healthcare system obtains funding from multiple streams. The primary and secondary care facilities receive budgetary allocations from the MoF through the Local Councils. The tertiary facilities receive direct funding from the MoHS allocations and donors through accounts held separately and not associated with the Local Councils.

Development partners – both multilateral and bilateral organisations – fund specific-programmes, including:

a) Free Healthcare Initiative (FCDO)
b) Procurement of medicines and medical supplies (HIV, TB prevention and treatment (USAID and CDC)
c) Immunisation (GAVI)

d) HIV, TB and malaria (Global Fund)
e) Reproductive and Child Health (RCH) through performance-based financing (PBF) (World Bank)
f) Health systems strengthening (WHO, World Bank and GIZ).

Other partners include the Institute for Security and Development Policy (ISDP), the Arab Bank for Economic Development in Africa (BADEA), Ireland, the African Development Bank (AfDB), the European Union (EU) and United Nations (UN) agencies. These groups normally channel their funds through international and local non-government organisations (NGOs) to implement activities on their behalf.

Through OOP, households make direct purchases of healthcare services from the various providers, having the latitude to make direct decisions on how they utilise their funds. The multiple flows have led to relatively stable and predictable funding for the healthcare sector, especially for the vertical programmes such as HIV/AIDs, TB, immunisation and malaria – during delays in the disbursement of government funds. Even then, the healthcare financing system remains fragmented, characterised by multiple funding streams that may not necessarily be well aligned with government priorities at the service delivery levels. The streams vary by source, development partner, national government or District Councils and by households, and whether the funds are 'off budget' or 'on budget'.

As Sierra Leone's healthcare sector has grown to become more diverse, the fragmentation and distortion of priorities, especially related to external development assistance, have continued to limit development progress. This has undermined the effectiveness of healthcare system strengthening efforts and has contributed to the inefficient use of scarce healthcare sector resources [14]. As noted by Tengbeh A. F. et al. (2020)[15], among others, there is clear evidence of multiple programme-based funding streams, parallel medical supply chains, fragmentation in policy and planning, service delivery and governance structures, and across partner relationships. Tengbeh A. F. et al. (2020) cite cases where development partners implement activities on their own, with minimal reference to the District Health Management Teams (DHMTs) or hospital management and do not share their budgets and financial reports of activities/programmes being implemented in the districts or hospitals. Development partners are also known to implement disease-specific interventions that create parallel structures and programmes while neglecting a long-term vision for healthcare systems strengthening. For example, vertical programmes (e.g., HIV, TB, malaria, immunisation, family planning, nutrition, and neglected tropical diseases (NTDs)) in the country are known to have parallel medical supply chains, with separate logistics systems that are weakly linked to mainstream government systems. This arrangement encourages the

[14] Technical Brief Series – Brief No. 5 (Fragmentation in pooling arrangements), The World Health Report, Health Systems Financing, WHO 2010

[15] Tengbeh, A.F., Hastings-Spaine, F., Marion Sillah, Kamara, A., Tucker L. (2020), Sierra Leone Rapid Needs Assessment Team Report, Sierra Leone (Supported by the World Bank)

duplication of activities and resource wastage. Despite the GoSL having introduced reforms to strengthen the coordination, integration, and governance of healthcare sector activities and partner engagement, fragmentation provides a major barrier to this progress.

As early as 1987, the country implemented the Bamako style of revolving drugs fund scheme, aimed at 80% cost recovery; it was later revised to 40% cost recovery. Local facilities were allowed to retain 60% of the revenue generated and remit the remainder to the DHMTs. The districts and communities had the discretion to provide fee exemptions to groups, such as children under the age of five, pregnant women, emergency cases, the destitute and priority diseases, such as TB and HIV/AIDS. At the same time, user charges were levied by the healthcare facilities in the form of fixed charges for consultations at the primary healthcare units and flat rate charges for outpatient consultations, for overnight stays and other services. Fees were set by the district committees in consultation with the local communities, including village development committees, and city and district councils. As in the case of cost recovery, the revenue raised was retained by the healthcare facility to improve the quality of services. As documented by Ensor T. et al. (2008)[16], in 2007 and 2008, user charges provided the only reasonably stable resource flow of any type estimated at 4–8% of total government funding to facilities that did not receive substantial non-government support.

With the enactment of the Local Government Act 2004, primary and secondary healthcare services were devolved. Local Councils were mandated to oversee the DHMTs who are responsible for primary care. Secondary care was to be provided by the district hospitals and the District's Health Committee and the Hospital Boards serve as the bridge between the healthcare sector and the council. Tertiary hospitals receive direct funding from MoHS allocations[17]. Secondary and tertiary healthcare facilities receive funding from the central MoHS pool and from donors through accounts held separately from those associated with Local Councils. Since the start of the NHSSP 2010–2015, government has embarked on a series of improvements in the healthcare sector. The country embarked on a decentralisation-by-devolution model, where the MoHS provides stewardship of the healthcare sector, having direct control over tertiary hospitals. The Local Councils, with the administrative support of the District Medical Officers (DMOs) and the DHMTs, own the healthcare facilities and are responsible for the healthcare service provision (Cordaid 2014 p. 64).

The country launched the Free Healthcare Initiative (FHCI) in April 2010 with the support of key development partners such as the FCDO of the UK Government (formerly DFID) and the Global Fund to increase access to healthcare services by pregnant women and children. The initiative that provided cash grants to facilities to buy inputs, especially essential supplies has recorded remarkable success going by the increases in the under-five outpatient consultations

[16]Ensor, T., Lievens, T and Naylor, M., 2008, Review of Financing of Health in Sierra Leone and the Development of Policy Options, Technical Report (Final Report), Oxford Policy Management, July. Https://Www.Researchgate.Net/Publication/273259069

[17] For the period 2010-2013 Tertiary Hospitals received funding through Local Council budgets

(250%) [18]in one year, and immunisation coverage from 67% in 2006 to 82% in 2011. While this collaborative effort provides the backbone for improving healthcare in Sierra Leone, it continues to be over-reliant on donors, raising sustainability questions. Also, in as much as FHCI was meant to remove financial barriers to basic healthcare, there are still elements of bribery and informal/unauthorised charges to access healthcare among the poor and less educated (Mitchell (2017)[19], 2018 Afrobarometer survey[20]).

In 2011, PBF was introduced in Sierra Leone as a mechanism to change providers' behaviour, with the ultimate objective of improving the quality of services under the free healthcare policy. This approach included the provision of cash to facilities to cater for the local cost of delivering services. It also provided financial incentives to facilities to increase productivity and quality and increase equity in the distribution of resources, with the facilities being allowed to use funds from PBF to contract healthcare workers and finance outreach activities.

Despite PBF having improved patient satisfaction and quality of service, the operationalisation of the scheme faced many challenges, as documented by Cordaid (2014, p. 73–74)[21]:

a) There were delays in the transfer of PBF funds leading to the patients being charged 'informal' fees for items such as patient records when funds dried up.
b) The relationship between performance and payments was found to be weak for healthcare workers, with this group categorising the incentive system as not being transparent enough.
c) Payments were delayed to the extent that they were no longer regarded as reward for good performance.
d) The flow of funds was not regular enough to hire contract workers and, in turn, equity of distribution of funds was not seen to have taken place.

Guided by the country's development agenda – Agenda for Prosperity (A4P) 2013–2018 Pillar 7 (Governance and Public Sector Reform) – significant reforms have been undertaken in PFM at the national and devolved levels through the support provided by development partners, such as[22] AfDB, the DFID/FCDO, the EU and the World Bank. These efforts have remarkably strengthened the country's PFM systems and structures. Even then, significant gaps still exist in PFM and this

[18]Cordaid (2014), External Verification Performance Based Financing in Healthcare in Sierra Leone, Vol. 1, Main Report (Report External Verification), June.

