

Sierra Leone's Free Health Care Initiative: Financing implications



Overview

In 2010 the Government of Sierra Leone (GoSL) took the bold move to establish the Free Health Care Initiative (FHCI). At its core, this was the removal of user fees (on drugs and consultations) for pregnant women, lactating mothers and children under 5. The major objective of the scheme, as far as health financing was concerned, was to reduce the strain on households from out of pocket (OOP) expenditure on health, replacing it with an increase in public (pooled) resources and new mechanisms to channel these resources to health facilities. Key concerns were that the scheme would lead to a loss of revenue to the health system (through the removal of fees) and a reduction in the availability of money at local facilities. In this case, the desired increase in demand for health services could have put too much strain on the remaining budgets (most notably for salaries and drugs).

The brief is based on an independent review of the FHCI completed in 2016, which looked at financing changes following the initiative's launch, and focuses on the pre-Ebola outbreak years (2010-2013). It outlines how financing flows changed and highlights some of the major strengths and weaknesses in resourcing the initiative.

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Key Messages

- The FHCI provided an opportunity for increased coordination in the health sector between government and development partners as well as within government itself. However late disbursement of financing remains a challenge
- Donor funding to government and also on drugs and medical consumables was key to the increase in spending on health
- Total health expenditure (THE) is estimated to have increased, driven by new money from donors. The proportion of THE spent by households decreased and the proportion spent by government remained constant, after having grown significantly in the years running up to the launch
- In 2012 government capital expenditure almost completely contracted. In the last three years, foreign financing of capital expenditure made up over 95% of the total capital budget. Government expenditure on health is increasingly being absorbed by the payroll. If this trend continues, and if donors withdraw, government will have hired a large workforce, but will not be able to afford to equip them to do the work they are paid to do.
- While there is an apparent increase in expenditure on outpatient and prevention services, 45% of THE is still spent in hospitals, compared to only 28% in Peripheral Health Units (PHUs) and private clinics.
- There are weaknesses in data collection and quality. In particular, we need to know more about what is spent outside government. For example, what is the overall true cost of the FHCI? And how much do households spend on health?
- Issues with central allocations and weaknesses in drug supply have meant that local facilities struggle to provide continuous service delivery. Keeping mechanisms such as PBF as a local financing source need further exploration.

Methods

To examine changes in financial resources for the national health system, trends in the Sierra Leone National Health Accounts from 2004 to 2013 were examined (published in 2007, 2012 and 2015). Government accounts – both budget estimates and actual figures – were analysed for further detail to examine how government prioritised such groups, including the magnitude and equity of transfers from national to sub-national levels. This trend analysis was compared with a number of surveys and studies conducted by NGO consortia throughout this period, such as Save the Children's in-depth Budget Tracking surveys, and other donor evaluations, such as the one by HDRC (in the resources section below). Key informant interviews were carried out with the main policymakers during this period, as well as with health district personnel and health workers and managers at facility level.

Trends in health financing

THE is estimated to have increased (Table 1), driven by new money from donors. The proportion of THE spent by households decreased and the proportion spent by government remained constant, after having grown significantly in the years running up to the launch (Figure 1). Government expenditure on health actually grew in 2010 and 2011, but then fell in 2012 and 2013. The proportion of THE spent on preventative health programmes and outpatient care increased, as the share spent on inpatient care decreased (Figure 2).

The direct incremental cost of the FHCI (the increase in spending on key items such as salaries, drugs and medical consumables that came as a direct result of the initiative) is estimated to have grown from US\$4-6 per capita between 2010 and 2013 (US\$25-40 million in total). The total incremental cost overall (total increase in expenditure sector wide estimated to be an indirect result of the FHCI) grew from US\$6-14 per capita (US\$40-90 million) over this period.

