NATIONAL HEALTH FINANCING STRATEGY

2022-2026

MINISTRY OF HEALTH

FOREWORD

Universal health coverage is top of the Government of Liberia's National Policy as they move toward attaining Sustainable Development Goals (SDGs). Liberia's Pro-Poor Agenda acknowledges that a healthy nation is a key to attending socioeconomic development. The Pro-Poor Agenda is aligned toward attaining universal health coverage for all citizens. The design of the strategies herein will foster innovative, predictable, and sustainable health financing mechanisms in line with the National Health Policy 2022-2031 and Plan 2022–2026.

Given the importance of sustainable financing for health care in Liberia, the Ministry of Health presents this Health Financing Strategy to support the sector's National Health Strategic Plan covering the period of 2022 to 2026. The Health Financing Strategy and the Pro-Poor Agenda for Prosperity and Development express the desire to attain equality in access to development opportunities for the Liberian people. It is premised on the guiding principles of equity, efficiency, transparency, accountability, effective partnerships, and evidence-based decision-making.

Under the strong leadership of H. E. Dr. George M. Weah, we, the people of Liberia, continue the process of transforming our country into a more secure, more prosperous, and healthier nation. To align our efforts, this document was guided by the Medium-Term Social and Economic Development and Growth Strategy, which sets the stage for Liberia to become a middle-income country by 2030.

This plan envisions a Liberia where all citizens have access to sustainably financed quality health care without facing the risks of catastrophic health expenditure or impoverishment as a result of paying for health care services out of pocket. Our strategy is to increase the availability of resources, and improve their equitable allocation and efficient utilization according to evidence-based management and policy decisions.

It is my view that with sustained and predictable levels of financing for health service delivery, the country will achieve the SDGs. To attain our goal over the next five years, I, therefore, urge all people involved in the implementation of this plan to fully dedicate themselves to this cardinal national assignment.

With this Health and Financing Strategy in place, built on a foundation of partnership and collaboration, we pledge to continue the march toward our ultimate goal of a healthy Liberia with health access for all of our citizens.

Wilhelmina Jallah, MD
Minister of Health

ACKNOWLEDGMENTS

Financing health in a sustainable way is a fight that this administration has endeavor to pick with determination to win. This health financing strategy outlines the government of Liberia's commitment to make health care universally accessible to all without financial hardship. This commitment underpins the strategies layout in this document for sustainable health financing in Liberia. It provides an overview of the health financing landscape and a roadmap for financing health sustainably into the future in Liberia. It is the product of close collaboration between the Government of Liberia through the Ministry of Health (MOH) and its partners and all stakeholders within the health sector.

The Health Financing Unit—under my stewardship and the direct supervision of Hon. George P. Jacobs, Assistant Minister for Policy and Planning—led the preparation of this Health Financing Strategy. Special recognition goes to Ernest Gonyon, Acting Director of the Health Financing and his technical team including Mr. Nuaker K. Kwenah and Mrs. Albertha Konneh Dudley, for their hard work that made this document possible. Thanks to the MOH Office of Financial Management, for contribution. The Liberia Revenue Authority, the Ministry of Finance and Development Planning, and the Central Bank of Liberia made significant contributions to this document and I thank them for that.

I also appreciate the technical inputs from development partners; Brendan Kwesiga and Dr. Charles Ocan of the World Health Organization (WHO), and Iwimbong Kum Ghabowen of the United States Agency for International Development (USAID)-funded STAIP project (USAID/STAIP) for their technical expertise in drafting this Health Financing Strategy. Special thanks go to the Global Financing Facility and Liberia's Health Financing Technical Working Group for their invaluable contribution to the development and finalization of this strategy. I greatly acknowledge the financial and technical support provided by WHO, USAID/STAIP, and the World Bank.

Our gratitude goes to individual staff and units of the MOH, County Superintendents, Ministry of Finance and Development Planning, Central Bank of Liberia, National Identification Registry, Ministry of Gender, Children and Social Protection, National Social Security and Welfare Corporation, and the Offices of the Chief Medical Officer and the Deputy Minister for Administration at the MOH, and everyone who played a significant role in the development and completion of this document.

A. Vaifee Tulay
Deputy Minister for Policy, Planning, and M&E

EXECUTIVE SUMMARY

This Health Financing Strategy (HFS) 2022–2026 provides a roadmap for health financing in Liberia for both government and partners within the period of implementation to achieve Liberia's aspirations for universal health coverage. These aspirations, which align with the Pro-Poor Agenda for Prosperity and Development and 10-year National Health Policy and Plan (NHPP), are within the overall direction set out in Liberia's Vision 2030 framework. These frameworks target strengthening human capital development, including improving population health outcomes. They are fundamental to accelerating the country's transformation as part of Pillar 1 of the plan to address pervasive poverty and inequality.

The Ministry of Health (MOH) and Health Financing Technical Working Group (HFTWG) led development of the HFS, using a participatory process over six months. They undertook a comprehensive Health Financing System Assessment. As part of the development process, the health policy review TWG Core team conducted a rapid assessment of Liberia's health financing systems. To complement this assessment, the HFTWG conducted an assessment using World Health Organization (WHO) guidance on health financing system diagnosis and the health financing progress matrix to develop a situational analysis. The key findings from the assessments formed the basis for developing the strategy.

Local organizations, international experts, and other critical stakeholders in the health sector reviewed the draft HFS. This working group presented their findings and approach for approval to the HFTWG representing Health Financing Steering Committee (HFSC). The Liberia health delivery system is currently grossly underfunded and heavily donor dependent. Liberia has employed a "Free Health Care for All" policy over the last 15 years, which has compromised the quality of care in public health facilities. It has also made health care inaccessible, non-affordable, and inequitable for the vast majority of the population.

The COVID-19 pandemic has worsened the health care delivery system's situation, threatens the marginal progress on health, and endangers long-term economic prospects. To mitigate the health system's worsening problems, the government of Liberia (GOL) will implement fee-for-service and Revolving Drug Fund schemes at the primary and secondary levels of the health care system in the next five years. The total government resource envelope remains constrained, which will continue to challenge its ability to increase domestic resources for the health sector. During the period of implementation of the previous policy (2011–2021), the fiscal envelope (% government spending to GDP ratio) average was projected at a deficit of 6.1% (a deficit of 19.9%) in 2019, up from a deficit of 4.8% (a deficit of 17.8%) in 2018.

The scope of increasing government revenue also remains constrained as the government revenue (tax as % of GDP) at 12.4% is among the lowest within Sub-Saharan Africa (18.56% average). The government has continued to rely significantly on deficit financing, with the current government debt estimated at 61% of the total US$ 5.2 billion over the five years. It is expected that within the period of implementation of the planned policy, the debt will decline as the GOL continues to implement measures to ensure adherence to borrowing ceilings. The economic uncertainties resulting from the 2014 Ebola epidemic and the COVID-19 pandemic not only highlight the critical need to ensure health security but also point to the need to address emerging health threats and underscore national commitment to strengthen mechanisms for prevention, detection, and response to public health threats due to the interface between humans, animals, and environment.

There remain high levels of poverty in Liberia. While the country has a high labor force participation of 77%, the population employment structure shows a very high level of informality—with only 7.3% of the labor force in formal employment. This has implications for exploring financing mechanisms for health. At the moment, health care services are free at the primary and secondary levels of care. These services do not have the corresponding budget to provide the Essential Package of Health Services (EPHS) stipulated, therefore quality is seriously compromised.
Concretely, the proposed five-year HFS addresses health financing challenges by increasing resource pools for the health sector. Methods include health sector pooled funds, revolving drug funds, capturing

household payments and channeling them efficiently in prepayment and pooling arrangements, and continued engagement with cooperating partners in financing the health sector. The key focus is to advocate for increases in the share of government funds allocated to the health sector and to ensure that households are not exposed to financial hardships in seeking health services. The strategy also aims to reduce inefficiencies in the system and improve the system for purchasing. The following is a summary of recommendations in the health financing functions.

Revenue Collection: Improve domestic resources for health to match growth in GDP. Strengthen donors' coordination through International Health Partnership+ (iHP+) implementation for harmonization and alignment.

- Increase resource mobilization with a plan to progressively build reliance on compulsory funding.
- Strengthen civil society institutions to advocate for the passage into law and roll-out of the Liberia Health Equity Fund (LHEF).
- Institutionalize efficiency analysis and explore actions for harmonization across health system functions.
- Ensure implementation of Revolving Drug Fund and cost-sharing with exempted targeted services in line with LHEF priorities.

Risk Pooling: Establish a single pool for proposed LHEF to ensure income and risk cross-subsidization. Ensure complementarity of various resource pools.

- Re-establish and institutionalize a Pool Fund to reduce duplications and fragmentations to ensure cost-effectiveness.
- Harmonize policies across schemes (e.g., benefit entitlements, efficient co-payments, provider payments mechanisms, etc.).
- Institutionalize health financing assessment and cross programmatic efficiency analysis and explore actions for harmonization across health systems functions.

Purchasing: Design a provider payment mechanism with appropriate incentives to ensure alignment with the budget.

- Strengthen government and civil society institutions to advocate for strategic purchasing.
- Harmonize provider payment mechanisms and rates within and across purchasers to ensure coherence in incentives.
- Ensure equity in the allocation and utilization of resources.
- Expand performance-based financing mechanisms to link payment to results.
- Establish an administrative mechanism to improve governance and strategic purchasing.
- Ensure implementation of health financing reforms in the short, medium, and long terms.

Benefits and Conditions of Access: Design an explicit benefit package that clearly defines entitlements (who is entitled to what services, and what, if anything, are they to pay at the point of use?) for LHEF.

- Establish transparent mechanisms to regularly review and reprioritize the EPHS into a cost-effective package.
- Improve alignment of payment systems with benefit entitlements and data use to strengthen strategic purchasing across the health system.

- Ensure planning, budgeting, execution, accountability, and reporting. Strengthen public finance management and Implementation Arrangements for effective utilization of public resources.
- Strengthen results-oriented health budgeting aligned to the strategic plans and implemented efficiently, equitably, and transparently within Liberia's public financial management systems.

Implementation of the HFS will be embodied within the NHPP. The MOH will develop annual plans in line with this strategic plan and take into account the County Health Teams' operational plans.

ACRONYMS

AIDS Acquired Immunodeficiency Syndrome
CBL Central Bank of Liberia
CHT County Health Team
CHW Community health worker
COVID-19 Coronavirus Disease of 2019
DFID Department of International Development
EPHS Essential Package of Health Services
EVD Ebola Virus Disease
FARA Fixed-Amount Reimbursement Agreement
FY Fiscal Year
GDP Gross Domestic Product
GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF Global Financing Facility
GOL Government of Liberia
HDP Health Development Partner
HEAL Health Equity Authority of Liberia
HFCBI Health Financing Capacity Building Initiative
HFS Health Financing Strategy
HFSC Health Financing Steering Committee
HFTWG Health Financing Technical Working Group
HFU Health Financing Unit
HIV Human Immunodeficiency Virus
IFMIS Integrated Financial Management Information System
LHEF Liberia Health Equity Fund
LIGIS Liberia Institute of Statistics, and Geo-Information Services
LMIS Logistics Management Information System
LRA Liberia Revenue Authority
M&E Monitoring and Evaluation
MFDP Ministry of Finance and Development Planning
MOH Ministry of Health
MTEF Medium-Term Expenditure Framework
NDP National Development Plan
NGO Nongovernmental Organization
NHA National Health Accounts
NHP National Health and Social Welfare Plan
NHPP National Health Policy and Plan
OFM Office of Finance Management
OOP Out-of-pocket
PAPD Poor Agenda for Prosperity and Development
PBF Performance-based financing
PFM Public Finance Management
PHC Primary Health Care
RDF Revolving Drug Fund
SDG Sustainable Development Goal
STAIP Strategic Technical Assistance for Improved Health System Performance and Health Outcomes TB Tuberculosis
THE Total Health Expenditure
TWG Technical working group
UHC Universal Health Coverage
UNICEF United Nations Children's Fund
US United States

USAID United States Agency for International Development
WHO World Health Organization

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1. INTRODUCTION

1.1 Policy Context

Liberia's second national Health Financing Strategy (HFS) provides a mechanism for guiding the financing of health policy and strategy for both government and partners within the period of implementation (2021–2026) to achieve Liberia's universal health coverage (UHC) aspirations. The formulation of this strategy is happening at a time when Liberia is still dealing with the effects of the global COVID-19 pandemic while also still recovering from the Ebola Virus Disease (EVD) epidemic that affected the country from 2014 to 2015. These health emergencies also resulted in economic shocks that threatened to derail the immense achievements made by the health sector since the end of the civil war in 2003.