[19] https://www.theguardian.com/global-development-professionals-network/2017/mar/08/corruption-in-healthcare-in-sierra-leone-is-a-taboo-but-it-does-exist

[20] https://afrobarometer.org/countries/sierra-leone-0

[21] Cordaid (2014), External Verification Performance Based Financing in Healthcare in Sierra Leone, Vol. 1, Main Report (Report External Verification), June.

[22]Government of Sierra Leone (GoSL) 2019, Health Financing Situation Analysis, Ministry of Health and Sanitation, February.

area provides the major challenge to the healthcare sector as also noted by Tengbeh, A.F. et al. (2020) and MoHS (2019)[23].

Some of the challenges include:

a) Delays in the disbursement of GoSL funds to the councils, DHMTS, and the District Hospitals (DHs) – by as much as six to eight months
b) Release of smaller than approved budgets (about 30%)
c) Inability of the budgets to capture the healthcare needs of the population
d) Weak capacities in the planning and budget formulation and in monitoring public spending under the Medium-term Expenditure Framework (MTEF), and limited participation of the senior leadership in the planning process
e) Fragmentation of domestic revenues, especially those collected by semi-autonomous agencies operating outside of the centralised budget process
f) Unrealistic macro-fiscal budget projections and the inability of the donors to declare the total resource envelope and the detailed breakdown of the support available
g) Inadequate documentation practices[24], a lack of comprehensive internal controls and auditing at the councils, a mismatch between spending priorities of the councils and DHMTS/DHS, and a lack of funds by the PHUs to address operational needs.

2.5 Hospitals' Autonomy in Managerial and Financial Decisions

While the public hospitals in Sierra Leone are largely financed from the state and Local Councils budgets, development partners and user fees/OOP, they are severely constrained in the use of the funds by rigid financing procedures that lead to significant inefficiencies. First, the hospital managers have limited leeway to reallocate resources between cost categories without being required to obtain permission from some authorities which can take considerable time and efforts. Second, the hospital managers lack the means to reward staff for good performances since not even savings can be used to supplement salaries. This results in less motivated staff and low performance of public hospitals, including poor quality of services. Moreover, the lack of hospital autonomy over staff has also been found to be a serious issue in Sierra Leone. The hospitals have had to use resources mobilised from user fees to supplement salaries for the healthcare workers. As the public hospitals mostly serve poor and low- to middle-income people (60% of population), improving their management will greatly benefit these groups.

Tengbeh, A.F., Hastings-Spaine, F., Marion Sillah, Kamara, A., Tucker L. (2020), Sierra Leone Rapid Needs Assessment Team Report, Sierra Leone

[24]The SDI, for instance, document only 15.1% of facilities having receipt books, 9.8% payment vouchers, and 12.9% have cash books to manage their finances.

The GoSL considers greater managerial and hospital autonomy of public hospitals as an important policy objective to:

a) Enhance efficiency
b) Rationalise use of resources
c) Improve clinical quality
d) Enhance consumer satisfaction with the care offered
e) Increase service access for the vulnerable groups
f) Promote containment and ownership of healthcare programmes by hospitals and communities.

This is in addition to reducing government's financial burden, expanding and upgrading hospital infrastructure, and addressing other common problems plaguing traditional public hospitals that operate as budgetary units of the MoHS or local governments. With autonomous status, the public hospitals are anticipated to more effectively fulfil their professional mandate. They should be more dynamic, imaginative, creative, and effective in using physical facilities, professional capacities and human resources potentials to mobilise additional resources to innovate and expand the range of services and improve service quality.

2.6 Social Protection, Equity, and Solidarity

The WHO (2006)[25] identifies certain characteristics in countries such as Sierra Leone that have OOP as a percentage of the THE of between 30–50%. To start with, equity is partially achieved for selected services only and gaps exist across population segments and geographical areas. There is also moderate physical and financial access to services with the rural population and the poor are often excluded. Still, universal coverage usually ranges from low to moderate with social healthcare insurance being generally available to only a few. Further, some essential healthcare interventions are funded publicly while most of the remaining funds are spent on home-based care and pharmaceuticals. Lastly, there is limited financial protection.

Indeed, Sierra Leone has a weak social protection [26] system and the healthcare sector has depended heavily on high OOP payments. This has, in turn, placed a great financial burden on vulnerable populations, including the least healthy, who are more likely to forgo healthcare or sacrifice other necessities to consumer care.

In light of the above, ordinary citizens who get sick can easily slide into poverty. Moreover, the prevalence of OOP as the major source of heath financing suggests serious inequities in the

[25] WHO (2006), Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions (2006–2010), WHO: Western Pacific Region South-East Asia Region

26 There was a mention of the existence of remittances used to pay for services and GoSL's solidarity – the overseas medical treatment option but, detailed information was not available at the time of writing this Strategy.

healthcare financing system. This is because it compels the sick to make direct payments for care at the point of need. As illness is unpredictable, and there is no way to align the time of availability of the funds that are used for OOP with the time of the need for healthcare, OOP should not be used as a cost recovery mechanism or at point of use for essential services. It should be maintained for co-payments or as a fee for service options. There is, therefore, the need to reduce financial barriers to service utilisation at the point of care via pre-payment schemes, subsidies and other means and to implement a broad-based social healthcare insurance programme to protect all citizens from excessive OOP payments during a period of illness or injury. This is in addition to the available social safety net supported by the World Bank and NASSIT. The country needs more safety nets to protect its people against the financial consequences of sickness. It is possible to slowly but steadily establish a viable social insurance scheme through a practical process of learning-by-doing. A small pool of insurance funds from internal and external sources can make a huge difference to the healthcare of the poor if properly used.

One recent attempt to address this gap in healthcare financing reform efforts has been the creation of the SLeSHI agency. The discussion on it has been ongoing since 2007, with the scheme having been launched in 2017. Although the SLeSHI policy was developed, the scheme itself never became operational. The NHSSP 2021–2025, which outlines national healthcare objectives, also calls for the establishment of SLeSHI to increase financial protection for the population in periods of illness by promoting pre-payments for healthcare services, mobilising financial resources equitably, and improving effectiveness, efficiency and accountability in the delivery of quality healthcare.

Notwithstanding the GoSL prioritisation of SLeSHI, the country is yet to establish the prerequisites for effective implementation and management of a functional social healthcare insurance scheme. Collections from mandated payroll taxes and social insurance contributions are severely restricted by the weak macroeconomic situation and by a small formal sector, the source of wage employment. Poverty levels are extremely high (56.7%) (NHA 2018).

Other factors include:

a) The required policy and regulatory framework
b) Large family sizes (5.6) imply large numbers of dependants
c) Fragmented service delivery and information systems
d) Inadequate healthcare workforce (number and quantity)
e) Shortage of PFM skills
f) Low enforceability of government laws and regulations that are required for quality assurance and speedy resolution of grievances.

2.7 Financing Framework for Epidemics and Outbreaks

The EBOLA and COVID-19 pandemics exposed the country's weak, overburdened and fragile healthcare systems, eclipsing other healthcare issues. The country experienced disruptions in the continuity of services such as maternal and neonatal healthcare (MNH), communicable and non-communicable diseases and the diversion of both human and non-human resources. There were also increasing incidents of cross-border transmission, mainly through long-distance truck drivers, communities who live across the country's border, and illicit transboundary movements. Intra-country transmissions were also facilitated by people travelling between different regions. Shocks to the country's healthcare system reverberated in the neighbouring countries and across the region. In such a healthcare system, morbidity is normally exacerbated, disability intensified due to both direct mortality from the outbreak and indirect mortality from co-morbidities, as well as a rise of avoidable and preventable conditions. With this experience, it is to be expected that such emerging diseases will continue to be a challenge to the healthcare system in the future. The MoHS and Local Councils should, therefore, allocate resources for these and any future similar emerging diseases.