Table 1: Total Health Expenditure (THE) (nominal), 2004–2013

Source: NHA 2004–2006, 2007–2010, 2013

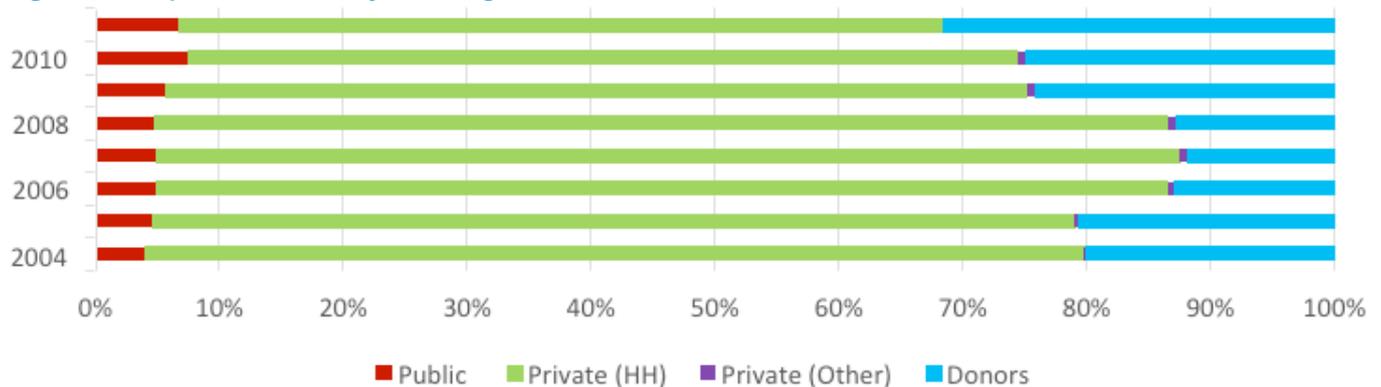
	2004	2005	2006	2007	2008	2009	2010	2013*
THE (SLL billions)	816	967	968	923	1,099	1,444	1,811	2,517
THE per capita (US\$)	60.70	65.67	62.67	57.83	67.13	75.26	78.71	96.47

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Figure 1: Composition of THE by financing source, 2004-2013



Source: NHA 2004–2006, 2007–2010 and 2013 (Public estimates for 2004–2006 have been taken from GoSL accounts rather than NHA given the data issues for those years)

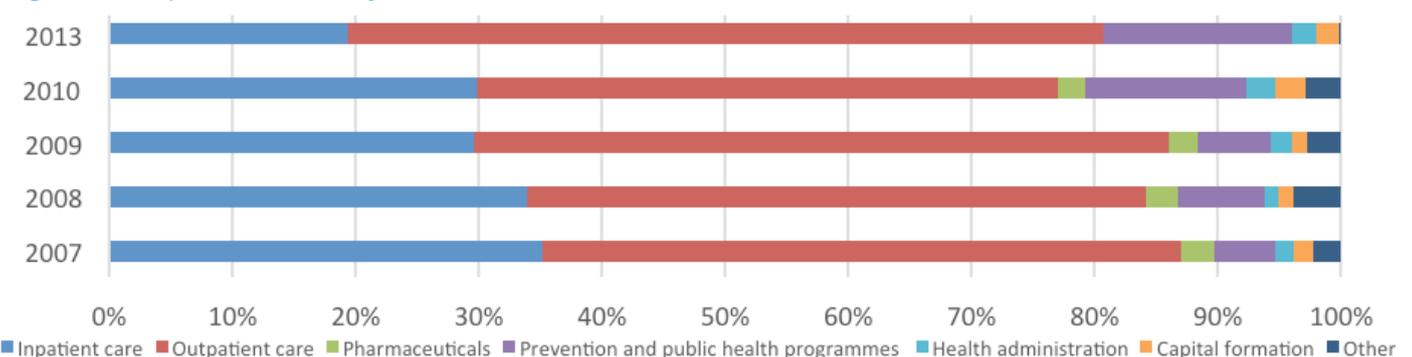
Some of this increase in donor funding was channelled through government. The most important example was the partial refunding of health worker salaries to government. The UK’s Department for International Development (DFID) refunded 27% and the Global Fund refunded 20% of the payroll over the first three years of the scheme. On the other hand, many inputs were procured directly by development partners. The most important examples of this were the drugs and medical consumables, which were paid for by DFID, procured by UNICEF and dispensed in government health facilities.

