Sierra Leone

Technical Note

Assessment of Health Insurance Options for Sierra Leone

Assessment, conceptual remarks and recommendations

International Labour Office
Social Security Department
Geneva, September 2009

Sierra Leone. Technical note : assessment of health insurance options for Sierra Leone : assessment, conceptual remarks and recommendations / International Labour Office, Social Security Department. - Geneva: ILO, 2009
1 v.

ISBN: 9789221229513; 9789221229520 (web pdf)

International Labour Office; Social Security Dept

health insurance / health service / social security financing / evaluation / Sierra Leone

ILO Cataloguing in Publication Data

Printed in Switzerland

Foreword

This report focuses on the request for technical assistance on policy and actuarial aspects in the context of the extension of social health protection in Sierra Leone. It concentrates on the assessment of health insurance options with a view to achieving universal coverage and access to health services for the most vulnerable population as regards design, financing mechanisms, benefits and administration and reflects the intense discussions held in the country at the national and local level including a broad-based validation process.

It was agreed that two advisory missions would be carried out, the first focusing on the overall assessment of the current situation and developing core concepts for financing the extension of social health protection. It involved a field mission by the study team to rural areas, which provided insight into the extent and depth of the current level of social health protection and the potential impacts of a nationwide extension of social health protection.

Prior to the second mission, H.E. Mr Mansaray, the Minister of Employment and Social Security, informed the ILO in Geneva about the National Consultations for the Establishment of a National Social Health Insurance. Against this background, the second mission aimed to receive feedback from the in-depth validation process at country level.

The present report provides an analysis of key considerations and data publicly available that was obtained from discussions with high-level representatives of the government, the labour unions, the employer associations and the development community active in social health protection.

Contents

Page

Foreword iii

List of Acronyms ix

Acknowledgements xi

1. Summary 1
   Key elements of the design 1

2. Background, Tasks, Activities and Methodology 5
   2.1. Background and tasks 5
   Sierra Leone: the country and its socio-economic and health background 6
   2.2. Activities 8
   2.3. Methodology 9

3. Conceptual Remarks 11
   Possible Options for Financing Health 11
   3.1. The ILO strategy on social health protection 11
   Coverage, access and affordability are at the core of the concept 13
   3.2. Beyond "pure" financing mechanisms 14
   3.3. The goals of health-care financing 15
   Providing quality services at the point of delivery 15
   Alleviating fears 15
   Improving quality 15
   Improving health status 16
   Building trust 16
   3.4. Rational use of pluralistic financing mechanisms 16
   3.5. Evaluation 17
   (I) Coverage 17
   (II) Access 17
   (III) Affordability and financial burden 18
   (IV) Quality 18

4. Service Provision, Health Financing and Perceptions in Sierra Leone 19
   4.1. The health care system 19
   Health system capacity indicators 20
   Public Health 21
   Health care planning 22
   4.2. Health care financing 23
   Sources of revenue / Paying for health 23
   User fees and access 23

The 2008 "Review of financing of health in Sierra Leone" 24
4.3. Public perceptions and fears 25
4.4. Discussions and interviews at central level 26
4.4.1. Government institutions 26
4.4.2. Local politicians and administration 26
4.4.3. NASSIT 28
4.4.4. Providers in Freetown and up-country 28
4.4.5. Unions and employees 29
4.4.6. NGOs 30
4.4.7. Private health insurers 31
4.4.8. Donors 32
5. A Plan for Health-Care Financing in Sierra Leone 33
5.1. The advantages of the proposed approach: combining a community-based approach with national technical pooling and capacities 34
5.2. SLeSHI governance and management 36
Governance 36
Management at the central level 37
Management at the local level 37
5.3. Division of labour between SLeSHI, the MoHS, and local institutions 40
5.4. Population coverage and benefit package 40
5.5. Revenue: sources and collection 42
A percentage from the salaries of the formally employed 42
A contribution from ALL economically active adult Sierra Leoneans 43
A percentage from the GST / VAT 43
The budget allocated by the MoF to local councils for curative health care 44
A percentage of the funds of the Social Safety Net Fund 44
Additional funding from consumption taxes 44
5.6. Types of care covered and referral 44
Referral scheme and gate-keeping 45
5.7. Eligibility and identification 45
5.8. Active purchasing and quality management 46
Accreditation 46
Human resources 46
Costing 46
Equipment 47
Provider payment, reimbursement and claims administration 47
Monitoring and quality control 47
5.9. Provider capacity nationwide 48
Infrastructure 48
Human resources 50
Reasons cited for high attrition in the public health sector 50
Throughput and other indicators 50
Training and capacity-building 51

