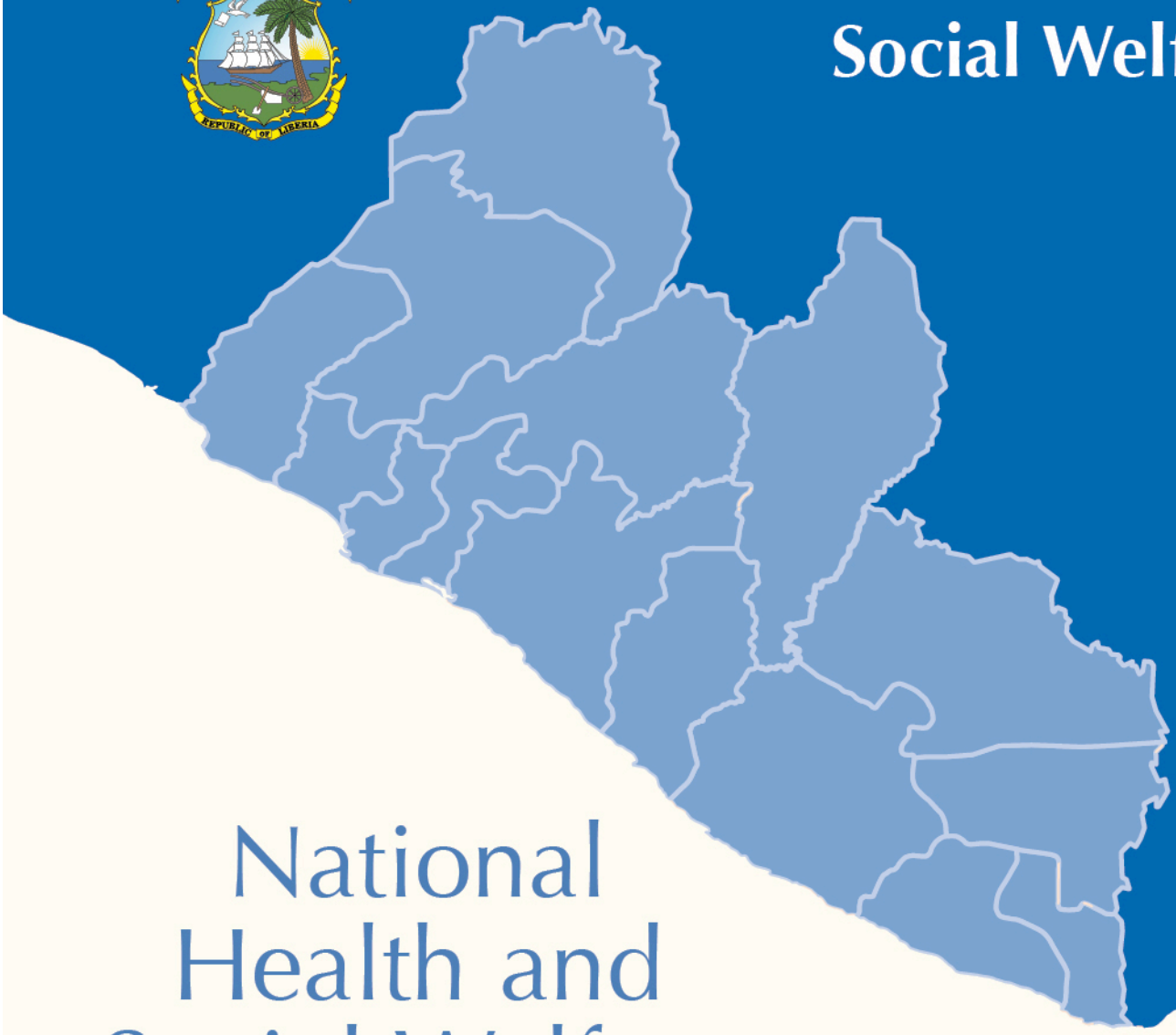
Republic of Liberia

Ministry of Health and Social Welfare



National Health and Social Welfare Financing Policy and Plan 2011–2021

Foreword

It is my honor to present the 2011 National Health and Social Welfare Financing Policy and Plan. This policy and plan represent our collective commitment to implement the National Health and Social Welfare Policy and Plan, 2011–2021, which we developed just a few short months ago.

Under the very strong leadership of President Ellen Johnson-Sirleaf, we, the people of Liberia, continue the process of transforming our country into a more secured, more prosperous and healthier nation. To guide our efforts, the Government has developed the Medium-Term Social and Economic Development and Growth Strategy, which sets the stage for Liberia becoming a middle-income country by 2030.

Recognizing that health and social protection are key determinants of human development and that financing is a critical component to success, the Ministry of Health and Social Welfare carried out a participatory process to develop this financing policy and plan in order to accelerate progress in social and economic development. Many individuals and organizations, from across the country and outside Liberia, have generously contributed to its development and we gratefully acknowledge all their contributions.

The goal for health and social welfare financing is to ensure that the health and social welfare services provided to the population of Liberia are affordable to the country while preventing catastrophic costs to households. Our strategy is to increase the availability of resources, improve their equitable allocation and efficient utilization according to evidence-based management and policy decisions.

In order to attain our goal over the next ten years, the network of functioning facilities must be expanded and resources available must be increased. This will require the sustained commitment of all stakeholders to wisely use every available resource in a participatory and transparent manner, along with strong Government leadership throughout the process.

With this health and social welfare financing policy and plan in place, built on a foundation of partnership and collaboration, we pledge to continue the march towards our ultimate goal of a healthy Liberia with social protection for all our citizens.