Replacing the lost cash flow at secondary and tertiary facilities (from consultation fees and sale of cost recovery drugs) was less challenging, as there were already government systems in place for transferring money from the Ministry of Finance and Economic Development (MoFED) to Local Councils, and to the hospitals. Replacing the lost cash flow at PHUs was much more complicated, with no previously existing systems in place. PHUs provide basic primary health care through a

network of over 1,000 facilities located throughout the country. After bank accounts were established, government started transferring SLL 1 million to each facility on a quarterly basis.

A year into the FHCI these lump sums were replaced by the World Bank funded Performance Based Financing (PBF) Scheme. Under this scheme PHUs were transferred variable amounts of money depending on their performance, measured by the quantity of services provided and a combination of cross cutting indicators such as hygiene and drug availability. A year later the major maternal and child hospitals in Freetown were added to the scheme, with payments calculated based on adherence to certain procedural and quality standards. Through the same programme (although not based on performance) the World Bank also funded transfers to the Local Councils, to be disbursed to the District Health Management Teams for monitoring and supervision of health facilities at the district level.

Figure 2: Composition of THE by health function, 2007-2013



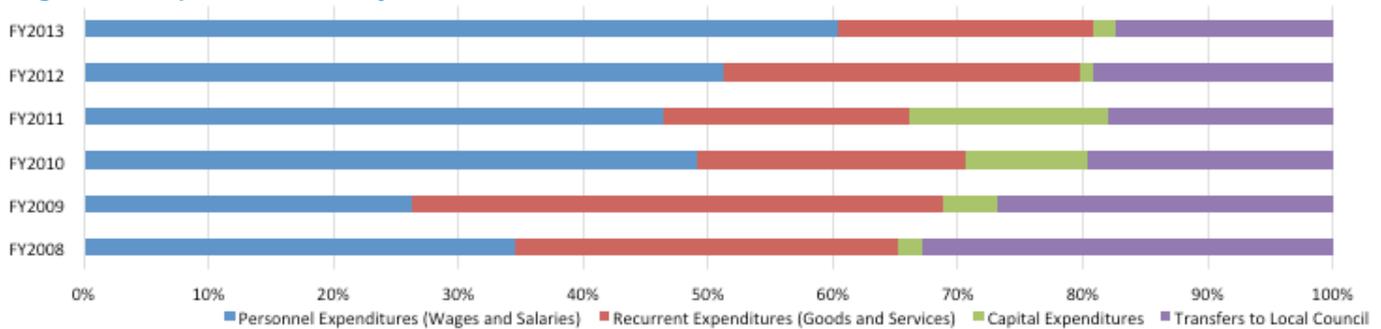
Source: 2007–2010 and 2013

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Figure 2: Composition of THE by health function, 2007-2013



Source: MoHS figures

Strengths

Total expenditure on health has continued to grow, with OOP expenditure accounting for a large but decreasing share. In a country with significant health problems, increasing the amount of pre-financed money available for health care increases the opportunities for improving welfare. It is important to note, however, that this is only a strength to the extent that the money is well spent.

The decreasing share of THE going towards inpatient care, and the increasing shares being spent on outpatient care, prevention and public health programmes is a positive sign. These health functions are generally considered to be more cost effective than inpatient care.

PBF payments to health facilities were adjusted to account for poverty and remoteness – so districts with higher levels of poverty and more hard to reach facilities (such as Koinadugu and Bonthe) received more per unit of activity than richer, more urban areas (such as Freetown). This is an example of a pro-poor redistribution mechanism being structurally built into the health sector.