5.10. Refining key elements of the emerging SLeSHI and feasibility study 52
Component 1: Legal framework 54
Component 2: Administrative setup 54
Component 3: Technical components 54
Component 4: Connecting with the field 55
Cross-cutting issues 55
5.11. Getting the message across: IEC and general training needs 55
National social dialogue 56
5.12. Limitations and open questions 57

6. Preliminary Actuarial Assessment of SLeSHI 59
6.1. Country macroeconomic context 59
Macroeconomic conditions in Sierra Leone: recent trends 59
Fiscal situation and the structure of the Sierra Leonean tax system 60
6.2. Population, insured persons, contributors and contributions 61
Contributors and contributions 62
6.3. Expenditure assessment: various scenarios 63
Benefits and expenditure 63
Costing medical services 65
6.4. Overall assessment of SLeSHI in 2008 67
6.5. Institutional framework for targeting and contribution collection 68

7. Next Steps 69

8. Annexes 71
8.1. Actuarial calculations and key assumptions 71
8.2. SLeSHI: Suggested key features for legislation 71
8.3. ToR for the team of consultants 74
a. Joint tasks of the project team 74
Assessment mission 74
b. Specific tasks of the team leader 74
Debriefing mission 74
c. Specific tasks of the external collaborator 75
Timeline, activities and outputs 75
8.4. Schedule of mission to Sierra Leone 76
8.5. List of persons met 77
8.6. Activity Plan for National Social Health Insurance Scheme 79
8.7. Refining key elements of the emerging SLeSHI – a study in the rapid implementation of policies and plans 80
1. Description of the four components 80
2. Cross-cutting issues 87
3. Setup concerning the implementation team 88
4. Study arrangements 89

5. Milestones 91
6. Results framework, monitoring and estimated cost 91

List of Tables

Page

Table 1: Country and health data Sierra Leone 7
Table 2: Number of staff by specialty and distribution (selected) 21
Table 3: Public health output indicators 23
Table 4: Coverage in primary and secondary care 45
Table 5: Distribution of health facilities, hospitals and beds per district population 49
Table 6: Time taken to reach a district hospital from health centre 49
Table 7: Staff-to-population ratios 50
Table 8: Capacity and throughput statistics for selected hospitals 52
Table 9: Key macroeconomic indicators − selected years 60
Table 10: Contribution of various revenue sources to total revenue and fiscal deficits in Sierra Leone 2002-2007 61
Table 11: Earnings in the formal and informal sector by occupation 63
Table 12: Various population coverage scenarios 64
Table 13: Cost of care per capita at various levels of care 67

List of Figures

Page

Figure 1: General flow of funds 13
Figure 2: The health and poverty trap 15
Figure 3: Some impressions from the hospital visits 22
Figure 4: Overview of financing sources and membership cards in SLeSHI 33
Figure 5: Overview of the SLeSHI management structure 38
Figure 6: Management structure at the central level 38
Figure 7: Overview of the setup involving MoHS, SLeSHI and local institutions 40
Figure 8: Benefit package and population covered in various approaches 42

List of Acronyms

ALOS	Average length of stay
ART	Anti-retroviral therapy
CBHI	Community-based health insurance
C/EmOC	Comprehensive/Emergency obstetric care
CIB	Complaints and Investigations Bureau
DFID	Department for International Development
DHMT	District Health Management Team
DMO	District Medical Officer
DPs	Development Partners
EU	European Union
FBO	Faith-based organization
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoSL	Government of Sierra Leone
GST	Goods and services tax
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HR	Human resources
IEC	Information, education and communication
ILO	International Labour Organization
IMF	International Monetary Fund
IRCBP	Institutional Reform and Capacity Building Project
Le	Leones (Sierra Leonean currency)
m	million
MCHP	Maternal and child health post

MDG	Millennium Development Goal
MoESS	Ministry of Employment and Social Security
MoFED	Ministry of Finance and Economic Development
MoHS	Ministry of Health and Sanitation
MoSWG	Ministry of Social Welfare, Gender & Children's Affairs
MoU	Memorandum of Understanding
MRC	Medical Research Council
MSF	Médecins Sans Frontières
MTEF	Mid-Term Expenditure Framework
NASSIT	National Social Security and Insurance Trust
NGO	Non-Governmental Organization
NHA	National health accounts
NIC	National Insurance Cooperation
NRA	National Revenue Authority
PHC	Primary health care
PCMH	Princess Christian Maternity Hospital
PHU	Peripheral health units
PPP	Public-private partnership
PRSP	Poverty Reduction Strategy Paper
SHI	Social health insurance
SL	Sierra Leone
SLeSHI	National Social Health Insurance Fund
TBC	Tuberculosis
UNDP	United Nations Development Programme
US$	United States dollar
VAT	Value-added tax
WHO	World Health Organization