Walter T. Gwenigale, MD
Minister
Ministry of Health and Social Welfare

Abbreviations

BIA	Benefit Incidence Analysis
BPHS	Basic Package of Health Services
CHSWT	County Health and Social Welfare Team
CSA	Civil Service Agency
EPHS	Essential Package of Health Services
EPSS	Essential Package of Social Services
FBO	Faith-Based Organization
GOL	Government of Liberia
HMIS	Health Management Information System
JFKMC	John F. Kennedy Medical Center
LDHS	Liberia Demographic and Health Survey
LISGIS	Liberia Institute for Statistics and Geo-Information Services
M&E	Monitoring and Evaluation
MDA	Ministries, Departments and Agencies
MMR	Maternal Mortality Ratio
MOE	Ministry of Education
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium-Term Expenditure Framework
NFP	Not-for-Profit
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHSWFPP	National Health and Social Welfare Financing Policy and Plan
NHSWPP	National Health and Social Welfare Policy and Plan
OGC	Office of General Counsel
OFM	Office of Financial Management
PCT	Program Coordination Team
PFP	Private-for-Profit
PHC	Primary Health Care
PRS	Poverty Reduction Strategy
SDP	Service Delivery Point
U5M	Under-5 Mortality Rate
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

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Summary

This first-ever National Health and Social Welfare Financing Policy and Plan (NHSWFPP) was established to supervise and standardize the finances to implement the National Health and Social Welfare Policy and Plan, 2011–2021 (NHSWPP). This process was participatory and evidence-based and included numerous studies, reports and stakeholder consultations at the county and national levels (*see* Annex 1: List of References).

The evidence base indicates that although the total health and social welfare expenditure in Liberia is significant, the cost of implementing the 10-year NHSWPP will exceed the current level of resources. In anticipation of gradual reductions in donor funding and the need to lower the high level of out-of-pocket expenditures, the Government of Liberia (GOL) must increase its spending on health and social welfare; however, spending increases alone will not be enough. Efficiency and effectiveness must become the measures by which all efforts are assessed in order to ensure their maximum contribution to the development of the system.

The overarching goal of this financing policy is to ensure that the health and social welfare services provided to the people of Liberia are affordable to the country while preventing catastrophic household expenditures. Sustained leadership, stakeholder commitment, resources and effort are needed to achieve this goal by accomplishing the following five objectives: (1) Increasing the mobilization and predictability of adequate, sustainable financial resources for health and social welfare; (2) improving the planning, budgeting and accounting for equitable resource allocations; (3) increasing the efficiency of resource utilization; (4) increasing systemic efficiency and equity through a harmonized provider payment mechanism; and (5) strengthening the financial evidence base for management and policy decision-making.

In accordance with the NHSWPP, the principles guiding this financing policy are equity, efficiency, quality, sustainability, decentralization and partnership. The overall strategy is to increase the availability of resources and improve their equitable allocation and efficient use according to evidence-based management and policy decisions. Use of performance-based provider payment mechanisms will be prioritized and potential prepayment and risk-pooling schemes will be piloted.

To oversee implementation, the Division of Health and Social Welfare Financing and Policy has been established in the MOHSW, which will continue to support the National Task Force on Health and Social Welfare Financing. The MOHSW will invest in the enabling environment by strengthening the legal framework, regulation and enforcement, and the National Health Accounts will be institutionalized to insure evidence-based planning, management and policy decision-making.

Based on the projected population size in 2021 and the service delivery coverage target (85%) established by the National Health and Social Welfare Policy and Plan, the public facility network is expected to increase by 70% over the next 10 years. Expanding the network and implementing the 10-year policy and plan will cost an estimated US$ 18 per person in 2011, increasing to US$ 44 by 2021, factoring for the larger workforce and inflation. The total cost of implementing of the 2011 NHSWPP in the public network of facilities is projected at over one billion US dollars (US$ 1,250,126,322), or $296 per person, over the next 10 years.

1. Introduction

1.1 Policy Context

This National Health and Social Welfare Financing Policy and Plan was formulated during a defining period in the national development process. Through the Ministry of Planning and Economic Affairs (MOPEA), the Government of Liberia has developed the Medium-Term Social and Economic Development and Growth Strategy to set the stage for Liberia becoming a middle-income country by 2030.

Recognizing that health and social welfare are key determinants of human development, and in the context of this national social and economic growth strategy, the Ministry of Health and Social Welfare recently led the development of one holistic National Health and Social Welfare Policy and Plan, 2011–2021 that will substantially improve the health and social welfare of the population today and in the future. The MOHSW developed this financing policy with sufficient detail to meet the long-term financing requirements for health and social welfare over the next 10 years.

The policy development process was consultative and participatory throughout. In 2007 a National Taskforce for Health and Social Welfare Financing was established by the MOHSW and included donor agencies, United Nations agencies, non-governmental and faith-based organizations (NGOs an FBOs), and relevant ministries, departments and agencies (MDAs) from within the GOL to guide the policy development process. A Health and Social Welfare Financing Secretariat was established within the MOHSW to support the taskforce and coordinate numerous studies and surveys necessary to inform this policy, which included among others the: Community Health Seeking Behavior and Health Financing Survey, National Health Accounts (NHA), Benefit Incidence Analysis (BIA), the Alternative Health Financing Policies Prefeasibility Study, and the Synthesis of Health Financing Studies Report (see Annex 1)

Representatives from communities, civil society and the Government were often consulted on topics such as performance-based financing and options for insurance schemes, culminating in 2009 in a 2-day National Conference on Health and Social Welfare Financing in Liberia at which major policy directions were agreed. Thus, the MOHSW is confident that this policy incorporates the national consensus on health and social welfare financing and reflects the best information and guidance available at the time it was developed.

By maintaining a robust analytical capacity to understand the changing environment, as well as institutionalizing the NHAs, this policy will be updated as experience is gained and knowledge accumulates.

1.2 Purpose and Scope

This Health and Social Welfare Financing Policy and Plan is intended to provide the detailed guidance necessary to finance implementation of the National Health and Social Welfare Policy and Plan, 2011–2021 at a cost that is affordable to the country. It has been developed to enable improvements to the health and social welfare status of the population of Liberia on an equitable basis. It focuses attention upon nationally established priorities on which all con-

cerned partners are asked to concentrate their efforts in order to develop the efficient, accessible and responsive system necessary to improve the health and social welfare of the population.

This policy applies to all institutions and organizations involved in financing health and social welfare, including the Ministry of Health and Social Welfare, other Government ministries, departments and agencies, donors, UN agencies and NGO/FBOs. It also applies to all workers within the sector, including those in public, private-for-profit (PFP), private not-for-profit (NFP) training institutions and facilities, among other stakeholders.