The development of this strategy is guided by the goals set out within Pro-Poor Agenda for Prosperity and Development (PAPD), which is the five-year National Development Plan (NDP) and is within the overall direction set out in Liberia Vision 2030 framework. These national frameworks are embedded within the broader socioeconomic context and significant health challenges facing the country. Within the PAPD, strengthening human capital development including improving population health outcomes is fundamental to accelerating the country's transformation as part of Pillar 1 of the plan to address pervasive poverty and inequality. This is premised on a theory of change that is mindful of the cross-sectional nature of sustainable development and actions required toward attaining the Sustainable Development Goals (SDGs), including SDG3 on universal health coverage (UHC), which is the main health goal in the SDG.

1.2 Purpose and Scope

Improving health financing by ensuring adequate resources are mobilized equitably and sustainably, and then allocated appropriately—with incentives organizing the flow of financial resources from source to provider within the health system—is critical to the improvement of health outcomes. By establishing the policy foundation and strategic direction for health financing reforms and interventions in Liberia, this document is expected to guide action by all health system actors in government, the private sector, and other non-state actors. The strategy identifies the necessary financing arrangements, including the legal environment, to ensure the identified strategies and interventions are implemented, and describes a framework for monitoring progress regarding implementation. The development of this policy and strategy recognizes that while better health financing is vital for improving health system performance in terms of health outcomes and achieving progress toward UHC, it is not sufficient on its own to achieve this goal. To cause this change, action must be taken by all health sector actors and, more critically, across all sectors.

1.3 Process of Development

The HFS was developed through the participation and contribution of various stakeholders within and beyond the Ministry of Health (MOH). A steering committee and thematic working group were established for this purpose, including developing clear terms of reference and a costed road map. The HF thematic working group consisted of representatives from the MOH, World Health Organization (WHO), U.S. Agency for International Development (USAID), World Bank Global Financing Facility (GFF), Last Mile Health, Partners in Health, and the United Nations Children's Fund (UNICEF).

As part of the development process, the Core team of the Health Policy Review working group conducted a rapid assessment of Liberia's health financing systems using the WHO Guideline of Health Financing System Diagnosis and the Health Financing Progress Matrix to develop a situational analysis report. The working group presented their findings and approach for approval to the HFTWG, representing the Health Financing Steering Committee (HFSC).

The final situational analysis integrated inputs generated from the consultative workshop. Information from the Ministry of Finance and Development Planning (MFDP), Central Bank of Liberia (CBL), Liberia

Revenue Authority (LRA), donors, implementing partners, and civil society organizations have been critical in the finalization of the strategy.

The HFTWG, discussed and agreed on the components and structure of the new strategy, including the strategic directions, objectives, and key interventions. Throughout the strategy development process, the HFTWG met regularly to discuss the process and content of the policy and strategy development. To promote the buy-in of all relevant stakeholders, the HFTWG presented a draft of the HFS to stakeholders in a consultative workshop to inform its finalization.

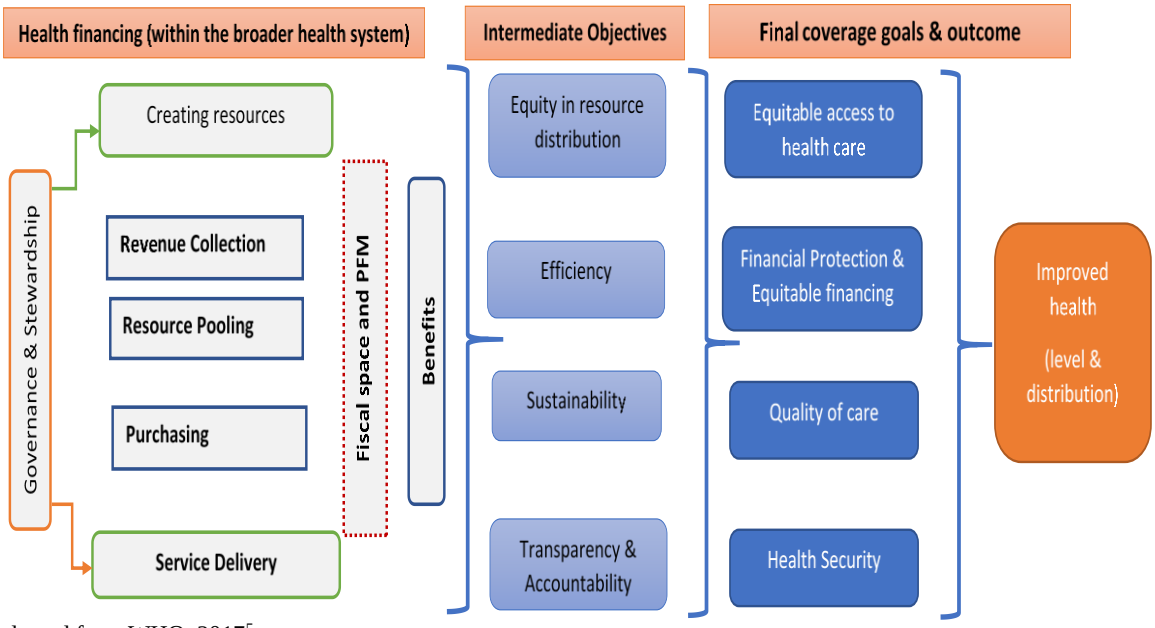
2. SITUATION ANALYSIS

As part of the development process, the HFTWG conducted a rapid assessment of Liberia's health financing systems using the WHO Guideline of Health Financing System Diagnosis and Health Financing Progress Matrix.[1,2] This section summarizes the key issues concerning health financing in Liberia. It is based on a more detailed situational analysis to inform the HFS.[3] The strategy uses the WHO health financing framework to demonstrate the linkage between health financing actions and the ability of Liberia's system to achieve the intermediate health system objectives. It further demonstrates that health financing works within and as a component of the health system. The public expenditures review reports: 1) low overall public spending on human development; 2) inequitable resource allocation; 3) inefficiency in public expenditures; and 4) severe lack of data and capacity to monitor and analyze developments.[4]

A health system is a set of all public and private organizations, institutions, and resources mandated to improve, maintain, or restore health. The core functions of a health system comprise a set of activities that a health system plays to achieve its goals. These functions include service delivery, financing, generating of human and physical resources/inputs, and stewardship/governance—all of which produce outputs that lead to outcomes. Ensuring clarity in differentiating the policy objectives/goals and the instruments (means to the goals, i.e., what actions need to be taken) is important in formulating health financing policy. The linkages between the functions and the objectives and goals are illustrated in Figure 1.
The health financing systems diagnosis identifies challenges/bottlenecks to attaining health financing system goals based on assessing strengths and opportunities. This is based on how the health financing sub-functions and the overall macro-fiscal environment and public finance management arrangements are currently organized. The overall focus is on overcoming challenges toward attaining intermediate goals (i.e., equity in resource distribution, efficiency, sustainability, and transparency/accountability) and final goals (equity in access, financial risk protection, quality, and health security).

[1] WHO. 2016. Health Financing Guidance No.1: Health financing country diagnostic:
a foundation for national strategy development.
https://apps.who.int/iris/bitstream/handle/10665/204283/9789241510110_eng.pdf
[2] WHO. 2020. Country assessment guide: for the health financing progress matrix. https://www.who.int/publications/i/item/9789240017801
[3] Ministry of Health. 2021. Situational Analysis and Review of Health Financing in Liberia.
[4] World Bank. 2020. Liberia - Public Expenditure Review: Human Development. https://openknowledge.worldbank.org/handle/10986/12313

Figure 1: How health financing policy affects intermediate and final health system goals and outcomes



Source: Adapted from WHO, 2017[5]

2.1 Macro-Economic and Fiscal Context

The total government resource envelope remains constrained, and this will continue to challenge its ability to increase domestic resources for the health sector. During the period of implementation of the previous health policy and related financing strategy (2011–2021), the fiscal envelope (% government spending to GDP ratio) averaged was projected at a deficit of 6.1%t (a deficit of 19.9%) in 2019 up from a deficit of 4.8% (a deficit of 17.8%) in 2018.[6] The scope of increasing government revenue also remains constrained as the government revenue (tax as % of GDP) at 12.4% is among the lowest within Sub-Saharan Africa (18.56% average).[7] The government has continued to rely significantly on deficit financing, with the current government debt estimated at 61% of a total US$ 5.2 billion over the five years.[8] It is expected that within the period of implementation of the planned policy, the debt will decline as the government continues to implement measures to ensure adherence to borrowing ceilings. The economic uncertainties resulting from the 2014 Ebola epidemic and 2020/2021 COVID-19 pandemic make the need to ensure health security an important consideration but also point to the need to address emerging health threats and underscore national commitment to strengthen mechanisms for prevention, detection, and response to public health threats due to the interface between humans, animals, and environment.

[5] WHO. 2017. *Developing a National Health Financing Strategy: A Reference Guide*. https://apps.who.int/iris/bitstream/handle/10665/254757/9789241512107-eng.pdf

[6] Ministry of Finance and Planning/GoL. 2020. *Liberia: Voluntary National Review on the Implementation Status of the 2030 Agenda for Sustainable Development*. https://www.mindbank.info/item/7145

[7] World Bank. 2022. *International Monetary Fund, Government Finance Statistics Yearbook* and data files, and World Bank and OECD GDP estimates. https://data.worldbank.org/indicator/GC.TAX.TOTL.GD.ZS

[8] Ministry of Finance and Planning/GOL. *Liberia: Voluntary National Review on the Implementation Status of the 2030 Agenda for Sustainable Development*.

2.2 Resource Mobilization, Predictability, and Stability of Flow of Funds

Although resources for the health sector have been increasing (almost four-fold from US$ 100 million in 2007/08 to $338.5 million in 2015/16), this is still inadequate when compared to the estimated health resource needs. The previous health sector plan had estimated a resource need of a total cost of over one billion US dollars (US$ 1,250,126,322), or $296 per person, over the past 10 years. It is expected that the resource needs will even be higher in the next strategic period. Of the current total health expenditure, the percentage contribution by the government is 16%, donors contribute up to 27%, and households contributing through direct out-of-pocket (OOP) payments at 53%.

The contribution by the government has been constrained by the very limited government tax revenue, as discussed in Section 2.1. Of the total government allocation for health, about 80% is used for payment of health care workers, with only 20% for other health system inputs required for service delivery. For instance, the annual allocation to essential medicines is only about US$ 3.8 million,[9] which has resulted in frequent stock-outs at the health facility level. The low government contribution has made it difficult to sustain the implementation of the free health care policy. The fiscal capacity in the short-to-medium term will remain limited within the period of implementation of this strategy. Revenue forecasting and collection challenges at MFDP are also likely to affect the predictability and stability of disbursements of public funds to health providers affecting service delivery. During the implementation of this strategy, the country is also implementing fiscal decentralization, which will introduce another layer in the flow and affect autonomy in the collection/receipt and use of funds at health facilities.

The pattern of donor funding peaked during the 2014 Ebola outbreak and has been declining in line with the trend observed globally. The pattern of reduced donor funding is a threat to the sustainability of various programs that are still predominantly dependent on donor resources. The observed reduced donor resources have been replaced mainly by household contribution through direct OOP payments, with contribution raising from 35% of Total Health Expenditure (THE) to 53% of THE when donor resources reduced from 47% of THE to 27% of THE.[10] This reduction in financing by donors without a matched increase in government resources has resulted in an increased burden on households for financing health care. In addition to the decreasing trend of donor financing globally, donor resources also face a challenge of predictability. As donor funds are expected to remain an important source of funding, this challenge must be addressed.

2.3 Pooling and Allocation of Resources

Currently, the main resource pools are allocation from MFDP and funds from on-budget donors, off-budget donors, and voluntary health insurance. Resources paid by households through OOP payments are not pooled. There have been continuous efforts made to minimize the extent of fragmentation across the resource pools in Liberia's health sector. This is meant to enable resource redistribution and enable complementarity of different funding sources toward a harmonized National Health Plan.

Between 2008 and 2019, the Health Sector Pool Fund was established to reduce transaction costs and achieve better coordination and alignment between the many actors involved in implementing the National Health and Social Welfare Policy and Plan (NHSWPP).[11] In pooling donor funds and enabling the MOH to propose allocations in line with the unfunded areas of the NHSWPP, the Pool Fund strengthened the MOH's capacity to implement the NHSWPP and increased its influence over the allocation of resources in the health sector. It also enabled the MOH to target delivery of the Basic Package of Health Services to under-served areas. While the Pool Fund aimed to increase the cost-effectiveness of donor funds, the mechanism

[9] Republic of Liberia National Budget Fiscal Year 2020/2021 July 1, 2020 to June 30, 2021. Page 202, Budget line 221805, www.mfdp.gov.lr.
[10] Ministry of Health. Liberia National Health Accounts Reports FY2015/16 and FY2018/19.
[11] Hughes J, Glassman A, Gwenigale W. 2012. *Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund – Working Paper 288*. Center for Global Development.
https://www.cgdev.org/sites/default/files/1425944_file_Hughes_Glassman_Liberia_health_pool_FINAL_0.pdf

was plagued by poor coordination, management issues, fund disbursement issues, and procurement problems.[12] Additionally, the Pool Fund represented only a fraction of total donor funding, the rest of which flowed through nongovernmental organizations (NGOs).