In terms of processes in health financing, the FHCI provided an opportunity for increased coordination in the sector between government and development partners as well as within government itself. A Health Financing Working Group was established, including representatives from each of the key stakeholder categories (donor, NGO, government, civil society etc.). In the early stages they met regularly and reported to the Health Sector Steering Group.

With this, the Joint Programme of Work and Funding (a three year costed plan for the entire health sector) was developed, including a section for health financing. This section focused on PBF, National Health Accounts and the design and piloting

of a social health insurance scheme. The future of PBF and the social insurance scheme are now under debate, but the health accounts are arguably on their way towards becoming institutionalised. The fourth set of accounts (for 2014) have now been validated, and funding for future iterations is secured from the Global Fund.

The final important strength relates to PBF. While its future is currently under debate, the basic level of knowledge and infrastructure for its implementation have been built. This is a very significant achievement that the ministry has worked hard to achieve. PBF provides the only direct channel to finance primary health facilities providing them with a level of autonomy and flexibility. Overall, around US\$0.5-1 per capita per year flowed through the scheme (including the hospitals). Cordaid's independent review concluded that, to some extent, it did provide financial incentives to increase productivity and quality of care. While there are implementation problems, it has potential as a foundation to be built on.



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Weakness/challenges

Most of the weaknesses that were identified are general health system challenges, not limited to the FHCI. Public (pre-financed) spend on health per capita is still below the levels needed to provide a basic package of quality reproductive and child health care. OPM's policy brief on future fiscal space for the FHCI predicts that, under business as usual, there will be a funding gap of US\$ 66 million by 2025, or 0.6% of GDP.

While there is an apparent increase in expenditure on outpatient and prevention services, 45% of THE is still spent in hospitals, compared to only 28% in PHUs and private clinics. PHUs are much more accessible than hospitals, but currently vastly under-funded. Specifically looking at human resources, a similar picture emerges. 50% of the health sector payroll is spent on staff working in hospitals, 38% on staff working in PHUs and 12% on staff in sector administration.

Financial disbursements from government are often late, damaging the implementing unit's ability to plan and carry out activities on time. This has been repeatedly reported anecdotally by many and systematically documented by the Budget Advocacy Network. Delays are encountered between MoFED and Local Councils as well as between Local Councils and DHMTs and hospitals. The initiative's effect at catalysing large donor resources in the sector has, to some extent, buttressed some of these limitations in government disbursement. However, significant financing outside of government's systems has in turn created weaknesses in coordination, accountability, and fiscal sustainability.

Government capital expenditure dramatically increased between 2009 and 2011, starting from a very low base. However, in 2012 capital expenditure almost completely contracted, with poor maintenance of facilities reported during stakeholder interviews. Development partner financing of capital expenditure is significant, growing from SLL 23 billion in the 2008 budget to SLL 140 billion in 2014. In the last three years, foreign financing of capital expenditure made up over 95% of the total capital budget. Conversely, government expenditure on health is increasingly being absorbed by the payroll, with capital expenditure almost disappearing (Figure 3). If this trend continues, and if donors withdraw, government will have hired a large workforce, but will not be able to afford to equip them to do the work they are paid to do (because government will be exhausting all of its resources on salaries).

Finally, there are important question marks over data availability and quality. While government keeps its own financial accounts, collecting data on health expenditure by development partners and households is much more complicated. Cordaid's study of 2014 showed that around 12% of eligible patients still had to pay for the FHCI in 2012. In terms of household OOP on health overall, official estimates have so far been based on the Sierra Leone Integrated Household Survey (SLIHS). Two of these have been conducted – one in 2003/4, the other in 2011. With only two data points, one long before the initiative's launch, it is difficult to comment on how much households are spending on health, let alone reproductive and child health specifically or on whether this has been influenced by the FHCI. Alternative estimates of OOP on health in 2011, based on data from the National Public Services Survey, are very different to those derived from the SLIHS, as are estimates of OOP as a proportion of wider economy indicators (such as gross domestic product) in countries around the region. These discrepancies call into question the reliability of the data.