3. HEALTH FINANCING PRINCIPLES AND GOALS

3.1 Principles

The principles that underpin the development of this SL Health Finance Strategy include the following.

The right to healthcare

The Sierra Leone Constitution, gives all Sierra Leoneans a right to the highest attainable standards of healthcare. The design of the healthcare financing system is an important step towards the realisation of this constitutional right.

Equity

Health financing and delivery models should ensure that contributions are made based on the ability to pay, while everyone benefits depending on their need for care. Equity must be improved, and financial risk protection provided to the poor, marginalised and other vulnerable groups who are unable to pay for healthcare services.

Solidarity in funding healthcare services

The cross-subsidy function of SLeSHI must be enhanced. Solidarity is better obtained through membership of each Sierra Leonean in SLeSHI and other pre-payment schemes, from the richest to the poorest and/or from the sick to the healthy.

Appropriateness and responsiveness

Innovative healthcare service delivery models specifically for UHC that take into account the local context, acceptability and are tailored to local healthcare needs, must be adopted. The healthcare system will be responsive to population needs, ensuring the provision of timely and continuous care, and respect for the individual.

Effectiveness and efficiency

Effectiveness will be achieved through evidence-based interventions and strong healthcare management systems. Efficiency will be achieved by increasing integration and reducing fragmentation and duplication across different levels, as well as promoting better performance of the healthcare systems.

Less choice, more protection

Despite the wealthy being used to a choice of services, and the freedom to choose among providers as a basic right, such a choice can adversely affect the gatekeeping function, translating into systems inefficiencies. To underscore the significance of overall healthcare system efficiency

as a goal, this principle will be applied and those who use the preferred provider system will obtain relatively higher protection compared to those who may want to retain the freedom to choose.

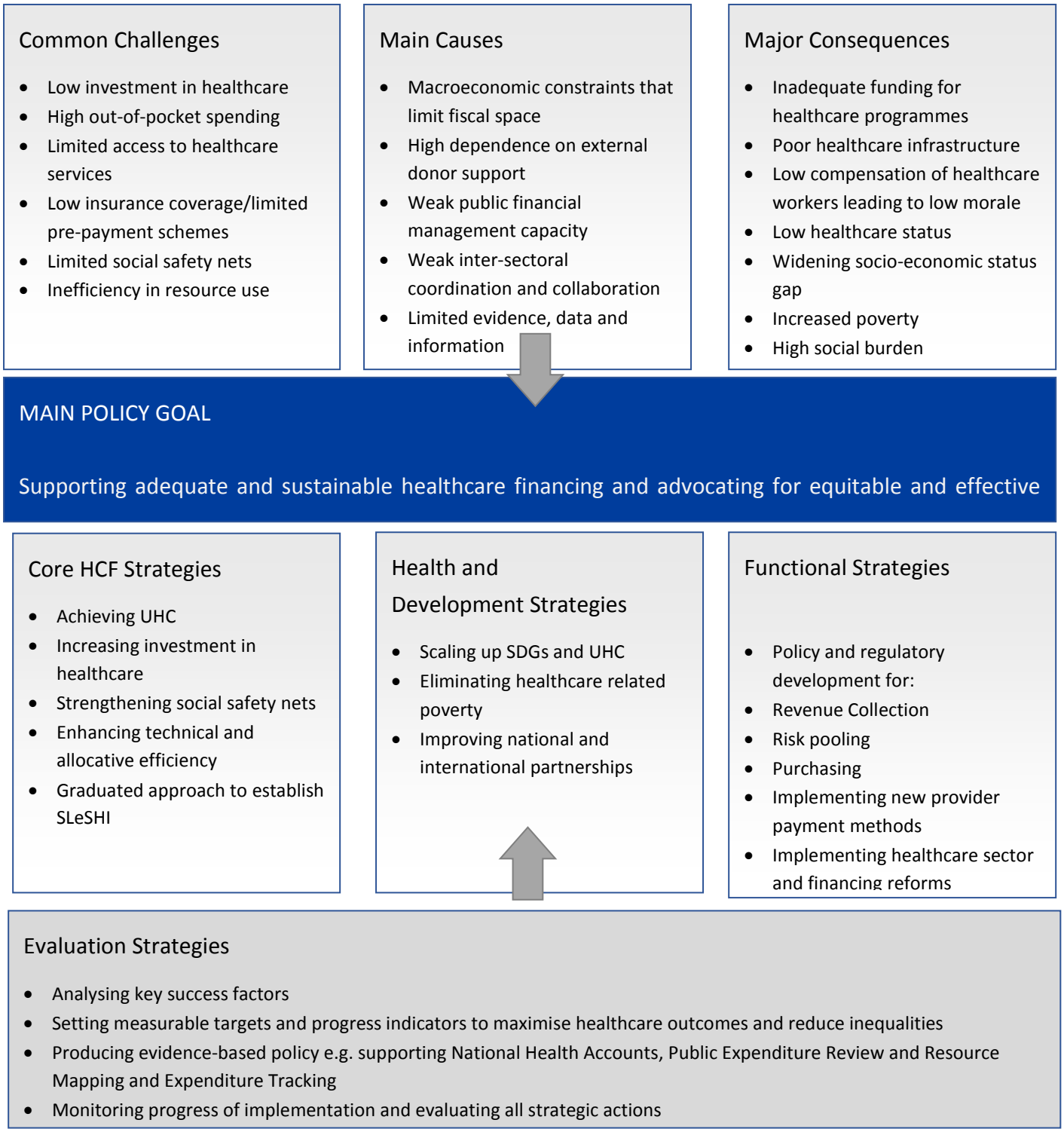
Accountability

This plan will ensure accountability for resources and results, with the focus on outputs, outcomes and impact, working with existing accountability innovations, policies, structures and systems.

3.2 Strategic Goals

Figure 2 summarises the framework for this SLHFS Strategy. The challenges, main causes and major consequences are based on documented lessons as provided above and are based on national, regional and global data. The framework is intended to guide the selection of interventions that will be implemented in the plan period.

Figure 2: Sierra Leone Health Finance Strategy Framework



Sierra Leone's healthcare financing challenges that require urgent attention include:

a) Underspending in healthcare
b) Fragmentation of the healthcare financing system
c) Weak social protection and inequities
d) Inappropriate incentive structures.

This HCF Strategy responds to this call and proposes strategic interventions for addressing the challenges. The interventions are categorised in the following priority areas as guided by the framework above:

4. STRATEGIC INTERVENTIONS

Sierra Leone's weak macro-fiscal environment, including restricted fiscal space is unlikely to allow a significant increase in public financing for healthcare as a share of the THE. While remaining optimistic about the recovery of the economy from the triple shocks — the Ebola epidemic (2014–2015), the low international price of iron ore (the key export) (2015) and the COVID-19 pandemic – it is unlikely that economic growth in the next five years will translate to increased public healthcare spending as a share of the THE, especially considering that other sectors are also being prioritised. Also, despite the significant financing from development partners, it is unsustainable in the long term, and may dwindle as the economy recovers. The most viable strategy in the plan period is to focus on improving the efficiency of existing outlays, a situation that will require rethinking on how the government pools and allocates scarce resources, and how it purchases healthcare services and enhances DRM. The long awaited SLeSHI – aimed at reducing the high OOP and meeting the goals of resource mobilisation, universal membership, allocative efficiency and technical efficiency – may not be realised until the next planning period (after five years) when the scheme is established and becomes fully operational. The most viable strategic interventions to address the healthcare financing challenges for the next five years are provided below.