Despite the shortcomings, the Pool Fund overall reduced the fragmentation of the financing for the NHSWPP by consolidating the financial support from four donors and linking directly to the National Health and Social Welfare Policy and Plan (NHSWPP). This contributed to improved harmonization and alignment of donor support to health. Also, coordination improvements materialized both in terms of defragmentation of donor funding through the Pool Fund itself and a reduced number of NGOs funded per county, resulting in less effort required by the County Health Teams (CHTs) to manage and coordinate partners. There was maximum accountability for service delivery and use of resources. Other positive results of the Health Sector Pool Fund included: 1) increased capacity of national systems; 2) improved coordination of donor funding; and 3) increased stewardship of service delivery. Moreover, it expanded the public network of facilities by 24% (from 306 in 2006 to 378 in 2011) and increased the percent of facilities providing the Basic Package of Health Services from 36% to 82% in just two years of implementation. This was evidenced by the substantial increase in stewardship for service delivery.

Short-term donor support to the NHSWPP, high levels of poverty, and lack of financial protection offered by formal risk and revenue pooling arrangements have led to unpredictable revenues for health, which constrains planning and affects service delivery.[13] The Pool Fund closed in 2019 without establishing any new pooling mechanism for donor financing. There remains a need for a single, national Pool Fund for health that provides compulsory or automatic coverage for the entire population for the essential package of health service II through a national fund managed by a separate pooling and purchasing agency, usually with a purchaser-provider split.

The Office of Finance Management (OFM) has been keeping account not only of GOL resources but also of partner resources, including preparing statements, handling administrative issues, and providing technical support related to keeping and preparing accounts. On average, 66% of total resources for FY16/17, FY17/18, and FY2018/19 were on-budget. This means that resources were channeled through the MOH, OFM, or other entities within the health sector or County Health Teams (CHTs) that stakeholders at the level of the MOH are aware of. Given the large size of off-budget financing on average and the percent of financing on-budget, it raises the issue of coordination and transparency that should claim the attention of all health sector stakeholders.

From FY10/11 to FY18/19, the OFM managed and expanded a total of US$ 686.4 million from government, donors, and NGOs. Actual government disbursement for health amounted to US$ 377 million, accounting for 55% of the total resource envelope, while the project account (including resources from donors) and Pool Fund accounted for 36% and 10%, respectively. Of the total project account, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) accounted for 80%, US$ 141.1 million for malaria, tuberculosis, and HIV/AIDS between FY2010/11 and FY 2018/19. These expenditures exclude expenses from the other two principal recipients of the GFATM in Liberia. Apart from the GFATM and Pool Fund, resources from external partners were captured into the project account. Challenges to the co-financing requirement are associated with decreasing proportion of health funds channeled through pool funds, legal impediments faced by some donors that prohibit participating in multi-donor pooling mechanisms, and an inadequate amount of investment in increasing the strategic orientation and the absence of sustainable, domestic investment.

The health insurance market in Liberia is small and fragmented. It consists of mainly voluntary schemes which cover mostly rich households. Health insurance coverage is low, with only 4% of women and 7% of

[12] Department for International Development. 2011. Innovative service delivery stock take: DFID case study of service delivery in fragile & conflict affected situations using CSAE framework: Liberia Health Sector Pool Fund.

[13] Ministry of Health. 2011. National Health and Social Welfare Financing Policy and Plan 2011–2021. https://moh.gov.lr/documents/policy/2019/national-health-policy-plan-2011-2021/

men age 15-49 having any type of health insurance..[14] There is no mechanism for cross-subsidization/resource equalization and common data-sharing platforms for the existing private health insurance schemes. Given the low level of insurance coverage (mainly consisting of voluntary private insurance covering employees and dependents), the government has been exploring establishing the Liberia Health Equity Fund (LHEF) as a mechanism for income and risk pooling.

2.4 Purchasing Arrangements and Provider Payment

The market structure for purchasing is fragmented into the public sector, NGOs/implementing partners, and the private sector as representative of the funding pools. Meanwhile, individuals purchase directly through OOP payments. Desirable purchasing mechanisms should ensure resource allocation and provider payment is driven by information on the health needs and utilization across the population.

The public sector represents the biggest pool of prepaid funds purchases mainly through traditional input-based purchasing. Budget allocations are made to different MOH budgetary programs and semi-autonomous MOH entities for the payment of different inputs used in service delivery. However, the input-based budgets are not well aligned to reflect overall sector performance objectives and linkage with the outcomes.

While moving toward strategic purchasing emphasizes the need to ensure a linkage between the allocation of funds and health system needs, the focus shall be on how to ensure equity and efficiency. In so doing, as the government works on setting up systems for implementing LHEF, consideration shall be given to health system inputs such as human resources, infrastructure, and pharmaceuticals, which are more likely to still be allocated through the input-based system in the short-to-medium term. This latter strategy includes the opportunity to use performance-based financing (PBF) as one of the mechanisms to strategically purchase health services from providers, linking them to priority targets and outputs, rather than simply paying for inputs. Strategic purchasing will become even more important as Liberia is set to strengthen decentralization as envisioned in its decentralization policy. This will require appropriate structuring of incentives balanced with ensuring the twin, but often discordant, objectives of stronger autonomy/flexibility and improved accountability are achieved.

From 2011 to 2015, USAID's health sector Fixed-Amount Reimbursement Agreement (FARA) supported the GOL with US$ 42 million in PBF for the delivery of the Essential Package of Health Services (EPHS) at the primary health care (PHC) level in three counties. FARA awarded performance-based contracts to NGOs to provide service delivery for family planning, immunizations, malaria, maternal and child health, and water, sanitation, and hygiene programs. With support from the World Bank/ GFF, the MOH implemented a PBF contracting-in approach, in which the GOL directly contracts counties with the lowest performance on basic health and service indicators to provide reproductive, maternal, newborn, child, and adolescent health services. Additionally, the MOH is working with the World Bank to implement PBF in secondary and tertiary hospitals to improve the quality of care. The World Bank mechanisms, with support from USAID, are intended to build upon, learn from, and harmonize with the FARA mechanism. A medium-term objective is for the MOH to design a strategic purchasing strategy built upon lessons learned from the performance-based provider payment mechanisms within the LHEF.

Preliminary results from the PBF implementation research and the World Bank/GFF impact evaluation show that PBF led to an increase in outreach and community strengthening. In decentralizing decision-making to the periphery, communities got more involved in taking on decisions related to their health, with 29 health facilities opening and managing their facility bank accounts. For stewardship, PBF contributed more to the purchaser-provider split, but the main challenge remains the need for primary-level health facilities to be given more autonomy (e.g., financial flows directly to health facilities). In Liberia's current situation, decisions shall be made based on lessons learned to foster health facility autonomy and how the

[14] Liberia Institute of Statistics and Geo-Information Services, Ministry of Health, and ICF. 2021. *Liberia Demographic and Health Survey 2019–2020*. https://www.dhsprogram.com/pubs/pdf/FR362/FR362.pdf.

costs/ benefits can be maximized. Sustainability of the PBF program remains a concern. Up to the present, PBF has been a donor-financed initiative. Considering the complementarity of strategic purchasing mechanisms, input-based and performance-based fund allocations within the health system are still considered separate financial streams.

Within the LHEF, it is envisioned that payment for human resources for health will factor a pay-for-performance approach to make the health system more responsive to patients and consumer preferences and thereby improve quality. Achieving this will require the health system to carefully consider the appropriate multidimensional human resources for health performance parameters that could be used to achieve this objective. This could be informed by lessons learned and challenges in the PBF program implementation.

2.5 Health Benefits Package Design and Conditions for Access

While the essential package of health services was developed with the intent to be used as the basis to establish the benefits package, yet it is not explicit on inclusion or exclusions. As a result, the benefits package does guarantee access to the defined services in the package. It is thus not surprising that even with free services provided by the government, OOP spending is still increasing among the poor. This means conditions of the poor have not been prioritized in the delivery of care to ensure access and that health care expenditures do not lead to catastrophic payments. Furthermore, the packages and the reimbursement rates for the services for the existing private schemes are not routinely monitored in terms of composition and pricing. There is thus a potential for distortion within the private insurance market as well as interaction with the public health system.

In the private sector, reimbursement is currently through a fee-for-service approach. The existing private health insurance schemes also pay through itemized fees for service. This approach for payment is associated with cost escalation and does not have incentives for providers to improve quality and responsiveness. It is envisioned in the concept note for the creation of the LHEF as an opportunity to implement a provider-purchaser split with specific emphasis placed on developing the benefits package, determining reimbursement rates, and appropriate provider payment mechanisms for the enrolled providers.

2.6 Public Finance Management (Planning, Budgeting, Execution, Reporting)

In terms of planning and budgeting, Liberia has moved toward the January–December fiscal calendar as part of the process of full institutionalization of the budget calendar. While there have been previous efforts aimed at exploring implementing multi-year planning and budgeting through establishing a Medium-Term Expenditure Framework (MTEF) to ensure fiscal discipline and allocative efficiency, this is yet to be fully implemented. This is a major challenge to ensuring harmonized long-term planning aligned to the PAPD and NHSWPP. Assessments by the MOH's Health Financing Unit (HFU) have identified challenges concerning communication and coordination between the central Ministry and CHTs and major health facilities when planning and drafting the budget for the health sector. The CHTs are generally not fully included in the process and are not informed of the available funding ceilings before the annual county planning and budgeting process nor consulted before the budget is submitted to Ministry of Finance and Development Planning (MFDP) by the central Ministry. There is a limited capacity of CHTs to undertake planning and budgeting without support from the central Ministry.

The current budget structure mainly uses line-item budgeting. Line items are currently predominantly categorized as: 1) personnel, 2) goods and services, 3) capital investments, and 4) transfers and subsidies (can encompass any of above 1 through 3). Line-item budgeting is associated with rigidity as it restricts options available to implement a resource allocation framework/allocate resources more efficiently. The utilization of line items makes it difficult to track GOL's adherence to spending requirements toward priority programs that responds to the needs of the health sector. However, the MFDP has indicated that they are progressively working toward the implementation of program-based budgeting.

While there have been previous efforts to develop an equity-based resource allocation formula for government resources,[15] the GOL does not use a formula to allocate resources to the health sector and within the health sector. Allocations are made based on historical estimates and not updated to reflect actual needs. Resources allocated to the counties flow from MFDP through the MOH/OFM, which uses two systems: 1) the integrated financial management information system (IFMIS) for government allocated funding; and 2) NETSUITE for internal transaction and consolidation of both government and donor-funded activities. Only the central-level MOH and the four counties implementing fiscal decentralization use the IFMIS. However, NETSUITE is being used by some hospitals and all CHTs. NETSUITE is also being used by the national programs (i.e., Malaria Control Program, HIV/AIDS Control Program, TB and Leprosy Control Programs, Blood Safety, and the Central Medicine Store).

The government is currently implementing fiscal decentralization reform with the health sector as part of the pilot sectors. This reform is expected to reduce travel time and resources between counties and central MFDP. As part of this reform, the County Health Board headed by the County Superintendent has been established and is headed by a County Superintendent in each of the 15 counties. Currently, Grand Bassa, Margibi, Nimba, and Bong Counties are implementing fiscal decentralization. Counties implementing this reform receive their budgetary allocation from the central MFDP instead of the MOH. However, these transfers are still captured in MOH financial statements. The County Treasury is MFDP at county levels. It is important to note that while the government strives to achieve complete fiscal decentralization, the MOH/OFM is working to expand the system (IFMIS) to the rest of the counties. However, while procurement functions have been devolved to the pilot counties (up to a maximum of US$ 10,000), health facilities (apart from the hospitals) do not have the autonomy to incur any expenditures. Still, the MFDP has given the MOH special leverage to pilot financial autonomy by allowing 29 clinics in Sinoe, Rivercess, and Gbarpolu, to receive and spend money. If successful, the MOH may do the financial transaction with health facilities directly. It is important to note that the pilot is yet to be evaluated.

Despite challenges in revenue collection, the sector has experienced incremental growth in budgetary allocation. The health sector budget has doubled from US$ 32.4 million in FY10/11 to US$ 75.7 million in FY20/21. The budgetary allocation has fluctuated between US$ 48.9 million FY11/12 and US$ 75.8 million FY20/21, with an average allocation of US$ 72.4 million annually. A total of US$ 88.8 million was projected for FY 2017/18 from off-budget grants and loans for the health sector, but US$ 119.5 million was disbursed, 35% more than what was planned.[16] Out of the revised allocation to health, 95% was disbursed, of which 91% was expended, although there was some variation between sub-budget lines.[17] A 95% budget disbursement rate is commendable, and the 91% budget execution rate shows good absorption capacity for money that is released to health.[18] This is an improvement over budget execution rates in FY 2015/16 (89%) and FY 2016/17 (71%).[19]

The budget execution rate has been steadily improving between FY2010/11 and FY2018/19. However, the health sector still has challenges of the low absorptive capacity as all the funds allocated are not fully utilized even when we have noted significant inadequacy and resource gaps. It is worth noting that the lowest execution rates were noticed during the Ebola outbreak in 2014. Analysis by the HFU shows that the reasons currently explaining the low levels of budget execution are delays in the approval and disbursement of the national budget, delays in transfer to MOH and other health sector institutions, and variation in the allocation to the MOH versus what is disbursed. Other challenges include internal bureaucracies associated with processing payments and delays in the release of quarterly allotments.