2. Situational Analysis

2.1 Demographic Status

Liberia continues to be one of the poorest countries in the world, ranked 162 out of 169 in the 2010 UNDP Human Development Index. With a growth rate of 2.1 percent, the population of 3,476,608 will reach 4.5 million by 2021.[1] A large proportion (47%) of the growing population is concentrated in densely populated urban areas, while a majority remain in sparsely populated rural areas, often long distances from the nearest point where services are delivered by a skilled provider. Despite the success of the 2007 NHP, Liberia continues to suffer from poor health indicators, especially among women and children, particularly in rural areas. The maternal mortality ratio is an extremely high 994 deaths per 100,000 live births, and only 37 percent of deliveries take place in a health facility (26% in rural areas). While the under-5 mortality rate (U5M) and childhood malaria prevalence (32%) have improved, malaria remains the leading cause of morbidity and mortality and the U5M remains high (110 per 1,000 live births).[2]

2.2 Mobilization and predictability of financial resources

The 2009 National Health Accounts Report (NHA) for fiscal year 2007–2008 reported total health and social welfare resources of US$ 103,496,421, or over US$ 29 per person. Donors and out-of-pocket (OOP) financing accounted for most of the funds mobilized (47 and 35%, respectively). Fifty-nine percent of donor funds are channeled through NGOs and, while a health sector pool fund exists, only a small number of donors use the pool fund. Government's share of the resources was 15 percent of the total and has remained stable as a percentage of the national budget (between 7 and 8%) over the last four years, although it more than doubled in absolute terms from US$ 10,913,584 in fiscal year 2006 to US$ 25,767,030 in fiscal year 2009. However, the GOL relies upon an annually approved national budget for health that is rarely fully executed. Most donor support is limited to 1- to 2-year obligations, although pledges of support are sometimes for longer periods. The high level of poverty and lack of safety nets from catastrophic healthcare costs effectively eliminates out-of-pocket payments from patients as a reliable source of funding. Thus, financial resources for health and social welfare are generally unpredictable and constrain planning to short-term periods.

2.3 Resource allocation

No formulas exist for determining the level of resource allocation between the central MOHSW and counties, for health and social welfare activities, and for operating costs and capital investments; nor are allocations based on population, utilization and access criteria. Some very small-capacity facilities are serving large catchment populations with inadequate resources, while some facilities are too large for the populations they serve. Among government and donors, resources are not pooled for purposes of collective planning, budgeting and reporting within an agreed expenditure framework. These inefficiencies in funding diminish the resources available to improve the overall quality of care.

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[1] *Population and Housing Census Final Results*, LISGIS, 2008.

[2] *Liberia Malaria Indicator Survey*, Ministry of Health and Social Welfare, 2009.

2.4 Efficiency of resource utilization

Although one study was conducted to estimate the cost of providing the Basic Package of Health Services, the study was partial and included only facility-level, primary health care costs.[3] No study has been carried out to determine the cost of providing the Essential Package of Health Services at the primary, secondary or tertiary level, as well as the Essential Package of Social Services, as provided for in the NHSWPP, 2011–2021. County Health and Social Welfare Team (CHSWT), health district and facility level capacity to efficiently plan, budget, purchase and financially manage resources is inconsistent and in most counties extremely weak. Information is not readily available to determine whether intended resources reach facilities and where blockages exist.

2.5 Provider payment mechanisms

Fifty-nine percent of donor funds are spent on contracts that support 292 health facilities (representing 75 percent of the functioning government facilities), 232 of which are performance-based.[4] However, anecdotal and unconnected reports of low quality of care at public facilities and the low utilization of the public facility network shown by HMIS data indicate that the health system is generally not responsive and results-oriented. The same problems prevail at facilities supported by CHSWTs exclusively with government block budgets, which are in effect input-financing. In the absence of data about the cost of providing services, as described in section 2.4, and therefore unit costs for services, there is little basis for comparability between providers and for contract negotiations. Similarly, contracts that are facility-oriented, rather than territorial or population-based, also lack the basis for contract comparability, negotiation and performance monitoring. The MOHSW has yet to institutionalize and implement price-setting and payment mechanisms that are performance-based, and CHSWTs lack the capacity to establish county-specific targets, monitor performance and manage complicated funding from multiple sources that could be linked to improving individual facility performance.

2.6 Evidence base for management and policy making

MOHSW continues to improve its capacity to generate financial information essential for management and policy-making. Regular monthly and quarterly reports are issued by the Office of Financial Management (OFM) about government and project funds managed by MOHSW. However, the MOHSW central financial management system is not yet linked to the HMIS system, and management reports are not yet systematically generated at the county level. Because OFM reports only include expenditures made by the MOHSW, sector-wide expenditure information is not recorded and incorporated into decision-making. One complete National Health Accounts survey was completed in 2009 and a second survey was partially completed in 2011; however the NHA data collection process has not yet been institutionalized within the MOHSW nor is NHA data yet captured with sufficient detail to satisfy management decision-making needs in areas such as human resources and pharmaceuticals.

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[3] *Costing the Basic Package of Health Services at Clinics and Health Centers in Liberia*. United States Agency for International Development (USAID) through the Rebuilding Basics Health Services (RBHS) Project, 2009.

[4] *County Situational Analysis Report*, Ministry of Health and Social Welfare, 2011 (page 17).

3. Policy Orientations

3.1 Policy Foundations

The National Health and Social Welfare Financing Policy and Plan is based on and is essential for the implementation of the National Health and Social Welfare Policy and Plan, 2011–2021, and it should be read in conjunction with the Public Financial Management Act and the Public Health Law, as amended.

The mission, vision and goal of the NHSWPP, which the HSWFPP serves to implement, is:

Mission The *mission* of the MOHSW is to reform and manage the sector to effectively and efficiently deliver comprehensive, quality health and social welfare services that are equitable, accessible and sustainable for all people in Liberia.

Vision Liberia's *vision* is a healthy population with social protection for all.

Goal The *goal* is to improve the health and social welfare status of the population of Liberia on an equitable basis.

The *overarching goal* of health and social welfare financing is to ensure that the services provided to the population of Liberia are affordable to the country, while preventing catastrophic household health and social welfare expenditure. In accordance with the NHSWPP, the principles guiding this financing policy are equity, efficiency, quality, sustainability, decentralization and partnership.