4.1 Enhance Resource Mobilisation

4.1.1 Increase government budgetary allocation from 9.7% to 15% of the GDP as envisioned in the NHSP

The GoSL has committed to "… *progressively increase in public healthcare expenditure to 15 percent of the GDP*. (NHSP 2019, p. 6). Against this background, we sought to determine the feasibility of meeting this target in the plan period. The share of government spending in GDP is currently small, and there is scope for expansion. With the projected GDP growth rate at 2019 constant prices, GDP is estimated to rise to US$4.96 billion (2013) and US$5.41 billion in 2025 (Table 12). Starting with the 2019 Government Expenditure as a percentage of GDP (9.7%) and providing for an increase of 0.5% per annum, the respective contributions will be 11.7% (or US$580 million) in 2023 and 12.75% (or US$698.72 million) in 2025, falling slightly short of the 15% NHSP aspiration. Ideally, we would have provided for a 1% growth rate per annum as recommended by the Macro Economic Commission but opted to provide a conservative figure as it may take longer than expected for the economy to rebound. With a population growing at 2.1% per annum, projected per capita government spending will be US$68 in 2023 and US$78 in 2025.

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. General taxation will remain the

predominant means for financing healthcare. The GoSL could consider imposing taxes on specific commodities, such as taxes on tobacco, alcohol and food that has a negative impact on healthcare, taxes on extractive industries and pollution taxes. Funds from development partners and under corporate social responsibility would also be leveraged for targeted programmes aiming to address healthcare goals.

Table 12: 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[27]

Against the background of significant support by the development partners to the healthcare sector, this Strategy proposes the streamlining of donor interventions in the healthcare sector to ensure they are used efficiently. The MoHS and the MoF will embark on building capacity of those with fiduciary responsibilities in PFM, costing and programme-based budgeting (PBB). This will enhance transparency and accountability of the available resources and enable the partners, including government and development partners, to work under the SWAp approach.

4.1.2 Internally generated revenue (IGR)

User fees (out-of-pocket payments at the point of care) are a common feature of healthcare system financing in resource-poor countries, particularly in African countries. In general, some form of fee is paid by the patient for curative care services at the point of use, which accumulates to internally generated revenue for the healthcare facility. Both cost recovery and user fee charges were most likely to be set by clinic staff, followed by the DHMT, with village committees having a role in a minority of areas. Charges vary considerably across the country with some districts choosing to levy no charges, at least at PHUs. In hospitals, charges are collected by

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

individual departments and accounted for on a regular (daily) basis by the facility accountant. Part of the money collected by each department is returned to be used for staff incentives and operating expenses. Revenue is sometimes largely retained by the healthcare facilities.

Due to the fragmented system of managing revenue generated at healthcare facilities, it is imperative that MoHS consider the following:

a) Digitalise the internally generated revenue at all facilities
b) Ensure clearly defined management of the revenue
c) Deploy finance officers to facilities.

4.2 Improve Resource Allocation

4.2.1 Equitable resource allocation for efficiency gain

This Strategy proposes that public spending on healthcare be allocated to high impact interventions with the greatest impact on healthcare outcomes.

Resource allocation criteria to the PHUs, district hospitals and regional/teaching hospitals should consider:

a) Population healthcare needs as reflected by epidemiological patterns
b) Cost-effectiveness paying attention to shifts towards healthcare orientation (as opposed to disease orientation)
c) Use of medical procedures, technologies, and medicines that have proven efficacy, among others.

The present resource allocation criteria will be reviewed to obtain equity in line with these objectives. Table 13 provides a few indicators to be considered, in addition to the current ones, in coming up with a more equitable weighted resource allocation criterion.

Table 13: 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	

4.2.2 Who pays for what services?

This Strategy recommends the following:

a) The GoSL, through the MoHS, to keep control of the infrastructure and equipment of the public hospitals to enhance capacity and ensure the availability of a proper mix of facilities that promote access, quality, and equity
b) SLeSHI, once operationalised, must be the main payer of personal care, acting on behalf of its members, fully exploiting its purchasing power function to improve the cost effectiveness of service delivery and to cover outpatient drug costs on the grounds of financial protection, and to ensuring the rational use of medicines
c) Payment of different reimbursement rates for the public and non-public facilities, as the latter do not benefit from government subsidies, particularly for infrastructure and equipment
d) The District Councils to continue funding public healthcare interventions in their respective areas until SLeSHI is in place and consideration given to what to purchase.

4.2.3 Separating the 'purchaser' from 'provider' of services

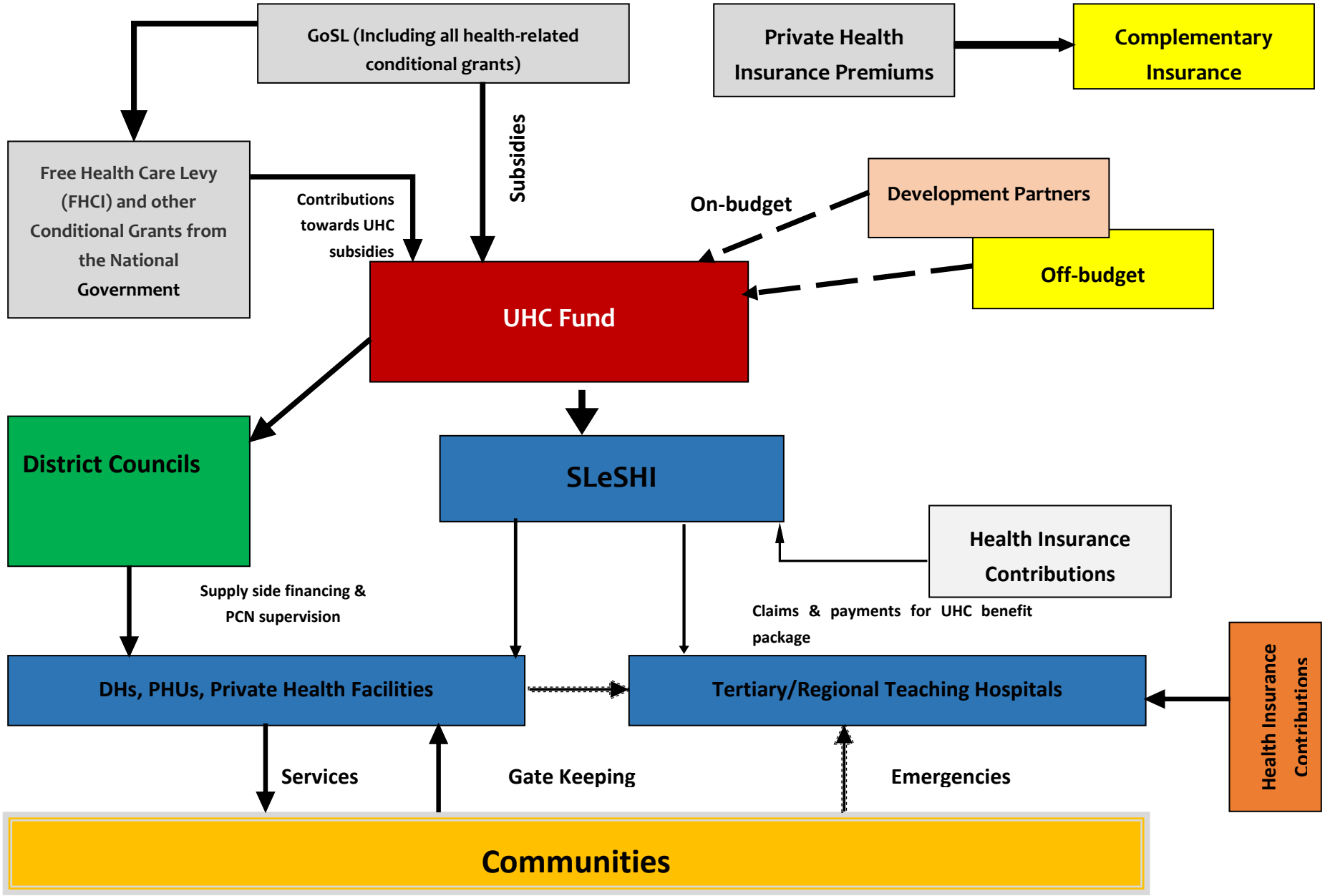
This Strategy proposes to separate the 'purchaser' from 'provider' of services, so that providers can focus on the effective and efficient management of their facilities, without worrying about the funds required to purchase their services. In a shift towards strategic purchasing, away from the traditional 'passive purchasing', providers will be paid on the basis of type and quantity of services delivered, and the basis of the context in which delivery takes place. Budgets will be determined largely by the volume of services and not historical trends. New methods and conditions of payment will be developed to ensure the managers of healthcare facilities know what level of funding to expect. These efforts will facilitate better planning and management of healthcare resources. The MoHS will also be capacitated to manage contracts in a purchaser–provider mechanism as this will be critical for the implementation of SLeSHI.