[15] Ministry of Health and World Bank. 2012. *National Health Accounts*. 2012c, p. 49.
[16] Ministry of Financial and Development Planning. 2018. *Financial Report*. 2018a.
[17] Ibid.
[18] Ibid.
[19] Ibid.

2.7 Financing Programs and Public Health Functions

While the resource envelope for health has been increasing and remains important, funding especially from donors has mostly gone into vertical programs. However, with the economic contraction in most of the donor countries as a result of COVID-19, coupled with decreasing development aid for health, Liberia needs to explore further how best to ensure the coverage and health gains achieved with aid are sustained. There is a potential to leverage gains by eliminating duplications, overlaps, or misalignments across core health system functions (financing, governance, inputs, and service delivery) that constrain the level of effective coverage potentially achievable by the health system.

In the context of a health emergency, the MOH shall ensure that the estimation of funding/budgetary requirements guides the availability of funds to service delivery disbursing them efficiently as related to control, tracking, and accountability of the resources deployed. Ensure the reports is transparent and timely. The effect of the EVD outbreak on Liberia's health sector and the experience with response to the global COVID-19 pandemic has brought to the fore a need for building Liberia's health financing capacity to prepare and respond to future pandemics. Some of the challenges identified within the public finance management (PFM) system also affect the ability of the health system to implement an agile emergency response. In response to EVD, the government was able to set up and implement an inter-sectoral Ebola response through an extra-budgetary mechanism (i.e., The Ebola Trust Fund set up by MFDP). This enabled the government to pool resources from other government ministries, agencies, and international and local NGOs, as well as bilateral, multilateral, and private donors. This extra-budgetary fund was implemented through a regular PFM system and leveraged the existing systems to ensure accountability, reporting, and complementarity across various sources.

During the COVID-19 global pandemic, an Emergency COVID-19 Relief Fund was planned to complement the GOL's purchase of necessities—such as food, medicines, testing kits, and personal protective equipment—for vulnerable people and responders. The Relief Fund was to be funded by an assessment of 25% of the net salaries of all employed persons (both in the private and public sectors) for two months (May and June 2020). Payment to the Emergency COVID-19 Fund was to be made in the same manner as payroll taxes collected through the LRA as the intermediary, and all money collected by the LRA would have been deposited into the account(s) established at the commercial bank(s) designated by the MFDP. However, the plan to establish the emergency Relief Fund did not materialize. Although MFDP has a contingency fund, transfers from the contingency fund are not specific for health emergencies but for addressing unplanned urgent expenses that are brought to MFDP. Learning from previous experiences with pandemics, there are plans to establish a health emergency response fund.

2.8 Summary of Emerging Issues, and Recommendations

Revenue collection

- Although tax revenue has been increasing, fiscal constraints with minimal potential for increased resource mobilization (in the short term) limit the ability of the GOL to increase additional tax financing. However, there is a need to ensure that revenue growth and increases in GDP are matched with increases in domestic resources for health.
- Given that the country remains significantly dependent on donors, there is a need for a clear mapping of current donor support to ensure optimal utilization. The GOL also needs to develop a transition plan with a clear estimation of costs to inform planning processes and efforts for harmonization and alignment. A Resource Mapping and Expenditure Tracking exercise should be completed annually to assess how much donors are contributing across programmatic areas and geographies. To complement this annual exercise, the National Health Accounts should be conducted to monitor the execution of different financing resources across programs.
- To increase domestic resources for health in the short term, there is a need to continue with the currently planned activities toward implementing the Revolving Drug Fund **(**RDF). To ensure sustainability and

affordability in the design and strategy, the determination of rates and approach to charging that balances cost-recovery goals should ensure that the poor are protected with specific exemptions around target population groups and services. The RDF should be complementary to donated/government-supplied drugs. RDF is a strategy to address the shortage of essential medicines at public health facilities in the short term while the government develops other innovative prepaid mechanisms through the LHEF.

Fund pooling arrangements

- To reduce fragmentation, duplication, and overlap in the use of the available resources a Health Sector Pool Fund (closed in 2019) should be re-established and institutionalized within the government structures to ensure cost-effectiveness and a plan on how to transition management toward government PFM systems.
- While funding from progressive taxation ensures that the funding is pro-poor, currently there is no clarity on the contribution mechanisms/rates used for the existing voluntary health insurance scheme and how to ensure there is pro-poor redistribution. This should be a major consideration for designing LHEF.
- Regarding the LHEF, resource pooling does not maximize the redistributive capacity of available prepaid funds and explicit complementarity of different funding sources. The LHEF design should ensure the complementarity of public and donor resources by ensuring implementation is guided by a single plan that is jointly implemented and monitored. A single income and risk pool for the proposed LHEF should be established in the design to ensure income and risk cross-subsidization.

Strategic purchasing

- Purchasing is mainly input-based, with funds flowing to the health facilities through inputs used in service provision. The mismatch between health expenditure and health utilization (private versus public sectors) could indicate that provider payment is currently not linked to need/utilization.
- The GOL needs to harmonize provider payment mechanisms and rates within and across purchasers to ensure coherent incentives. For now, the main purchasers are the implementers of the PBF projects, but this could also be extended to insurance schemes. PBF has been implemented by donors to increase the linkage between payment and health care needs but needs to be scaled up to maximize its benefits. Following the gains from implementing PBF, it is recommended that PBF be used as a mechanism to link payments to outputs and even outcomes (incentives at both facility and county levels).

Public financial management functions

- Rigidity in the budgeting structure restricts options available to implement a resource allocation framework and allocate resource more efficiently. The utilization of item lines makes it difficult to track the GOL's adherence to spending requirements toward priority programs such as Malaria, TB, and HIV/AIDS to qualify for grants made by GFATM.
- The formulation of result-oriented health budgets should be strengthened to ensure they are aligned to the strategic plans and are implemented in an efficient, equitable, and transparent manner within the country's PFM systems.
- The absence of budgeting for unit-specific operational budgets limits the ability of MOH units to operationalize their work plans.
- A resource allocation formula should be developed to ensure equity, especially for external funding (emphasis on linkage to health outcomes, improving efficiency, prioritizing PHC, and providing cost incentives).

- Multi-year planning is currently not implemented due to the lack of a fixed and institutionalized budget and planning calendar, leading to delays in the national budgeting process. To strengthen the planning process, there should be a focus on prioritization and linkage to realistic budgeting and the transition toward program-based budgeting to minimize rigidity in the budget. Appropriate linkages should be ensured between budget authorities who incur expenditure and unit operational heads so that the unit heads can operationalize their work plans.
- A mechanism should be put in place to ensure communication and coordination between the central Ministry and CHTs and major health facilities during budgeting. Program-based budgeting should be used in budget formulation to ensure alignment of budgets to priorities and increase managerial autonomy for the program budgets.
- Within the decentralization agenda, the capacity at the county health department, district, and facility levels to manage the decentralized health sector—including planning, budgeting, purchasing, and financial management—should be built as contained in the decentralization policy. This will address upstream challenges with revenue and expenditure planning.
- The design of intergovernmental transfers in the implementation of fiscal decentralization has been documented to ensure alignment of priorities at the central and district levels. This will reduce bureaucracies in the authorization/approval process in spending by putting in place penalties at various levels of delays. Timely reporting can further be reinforced by penalties for timely submission of liquidation reports.

Benefits package and design

The EPHS prioritizes services that reflect the prevailing disease burden and health conditions affecting the population. The EPHS prioritizes those services that are necessary for the social well-being of the population, especially those considered most vulnerable. There are limited institutional mechanisms for design benefits and conditions of access both for free care policy services, RDF, and proposed LHEF. A free essential benefits package has been developed, but it is not explicit on inclusion/exclusions and hence has no guarantee of access to the defined services in the package. Thus, there is a need to plan how this can be improved currently and in the design of the LHEF.

The design of the LHEF should clarify the population's entitlements and obligations (who is entitled to what services, and what, if anything, are they meant to pay at the point of use that aligns with available resources). The LHEF should operationalize and define the process of reviewing and update of the benefit packages with a mechanism for defining monitoring/review of user charges/provider payment rates.
Building on the referral pathway established with the PBF, a clear definition of the referral pathway for access to services should be established and should align with the health sector referral strategy.

3. HEALTH FINANCING POLICY AND REFORM STRATEGY

3.1 Policy Orientation

The policy orientation is guided by the national health policy and overall Liberia Vision 2030.

- **Vision:** A health financing system that ensures a healthy population for Liberia to attain sustainable development
- **Mission:** To transform the health system to become effective, efficient, and equitable, to attain UHC enabling access to quality care without suffering financial hardship
- **Goal**: To achieve adequacy, efficiency, and fairness in the financing of health services in a manner that guarantees access to essential and high-quality services

3.2 Policy Objectives

Based on the performance problems identified in the situation analysis of Liberia's health financing and the diagnosis of underlying causes of these identified issues, the overall policy objectives of focus will be as follows.

- To increase mobilization of resources collected through equitable and sustainable revenue collection mechanisms
- To improve equity and efficiency in the allocation and use of health care resources
- To ensure alignment between population needs and health benefits through provider payment reform and use of data to guide strategic purchasing decisions
- Improve the planning, budgeting, execution, and reporting to achieve equity and efficiency in resource utilization while also achieving desired health service delivery outcomes
- To improve institutional capacity for production and use of evidence for transparent decision-making in priority-setting and resource allocation

3.3 Guiding Principles

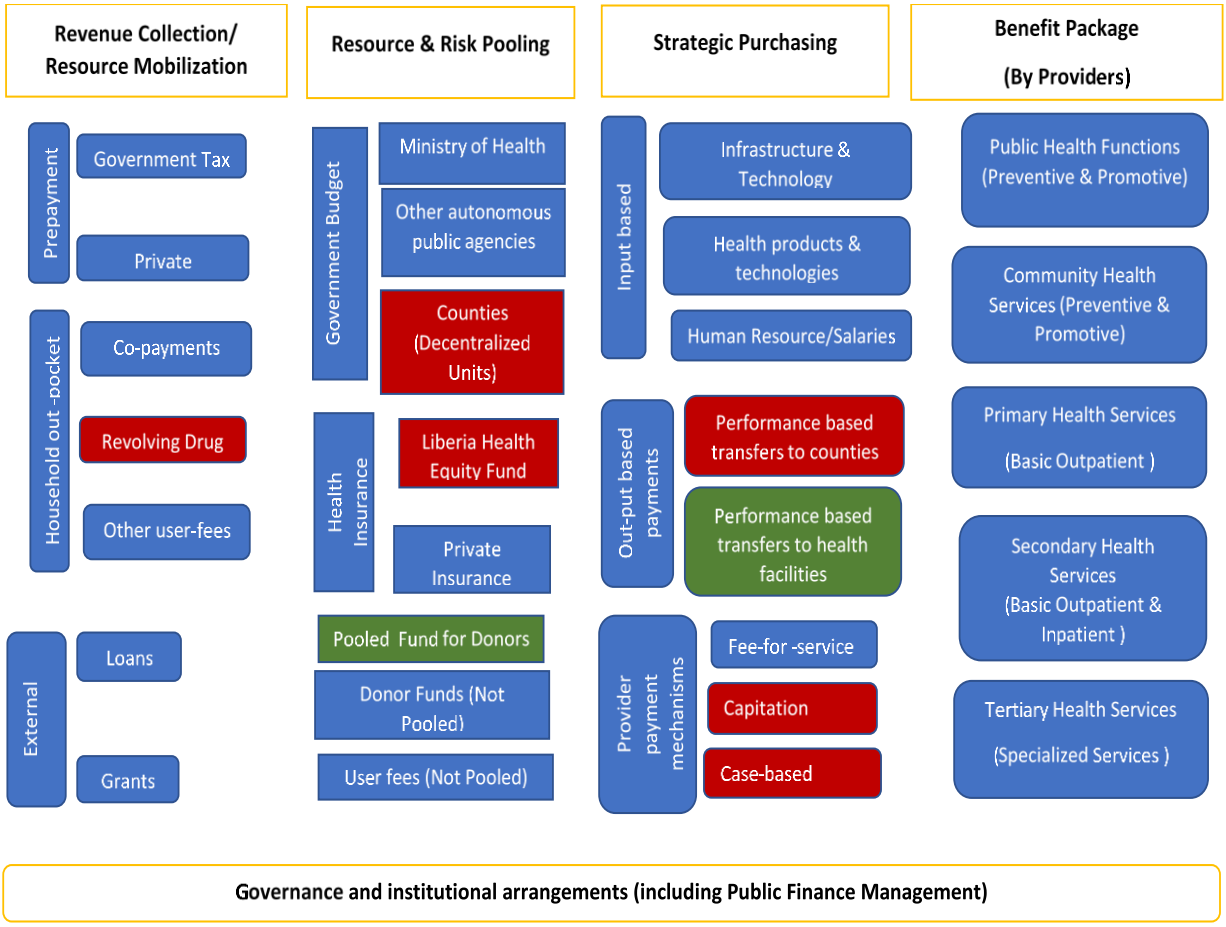
The implementation of the reforms proposed in this HFS will be guided by the following core principles:

- **Equity in the collection and allocation of resources:** Payments should be made based on the ability to pay, while everyone benefits depending on their need for care. Resource collection, pooling, and purchasing arrangements will be designed to ensure equity in access to high-quality services for all.
- **Efficiency** through promoting alignment and reducing duplication across different levels, as well as promoting the better performance of the health care systems.
- **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 to satisfy patients.
- **Transparency and accountability** through promoting strong governance: Regulation structures will be put in place for organizations and institutions responsible for revenue collection, pooling, and purchasing, and ensuring participation will be promoted at all levels of the health system.
- **Social solidarity** through promoting health for all, with consideration for the poor and vulnerable, through the realization of the income and risk cross-subsidization.
- **Partnership and collaboration** in implementation to ensure alignment and harmonization in the implementation.
- **Sustainability** through a move toward increased country ownership and increased domestic resource mobilization.