Equity: The government's pro-poor commitment to equity will be demonstrated by concrete measures taken to ensure that all people in Liberia have access to and utilize effective health and social welfare services, irrespective of socio-economic status, origin, gender, age, ethnicity and geographic location.

Efficiency: The greatest potential gains will be realized from the inputs of all stakeholders in order to maximize efficiency, creating a culture at all levels of the system that values and strives to do more for the population within existing levels of resources. Priority will be given to improving the coordination of all efforts to support health and social welfare services, thereby eliminating duplication and minimizing gaps.

Quality: Concerted effort will be made to improve the degree to which services increase the likelihood of desired outcomes. Decision-making will be predicated on doing the right thing, in the right way, at the right time and making the best use of the resources available in order to satisfy patients.

Sustainability: This principle emphasizes the positive economic benefits of high-impact interventions that address the main causes of morbidity and mortality. It promotes developing appropriate solutions that are locally manageable and that develop local and systemic capacity. Cost ceilings considered affordable in the foreseeable fiscal framework will be the determining factor in the development of sustainable plans.

Decentralization: In accordance with the National Decentralization Policy, the de-concentration of MOHSW financial management responsibilities and the building of performance management systems at the county level will adapt to the county administrative structure in an incremental and pragmatic way.

Partnership: In order to enable participation and to ensure that actions are in accordance with the principles of this financing policy, the GOL will continue to guide partnerships in order to create long-term, sustainable and accountable working relationships. Frank consultations, clear rules, transparent transactions and explicit incentives will characterize partnerships.

3.2 Policy Objectives

Sustained leadership, stakeholder commitment, resources and effort are needed to achieve the vision and goal of the NHSWPP by accomplishing the following overall health and social welfare objectives:

- Increase access to and utilization of a comprehensive package of quality health and social welfare services of proven effectiveness, delivered close to the community, endowed with the necessary resources and supported by effective systems;
- Make health and social welfare services more responsive to people's needs, demands and expectations by transferring management and decision-making to lower administration levels, thereby ensuring a fair degree of equity;
- Make health care and social protection available to all Liberians, regardless of their position in society, at a cost that is affordable to the Country.

In pursuit of these overall NHSWPP objectives, in particular health care and social protection at a cost that is affordable to the country, this financing policy has five objectives:

i. Increase the mobilization and predictability of adequate, sustainable financial resources for health and social welfare;
ii. Improve the planning, budgeting and accounting for equitable resource allocations;
iii. Increase the efficiency of resource utilization;
iv. Increase systemic efficiency and equity through a harmonized provider payment mechanism;
v. Strengthen the financial evidence base for management and policy decision-making.

The overall strategy is to increase the availability of resources and improve their equitable allocation and efficient utilization according to evidence-based policy decisions.

3.2.1 Objective 1: Increase the mobilization and predictability of adequate, sustainable financial resources for health and social welfare

The Government of Liberia is committed to financing health and social welfare at the highest level possible. In order to maximize the resources available from all sources, this financing policy establishes a mixed approach to mobilizing resources that includes a sustainable level of government financing, more efficient use of donor support and potential alternative financ-

ing mechanisms. The GOL will do its part by progressively increasing the share of the national budget that goes to the health and social welfare sector. Donors will be encouraged to direct their resources in a predictable manner through the preferred government funding channels, first via the pool fund and eventually through sector or general budget support. User fees at Government-owned facilities will remain suspended until at least 2013, after which fees will be selectively used to discourage unnecessary use of referral services for minor conditions and as an incentive for beneficiaries to enroll in prepayment plans. Community-based and/or social insurance plans will be piloted and the manner in which they could be expanded will be assessed, with attention given to the proportion of the population covered and potential resources raised.

3.2.2 Objective 2: Improve the planning, budgeting and accounting for equitable resource allocations

All financial support of health and social welfare shall be consistent with this health and social welfare financing policy, which is based on the primary health care approach. In the PHC approach, the household, community, district and county levels serve as centers for decision-making about resource management and service delivery. Therefore, resource allocation planning will include representatives from the affected communities. In order to ensure equitable access to quality health and social welfare services formulas will be established at the county level to allocate resources to for diverse purposes, including system management, the service delivery operating costs and capital investments, based on population size, density, geographic location and utilization of services.

Multiple stakeholder groups, including the Government, donors and the private sector, will contribute resources to the fund. The MOHSW will work with all stakeholder groups, including the Ministry of Finance and other Government agencies, to establish a comprehensive cost framework for the sector, using standard classifications and a multi-year horizon, from which all allocations will be made. Resources will be combined from all sources, including the major disease prevention and control programs, to satisfy the components of the cost framework. Resource pooling and harmonization will enable all financial support to be on plan, on budget and based on common procedures for expenditure and reporting.

3.2.3 Objective 3: Increase the efficiency of resource utilization

The comprehensive cost framework for resource allocations described in Section 3.2.2 will be evidence-based and will prioritize the financing of high-impact interventions. A study of the expected costs of implementing the Essential Package of Health Services and the Essential Package of Social Services at all levels will be used to ascertain unit costs per contact and costs per capita. An informed balance will be maintained among the different levels of the system to avoid over- and under-funding levels of care. The process of conducting this study will create within the MOHSW a capacity to determine the cost of providing services, linked with an increasing institutional capacity for public financial management. Similar capabilities will also be established at the county, health district and facility levels to manage the decentralized public system, supported by effective financial planning, budgeting, purchasing, accounting and reporting. Expenditure tracking surveys will determine whether the intended health and social welfare resources reach the beneficiaries, where blockages exist, and how to eliminate them.

3.2.4 Objective 4: Increase systemic efficiency and equity through a harmonized provider payment mechanism

Establishing an equitable, harmonized provider payment mechanism within the network of public facilities will increase systemic efficiency. MOHSW will analyze and implement price-setting for services provided at each type of service delivery point. All allocations for service delivery will gradually shift from block-budgets to performance-based contracts with the aim of stimulating development of a more responsive, results-oriented system. CHSWT capacity will be developed to manage resources from the multiple sources contributing to the sector budget and to negotiate contracts, set targets and monitor performance. Unit costs per type of service will be revised regularly to facilitate contract negotiation. County health systems and health districts, rather than facilities, will be used as the basis for contractual arrangements in order to link the territory and catchment population to a network context and improve the measurability of results.