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

4.3.1 Establish a UHC Fund

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. As shown in Figure 3, 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 DHs, PHUs, private healthcare facilities and tertiary/regional teaching hospitals, on a reimbursable basis. Where feasible, the MoHS/NaCSA will support community or mutual aid initiatives, such as the community loan schemes, to convert to insurance schemes and/or join SLeSHI. Through these efforts, the schemes will be strengthened to become financing agents for services provided through primary care and secondary care. The District Councils and local communities will come in handy by pooling OOP to provide complementary funding to healthcare facilities. An effective gate-keeping policy will be maintained to avoid unnecessary referrals to the higher levels of care. The aim is to reduce direct OOP spending to at most 40% in 2025 as well as to improve financial protection for all through the proposed UHC Fund.

Figure 3: Establishment of a UHC Fund



4.3.2 Establish systems and structures for the implementation of UHC under SLeSHI on a pilot basis

Service delivery fragmentation will change with the entry of the SLeSHI scheme as a resource pooling and a service purchasing agent. Resource pooling involves putting together healthcare funds made available by people with different healthcare risks (different probabilities of falling ill or of needing healthcare) and with different abilities to pay (different incomes). Thus, the resultant single pool of funds facilitates cross-subsidisation of service consumption by the sick and/or the poor (on the basis of the solidarity principle), using the contributions made by the healthy and/or the wealthy. Such a welcome cross-subsidisation is not possible without the pooling of different insurance contributions. The pooling further facilitates the centralised purchasing of drugs and supplies, which lowers unit costs via the bargaining power of a single purchaser, thus benefiting all members of SLeSHI. Ideally, resource pooling enables the separation of the service provision function from the service purchasing function, thus creating opportunities for efficiency gains.

4.3.3 Reliance on the government for SLeSHI's seed capital

Based on the Willingness and Ability to pay study[28] and the World Bank (2019)[29], contributions to support SLeSHI in the initial phase will be raised from formal sector employees (6% of salaries payable through payroll on a monthly basis) and from the informal sector employees[30] (SLL20,237.16 (US$3.6) per adult, in the range of SLL14,000 (US$2.5) to about SLL35,000 (US$6.2), SLL15,000 voluntary contribution per month). Both formal and informal membership contributions will generate about US$54.4 million per annum and US$79.99 million per annum, respectively.

An additional US$27.8 million per annum in contributions is also expected from various sources:

a) 2.5% on Goods and Services Taxes
b) 2.5% of non-tax revenue, 0.25% of the revenue generated from Motor Vehicle Licensing
c) 40% of the GoSL Curative budget for PHC for Councils
d) Contributions from Social Safety Net Funds.

[28] Jofre-Bonet, M and Kamara, J. 2018, *Willingness to pay for healthcare insurance in the informal sector of Sierra Leone*, Published: May 16, 2018 (https://doi.org/10.1371/journal.pone.0189915)
[29] World Bank 2019, Sierra Leone Financing Situational Analysis (Draft), p. 29
[30] Jofre-Bonet, M and Kamara, J. 2018, *Willingness to pay for healthcare insurance in the informal sector of Sierra Leone*, Published: May 16, 2018 (https://doi.org/10.1371/journal.pone.0189915)

Against estimated costs of US$240 million per annum, which is required to run SLeSHI, the scheme will need additional funding that is to be generated through budgetary allocations and other tax revenues. SLeSHI's financing gap is anticipated to grow if the government honours its plan of exempting about 62.2% of the population from paying insurance premiums. The estimates[31] are based on the GoSL 2018 Budget Profile, NASSIT membership and formal sector salaries as per the Sierra Leone Labour Survey and 2015 Population Census.

The MoHS will work with the MoF to explore several options within the provisions of the PFM Act to expand the fiscal space for healthcare in Sierra Leone and ringfence the funds. Options include mobilising more resources from fines and taxations for practices that adversely affect one's health status, for instance, the use of tobacco and alcohol, carbon emissions, deforestation, garbage dumping, corruption and mining practices that pollute the environment and water sources. Other sources include healthcare related legal fines, property taxes, fuel taxes, market dues, vehicle and motorbike licences, etc. Such taxes provide a deterrent to certain practices or the consumption of certain consumer goods and, by implication, lower healthcare expenditures on related illnesses. This is a widely accepted taxation system, as it is considered more politically viable than income or sales taxes. The costs will be credited back to the government to fund public healthcare programmes. It should, however, be noted that healthcare taxes are valuable mainly because of their public healthcare benefits rather than because of their revenue raising potential. The cost of raising each of these revenues is also an issue to be considered.

Key interventions in the operationalisation of SLeSHI include the following.

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. The proposed phased implementation of SLeSHI will enable the GoSL to rapidly test and draw lessons on such key aspects as cost implications, including the provision of the benefits package.

[31] These estimates will be updated with the results of the new SLeSHI Acturial Study that is underway.

It will depend on:

a) The ability of the healthcare system in the pilot districts to effectively respond and adapt to an increase in demand for healthcare services
b) The extent to which the healthcare needs of the population are met
c) The effectiveness of the public healthcare facilities management, including financial management and the implications on healthcare service delivery
d) Efficiency with which the funds flow from the scheme to the providers
e) The effectiveness of the referral system
f) The ability of Sierra Leone's National Medical Supplies Agency (NMSA) to effectively supply quality and affordable commodities.

Given that the MoHS is starting PBF again in 2021, the scheme may be used to prepare for SleSHI and/or to pilot it.

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. The legal framework within which SLeSHI will operate also needs to be reviewed or updated if this has not been done. Appropriate healthcare sector reforms will also be undertaken to enable SLeSHI to adequately prepare for its envisaged strategic purchasing function.

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.

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.

Design high impact and affordable benefits package

The SLeSHI UHC benefits package will need to be re-designed to reduce OOP payments for the general population. It would make sense to provide PHC services for free, though this comes at a cost to the government. The main focus should be on ensuring that the quality of service is high and the population has access to the sources of care. At the same time, community level interventions to generate demand for primary care services should be put in place. This can be done through partnership with NGOs and the private sector (tele-companies (TELCOs)) to educate the population on the availability of services and the need to use them. Strong community healthcare programmes, supported by well-trained frontline community healthcare workers, can be a game changer. Not only can they provide a number of high impact interventions such as family planning, immunisation and the treatment of common ailments, but they can also provide them close to the people. The country needs to build a proper programme with a paid cadre of community healthcare workers, while recognising the need for volunteers who might be motivated by non-economic incentives. With support from the GoSL, the community healthcare workers should have work kits that are well equipped with appropriate supplies and medicines.