4. HEALTH FINANCING STRATEGIC AGENDA

The following sections present the financing reforms necessary to address the key issues identified in the Liberia MOH financing system. The core strategic orientations in the HFS are the areas of revenue collection, pooling, and purchasing. Figure 2 shows how these functions are linked to a health financing framework. As such, to achieve the objectives of this strategy, the MOH and its partners will need to intervene in each of the functions of a financing health system.

Figure **Error! No text of specified style in document.**-2: Illustration of linkages of health financing reform strategic interventions



4.1 Strategic Intervention 1: Resource Mobilization

The main rationale for planning interventions for resource mobilization is to address the funding shortfalls for the health sector, limited pre-payments, and the probable catastrophic health expenditures due to heavy reliance on OOP (53%). The guiding principle for strategic orientations for resource mobilization used in this section is to promote cost-sharing in the short term and prepayment mechanisms in the long and medium term to reduce OOP health care expenditures. In the next 10 years, several interventions will be implemented to increase resource mobilization with a plan to progressively increase reliance on compulsory funding sources and improve the predictability and stability of flows of public funds to health at the national, county, and service delivery levels.

Table 1: Priority interventions for improved resource mobilization

Area/ strategy	Priority intervention	Milestones	Responsible institution	Outcome
Increase resource mobilization with a plan to progressively increase reliance on compulsory funding	Ensure the comprehensiveness of the annual health sector resource mapping to inform budgeting and planning, resource availability, and gap analysis, and avoid duplication of mapping activities	• MOH team trained on resource mapping • Partners oriented on reporting; a developer for an online tool maintained	MOH, partners	Resource mapping done

Area/ strategy	Priority intervention	Milestones	Responsible institution	Outcome
	Map areas of support and estimate costs of transition to inform government planning processes jointly with MFDPP	• Technical assistance contracted	MOH, partners	Areas of support mapped Cost of transition estimated
	Implement the planned RDF; there is a need for mechanisms to determine rates and approaches to charging those balances cost-recovery goals (sustainability and affordability) and ensure there is a definition of target groups/services that will be exempted	• RDF strategy and design developed • RDF training manual developed • PFM laws to identify and address any bottlenecks reviewed • Governance structures of health facilities to enhance autonomy established/ strengthened	MOH, legislators, Parliament	RDF implemented with clear rates and exemptions defined
	Design revenue collection mechanisms for the planned LHEF; there is a need to ensure the mechanisms for revenue collection/contribution are fair (pro-poor)	• Draft LHEF legislation reviewed • Stakeholders sensitized to LHEF • LHEF implementation manual developed	MOH, partners	Equity criteria for the LHEF established
	MFDP to allocate the emergency fund for response to epidemics and outbreaks	• Emergency fund regulation guidelines drafted • Stakeholders sensitized on the operations of the emergency fund	MOH, MFDP	Emergency fund allocated
	Conduct National Health Accounts study to monitor the execution of donor and public funding	• National Health Accounts study conducted and disseminated bi-annually	MOH	National Health Accounts study conducted
Improve the predictability and stability of flows of public funds to health at national, county, and service delivery levels	MOH work with MFDP to ensure implementation of Medium-Term Fiscal and Expenditure Frameworks informed by the Health Sector Policy and Strategic Plan	• Medium-Term Fiscal and Expenditure Frameworks informed by the Health Sector Policy and Strategic Plan implemented	MOH, MFDP	NHPP informs the Medium-Term Fiscal and Expenditure Framework
	MTEF should include medium-term projections of donor resources for on-budget support; move toward ensuring donor resources are captured on a budget (by working	• Include medium-term projections of donor resources for on-budget resources • Donor resources captured on budget	MOH, MFDP, donors	Medium-term projections of donor resources for on-budget resources included in the MTEF

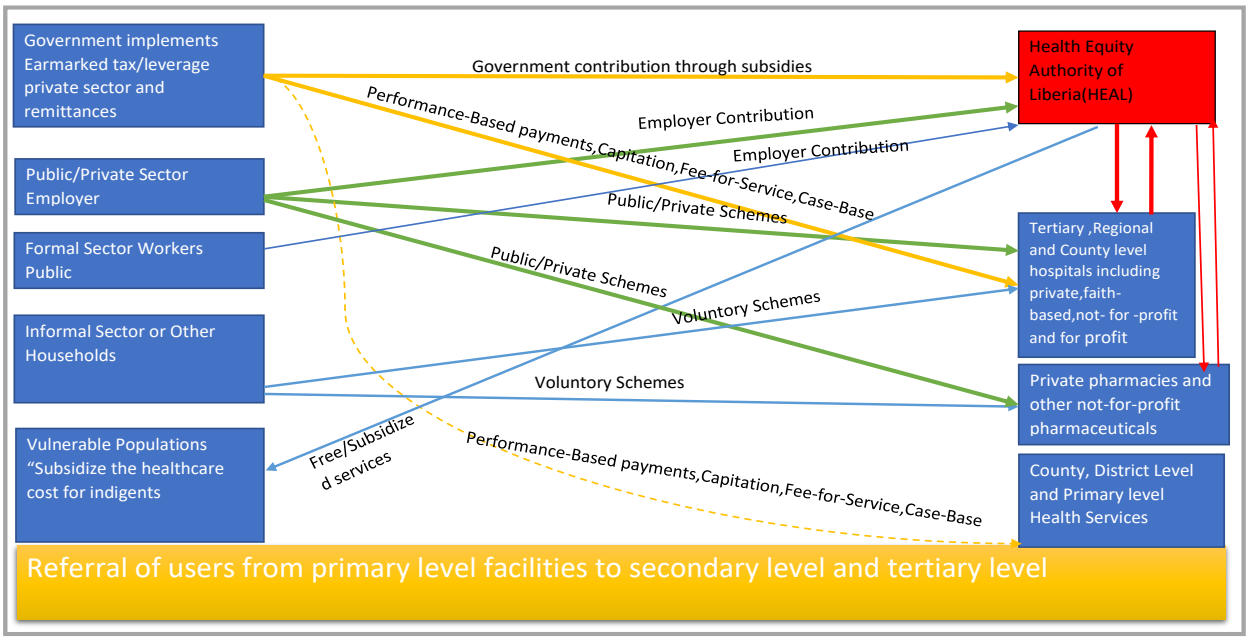
Area/ strategy	Priority intervention	Milestones	Responsible institution	Outcome
	with MFDP to address donor PFM concerns around transparency and accountability)			
	HFU ensures comprehensiveness of annual health sector resource mapping to inform budgeting and planning, resource availability, and gap analysis to avoid duplication of mapping activities	• A relevant analysis of resource mapping data conducted • Data analysis informs budgeting and planning, resource availability, and gap analysis to avoid duplication of mapping activities	MOH	Comprehensive resource mapping done
	Routinely monitor timeliness in the flow of public funds to improve budget execution by undertaking routine health expenditure reviews to identify and address bottlenecks	• Timeliness in the flow of public funds monitored • Routine health expenditure reviews to identify and address bottlenecks	MOH	Routine health expenditure reviews are done by the HFU

Increase resource mobilization with a plan to progressively increase reliance on compulsory funding
The implementation of all health financing reforms stipulated in this strategy requires strong capacities in designing, implementing, and managing the reforms outlined herein, while ensuring a clear mapping of current donor support and using the information to ensure more harmonization/alignment. Mapping areas of support and estimating of costs of transition will inform government planning processes.

Implementation of the Revolving Drug Fund
To establish a functional RDF, there is a need for mechanisms to: 1) determine rates and approaches to charging that balances cost-recovery goals (sustainability and affordability); and 2) ensure there is a definition of target groups/services that will be exempted. The MOH will need support in the selection of the most cost-effective and equitable approach to RDF for the Liberian context. The MOH needs to develop new capacities (in some areas) and strengthen existing relevant capacities. The core competencies required include expertise in, among others: health financing, design and implementation of health insurance schemes, PBF, vulnerability assessments, designing exemptions for vulnerable groups, and actuary sciences.

Revenue Generation for the LHEF
While the resource envelope for health has been increasing and remains important, funding has mostly gone into vertical programs. However, with the economic contraction in most of the donor countries as a result of COVID-19, coupled with decreasing development aid for health, Liberia will need to explore further how best to ensure that coverage and health gains achieved through aid are sustained. Such gains will be at the cost of neglecting support systems that are essential to the effective delivery of health services within the framework of the LHEF. This will include the identification of revenue mobilization and sustainable financing options. Designing a revenue collection mechanism for the planned LHEF will require that mechanisms for revenue collection/contribution are fair (pro-poor). In the medium-to-long term, the government has the potential to generate additional revenues from taxes.

Figure 3: Illustration of proposed resource mobilization and fund flow for the Liberia Health Equity Fund



Financing of Public Health Functions/Emergency Preparedness and Response

The effect of the EVD outbreak on Liberia's health sector and the experience with response to the global COVID-19 pandemic has brought to the fore a need for building Liberia's health financing capacity to prepare and respond to future pandemics. Some of the challenges identified within the public finance management (PFM) system also affect the ability of the health system to implement an agile emergency response. In response to EVD, the government was able to set up and implement an inter-sectoral Ebola response through an extra-budgetary mechanism. During the COVID-19 global pandemic, an Emergency COVID-19 Relief Fund was planned to complement the GOL's purchase of necessaries such as food, medicines, face masks, and face shields for vulnerable people, as well as testing kits, personal protection equipment, and other protective gear for contact tracers and health workers. To sustain the gains and experiences of the GOL in emergency preparedness, the MFDP should be strengthened to implement the emergency fund for response to epidemics and disease outbreaks.

4.2 Strategic Intervention 2: Resource Pooling

This strategic orientation aims to reduce fragmentation in resources and risk pools. Effective pooling includes public resources, external resources, and resources generated through the different health insurance schemes, with the view to providing the same essential health benefits package for all people covered. The emphasis for pooling is not just to create income pools but also to ensure that these pools are integrated and coordinated to promote the achievement of income and risk cross-subsidizations between the rich and the poor and between the sick and the healthy. The priority interventions for effective pooling are described and summarized below.