3.2.5 Objective 5: Strengthen the financial evidence-base for management and policy decision-making

Health and social welfare financing policy and management decisions must be evidence-based in order to augment the efficiency and effectiveness of the system. Therefore, this financing policy and plan will link with the Integrated Financial Management Information System and become part of the simple, coherent, scientifically sound and easily understandable overall Health Management Information System (HMIS). The HMIS will collect data in ways that will allow stakeholders to study how resources are allocated and consumed across different levels of care, between central and peripheral administrative bodies, between urban and rural areas, and among counties. This will encourage an informed policy discussion about equity, efficiency, decentralization and adherence to the primary health care approach. In addition, the National Health Accounts and other key sector monitoring tools, such as Public Expenditure Reviews and Benefits Incidence Analysis, will be institutionalized within the MOHSW and arrangements will be made with LISGIS to ensure that there is a component on health expenditure in all relevant population-based surveys.

3.3 Enabling Environment

The MOHSW will strengthen the enabling environment for financing health and social welfare by investing the legal framework, regulation and enforcement.

3.3.1 Legal Framework

Health and social welfare financing, whether in the public or the private sector, is governed by Title 33 of the Liberian Code of Laws Revised, also known as the Public Health Law, and the Public Financial Management Act, as may be amended or revised from time to time, and other rules and regulations that may be established by independent agencies. The MOHSW and the independent agencies shall each, in accordance with its mandate, review, amend and reinforce health financing legislation, as necessary and shall recommend legislative reforms. When necessary or desirable, the MOHSW and the independent agencies shall collaborate in furtherance of their mandates.

3.3.2 Regulation

The MOHSW and other independent agencies that may be created (as mandated and, if necessary or desirable, in collaboration with national judicial, regulatory and enforcement authorities) are to promote the monitoring and reinforcement of the Public Health Law, as the same may be amended or revised from time to time, in the following areas, including but not limited to: professional public, private for profit and private not-for-profit health and social welfare institutions, departments, programs and facilities. The MOHSW and other independent agencies that may be created, shall institute mechanisms to ensure that the sector complies with existing legislation, regulation, policies, standard operating procedures, protocols and guidelines. Particular care will be given to separating regulatory responsibilities from the MOHSW's service delivery duties in order to avoid conflicts of interest.

3.3.3 Enforcement

In conjunction with the judicial and regulatory enforcement authorities, the MOHSW will promote the monitoring and enforcement of the Public Health Law, the Public Financial Management Act, and other rules and regulations that may be established by independent agencies. Mechanisms will be established to ensure compliance with existing and new financing legislation, regulations, policies, standard operating procedures, protocols and guidelines. Pre- and in-service professional training programs will reinforce these compliance mechanisms as well as the study of the legal aspects of health and social welfare financing. The Ministry will develop a public awareness program to inform the public about health and social welfare-related financing practices that are allowed and those that are forbidden by law and how to proceed when legal infringements are suspected.

4. Strategic Plan

Overview of plan goal, objectives and activities

As the National Health and Social Welfare Plan, 2011–2021 is the instrument dedicated to implementation of the 2011 National Health and Social Welfare Policy, so too is this 10-year strategic plan the principal instrument for implementing the National Health and Social Welfare Financing Policy. Therefore, the financing policy and strategic plan serve the same ***overarching goal:*** to ensure that the services provided to the population are affordable to the country, while preventing catastrophic health and social welfare expenditure.

Attainment of the goal shall be guided by the same ***principles*** of equity, efficiency, quality, sustainability, decentralization and partnership. Building upon the five objectives and main strategies articulated in the policy, the following is an overview of the main ***activities by objective*** in the health financing strategic plan.

4.1 Objective 1: Increase the mobilization and predictability of adequate, sustainable financial resources for health and social welfare;

Rationale: Although the National Health Accounts report indicates that health and social welfare funding is relatively high, the annual national budget is usually under-executed (i.e., not fully disbursed); most donor support is limited to 1- to 2-year obligations and is gradually declining. The high level of poverty and lack of safety-nets for catastrophic health care costs effectively eliminates out-of-pocket payments as a reliable source of funding. Thus, financial resources for health and social welfare are at risk, unpredictable and a constraint to effective planning. The following steps to meet this objective are proposed: [5]

A1.1 Analyze, cost and plan in detail the investment needs for implementing the National Health and Social Welfare Policy and Plan, 2011–2021 that will form the basis for a multi-year sector budget. [2011–2013]

A1.2 Establish a common planning cycle that includes the projection of donor support and Government resources with a medium-term horizon. Tools and events that make up the cycle will be part of both the annual operational plan and a medium-term expenditure framework (MTEF) (see A2.3). [2014–16]

A1.3 Negotiate with MOF the government budgetary allocation for health and social welfare in the context of an MTEF. Specific issues to consider are forecasting personnel and capital expenditure, and the practicality of allocating debt relief derived–funds to the sector. [2011–2013]

A1.4 Low budget execution has been blamed for cash-flow problems, accounting problems and even planning problems. The whole budget execution process will be analyzed and streamlined to increase budget execution and eliminate bottlenecks. [2011–2013]]

[5] The time period for implementing the proposed activities is shown in brackets after each activity and the activities have been numbered for easy reference when referring to the costing of these activities.