4.4 Document and Account for Health Spending

4.4.1 Enhance the capacity of the MoHS, Local Councils and Health facilities in PFM

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. The accountants, finance officers and leadership at the MoHS, Local Councils, healthcare facilities and DHMTs and finance officers at the hospitals will also need to be strengthened in PBB. This is a framework for planning, management and monitoring budgets that relates to the purposes of resource allocations. The PBB will help to effectively achieve the desired outcomes and cost healthcare services to support the development of the healthcare facility and Annual Health Work Plans that align resource allocation with service delivery policy priorities in the context of the MTEF.

4.4.2 Engage citizens to hold District executives and political leaders accountable through public participation for social accountability

This Strategy proposes the empowerment of communities to become active participants in the planning, budgeting and priority-setting process and to increase their voices in the demand for increased accountability and transparency. This will be obtained by working with the relevant authorities to:

a) Inform communities on what was budgeted for and approved in their locality
b) Use the media to publicise, package information factually and in a compelling way, and post the same information within the facilities where the funds are to be used
c) Enhance the capacity of various groups – such as CSOs, youth champions, women leaders and healthcare and budget committees – on basic PFM principles so as to be more informed and active in public budget hearings
d) Highlight different but complementary roles played by the district, community and the political leadership in fiscal management.

4.4.3 Enhance cross-programme efficiency, particularly for the vertical programmes supported by development partners

The MoHS will commission a cross-programmatic efficiency assessment to identify existing overlaps, redundancies, duplications, and misalignments across the healthcare system that needs to be addressed so as to make the healthcare system more efficient and sustainable. This will include an exploration of the programmatic arrangements at the MoHS and between the MoHS and the District Councils, and examine how function assignment across programmes and agencies influences the efficiency of the Sierra Leone healthcare system. The resulting information is to be fed into the development of a sector-wide transitional

road map, providing recommendations on how to improve the overall healthcare system's efficiency to maximise outcomes under UHC.

Additionally, technical and allocative inefficiencies will be monitored on a regular basis by:

a) Encouraging joint planning and budgeting sessions through sector working groups
b) Ensuring that budget statements and appropriation bills capture priorities identified during the planning and budgeting stages
c) Ensuring that resources are spent as per approved priorities in a timely and efficient way that demonstrates value for money
d) MoHS's M&E, audit and oversight
e) Documentation of lessons/best practices
f) Undertaking annual expenditure reviews to determine absorptive capacity and performance.

4.4.4 Staff Needs Assessment on finance and accounting skills, and competencies and appropriately re-deploy to obtain efficiency

This Strategy proposes an elaborate Staff Needs Assessment to determine the skills and competencies of those who work in the districts, programmes, and healthcare facilities and who hold fiduciary responsibilities. This is to determine adequacy in the number and qualifications of staff, providing a basis for catch-up capacity building in PFM as stated earlier or redeploy staff to more suitable areas. Appropriate performance management systems with clear targets will also be developed for the finance and accounts staff.

4.5 Strengthen Health Systems Governance

4.5.1 Digitisation of user fees collection on a pilot basis for more efficient management

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.

Additionally, the hospitals will be capacitated to develop financial management systems for:

a) Accounting and reporting
b) Issuing country-wide fee guidance through user fee operation manuals
c) Issuing user fee supervision manuals that will detail modalities for:
    - Collecting revenue
    - Recording
    - Reporting
    - Planning
    - Approval
    - Expenditure
    - Regulations governing the loss of public funds through neglect, fault or fraud.

Further, 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.

Regular supervision of hospitals and healthcare facilities is critical to the proper establishment and operation of the user fees programme. In this regard, the Health Service Commission, which oversees the setting of fees, will institute a two-step supervision process that involves:

a) Regular reviews of key user fees performance reports to identify performance problems with individual hospitals or healthcare facilities
b) Conducting supervisory visits using supervisory checklists for hospitals or healthcare facilities to verify the accuracy of performance reports and ensure that correct actions are being taken in problem areas.

The re-design of the user fees programme will include the deployment of a financial management information system that allows the implementers of the programme to assess, among others:

a) Collection performance
b) Claiming and reimbursements from insurance organisations
c) The number and amount of waivers and exemptions granted
d) Cash balance
e) Cash banking records
f) Hospital expenditures.

The ultimate objective of the digitisation of the user fee programme on a pilot basis is to enhance the effectiveness in the management of the resources being raised to improve the quality of curative and preventive healthcare services at these facilities. It will also encourage the use of cost-effective preventive and promotive healthcare services. Should this be successful, the initiative will be rolled out to the entire healthcare system in a phased approach, starting with the tertiary facilities, followed by regional hub hospitals, district hospitals and, lastly, secondary care level hospitals.

4.5.2 Pilot test the establishment of amenity wards in a few hospitals

The MoHS will provide guidance on the establishment of amenity wards to run concurrently with the general wards in public hospitals. The aim will be to generate additional income by, for example, attracting more fee-paying, high-income patients and thereby retaining the specialists within the hospitals. The revenue generated will be used to improve the quality of services and cross-subsidise the poor from the net financial surplus. The main payment mechanisms for the amenity wards will supported by government, private insurance and OOP. The MoHS will provide more financial autonomy to the hospitals that are operating the amenity wards, thereby providing more flexibility in the use of the funds to enhance operational efficiency. This will be monitored by the respective hospital management boards or committees, with strong community participation. This group will be capacitated to develop specific reporting requirements to include essential information to monitor performance.

4.5.3 Secure managerial and fiscal autonomy of tertiary facilities

Through this Strategy, public hospitals will be granted partial financial autonomy starting from 2021. This is particularly important for using the current budget and revenues for service-related activities by developing their own internal spending regulations that stipulate spending levels/items that are tailored to the local context and developing individual staff reward systems to improve productivity and work efficiency. Accountability

for the hospitals will also change from following directions and often seeking 'permission' from the government hierarchy to being more accountable to the respective hospital boards for performance and compliance with contracts and regulations.

Mechanisms will be developed to drive the autonomous hospitals to achieve the goals of equity, clinical quality, the rational use of healthcare services, and rational investment by:

a) Providing strict guidelines for setting prices for essential services in hospitals at a level that covers the costs of the public healthcare services and those that target the vulnerable, regulating the prices of private services, drug sales and diagnostic tests, so that hospitals do not make excessive profits from these services and fully fund the social obligations of the hospital that cover the vulnerable groups
b) Exercising considerable autonomy in the procurement of drugs, medical supplies and specialised medical equipment
c) Wielding considerable autonomy in decision-making on day-to-day management of hospitals.

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.

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

Governance

Governance functions for autonomous hospitals will require specialised, high-level expertise to capture good hospital performance data and data analysis. These functions require new capacities and skills in the Directorate of Hospitals and Local Councils or a GoSL Special Semi-Autonomous Hospital Authority (SSAHA). Such a specialised authority will be equipped with high-level expertise to monitor the performance of hospitals and oversee the appointment and development of hospital management.

Legal and Regulatory Framework

The GoSL will develop and operationalise the appropriate policy and legal frameworks that provide for hospital autonomy (partial or full) and ensure the establishment of an *independent* top-level decision-making organ to manage the hospitals. A state corporation model will be adopted to grant increased managerial and financial autonomy to the public hospitals, giving responsibility and authority to the boards to run individual hospital. The government will retain some control in certain other key areas, such as board

appointments, funding levels, fee structures, and staff remuneration. The framework will also define how the hospitals graduate from the present status to a semi-autonomous status in the medium term and, full autonomy in the long term. The legislation will be crafted to ensure close interconnectivity between the hospitals with the healthcare insurance to enable the healthcare insurance organisations to act as the main purchaser of healthcare services.
Other areas to be addressed include:

a) The application of corporate taxation
b) Investments
c) Classification of partly autonomous hospitals
d) Regulation of income top-ups with staff to reduce the income inequalities across specialties and hospital levels
e) Enhancing monitoring, inspection and the enforcement of hospital regulations.