Table 2: Priority interventions for resource pooling

Area/ strategy	Priority intervention	Milestones	Responsible institution	Outcome
Maximize the resource pooling capacity of available resource pools and complementarity of different funding sources	Ensure complementarity of various resource pools	Established Health Sector Pool Fund and - LHEF Pool Fund	MOH, partners	Complementarity of various resource pools ensured
Allocate public and donor resources to a jointly agreed plan that is jointly implemented and monitored	Develop Strategic Plan on the allocation of donor resources	Resource allocation Strategic Plan costed	MOH, donors	Jointly agreed plan to monitor donor and public established
Reduce fragmentation, duplication, and overlap in the use of the available resources	Rejuvenate the Health Sector Pool Fund institutionalized within the government structures to ensure cost-effectiveness	Health Sector Pool Fund instituted	MOH, donors	Health Sector Pool Fund institutionalized
	Expand the number of donors using the Pool Fund mechanism by making its proceedings clear and transparent and by simplifying planning and execution procedures	Health Sector Pool Fund expanded		The number of donors for the Pool Fund expanded
	Coordinate donors on budget support	Donor budget Coordinated through the Pool Fund		Donor on-budget support coordinated
	Ensure complementarity of public and donor resources by ensuring implementation is guided by a single plan that is jointly implemented and monitored	Establish a single plan for donor resources		A single plan to jointly monitor donor and public resources implemented

Area/ strategy	Priority intervention	Milestones	Responsible institution	Outcome
	Conduct cross programmatic efficiency analysis and explore actions for harmonization across health system functions (governance and stewardship, financing, inputs, and service delivery)	Conduct a study on cross programmatic efficiency		Cross programmatic efficiency analysis done
Establish single income and risk pool for proposed LHEF to ensure income and risk cross-subsidization	Establish Pool Fund specific to the LHEF	Pass a law establishing the LHEF Pass a law establishing the NHEA	MOH, lawmakers	Single income Risk Pool Fund for the LHEF established
Strengthen regulation of private health limit distortionary effects of voluntary health insurance on equity and efficiency by monitoring benefit packages services provided and pricing	Develop explicit mechanism to ensure complementarity between existing voluntary private health insurance and public financing mechanisms	Define the potential role of the existing voluntary schemes for consideration in designing LHEF Study composition and coverage (in terms of benefits) of the pools under the voluntary schemes	MOH, Central Bank	Regulation of private sector insurance strengthened

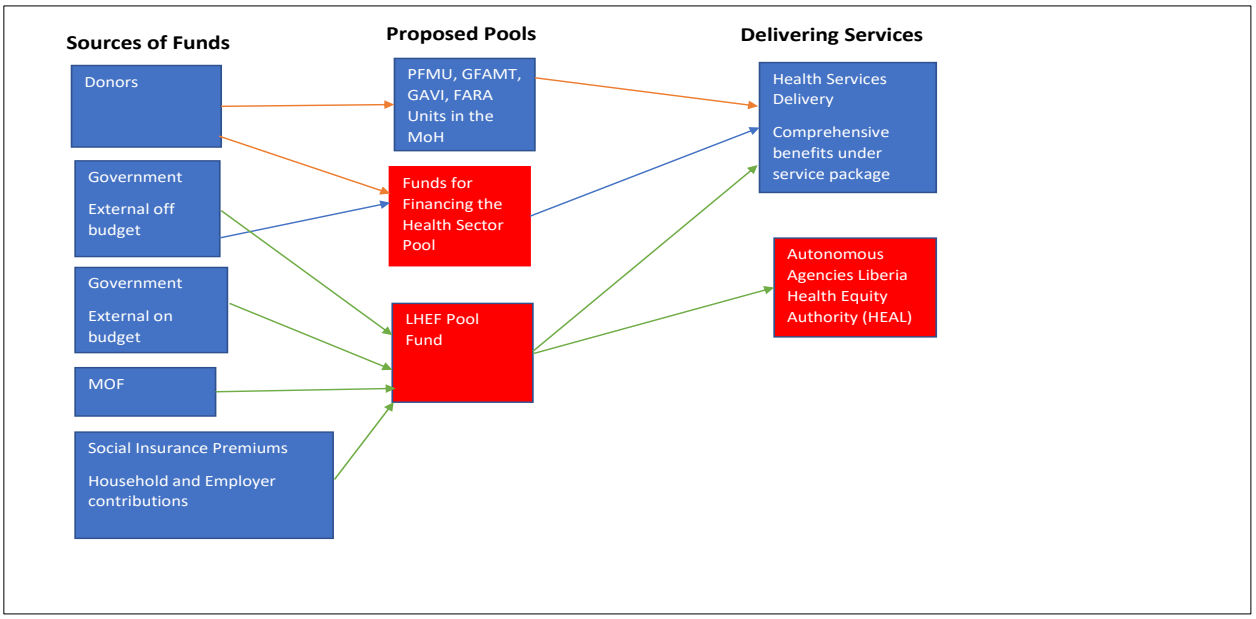
Establishment of a Health Sector Pool Fund instituted: To Maximize the resource pooling capacity of available resource pools and complementarity of different funding sources, the GOL will establish a health sector pulled fund that will prioritize funding the EPHS and emergency preparedness. Public and donor resources would be allocated jointly on the agreed plan that is jointly implemented and monitored. This will reduce fragmentation, duplication, and overlap in the use of the available resources in government structures to ensure cost-effectiveness. A mechanism will be put in place to expand the number of donors in the Pool Fund by making its proceedings clear and transparent and by simplifying planning and execution procedures. Institutions within the Pool Fund will coordinate donors on budget support and ensure complementarity of public and donor resources by ensuring implementation is guided by a single plan that is jointly implemented and monitored

Maximizing efficiency gains from the existing resources: The health sector will leverage resources by addressing existing inefficiencies. The first step will be to carry out cross programmatic efficiency analysis and explore actions for harmonization across health system functions (governance stewardship, financing, inputs, and service delivery). The outcome of this assessment will inform the specific actions required to achieve efficiency gains. To achieve this, efforts will be directed toward: strengthening mechanisms of governance and accountability across the whole system; building capacity in financial management for all actors, especially the health facilities; human resource management; and rationalizing the use of medicines and pharmaceutical supplies, which are key cost drivers within the health system. Some of the interventions that will help in achieving efficiency gains—including the RDF, performance-based mechanisms for reimbursing health providers, and the Liberia Health Equity Fund—are discussed elsewhere in this document. In addition, efficiencies will also be made through a shift in emphasis from curative services to disease prevention and health promotion services, through intense efforts to encourage households to

"create health at home." This shift will be reinforced through a community health worker initiative, as it is cheaper to maintain health than to repair it once it compromised. Furthermore, efficiency gains are anticipated from addressing the existing inefficient areas in the sector which include absenteeism of staff at health facilities, stock-outs of commodities, expiry of drugs, limited growth in infrastructure that is not matched to need and not matched to the availability of other key inputs, and the absence of equipment that is not aligned to need and/or suited to the country's context. Resources raised from efficiency gains will be channeled through the appropriate financing mechanisms.

Establishment of single income and risk pool for proposed LHEF: In the long term, the MOH aims to establish the LHEF, as articulated in the NHPP. In the short-to-medium term, systems for implementing the LHEF will be put in place through mechanisms of the RDF (to reduce supply chain inefficiencies) and PBF (as a strategic purchasing mechanism for the LHEF), and any additional implementation activities not feasible in this period will be implemented in subsequent periods. The LHEF will provide the legal framework for an overall pool that will bring together resources from the different insurance schemes, with the view to facilitate income and risk cross-subsidization and to permit effective strategic purchasing of the same essential benefits package for all. Having established different health insurance schemes, it will be necessary to reduce the fragmentation of these pools to ensure income and risk cross-subsidization, strengthen regulation of private health, and limit distortionary effects of voluntary health insurance on equity and efficiency through monitoring benefit packages services provided and pricing.

Figure 4: Illustration of proposed pooling to reduce fragmentation in resources and risk pools



4.3 Strategic Intervention 3: Strategic Purchasing of Defined Health Benefit Package

Except for the pilot PBF schemes, other purchasing arrangements in Liberia do not have explicit incentives in place to encourage equity, efficiency, and provision of quality services. To achieve strategic purchasing, MOH will implement interventions aimed at addressing these challenges. These interventions are described briefly in this section and are summarized in subsequent sections to improve the alignment of payment systems with benefit entitlements and data use to improve strategic purchasing across the health system.

Build institutional capacity for strategic purchasing
The MOH shall build capabilities for health financing activities to accelerate UHC. Building on the Health Systems Strengthening Accelerator Studies on Liberia Capacity Building for Health Financing, the MOH and its stakeholders proposed a high-level training workshop for MOH policymakers and a Health Financing Fellowship for Health Financing Technicians learning from the idea of the Health Financing Capacity Building Initiative (HFCBI) to address the generic health financing capability gap present in many low- and middle-income countries. The HFCBI model will bring together excellence in global expertise and local potential to build top-quality health financing capabilities tailored to the Liberian context.

Performance-based financing
The desired direction for the GOL is to move toward PBF. In the short term, providers of services will be remunerated based on the quality and volume of services offered. Action will be taken to develop the institutional capacity of the MOH and providers to implement a national approach to PBF and contracting mechanisms. PBF will be scaled up to link payments to outputs and even outcomes (incentives at both facility and county levels) including indicators for quality of care. The process of setting up the structures and mechanisms required for PBF will draw lessons from previous PBF pilots of the World Bank and USAID/FARA projects (including both supply-side and demand-side options). Details relating to the harmonization and scale-up of PBF are articulated in the PBF operational manual.

Purchasing community health worker (CHW) services through PBF: The GOL shall introduce a mechanism through which CHWs will obtain incentives by producing predetermined results after duly contracting with the health facilities through the community PBF program. In this approach, health facilities incorporate the contracting and payment of incentives of CHWs within PBF at the facility level. Performance pay of the CHWs will work within the same financing structure as the rest of PBF, thus independent monitoring of performance by the National Verification Agency or similar structures.

Purchasing services through the National Community Health Service Program
The MOH shall achieve the institutionalization and sustainability of the National Community Health Services Program by increasing the government's oversight and management of all aspects of the Program. To do so, it shall ensure adherence to the 'One County, One Partner' strategy -with distinct, non-overlapping geographic coverage and a single implementing partner in each county- and it shall increase domestic financial contribution overtime through the design and implementation of a National Community Health Service Program transition plan. Moreover, the MOH shall lead donors and implementing partners to standardize purchasing and payment mechanisms, develop a common approach for costing the Community Health Program in all counties, and increase visibility and transparency of program costs to ensure that the program components in all counties are aligned with the relevant policy. The development of the costed plan/roadmap will be the basis and will provide the framework to achieve the recommendations.

Development of benefits package: One of the objectives of this financing strategy is to facilitate the process of determining a package of essential health services that will be purchased. The objective of the MOH is to have a uniform essential package across different pools from the outset. In the long term, as the sector achieves an integration of resource pools, MOH shall move toward expanding the essential package to a uniform, comprehensive package for all people, across all resource pools.

Purchasing services for counties and health facilities
Implementing the above-proposed strategies will require that the service provider receive and manage payments. The MOH will harmonize provider payment mechanisms and rates within and across purchasers to ensure that coherent incentives go to the service providers. For now, the main purchasers are the implementers of the PBF projects, but this could also be extended to insurance schemes or be taken over by the Health Equity Authority of Liberia (HEAL) when enacted into law. For efficiency and to achieve the benefits of economic multiplier effects, the MOH will institute the following:

- Establish administrative mechanisms to routinely monitor the price and quality of care provided in both the private and public sectors (address potential over- or under-provision).
- Improve provider autonomy with appropriate mechanisms for financial and output/programmatic accountability upon implementation of fiscal decentralization.
- Improve governance of information on strategic purchasing to address questions, including for whom to buy, what to buy, from whom to buy, how to pay, and how much to pay.
- Establish procurement units responsible for planning, processing, supply chain management, warehousing, and distribution within the counties once decentralization has been implemented.
- Establish data systems that track information pertaining to strategic purchasing and outcomes that would allow monitoring of the price and quality of care provided in both the private and public sectors.
- Any other goals that are proper and necessary for the achievement of strategic purchasing.