A1.5 In cooperation with the Ministry of Finance, conduct a study to assess the viability of additional revenue mechanisms, including hypothecated taxes, such as the VAT levy, mobile phone tax, "sin taxes," and other options, and to implement those that are feasible. Pursue with the Legislature expansion of the legal framework to accommodate implementation of any viable hypothecated taxes. [2014–2016]

A1.6 Pilot both social health insurance and community-based health insurance plans and assess the modalities under which they can be successfully implemented on a wider scale in Liberia. Pursue with the Legislature expansion of the legal framework to accommodate implementation of insurance schemes. [2014–2016]

A1.7 Review policy of charging user fees at primary health care facilities and clarify the fee structure appropriate for secondary and tertiary care facilities to prevent unnecessary utilization of referral services for minor conditions and to encourage beneficiaries to enroll in pre-payment plans. Evaluate the administrative structure necessary for collecting, managing and accounting for such fees and establish such a structure accordingly. [2011–2013]

A1.8 Expand the number of donors who use the pool fund by making its proceedings clear and transparent, simplifying planning and execution procedures, and linking use of the fund to the sector budget and MTEF. [2011–2013]

4.2 Objective 2: Improve the planning, budgeting and accounting for equitable resource allocations;

Rationale: No formulas exist for determining the level of resource allocation between the central MOHSW and counties, for health and social welfare activities, and for operating costs and capital investments. Some very small-capacity facilities are currently serving large catchment populations with inadequate resources, while some facilities are too large for the populations they serve. Among government and donors, resources are not pooled for purposes of collective planning, budgeting and reporting within an agreed expenditure framework. These inefficiencies in allocating funds diminish the resources available to improve the overall quality of care. To meet Objective 2, the following steps are proposed:

A2.1 Pooling monies from all sources, including the major disease prevention and control programs, enables resource to be easily allocated into single, comprehensive exercise. The MOHSW will therefore integrate financial management procedures in the following order:

1. **On plan:** Annual operational and multi-year investment plans will be based on all resources available. [2011–2013]
2. **On accounting:** All stakeholders and participants will agree on a basic set of common accounting procedures to be used to manage and track all expenditures of resources spent in the public system, simplifying the production of expenditure accounting into a single exercise. [2011–2013]
3. **On budget:** Funds will be integrated throughout the whole process, from planning to disbursement, expenditure and reporting. [2014–2016]

A2.2 At the national level, pooling of resources will occur within a sector budget and the MTEF, based on the findings of a costing exercise to determine the cost of the service delivery system by component, including human resources, drugs and supplies, equipment, capital assets, energy and other cost categories. [2011–2013]

A2.3 Working with the MOF and starting with the 2-year operational plan, a methodology will be developed and followed to produce and update a MTEF where priorities are discussed, resources identified and projected and allocation decided with a three- to five-year horizon. [2011–2013]

A2.4 Formulas will be established to allocate resources for diverse purposes, including system management, the service delivery operating costs and capital investments, based on population size, density, geographic location and utilization of services. [2014–2016]

A2.5 MOHSW will conduct a public expenditure review of the sector to develop more comprehensive data on public health expenditures, will review allocations and expenditures according the ministry's guiding principles (set out in Section 3.1), and will incorporate the findings into the resource allocation formulas and make adjustments accordingly. [2014–2016]

4.3 Objective 3: Increase the efficiency of resource utilization;

Rationale: No study has been carried out to determine the cost of providing the Essential Package of Health Services at the primary, secondary or tertiary level or the Essential Package of Social Services. County health and social welfare teams, health district and facility-level capacities to efficiently plan, budget, purchase and financially manage resources are inconsistent and in most counties extremely weak. Information is not readily available to determine whether intended resources reach facilities and where blockages exist. Thus, the following actions are proposed.

A3.1 MOHSW will conduct a study of the expected costs of implementing the EPHS and secondary and tertiary referral services. An informed balance of costs will be maintained among the different levels of the system to avoid over- and under-funding of the levels of care. [2011–2013]

A3.2 In the process of carrying out the EPHS and EPSS cost-study, institutionalize within the MOHSW a capacity to determine the cost of providing services and link it with an increasing institutional capacity for public financial management. [2011–2013]

A3.3 Develop capacities at the county, health district and facility levels to manage the decentralized public system, supported by effective financial planning, budgeting, purchasing, accounting and reporting. [2014–2016]

A3.4 Continue to strengthen MOHSW's capacity for strategic budgeting and public financial management. [2011–2013]

A3.5 Undertake public expenditure tracking surveys to determine if the intended health and social welfare resources reach the beneficiaries, where blockages exist, and how to eliminate them. [2014–2016]

4.4 Objective 4: Increase systemic efficiency and equity through a harmonized provider payment mechanism;

Rationale: Fifty-nine percent of donor funds are spent on contracts that support 292 health facilities (representing 75 percent of the functioning government facilities), 232 of which are performance-based.[6] However, anecdotal and unconnected reports of low quality of care at public facilities and the low utilization of the public facility network shown by HMIS data indicate that the health system is generally not responsive and results-oriented. The same problems prevail at facilities supported by CHSWTs exclusively with government block budgets, which are in effect input-financing. Similarly, contracts that are facility-oriented, rather than territorial or population-based, also lack the basis for contract comparability, negotiation and performance monitoring. The MOHSW has yet to institutionalize and implement price-setting and payment mechanisms that are performance-based, and CHSWTs lack the capacity to establish county-specific targets, monitor performance and manage complicated funding from multiple sources that could be linked to improving individual facility performance. To meet this objective, the following steps are proposed:

A4.1 Analyze and implement price-setting and payment mechanisms, weighing advantages and inconveniences of capitation, fee-for-service, and case mix, or a combination of these things, for services delivered at different levels (primary facilities and hospitals). Use pilot programs to test alternative methods. [2011–2013]

A4.2 Much funding is channeled through performance-based contracts without clear contract pricing, target-setting, or performance-monitoring criteria. Undertake an assessment of the performance-based contracting mechanism and make the necessary improvements. [2011–2013]

A4.3 Gradually replace the block budget as the provider payment mechanism, even for CHSWT, with performance-based contracts, with the aim of stimulating the development of a more responsive, results-oriented health system. Unit costs per type of service will be determined and revised regularly to facilitate contract negotiation. [2014–2016]

A4.4 County and district health systems, rather than facilities, will be identified as settings of contractual arrangements to give targets a territorial, population and network context. [2011–2013]

A4.5 County teams will be strengthened to improve their capacity to set and monitor performance targets, negotiate contracts and manage funds from different sources. [2011–2013]

[6] *County Situational Analysis Report*, Ministry of Health and Social Welfare, 2011 (page 17).