Autonomy of hospitals is a precondition for a sound purchasing process, since it allows hospitals to negotiate with the healthcare insurance organisation.

Increase hospital management authority over healthcare workforce

The public hospitals will be supported to transfer staff from civil service status to the hospital payroll under more flexible terms. To allay the fear of loss of civil service job security, pension security and career mobility, the Hospital Boards will negotiate with staff unions for an acceptable package of conditions for the transfer of staff to autonomous hospitals. The negotiations will include adoption of appropriate policies to protect the employment rights of transferring staff and providing a package of protection and support for any staff made redundant during re-organisation. The MoHS will support the hospitals to increase investments in the training of management for the new and more complex challenges under autonomy. This will include change management training for staff who are ill-informed regarding the change, lack of clarity on their new roles and responsibilities or have increased responsibility and authority emanating from autonomy.

The MoHS and the social insurance (SLeSHI) system will harness and support the healthcare workforce as partners and support the hospitals to develop appropriate performance management systems. This will include:

a) Developing professional hospital managers with continuing professional development
b) Merit-based selection and promotion
c) Clear performance objectives monitored regularly by the governance body
d) Recognition and reward for high performance (and vice versa)
e) Well-establish career paths.

Administrative and financial management

The main and predictable funding streams available for hospitals' autonomy include government's contribution, paid as grants, capitation payment from insurance companies user fees and donors. The MoHS (or SSAHA) will assess hospitals before they are granted autonomy status to ensure they have robust administrative policies and systems to manage:

a) The various funding streams
b) Personnel
c) Procurement and assets
d) The authority to carry out internal control and internal audit systems within the hospital and independent external audits
e) Transparent, competitive procurement and contracting procedures to cover any joint ventures or other forms of partnerships, including competitive procurement requirements for:
    - Leasing
    - Service contracts
    - Joint ventures
    - Build-operate-transfer (BOT) agreements, etc
    - Capacity to prepare key financial and activity reports that autonomous hospitals should provide to their respective governance boards
    - Mandatory publications of annual financial reports and annual reports on activity and other performance indicators.

Consistent and coordinated approach between the different institutions involved in hospital-related policies

This Strategy proposes the strengthening of the coordination between the MoHS and other ministries or agencies responsible for hospital planning and capital investment in hospitals; strong government leadership, accompanied by effective communication, to explain and defend essential elements of the reform policies that may be controversial. Autonomous hospitals will be closely linked and integrated to the rest of the healthcare system to ensure that patients' healthcare needs are addressed efficiently at the primary care or in a lower-level hospital and to avoid unnecessary attraction to tertiary level facilities. This will evidence the merger of hospitals into networks that include all levels of the hospital referral chain within a geographic area, the creation of regional hospital authorities to supervise and govern all the public hospitals within the catchment area of a tertiary hospital and give the authority power to organise the referral relationships between hospitals.

Develop healthcare information systems for increased accountability

The hospitals will be supported by MoHS (or SSAHA) to operationalise a hospital-wide electronic, network management information system and improve coding, validation and the audit of clinical records. The successful implementation of an automated healthcare information system will promote evidence-based decision making, support planning, budgeting, and link available resources to actual needs of hospitals. The hospital staff will also need to be equipped with skills in costing so as to promote effective service delivery. More state regulation will, however, be required to ensure outcomes that are economically efficient, consumer-friendly and politically acceptable.

Monitoring and supervision framework

The MoHS will need to be equipped with adequate capacity to monitor the transition process. This will require a phased approach with built-in mechanisms to learn from the implementation process and readjust implementation tools as required. Engagement with stakeholders will also be key to ensuring that convergence on the objectives and outcomes of the decentralisation process is achieved. The appropriate institutional framework will be developed for supervision and regulation of autonomous hospitals. The aim is to ensure that, in the transition period, management energy is not too focused on structural and organisational change, losing focus on clinical quality and clinical healthcare outcomes.

This Strategy proposes a balanced mix of multiple policy, governance and management mechanisms needed to optimise the impact of hospital autonomy and mitigate the risks of unintended effects. For the first two years, the facilities will remain as budgetary subordinate units of the MoHS or local government, financed from the budget and subjected to the same rules and controls as other government ministries. The SSAHA will initiate the process for the hospitals to become semi-autonomous units or autonomous government-owned bodies. Hospital directors will be appointed by the GoSL to run the institutions under an external supervisory board. Thereafter, the selected hospitals will be graduated to government-owned enterprises or corporations with a legal and financial structure and regulations similar to those of the private sector hospitals, but remaining in government ownership.

The corporate hospitals will have a board of external directors appointed by the SSAHA or government other appointed state enterprise. The hospitals will operate under two different sets of rules – traditional 'budget unit' rules for the subsidies they continue to receive from the budget and another more autonomous set of rules for the non-budget payments they receive from patients, and insurance funds. At this time, the hospitals will function as a hybrid of a traditional public hospitals and private hospitals.

4.5.4 Adoption of Sector Wide Approach (SWAp)

This Strategy proposes the establishment of a well-functioning SWAp in programming to bring all sector partners together under one common planning framework, one common budgeting framework (MTEF), one common funding mechanism, one common M&E framework, and common management arrangement based on the country's systems for channelling funds, that is, the Public Financial Management Act (PFM) and the Public Procurement and Disposal Act. SWAp will lead to the development of a single consolidated District Annual Health Plan, one coordination mechanism, one supervisory and monitoring system, and one healthcare information system under the leadership of the DHMTs with all the supporting development partners converging to this plan. Partners will have the opportunity to share planned activities, available budget, with the end result of the team agreeing on priorities, and targets for the year and ways to address the financing gaps.

4.5.5 Private Health Sector Financing

As part of the healthcare public–private partnership model, the GoSL will partner with the private sector on initiatives focused on local innovation, job creation, and the development of small and medium enterprises throughout the value chain of healthcare.

Through a Memorandum of Understanding or other mutually agreed arrangement, the private sector will:

Provide appropriate medical technologies

This Strategy proposes that the GoSL collaborates with the private sector in the modernisation and strengthening of the country's healthcare systems, with a focus on primary healthcare. In the proposed arrangement, the private sector will be contracted to provide appropriate medical technologies for maternal and essential new-born care, early detection of NCDs, safe surgery, and the management of injuries. As per the World Bank's recommendations [32], private sector manufacturers and/or major distributors of diagnostic equipment will supply, install, train users, and provide maintenance, repair and replacement services for specialised medical equipment. Illustrative equipment to be outsourced include theatre equipment, sterilisation equipment and theatre instruments, renal dialysis equipment, intensive care unit (ICU equipment, X-ray equipment, and other imaging equipment, depending on the level of healthcare facility.

[32] GoSL and World Bank (2020), Sierra Leone Private Health Sector Assessment, (authored by Obita, W., Marani, L., and Gitonga, N), World Bank/Sierra Leone (July)

Improvement of skills level of healthcare professionals

There is an increased role for the private sector to strengthen the capacity and skills level of healthcare professionals at all levels, thus bridging gaps in clinical and service delivery, as well as sustaining and scaling the impact of interventions. Skilled healthcare workers will, in turn, help to increase the quality of referrals, lower the number of clinical errors, and reduce the time required for regular maternal assessments or new-born procedures, resulting in increased confidence in handling and delivering care. This is in addition to increasing the awareness of safer surgical practices and the need for safe anaesthesia, reducing maternal and trauma-related complications and associated mortality.