Figure 5: Purchasing services and payment design in short term and in medium-to-long term

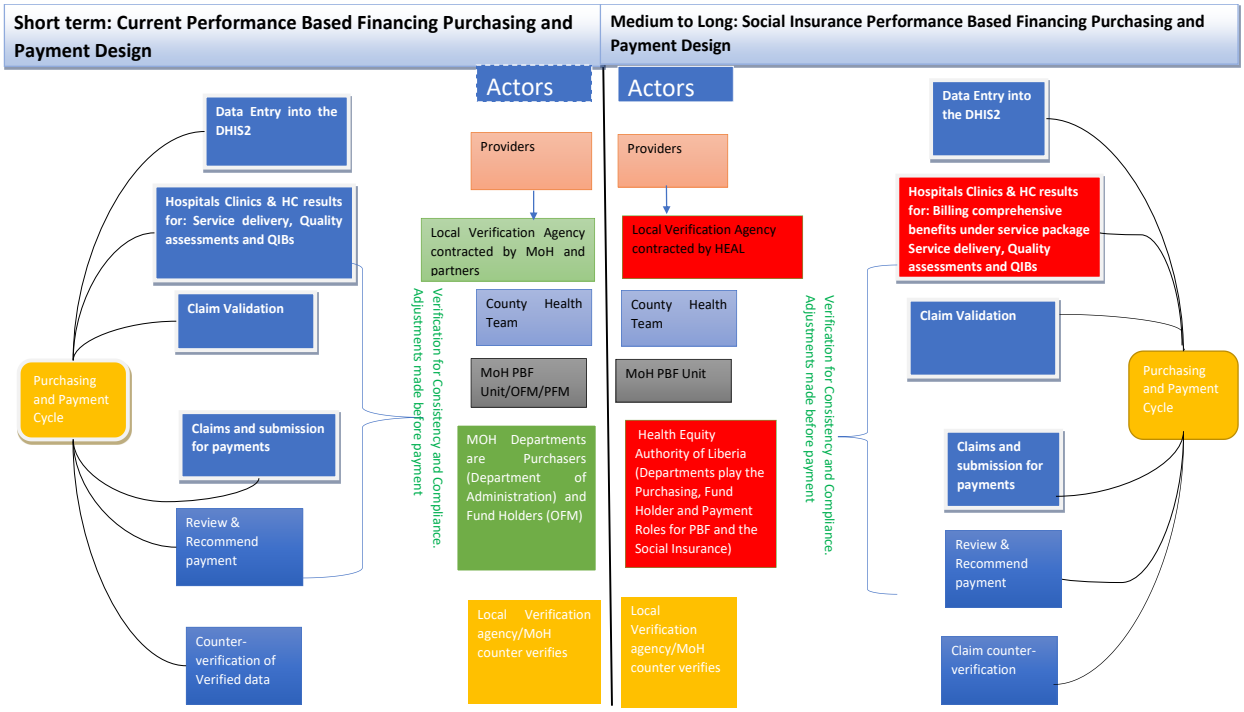


Table 3: Priority interventions for strategic purchasing

Area/ strategy	Priority intervention	Milestone	Responsible institution	Outcome
Improve alignment of payment systems with benefit entitlements	Scale up results-based financing to link payments to outputs and outcomes (incentives at both facility and county level), including indicators for quality of care	PBF scaled up to all counties covering all facilities LHEF roll-out in phases covering all counties	MOH, donors, MFDP, HEAL	Payment systems with benefit entitlements aligned

Area/ strategy	Priority intervention	Milestone	Responsible institution	Outcome
and data use to improve strategic purchasing across the health system	Harmonize provider payment mechanisms and rates within and across purchasers to ensure coherent incentives; for now, the main purchasers are the implementers of the PBF projects, but this could also be extended to insurance schemes	Harmonized national PBF manual developed and disseminated The LHEF Act enacted HEAL established	MOH, donors, MFDP, national legislature	-Provider payment mechanisms harmonized - The LHEF/HEAL bill passed
	Establish administrative mechanisms to routinely monitor the price and quality of care provided in the private sector (address potential over- or under-provision)	Framework for governance and regulation of private sector service providers Monitoring framework for prices and quality developed with private sector providers and applied Data system developed that can periodically capture relevant information to review and analyze from health facilities and region	MOH, donors, MFDP, HEAL	Administrative mechanisms to routinely monitor price and quality established
	Improve provider autonomy with appropriate mechanisms for financial and output/programmatic accountability upon implementation of fiscal decentralization	Conditional grant frameworks with clear guidelines of access and use of transfers from national to county developed	MOH, MFDP, HEAL	Provider autonomy improved
	Improve governance of information on strategic purchasing to address questions, including for whom to buy, what to buy, from whom to buy, how to pay, and how much to pay	Harmonized platform to monitor indicators of purchasing for all actors in the health sector established	MOH, MFDP, HEAL	Governance of information on strategic purchasing improved
	Strengthen units responsible for Procurement planning, processing, supply chain management, warehousing, and distribution	Relevant units trained within the counties	MOH, HEAL	Relevant units strengthened within the counties once decentralization has been implemented

4.4 Strategic Intervention 4: Planning, Budgeting, Execution, Accountability, and Reporting

Addressing PFM bottlenecks toward effective allotment, disbursement, and utilization of public resources will remain a core area of focus within this period. The focus will be on ensuring the formulation of result-oriented health budgets that are aligned to the strategic plans and are implemented in an efficient, equitable, and transparent manner within the country's PFM systems. The focus of this work will be on ensuring continuity on the issues identified.

Table 4: Priority interventions for improving planning, budgeting, accountability, and reporting

Area/ strategy	Priority intervention	Milestone	Responsible institution	Outcome
Strengthen the formulation of result-oriented health budgets that are aligned to the strategic plans and are implemented in an efficient, equitable, and transparent manner within the country's PFM systems	Develop a resource allocation formula to ensure equity, especially for external funding	• Resource allocation formula developed	MOH, MFDP	• External funding linked to health outcomes • Improved efficiency • PHC incentive scheme to improve efficiency instituted
	Transition to implementation of program-based budgeting	• Program-based budgeting system developed and presented by the program • Training conducted on the use of the program-based budgeting system	MOH lead, MFDP	• Budgets are aligned to priorities • Budget rigidities are minimized • Managerial autonomy for program budgets instituted
	Develop capacities at the national and county health division, district, and facility levels	• Training conducted on PFM processes for national and county staff	MFDP, MOH	• Decentralized health sector management achieved • Planning, budgeting, purchasing, and financial management contained in the decentralization policy adhered to
	Design intergovernmental transfers in the implementation of fiscal decentralization	• Develop guidelines for disbursement and use of intergovernmental transfers • Develop, monitor, and evaluate the framework for intergovernmental fiscal transfers • Conduct monitoring and reporting on the transfers	MOH, MFDP	Alignment of priorities at the central and district levels achieved
	Reduce bureaucracies in the authorization/ approval process in spending	• Bureaucracies (approval processes, number of signatories, turnaround time) and authorization/approval process in spending within the OFM are reduced	MOH, MFDP	Bureaucracies in the authorization/approval process are reduced

Area/ strategy	Priority intervention	Milestone	Responsible institution	Outcome
	Promote routine reporting and analysis of financial data	• Timely quarterly reporting • Timely analysis of financial reports	MOH, MFDP	• Efficiencies between the OFM and other programs improved • Efficient utilization of resources • Reports are analyzed to inform future planning
	Strengthen accountability mechanisms	• MOH team trained on financial management and accountability • MOH team oriented on revised financial management manual	MOH, MFDP	• Liquidation processes improved • Improved transparencies in financial management • Timely disbursement facilitated

5. IMPLEMENTATION ARRANGEMENTS

This section outlines the implementation arrangements for the HFS and includes institutional arrangements and governance mechanisms required for successful implementation and a brief description of roles. It also identifies the required legal and regulatory reforms needed to ensure that the identified strategic interventions are implemented.

5.1 Roles of Institutions

The **MOH** has the mandate to coordinate all stakeholders involved in financing health services. In particular, all relevant structures within the MOH will participate in different aspects of implementing HFS. This includes key directors, technical working groups, policy advisory groups, senior management teams, and others.

To accomplish this, the **HFU** was established within the MOH to implement the HFS. This unit will maintain the necessary expertise to fulfill its core functions, which include policy development, health economics, health insurance, and PBF, among others. Some of the specific duties of the HFU include:

- Conducting studies and surveys of financing programs and their impact, in coordination with the MOH's Research Unit
- Coordinating the implementation of pilot programs related to health and 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 MOH's Office of General Counsel (OGC)
- Ensuring adherence at all levels to the financing policy and strategic plan and coordinating its implementation
- Coordinating donor support for health and financing, in collaboration with the MOH's External Aid Coordination Unit
- Communicating with other branches of GOL 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

Other Line Ministries and Government Agencies: The multi-sectoral approach which has been emphasized in health policies and plans will guide the implementation of the HFS. In addition to the MOH, other line ministries and institutions of government will be crucial in implementing the HFS. Some of the key institutions include the National Legislature, MFDP, Ministry of Gender Children and Social Protection, Ministry of Internal Affairs, Liberia Institute of Statistics, and Geo-Information Services (LIGIS), etc.

CHTs: The County Health Services will work with the county administration in ensuring the successful implementation of the reforms. All other structures within a county will participate in the implementation of the reforms, where deemed necessary.

Some institutions will be established and/or operationalized to enable the successful implementation of the HFS. They include:

PBF Unit: This is already established within the Department of Health Services in the MOH. The PBF Unit is responsible for the purchasing sub-function and performing coordination of PBF activities within the health sector. It will be composed of a team of experts with relevant skills in PBF, health financing, actuarial science, etc. In the short-to-medium term, the PBF Unit will advise the MOH on the package of services to be purchased. In addition, they will work with other relevant structures to develop standards for service provision and be involved in the enrollment of providers from whom services will be purchased.

The **fund holder** is responsible for the disbursement of funds to service providers. In the short-to-medium term, the fund holder will be the government through the MOH/OFM, a donor, or the private sector (NGO, private donations). In the long term, the fund holder will be the MFDP.

Health Equity Authority of Liberia (HEAL): The structures for the National Health Insurance scheme are described in the draft LHEF Legislation. The HEAL will be a corporate body with perpetual succession powers. This entity will be governed by a Board of Directors constituted by the LHEF Legislation. The Board of Directors shall:

- Determine the policies of the scheme
- Ensure the effective implementation of the policies of the scheme
- Carry out any other lawful functions that may be necessary for purposes of achieving the objective of the scheme

The Board of Directors shall recommend to the President, the Director-General, and the two principal Deputies for the appointment. The Director-General of the scheme shall have the necessary training and experience in health insurance, health financing, institutional management, or the provision of health care services. With the approval of the Board of Directors, the Director-General shall recruit other officers and employees as may be deemed necessary for the proper and efficient discharge of the functions of the scheme.

5.2 Governance and Coordination Mechanisms

Health Development Partners (HDPs): The HDPs have a critical role in the transition from free health care to sustainable health financing. They will do this by increasing institutional capacity, reducing the transaction costs associated with managing multiple donor projects, and fostering the leadership of the MOH by allocating funds to national priorities in financing the sector. Accordingly, HDPs will have a pivotal role in the implementation of some of the financing reforms, particularly those that relate to coordination, harmonization, and alignment the health policies.

National Health Financing TWG: The MOH has established a TWG for National Health Financing that reports to the Minister of Health through the Deputy Minister of Policy and Planning, and Monitoring and

Evaluation (M&E). Additionally, the TWG makes a report to the Health Sector Coordinating Committee and the Health Coordination Committee. The HFU serves as a secretariat to the TWG. The main duties of the TWG are to:

- Provide support to the MOH in maintaining a policy framework for adequate, sustainable health and 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 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 are maintained with all public, private, and civil society stakeholders involved in health and social welfare financing

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

5.3 Laws and Regulations

The implementation of the HFS will require establishing an enabling legal and regulatory framework. The key reforms are outlined below.

- Legislation for the LHEF that establishes an institutional framework for operationalization, resource mobilization, risk pooling, strategic purchasing mechanisms, population targeting, and selection of beneficiaries (the legislation will also enable the establishment of the HEAL as the implementing agency for the LHEF)
- Establishment of a Fund as a mechanism for health emergencies through regulation
- Legislation for the establishment of the RDF and cost-recovery scheme regulations to provide health facilities (individual or through a network) autonomy to receive and spend resources for procurement of medicines and essential supplies.

5.4 Mechanisms for Transparency and Accountability

The GOL and all stakeholders shall ensure that health financing decision-makers are accountable for the transparent use of health resources under the following mechanisms

- The sector-wide approach to enabling the public to understand how decisions are taken
- Accountability in resource utilization and results achieved (to this effect, all resources—internal and external, public and private—shall be judiciously monitored, accounted for, and transparently reported)
- A monitoring system, designed to enable stakeholders to verify adherence to laws regulations, and applicable health financing principles

5.5 Risk Assessment and Mitigation

Implementation of the identified strategies will not be without some risks that may threaten the attainment of the intended goal. Below are the major risks and the mitigation strategies.

- Fiscal decentralization: Although the planned implementation of fiscal decentralization will come with advantages—including but not limited to making service delivery responsive to the population—it will also come with some challenges. The key risk will be increased delays in the flow of funds due to the addition of another layer (county level) and potential leakage as resources flow through different levels. This risk will be mitigated by ensuring the design and implementation of intergovernmental transfer frameworks which shall be routinely reviewed and any bottlenecks to predictability and timeliness of resources addressed.
- Continuing reduction in donor funding: There has been a pattern of decreasing donor funding for the health sector since 2015. Given the effect of COVID-19 on the global economy, the contribution of donors to health financing—which remains very critical given the limited fiscal space—is likely to be further affected. To mitigate this challenge, the government continues to explore avenues for increasing domestic financing for health. In addition to this, the government continues to reduce vertical program implementation which exacerbates inefficiency in the use of scarce resources.
- Implementation of PFM reforms: Effective use of available public resources depends on having well-established systems for PFM. Liberia has been in the process of the roll-out of PFM reforms focusing on improving planning/budgeting, execution, and accountability and reporting. The risk is with regards to slow/no implementation of these reforms or the likelihood of misalignment of the PFM reforms and health financing arrangement. Addressing this risk will require the MOH to work collaboratively with the MFDP in the roll-out of PFM reforms.
- Emergencies and pandemics: In the past decade, Liberia has faced immense shock as a result of the EVD epidemic and more recently COVID-19. The country remains at immense risk due to these emergencies and mitigation will include actions toward building health system resilience through strengthening public health functions. On the financing side, this will not only require directing funding toward strengthening these functions but also putting in place mechanisms for emergency funding.