4.5 Objective 5: Strengthen the financial evidence-base for management and policy decision-making.

Rationale: The MOHSW central financial management system is not yet linked to the HMIS system and Office of Financial Management reports are not yet systematically generated for the county level. Because OFM-generated reports only record expenditures made by the MOHSW, sector-wide expenditure information is not recorded and incorporated into decision-making. The NHA data collection process has not yet been institutionalized within the MOHSW nor is NHA data yet captured with sufficient detail to satisfy management decision-making needs in areas such as human resources and pharmaceuticals. To meet Objective 5, the following actions are proposed:

A5.1 Link this financing policy with the Integrated Financial Management Information System as part of a simple, coherent, scientifically sound and easily understandable overall Health Management Information System (HMIS).

A5.2 Modify the HMIS to collect data in ways that will allow stakeholders to study how resources are allocated and consumed across levels of care, between central and peripheral administrative bodies, between urban and rural areas and among counties.

A5.3 Strengthen financial management systems to integrate financial information from all sources—the central government, donors, local authorities, user fees, etc.

A5.4 Institutionalize the National Health Accounts and other key sector monitoring tools, such as Public Expenditure Reviews and Benefits Incidence Analysis

A5.6 Make arrangements with LISGIS to ensure that there is a component on health expenditure in all relevant population-based surveys.

A5.7 Undertake a mid- and end-of-term review of the implementation of the Health and Social Welfare Financing Policy and Strategy.

5. Implementation Arrangements

5.1 Role of the Ministry of Health and Social Welfare

Pursuant to its mandate, the Ministry of Health and Social Welfare will coordinate all stakeholders involved in financing health and social welfare services. To accomplish this, a Division of Health and Social Welfare Financing and Policy (DHSWFP) has been established within the MOHSW to implement the National Health and Social Welfare Financing Policy. This division will maintain the necessary expertise to fulfill its core functions, which include: policy development, health economics, health insurance and performance-based financing, among others. Some of the specific duties of the DHSWFP include:

- Conducting studies and surveys of financing programs and their impact, in coordination with the MOHSW's Research Unit;
- Coordinating the implementation of pilot programs related to health and social welfare financing, such as insurance plans;
- Designing and developing financing systems appropriate for the sector;
- Establishing policies, guidelines and regulations related to sector financing, in collaboration with the MOHSW's Office of General Counsel;
- Ensuring adherence at all levels to the financing policy and strategic plan and coordinating its implementation;
- Coordinating donor support for health and social welfare financing, in collaboration with the MOHSW's External Aid Coordination Unit.
- Communicating with other branches of Government and other ministries, departments and agencies on issues related to implementing this policy, in coordination with the offices of the Deputy Minister for Administration, Deputy Minister for Planning, the Controller and the Office of the Minister, among others.

5.2 National Task Force on Health and Social Welfare Financing

The MOHSW has established a National Task Force on Health and Social Welfare Financing, which reports to the Health Sector Coordinating Committee and its chair, the Minister for Health and Social Welfare, through the Deputy Minister for Planning. The DHSWFP serves as secretariat to the task force. The main duties of the task force are to:

- Provide support to the Government of Liberia in maintaining a policy framework for adequate, sustainable health and social welfare financing, ensuring that fiscal, labor market, equity, and other implications are fully considered;
- Make recommendations about future financing policy directions and advise on establishment or revision of regulations and guidelines;

- Propose health and social welfare financing options and approaches such as: hypothecated taxes, insurance schemes, user fees and exemption criteria;

- Advocate and mobilize financial sources for implementation of this policy from government and external sources, and develop or endorse funding proposals;

- Ensure that open dialogue and information sharing is maintained with all public, private and civil society stakeholders involved in health and social welfare financing;

- For the task force to function, the DHSWFP will provide committee members copies of meeting minutes and materials, various monitoring reports, including comprehensive annual reports.

The Health and Social Welfare Financing Task Force shall consist of representatives of the following bodies:

Deputy Minister for Planning, MOHSW, Chairperson
Department of Social Welfare, MOHSW
Department of Health Services, MOHSW
Department of Health Administration, MOHSW
Office of Financial Management, MOHSW
Ministry of Planning and Economic Affairs
Ministry of Finance
LISGIS
Legislature of Liberia(Senate and House of Representatives)
UNICEF
UNFPA
USAID
WHO
World Bank
European Union
NGO representatives
Christian Health Association of Liberia
Private Sector / Liberia Business Association
Other interested donors (e.g., DFID, Irish Aid)
Other members to be co-opted (consultants, etc.)

5.3 Monitoring and Evaluation

In accordance with the National Monitoring and Evaluation Policy and Strategic Plan, this health financing policy will link with the Integrated Financial Management Information System and become part of the Health Management Information System (HMIS). The HMIS will collect data in ways that will allow stakeholders to study how resources are allocated and consumed across levels of care, between central and peripheral administrative bodies, between urban and rural areas and among counties. This will encourage an informed policy discussion about equity, efficiency, decentralization and adherence to the primary health care approach.

The activities in Section 4 (above) provide for several monitoring stages that are to be carried out by different stakeholders during implementation of this policy, including:

- The National Task Force on Health and Social Welfare Financing will meet at least quarterly to monitor the implementation of the policy and adjust plans as necessary. For the technical committee to accomplish this function, the DHSWFP will provide committee members with copies of all surveys, studies and annual reports for review;

- The Monitoring and Evaluation Unit of the MOHSW, as the unit responsible for monitoring the NHSWPP, will support the DHSWFP in monitoring and evaluating implementation of the National Health and Social Welfare Financing Policy;

- The National Health Accounts survey and reporting process will be institutionalized within the MOHSW and carried out every two years. Arrangements will be made with LISGIS to ensure that there is a component on health expenditure in all relevant population-based surveys to inform monitoring of this policy;

- The DHSWFP will make regular presentations to the MOHSW's Program Coordination Team and MOHSW senior staffs, and at the National NHSWPP Review Conferences on progress made implementing this policy, in addition to annual written progress reports.

- The MOHSW will undertake a mid- and end-of-term review of the implementation of the Health and Social Welfare Financing Policy and Strategy.