Acknowledgements

This report was drafted in the context of the ILO project on the "Preliminary assessment of health insurance options for Sierra Leone" requested by NASSIT by a study team composed of Konrad Obermann, Mannheim Institute of Public Health, Heidelberg University, and Professor at Steinbeis University Berlin, Germany, expert in the field of health policy and health financing, and Felix Massiye, health economist and actuary, Harvard University, USA, and Professor at the University of Lusaka, Zambia.

We would like to thank the ILO Social Security Department, Ms Xenia Scheil-Adlung, Health Policy Coordinator, who led the mission teams and provided important guidance, Ms Veronika Wodsak and Mr Thomas Wiechers, Health Policy Officers, as well as the peer reviewers for the extremely valuable advice provided; they all significantly supported the work. The report was further reviewed and approved by Ms Anne Drouin, Mr Hiroshi Yamabana and Mr Charles Crevier, and it has also been approved by Michael Cichon, Director of the Social Security Department.

We are especially grateful for the advice and insights provided by the President, His Excellency Dr Ernest Bai Koroma, His Excellency Vice-President Sahr Sam-Sumana, the Honourable Minister Mr Minkailu Mansaray, Minister of Employment and Social Security, the Honourable Minister Dr Kabia, Minister of Health, Mr Sheku Sesay, Financial Secretary of the Ministry of Finance & Economic Development, and Mr Allieu Sesay, Commissioner General of the National Revenue Authority.

We are very grateful to the most helpful support received from Mr Jacob S. Kanu, Chairman of the NASSIT Board, Mr Edmund Koroma, Director-General, Mr Sahr Ngayenga and Mr Gibril Saccoh, Deputy Directors-General, Mr Cyrill Jalloh, Mr Andrew Allieu and the NASSIT team, all of whom provided valuable advice. The regional NASSIT offices provided excellent hospitality and very useful data. Finally, we would like to thank the social partners for their important viewpoints as well as the various experts, civil society, the development community, and the most friendly people of Sierra Leone, whose willingness to cooperate and share information formed the basis of what we have been able to achieve.

The authors would like to emphasize the close cooperation and intense discussion with all of the different stakeholders, which eventually led to the proposed plan for a national social health insurance scheme (SLeSHI).

1. Summary

The **purpose** of this consultancy is to assess the policy options for social health insurance in order to address the low health status of the population and the severe impoverishing effects of ill health in Sierra Leone.

There is a very strong political will in the government to establish social health insurance and the population is willing to pay for quality health care. Particular emphasis is placed on **designing a universal, unitary national health scheme that covers the whole population including the poor**. The process is strongly supported and followed up by His Excellency the President of Sierra Leone. On the basis of their professional background in private insurance and positive experience with the existing pension scheme run by **NASSIT**, several government ministers took study tours to Ghana to learn about design and experience with the Ghanaian health insurance scheme.

A first assessment mission to Sierra Leone was conducted in September 2008 to obtain information on health financing and provision. Discussions were held with regional and central stakeholders on current gaps in health financing and provision and on possible ways to establish a new scheme. A second mission took place in June 2009 with a view to contributing to the National Consultative Conference.

The mission received crucial input and support from high-ranking government officials: the President, His Excellency Dr Ernest Bai Koroma, the Vice-President, His Excellency Sam Sumana Honary Mansaray, the Honourable Minister Mansaray, Minister of Employment and Social Security, the Honourable Dr Kabia, Minister of Health, the Honourable Mr Sheku Sesay, Financial Secretary of the Ministry of Finance & Economic Development, and Mr Allieu Sesay, Commissioner General of the National Revenue Authority. NASSIT and its Board Members, including the former Central Bank President, and representatives of the economy, unions and employers provided important insights and emphasized the importance of establishing a national insurance scheme.

Against this background and on the basis of the data available, desk and field studies conducted prior to the mission, and the preliminary results of actuarial evaluations, a tentative outline of a health financing mechanism emerged in the course of the discussions. Moreover, the significant ideas and proposals of providers, NGOs, and external donors were also crucial in the development of the proposed plan.

A **draft report** was submitted in December 2008. Regional stakeholder discussions and validation workshops were subsequently organized by the government in all districts of Sierra Leone during the first half of 2009. A **National Consultative Conference** was held in Freetown on 24 – 25 June 2009 to validate the proposal.