5.6 Communication and Advocacy

Appropriate and effective communication is an enabling factor in ensuring the successful implementation of the Health Financing Policy. The communication strategy will be an integral element in implementing the HFS. The advocacy strategy will aim at creating linkages between the strategic and operational levels and seek to sensitize all stakeholders by:

- Ensuring that all stakeholders are fully informed about and understand the HFS
- Securing buy-in from stakeholders to encourage their effective participation in the implementation of the HFS
- Enhancing strategic consultation with agencies in achieving set outcomes

One of the key documents to facilitate HFS implementation is a detailed communications plan with stipulated actions, timing, and responsibilities. Its development will be preceded by a communications audit that will be used to establish the existing channels of communication, who they reach, and how effective they are. The audit will also outline the key and secondary target audiences and spell out each stakeholder's communication goals and objectives. The communication plan will articulate the following:

- The key messages for communicating to the relevant stakeholders
- The method by which these key messages are communicated to key stakeholders
- The actions required for the implementation of the strategy and the communication roles

- Resources needed to undertake the communication tasks
- Communication risks
- Methodology and time frame for evaluating the effectiveness of communication

6. MONITORING AND EVALUATION

Following the National Monitoring and Evaluation Policy and Strategic Plan, this HFS will link with the IFMIS and become part of the health information system. The health management information system will map resources in ways that will allow stakeholders to study how resources are allocated and utilized across levels of care. This communication is between central and peripheral administrative bodies, between urban and rural areas, and among counties. This will influence policy discussion pertaining to equity, efficiency, decentralization, and adherence to the PHC approach. The following monitoring stages are earmarked to be carried out by different stakeholders during the implementation of this strategy.

- The Health Financing TWG will meet at least quarterly to monitor the implementation of the policy and strategy, and adjust plans as necessary. For the TWG to accomplish this function, the HFU will provide TWG members with copies of all surveys, studies, and annual reports for review.
- The M&E Unit of the MOH will support the HFU in monitoring and evaluating the implementation of the HFS.
- A Resource Mapping and Expenditure Tracking exercise will be completed annually by the MOH to assess the financial landscape and make programmatic and budgetary decisions.
- The National Health Accounts survey and reporting process will be institutionalized within the MOH and carried out every two years.
- Arrangements will be made with the Liberia Institute of Statistics and Geo-Information Services to ensure that there is a component on health expenditure in all relevant population-based surveys to inform monitoring of this policy.
- In addition to the annual written progress report, HFU will make regular presentations to the MOH's Program Coordination Team and MOH SMT, and at the National Health Review Conferences on progress made in implementing this strategy.
- The MOH will undertake a mid-term and end-of-term review of the implementation of the Health Financing Policy and Strategy. It is important to note that to ensure coherence in addressing findings from evaluation exercises across the health system, evaluations will be undertaken jointly with the HFU.

Objectively verifiable quantitative indicators

The HFU will work closely with the M&E Unit to monitor indicators for the implementation of this strategy. Potential indicators by objective or the main focus of monitoring are:

- Adequacy of financing
- Equity/fairness in contribution
- Sustainability of resources
- Equity and efficiency in utilization
- Financial risk protection

The indicators for measuring these dimensions are further categorized into input, process, output, and outcome. The source of data and frequency of collection for each indicator are summarized in Table 5 below.

Table 5: Health financing key indicators

Indicators	Indicator category	Indicator definition	Measurement	Data source	Frequency of collection	Baseline	Target
Government expenditure on health as a percentage of total government expenditure	Revenue Collection	**General government expenditure on health**: The sum of health outlays paid for in cash or supplied in-kind by government entities, such as the MOH, other ministries, parastatal organizations, or social security agencies (without double counting government transfers to social security and extra-budgetary funds). It includes all expenditures made by these entities, regardless of the source, so includes any donor funding passing through them. It includes transfer payments to households to offset medical care costs and extra-budgetary funds to finance health services and goods. It includes current and capital expenditure. **General government expenditure**: Includes the consolidated outlays of all levels of government: territorial authorities (central/federal government, provincial/regional/state/district authorities, municipal/local governments), social security, and extra-budgetary funds. The revenue base of these entities may comprise multiple sources, including external funds and loans. It includes current and capital expenditure.	**Numerator**: General government expenditure on health **Denominator**: General government expenditure	National Health Accounts (NHA); WHO Global Health Expenditure Database	Yearly	10%	15%
Per capita public health expenditure (US$)	Revenue collection	**Total public government expenditure on health**: The sum of all outlays for health maintenance, restoration, or enhancement paid for in cash or supplied in-kind.	**Numerator**: Total expenditure on health **Denominator**: Total population	NHA (for numerator); UN Population Division (for denominator)	Every 2 years		Health Sector Policy and Plan (US$1,250,126,322) or $296 per person, and benchmark estimates for delivering an essential package for UHC (US$112)

Indicators	Indicator category	Indicator definition	Measurement	Data source	Frequency of collection	Baseline	Target
The percentage of indigents benefiting from the LHEF	Risk Pooling – Financial Risk Protection	**Indigents**: Total number of persons who, despite the dire need for health services, are deemed as being extremely poor and therefore incapable of financing the cost of their health needs. **LHEF**: The Liberia Health Equity Fund is a mechanism of social protection providing improved access to health services for the poor.	**Numerator:** Total number of indigents benefiting from health services through the LHEF **Denominator:** Total number of clients/patients identified as being indigent	Social Registry	Yearly	0%	100%
The percentage of indigents benefiting from the RDF through fees exemption	Risk Pooling – Financial Risk Protection	**Indigents**: Total number of persons who, despite the dire need for health services, are deemed as being extremely poor and therefore incapable of financing the cost of their health need. **RDF**: A regulated mechanism for improving instantaneous access to drug and medical supplies through a regulated user fee system.	**Numerator**: number of clients classified as indigent and benefiting from the RDF program through targeted fees exemption **Denominator**: Total number of indigent accessing health services during the period	Social Registry	Yearly	0%	100%
The percentage of indigents benefiting from the PBF	Risk Pooling – Financial Risk Protection	**Indigents**: Total number of persons who, despite the dire need for health services, are deemed as being extremely poor and therefore incapable of financing the cost of their health need. **PBF**: PBF is a systems approach with an orientation on results defined as quantity and quality of service outputs **and inclusion of vulnerable persons**. This approach entails making facilities autonomous agencies that work for the benefit of health or education related goals and their staff. It is also characterized by multiple performance frameworks for the regulatory functions, the contract development and verification agency, and community empowerment. PBF applies market forces but seeks to	**Numerator**: Number of clients classified as indigent and benefiting from the PBF program through targeted fees exemption **Denominator**: Total number of indigent accessing health services during the period	Social Registry	Quarterly	0%	100%

Indicators	Indicator category	Indicator definition	Measurement	Data source	Frequency of collection	Baseline	Target
		correct market failures to attain health or other sector gains. PBF at the same time aims at cost-containment and a sustainable mix of revenues from cost-recovery, government, and international contributions. PBF is a flexible approach that continuously seeks to improve through empirical research and rigorous impact evaluations, which lead to best practices.					
OOP health expenditure as % of THE	Risk Pooling – Financial Risk Protection	**OOP expenditure:** The expenditure on health by households as direct payments to health care providers. It should be netted from reimbursements from health insurance. **Total expenditure on health:** The sum of all outlays for health maintenance, restoration, or enhancement paid for in cash or supplied in-kind.	**Numerator:** Total OOP expenditure on health **Denominator:** Total health expenditure	NHA	Yearly	35%	0%
Incidence of catastrophic health expenditures at the 10% threshold of household consumption expenditure	Risk Pooling – Financial Risk Protection	**OOP expenditure:** The expenditure on health by households as direct payments to health care providers. It should be netted from reimbursements from health insurance. **Catastrophic threshold:** Health spending is considered catastrophic when a household must reduce its basic expenditure over a period of time to cope with health expenditures. There is little consensus on the threshold for catastrophic health care payments. One benchmark used by the WHO and the World Bank is OOP spending that exceeds 25% of non-food income. Two other commonly used thresholds are OOP spending that exceeds 10% of total income or 40% of non-food income. Total consumption or total household	**Numerator:** Number of households spending more than a specified percentage of their income or expenditure on health (based on country, the specific threshold for catastrophic expenditures) **Denominator:** Total number of households	Population-based surveys (e.g., the Living Standards Measurement Survey), World Bank Adept software program	Yearly	Unknown	0%

Indicators	Indicator category	Indicator definition	Measurement	Data source	Frequency of collection	Baseline	Target
		expenditure is typically used as a proxy for income in the denominator.					
Per capita public health expenditure (US$)	Risk Pooling – Financial Risk Protection	**General government expenditure on health as a percentage of total government expenditure**: This indicator is defined as the level of general government expenditure on health expressed as a percentage of total government expenditure. It shows the weight of public spending on health within the total value of public sector operations. This indicator includes not just the resources channeled through government budgets, but also the expenditures channeled through government entities for health by parastatals, extra-budgetary entities, and, notably, compulsory health insurance. The indicator refers to resources collected and pooled by public agencies, including all revenue modalities.	**Numerator**: Share of GDP for health **Denominator**: Total health spending and in US$ per capita (using economy-wide PPPs)	NHA	Every 2 years		Health Sector Policy and Plan (US$1,250,126,322) or $296 per person, and benchmark estimates for delivering an essential package for UHC (US$112)
The proportion of external assistance as a proportion of total health expenditure (%)	Risk Pooling – Financial Risk Protection	**External resources**: The sum of resources channeled to health by all non-resident institutional units that enter into transactions with resident units or have other economic links with resident units, explicitly labeled for health or not, to be used as a means of procuring health goods and services or as an investment in capital goods by financing agents in the government or private sectors. They include donations, loans, cash, and in-kind donations. **Total expenditure on health:** The sum of all outlays for health maintenance, restoration, or enhancement paid for in cash or supplied in-kind.	**Numerator:** Total expenditure on health spent by external sources **Denominator:** Total expenditure on health	NHA	Every 2 years	50%	NA

Indicators	Indicator category	Indicator definition	Measurement	Data source	Frequency of collection	Baseline	Target
Amount of resources from efficiency gains	Strategic Purchasing	Improving efficiency through strategic purchasing of services and increased financial autonomy for facility managers.	**Numerator**: Number of public health facilities with financial autonomy **Denominator**: Total number of public health facilities	MOH Financial Reports	Quarterly	0%	100%
Introduction of LHEF	Risk Pooling – Financial Risk Protection	Establish single income and risk pool for proposed LHEF to ensure income and risk cross-subsidization.	LHEF legislation established	Legislature	NA	NA	NA
Scale-up of PBF	Strategic Purchasing	Scale up results-based financing to link payments to outputs and outcomes (incentives at both facility and county levels), including indicators for quality of care.	**Numerator**: Number of health facilities (both private and public) implementing PBF **Denominator**: Total number of health facilities	PBF Management Tool	Quarterly	294 (41.5%)	708 (100%)
Introduction of RDF	Resource Collection	Implement the planned RDF; there is a need for mechanisms to determine rates and approaches to charging those balances cost-recovery goals (sustainability and affordability) and ensure there is a definition of target groups/services that will be exempted.	**Numerator**: Number of health facilities (both private and public) implementing RDF **Denominator**: Total number of health facilities	Logistics management i nformation system (LMIS) and electronic LMIS	Quarterly	0%	100%
Proportion of the population enrolled any in health insurance schemes	Risk Pooling – Financial Risk Protection	Percentage of population who reported being covered by any type of health insurance program.	**Numerator**: Number of population currently enrolled in a health insurance **Denominator**: Total population	DHS, NHA, Social Registry	Yearly	4% of women and 7% of men aged 15–49 have any type of health insurance	100% of women and 100% of men aged 15–49 have any type of health insurance
Proportion of the population	Risk Pooling – Financial	Percentage of population who reported being covered by the social health insurance program (under the LHEF).	**Numerator**: Number of population currently	DHS, NHA,	Yearly	0%	100%

Indicators	Indicator category	Indicator definition	Measurement	Data source	Frequency of collection	Baseline	Target
covered by LHEF	Risk Protection		enrolled in the social health insurance program **Denominator**: Total population	Social Registry			
Proportion of indigents covered by insurance	Risk Pooling – Financial Risk Protection	Percentage of indigent population who reported being covered by the social health insurance program (under the LHEF).	**Numerator**: Number of indigents benefiting from the social health insurance program **Denominator**: Total indigent population	DHS, NHA, Social Registry	Yearly	0%	100%

Qualitative indicators of reform implementation.
To understand and explain the pattern of change in the quantitative indicators, we will also undertake qualitative monitoring. For system-level monitoring, we will rely on the health financing progress matrix which will be done every two years to assess progress toward achieving the desirable financing attributes.

The qualitative indicators will build on both facility-based quality and community verification indicators within the PBF mechanism. This means that the indicators are easy to verify and will produce the same results when two independent verifiers conduct the same evaluation. Qualitative reviews will include the full scope of the EPHS.

7. REFERENCES

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