Potential Indicators by Objective:

The M&E Unit will assist the DHSWFP to identify the monitoring indicators for implementation of this policy. Potential indicators by Objective include:

1. Increase the mobilization and predictability of adequate, sustainable financial resources for health and social welfare;
    - Total expenditure per capita on health and social welfare
    - User fees in public facilities as a percentage of total public expenditure
    - Government budget for health and social welfare as a percentage of the national budget

2. Improve the planning, budgeting and accounting for equitable resource allocations;
    - Establishment and use of the medium-term expenditure framework(MTEF)
    - Percentage of the annual public budget for health and social welfare executed (spent)
    - Percentage of external assistance channeled through budget and sector support mechanisms

3. Increase the efficiency of resource utilization;
    - Establishment and use of resource allocation criteria (formula)
    - Percentage of facilities that have adopted bottom-up budgeting
    - Percent of public facilities with performance-based contracts

4. Increase systemic efficiency and equity through a harmonized provider payment mechanism;
    - Percentage of external assistance adopting the harmonized provider payment mechanism
    - Percentsge of total assistance channeled through performance-based financing mechanisms
5. Strengthen the financial evidence-base for management and policy decision-making.
    - Public expenditure review produced every two years
    - National Health Accounts (NHA) and Benefit Incidence Analysis (BIA) conducted every two years

5.4 Operational Plans

An operational plan will be important to facilitate the financing, implementation, monitoring and review of the activities in Section 4 and will be fully aligned with the goal and objectives of the NHSWFPP. The first operational plan will cover a period of two years from July 1, 2011 through June 30, 2013. In 2012, based on a first annual review of the implementation of this policy, a revised annual plan will be developed for the period July 1, 2012 through June 30, 2013. In 2013, a new annual plan will be developed after the previous has been reviewed, and so on.

All operational and annual plans will be time- and cost-indicative. Time-indicative plans will facilitate the development of quarterly, monthly and weekly plans and budget for the DHSWFP, enable assessment of the percentage of planned activities successfully implemented within the planned period, and help to determine how effectively the Division has been in reviewing and developing realistic plans. Plans will be cost-indicative in order to determine the costs for each strategic action to assess its cost-efficiency, rationalize and prioritize resource planning, and solicit funds when necessary.

All national-level time- and cost-indicative plans will be approved by the National Task Force on Health and Social Welfare Financing prior to dissemination to all relevant institutions, organizations, programs, CHSWTs and facilities to ensure that their plans will be aligned with the national ones and are realistic and achievable.

5.5 Cost-Estimate

The table below presents the results of the cost projection exercise for the National Health and Social Welfare Policy and Plan, 2011–2021.[7] It is a conservative cost estimate based on a number of assumptions and calculated only for the public network, composed of government and selected NFP facilities. Actual figures must be reviewed on an ongoing basis and will potentially be higher.

[7] *National Health and Social Welfare Policy and Plan, 2011–2021*, Ministry of health and Social Welfare, Monrovia, 2011 (page 81).

Expenditure per head (at 2011 prices) will increase from US$ 18 to US$ 29 over the 10-year period. However, factoring for an inflation rate of 5%, expenditure per head grows to reach US$ 44 in 2021.

National Health and Social Welfare Policy and Plan, 2011–2021, Implementation Cost by Year (US$)

Fiscal Year	Service Delivery	Management	Total Cost	Inflation-Adjusted Total Cost	Per Capita Cost
2011–2012	48,646,092	17,959,669	66,605,761	66,605,761	18
2012–2013	54,782,359	17,584,855	72,367,214	75,985,575	20
2013–2014	61,052,003	14,122,987	75,174,990	82,880,427	21
2014–2015	67,459,100	15,924,545	83,383,645	96,526,991	24
2015–2016	74,007,834	16,917,557	90,925,391	110,520,381	27
2016–2017	80,702,507	18,193,507	98,896,014	126,219,160	30
2017–2018	87,547,539	19,560,628	107,108,167	143,535,187	34
2018–2019	94,547,469	21,028,036	115,575,505	162,626,343	37
2019–2020	101,706,964	22,605,760	124,312,724	183,666,511	41
2020–2021	105,622,533	24,304,832	129,927,365	201,559,986	44
Total	**776,074,400**	**188,202,376**	**964,276,776**	**1,250,126,322**	**296**
Average Proportion	81%	19%	100%	100%	-

The total cost of implementing of the National Health and Social Welfare Policy and Plan, 2011–2021 in the public facility network will total over one billion dollars (US$ 1,250,126,322), or approximately $296 per capita over the lifespan of the 10-year policy and plan. The cost of service delivery accounts for 81% of the total, and the cost of management at all levels will make up the remaining 19%.

5.6 Risks and Assumptions

There are many risk factors of enforcing the NHSWPP and implementing this financing policy that will be considered:

- Inconsistent leadership, political turnarounds or corruption cause the deterioration of the Government's credibility and push the sub-sector in different directions.
- Emergencies (within and outside Liberia) draw attention and resources away from the NHSWPP or require a significant reallocation of resources within it.

- Divergence from the national strategy for decentralization result in unforeseen implications on this policy and plan.
- The resources available are less than anticipated to implement this policy and increased efficiency cannot compensate for the shortfall.
- Proliferating, competing priorities, including donor preferences and political pressures, compromise the enforcement of this policy and implementation of the plan.
- Inadequate monitoring results in the financing policy becoming a dead document that may sometimes be referred to but not be used consistently to guide decisions.

This financing policy has been formulated on basis of a number of assumptions:

- The country will enjoy political stability and economic growth.
- The GOL will improve the national infrastructure, particularly in hard-to-reach areas.
- The GOL will increase annually its financial allocation to the MOHSW
- The GOL will continue to raise the visibility of health and social welfare financing
- Development partners will provide generous and sustained financial and technical support to the implementation and monitoring of the financing policy
- The MOHSW will be committed to:
    - Develop, implement and monitor the sector budget and MTEF for health and social welfare, in collaboration with relevant partners;
    - Develop, implement and monitor time- and cost-indicative operational and annual plans;
    - PIlot, monitor, evaluate prepayment plans and implement them if they are determined to be feasible in Liberia;
    - Establish criteria and implement resource allocation formulas for recurring costs and capital investments at the county level;
    - Establish a harmonized provider payment mechanism;
    - Expand use of performance-based financing and increase the institutional capacity of the MOHSW and CHSWTs to manage performance-based contracts;
    - Carry out the studies and surveys necessary to insure evidence-based management and policy decision-making.

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