The following plan for a national social health insurance scheme reflects these extensive consultations and numerous valuable inputs.

Key elements of the design

A. **Ownership and governance**: An independent institution under the name of the Sierra Leone Social Health Insurance Fund (SLeSHI) operating at the national and district level and governed by a board representing all relevant stakeholders should be established under the supervision of the government. SLeSHI will have to be established by an act of parliament and relationships between SLeSHI, NASSIT and other relevant institutions will have to be guided by a Memorandum of Understanding (MoU). The combination of technical guidance at central level with local supervision

and decision-making is deemed essential for the wide acceptance and success of the scheme.

B. **Administration**: NASSIT will strongly support the new scheme by providing administrative staff and acting as facilitator in the setting up of SLeSHI; this will involve, for example, arrangements concerning office space, the sharing of experience in administrative procedures such as registration, the collection of contributions, the issuing of SLeSHI cards and the processing of claims. It was agreed that SLeSHI should initially be set up as an independent subdivision of NASSIT and should subsequently be separated from NASSIT after 5 years of operation. **SLeSHI's motto will be "Well-Bodi-Osusu" ("Health is Wealth")**. An initial outline of the administrative structure has been sketched and one key feature is the establishment of fully functioning local district offices with local oversight. Some core functions (standards, accreditation, quality management, pooling of funds, etc.) will be carried out centrally. There will be a Complaints and Investigation Bureau at both central and district level. Taken as a whole, the decentralized nature of the scheme will allow a combination of the advantages of local administration with those of economies of scale gained from having a national pool and unified national standards.

C. **Benefits** should include the provision of primary health care services that are reimbursed on a capitation basis and limited secondary care at district (referral) hospitals reimbursed on a fee-for-service basis. Traditional herbalists will also be covered for the treatment of a selected range of conditions. SLeSHI benefits will be **complementary to the established programmes** on malaria, HIV/AIDS, maternity care and other health issues. The details of the benefit package will be designed with a view to protecting against catastrophic health care costs, including, for example, coverage for caesarean sections and accidents. Tertiary care and public health activities such as sanitation, immunization and other preventive measures as well as vertical programmes will remain under the responsibility of the Ministry of Health.

D. It is suggested that, in close cooperation with the MoHS, the WB, UNICEF and other institutions, efforts be focused on achieving targeted quality improvement on a facility-by-facility basis, which would be funded through start-up outlay before the full rollout of SLeSHI. Further **quality improvements** will be addressed at various levels such as in accreditation processes and in the mechanisms for the purchase and payment of services and drugs. SLeSHI aims to link up with the activities of the MoHS that focus on improving staff management and addressing drug and health workforce shortage. Both public and private (profit-making and not-for-profit) institutions can apply for accreditation with SLeSHI.

E. **Coverage** is planned for the **whole population** including both formal and informal economy workers and their families, the poor and very poor, and children. The quality of care will be same for all members of SLeSHI. The details of exemption from payment of the "health contribution" and the details of how the contributions should be collected are still under discussion.

F. **Financing**: The introduction of SLeSHI will lead to an identical benefit package across the country. Financing will be done through both contributions and taxes/subsidies of SLeSHI. All economically active Sierra Leoneans will have to pay the suggested "**health contribution" of 10.000 Le per year**. Contribution waivers will be introduced for the very poor and other groups to be determined. The details of the waiver scheme (mode of identification, extent of waiver, execution) need to be discussed. The groups concerned will be identified at the district level. Furthermore, it emerged from the discussions that multiple domestic resources should be used – in addition to donor funds – including:

- redirection of the curative care budget, which is currently allocated by the Ministry of Health and Sanitation (MoHS) to local district hospitals, to SLeSHI

- 2-3 per cent of the general goods and service tax (which is set at 15 per cent) to SLeSHI

- a percentage of the social safety net funds implemented by the Ministry of Employment and Social Security(MoESS)

- replacement of the current employers' fringe benefits for medical care − amounting to 6 per cent of gross income − by a 4 per cent employer contribution and a 2 per cent employee contribution in the case of formal economy workers

- 3 per cent of VAT revenue.

G. Initial **actuarial evaluations** based on conservative assumptions point to the fact that pooling the above funds and making a sum available to cover limited start-up costs would make it possible to provide a uniform benefit package at the point of delivery for the whole population. The new scheme is expected to lead to significant reductions in impoverishment in the event of ill health and to improvements in the quality of services.