Increased scope in service delivery to reduce overseas medical treatment expenditures of GoSL

Opportunities will be exploited to support the private sector to establish Operate-and-Manage Patient Protection Policies (PPPs) for primary care, secondary and tertiary level healthcare facilities. Service contracts with private healthcare ICT providers must be established to provide ICT solutions to collect service delivery data, facilitate healthcare management through healthcare management information systems, provide consultation and referral services through remote telemedicine services and aggregate data for regulatory bodies among others.

Increase private sector participation in multisectoral engagements

The country needs to embrace the spirit of 'doing it together' to involve the private sector in the discussions taking place that will shape national policies and allow them to respond to ensure that the private sector contributions are given adequate attention. This Strategy calls for the establishment of national and district-level multisectoral PPP coordination frameworks involving healthcare and other sectors (for instance, education, agriculture, security and manufacturing, especially SMEs and cottage industries) for structured engagements between the public and private (for profit and not-for-profit) sectors. Such forums need to have an appropriate legal framework and be mandated to discuss and obtain consensus on, among others, the implementation of joint activities, the protection of gains already made and modalities of private sector funding, including priority areas for support and accountability mechanisms.

4.5.5 Financing of Health-related Epidemics and Outbreaks

From the country's preparedness and response to the Ebola and Covid 19 pandemics and, based on the provisions of the NHSSP (Health Security and Emergency), this healthcare financing strategy proposes several interventions to tackle the spread of future outbreaks of infectious diseases and similar threats.

These include:

Establishing an Emergency Preparedness and Response Fund (EPRF)

This Strategy proposes the earmarking of 0.1% to 0.5% healthcare funds at the MoHS and Local Council levels to establish an EPRF. Detailed guidelines should be developed, including:

a) The purpose for which the fund is established
b) What can or cannot be funded
c) Requirements for all arrangements or grants under the fund
d) Decision-making processes to access the fund
e) Recovery and post-disaster resilience measures
f) Pre-disaster resilience and preparedness
g) Disaster risk reduction and sustainability measures.

Targeted interventions to immediately address immediate safety net needs must be implemented to reduce the financial hardships of the vulnerable.

Improving the work environment for healthcare workers (HWs)

The MoHS and Councils need to ensure the safety and protection of the healthcare workers, especially those on the front line during the spread of infectious diseases, including epidemics and outbreaks. This Strategy proposes several interventions to accomplish this objective.
These include:

a) Providing adequate and effective personal protective equipment (PPE) to the HWs as well as training on their correct use and disposal
b) Enhancing the capacity of the HWs on how to identify and report any symptoms and what to do to lower transmission risks for themselves, their families and others
c) Improving occupational healthcare and safety management systems relating to the specific infectious diseases
d) Providing mental healthcare and psychosocial support to the HWs
e) Improving the capacity of the HWs to continue providing routine healthcare services alongside the pandemic(s)
f) Improving the capacity of the HWs facility managers to ensure facility systems preparedness
g) Providing real-time current guidelines on how to manage the pandemic and continue routine services.

Improving medical infrastructural support

Revamp the country's healthcare systems to increase critical care capacity at all levels. These include:

a) Facilitating a Geographic Information System (GIS) diagnostic testing platform that maps in the countries (including expanding the use of the current GxAlert platforms for the diagnosis of the pandemic)
b) Increasing investments in establishing and equipping regional 'hot spots', isolation centres and/or treatment units
c) Enhancing the capacity of surveillance for the pandemic or any future pandemic preparedness.

Enhancing behaviour change communication/strategies

Counter misinformation by provide support to enhance behaviour change communication strategies – including radio messaging, social media platforms, TV spots and other evidence-based models – contextualised to the realities of individual district or Local Council contexts to inform the public about the risks of COVID-19 and other infectious diseases and what measures should be taken.

Strengthening cross-border and internal coordination

Harmonise coordination and rationalisation of donor support to avoid duplications and ensure efficiency in the use of available resources. This will enhance regional surveillance efforts and response, epidemiology, modelling, diagnostics, clinical care and treatment, and other ways to identify, manage the disease and limit widespread transmission of the pandemic(s) or infectious disease. The support should also include strengthening support systems development for multisectoral/multidisciplinary coordination response to pandemic outbreaks.

Enhancing the use of evidence-based strategic information in decision making

Strengthen the country's capacity for early detection of new cases and respond quickly to disease threats and outbreaks based on data driven interventions and programmes to save lives. Illustrative interventions will include improving the country's active surveillance and response, including alert management systems, case investigations and contact tracing, and the use of service provider level data to identify abnormalities and/or unique symptoms well in advance.

Strengthening local capacity to engage in continuous research and adaptive learning

Areas of research should include:

a) Emerging knowledge of managing emergency patients in the country's context
b) Emerging knowledge from randomised controlled trials of treatment and preventive options in the country
c) Potential impacts of the pandemics on socio-economic conditions (e.g., nutrition, GBV, poverty), livelihood, education and skills development.

The research should include clear actionable recommendations.

Leveraging on public–private partnership (PPP) support

In response to unprecedented demand and severe disruptions to the global supply chain, the country will need to develop protocols aimed at streamlining the procurement of emergency items and those critical items facing global shortage at the West Africa Regional block level to take advantage of economies of scale. Additionally, through PPP, they need to utilise the existing local excess capacity to produce (where feasible) items such as medical oxygen, invasive and non-invasive ventilators, medical equipment and consumables such as masks, disinfectants, gloves, protective goggles and suits.

Developing, implementing or upgrading the use of integrated digital platforms (m-healthcare, e-learning, telemedicine, mobile phones) to deliver healthcare services

This applies particularly to early diagnosis and patient management in hard-to-reach rural areas, emergency care, healthcare centres and medical concierge services. The platforms can also be tailored to facilitate patients' registration, booking appointments, follow ups, reminders through alert systems setting, conducting ultrasound outreach consultations and conducting virtual HW training.

5. MONITORING AND EVALUATION (M&E) FRAMEWORK

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 in Figure 4. 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. Immediately below these are the intermediate outcomes defined in terms of access, quality and efficiency. The achievement of these intermediate outcomes, in turn, is determined by the completion of the major final outputs in the areas of financing, service delivery and policy/regulatory frameworks, as well as governance.

Figure 3: 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>

The implementation of healthcare financing policies and actions advocated and discussed in this Strategy needs to be monitored and evaluated at regular intervals. This exercise is needed for building more evidence for future policies and for the assessment of whether the policy objectives discussed in this Strategy have achieved the expected results. M&E strategies contribute to the assessment of progress towards the attainment of SDGs, NHSP and other national and international development goals. The evidence will be useful for better targeting domestic healthcare financing and coordination and the pooling of healthcare resources. The number of investments in healthcare, which various strategies have addressed, is expected to increase. Likewise, the attainment of universal coverage of essential healthcare services, as well as the population covered by SLeSHI and other prepayment schemes, should be monitored. On the expenditure front, the reduction in the share of out-of-pocket funding for healthcare also needs to be monitored. The strategies proposed are expected to evaluate and monitor the increase of investment in healthcare, attainment of universal coverage of essential healthcare services, the percentage of the population covered by prepayment financing schemes, the reduction in the share of out-of-pocket funding and other strategic interventions.

The M&E framework will track seven key SL-HCF strategies (refer to Tables 1 to 7) during the implementation of this Strategy and will strive to ensure that appropriate policy instruments and regulatory frameworks are put in place as a precondition for a sound healthcare financing environment.