Recommendations

Government should prepare a health financing strategy which outlines:

- A plan for future donor expenditure. This may include an increase in the immediate future, but should also guide the health sector's withdrawal from donor funding over the long term (see OPM Fiscal Space brief for Sierra Leone, 2016).
- A plan for increasing pre-financed domestic expenditure on health. Both the Budget Advocacy Network and OPM have independently explored how fiscal space for health in Sierra Leone could be increased through the introduction of certain new taxes or the enforcement of existing ones.
- A plan for improving the efficiency of existing expenditure on health, thereby increasing the amount that can be done with what is already available.
- A set of solutions that help align and coordinate government and donor funding, balancing fiduciary concerns of donors with the imperative of building government systems over time.

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To better understand spending on health government and stakeholders should:

- Continue to invest in institutionalising the National Health Accounts. There is still significant potential for improvement.
- Make methodological improvements to the implementation of the next SLIHS. Specifically, including a 'yes'/'no' question on whether prescription or consultation charges were paid, as well as ensuring consistency wherever necessary. Recall periods differed between the two previous surveys, making results less comparable.
- Conduct small scale regular surveys to monitor OOP expenditure. National surveys may be too expensive to provide the necessary information on a regular enough basis. Surveys targeting hotspots such as Croo Town or Waterloo, as well as some rural areas, may be a useful way to supplement irregular national surveys and directly inform policy making.

Government and donors should provide more flexible financing to the local level.

Government should consider expanding the FHCI to cover all services provided at PHUs.

This would be a significant move, but not impossible in the medium term. In 2013 OOP expenditure in PHUs is estimated to have been just over SLL 200 billion. Replacing this (on top of existing expenditure) would require a 20% real increase in donor and government expenditure. Some further increase would be necessary to cover an increase in demand resulting from the removal of fees. This would continue Sierra Leone's progress towards offering universal access to a basic package of essential health services, and should be encouraged.

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Key resources

OPM's full report, presentations and policy briefs: www.opml.co.uk/projects/evaluation-free-health-care-initiative-fhci-sierra-leone

President's priorities going forward: www.presidentsrecoverypriorities.gov.sl/

Save the Children's budget tracking work: www.savethechildren.org.uk/sites/default/files/docs/Sierra_Leone_Health_and_Sanitation_Budget_Tracking_2012.pdf

HDRC's evaluation of DFID support to healthcare workers: www.oecd.org/derec/unitedkingdom/18_DFID%20Support%20to%20Healthcare%20Workers%20Salaries%20in%20Sierra%20Leone.pdf

Budget Advocacy Network's evaluation of bottlenecks in the disbursement of funds: www.mamaye.org.sl/sites/default/files/evidence/Bottleneck%20Report%20-%20Dec%202014.pdf

Cordaid's external verification of the PBF scheme: www.cordaid.org/en/wp-content/uploads/sites/3/2014/12/PBF-external_verification_main_report_Cordaid_Layout_15062014.pdf

Edoka et al's research on OOP expenditure in Sierra Leone: www.researchgate.net/publication/303540431_Free_health_care_for_under-fives_expectant_and_recent_mothers_Evaluating_the_impact_of_Sierra_Leone%27s_free_health_care_initiative

HDRC's Evaluation of DFID support to healthcare workers' salaries in Sierra Leone: www.gov.uk/government/uploads/system/uploads/attachment_data/file/206761/evaluation-support-healthcare-workers-salaries-Sierra-Leone.pdf

MoHS's National Health Accounts 2013: www.mamaye.org.sl/sites/default/files/evidence/MoHS%20SL_2015_Sierra%20Leone%20NHA%202013.pdf

Save the Children's budget tracking of health and sanitation: www.savethechildren.org.uk/resources/online-library/sierra-leone-health-and-sanitation-budget-tracking-2012



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