H. **Key assumptions** were needed with respect to population development, socio-economic development, interest rates and inflation, utilization rates and cost. For this we used as much available data (e.g. UN projections, official statistics and projections, recent comprehensive reports) as possible and favoured a conservative approach in general.

I. The **presidential keynote address** at the National Consultative Conference emphasized the need for a national insurance scheme, the importance of pre-payment and the national harmonization of local initiatives. SLeSHI is seen as a national programme rooted in local and community-based micromanagement.

J. The **government** (Ministries of Finance, Health and Employment) has indicated that the sources mentioned above seem to be acceptable for financing a national social health insurance scheme. National discussions between the government, NASSIT and donors on funding start-up outlay have already begun and funds are supposed to be available for the next phase of the reform of social health protection.

K. The **key elements** of SLeSHI **will be refined** in pilot districts, starting with a detailed study, which will be closely coordinated with donors' facility-upgrading activities (such as current World Bank and UNICEF initiatives) and will link up with activities of the Ministry of Health and Sanitation (MoHS) providing free prenatal care, public health programmes on HIV/AIDS and malaria and TBC programmes funded by various donors including the Global Fund, vaccination programmes funded by GAVI, drugs, improved staff management initiatives addressing the health workforce shortage, etc. It is planned that capacity building and staff training activities for SLeSHI as well as an advocacy and information campaign will be developed and implemented in due course. This would pave the way for the **implementation** of the scheme. An additional document on the forthcoming feasibility study work (**Refining key elements of the emerging SLeSHI – a study on the rapid implementation of policies and plans**) has been annexed to the present report; it addresses major elements to be specified and discussed as well as information needs, capacity building, timelines, and the need for external advice as well as feasibility and "proof of principle" testing.

L. In discussions with the **social partners** concerns were raised about the following issues: availability of quality services, cost impact on labour, and affordability for the poor. Donors raised the issues of geographical access and coordination between different donor activities relating to health-financing reforms. These issues need to be taken very seriously and will be addressed in work on the forthcoming feasibility study.

The final report has emerged from a number of inputs from various stakeholders in the country with the support of national and international experts. Nevertheless, the authors consider that the further development of this national comprehensive health-financing scheme should be kept as open and as participatory as possible. The needs, preferences and concerns of the population should serve as guidance and there should be room for innovations and new approaches.

There is a clear need for significant political and financial (donor) support to further develop and implement the proposal. Only a joint approach with all relevant stakeholders will allow the lasting success of such a major and radical shift in the financing of medical care.

Finally, it is hoped that this report can contribute to the development of a comprehensive national health-care system where everyone can receive good treatment without fear of impoverishment.

2. Background, Tasks, Activities and Methodology

2.1. Background and tasks

In 2008, the National Social Security and Insurance Trust (NASSIT) requested technical assistance from the ILO to assess health insurance options in Sierra Leone. The request was based on strong government interest and a Pilot Survey on Social Security Priorities and Needs conducted by NASSIT. The Survey revealed in particular that the poor segments of the population prioritize health-care needs. The Government/NASSIT and ILO agreed to conduct a preliminary assessment of health insurance options aiming to increase access to quality health services for the poor based on extensive consultations and technical studies. The study consisted of an initial mission to Sierra Leone in September 2008, socio-economic and actuarial studies that resulted in a first draft project report.

The mission team was led by Xenia Scheil-Adlung, ILO, and included Veronika Wodsak and Thomas Wiechers, ILO, Konrad Obermann, Mannheim Institute of Public Health, Heidelberg University, and Professor at Steinbeis University Berlin, Germany, expert in the field of health policy and health financing, and Felix Massiye, health economist and actuary, Harvard University, USA, and Professor at the University of Lusaka, Zambia. The ILO mission assessed all available studies and data including those from donor activities and followed up on the results of the MoHS study with concrete suggestions on financing mechanisms.

The resulting draft project report was peer-reviewed and discussed broadly at country level in the Ministerial Steering Committee, the Technical Committee on Health Insurance, various Regional Validation Workshops in all districts and national consultations involving His Excellency the President, cabinet ministers and parliamentarians, national and international experts, and representatives of the donor community. The National Consultations were held in June 2009 with ILO participation. This report reflects the inputs from the various stakeholders' forums.

The current health financing system is characterized by a post-war recovery phase which involves high out-of-pocket payments, low quality of services, shortage of drugs and lack of health infrastructure, mostly in rural areas, leading to inequalities in access to health services, and it thus has little positive impact on the health and poverty status of the population. However, following the peaceful democratic elections in 2007, improved macroeconomic performance and reconstruction efforts have led to positive socio-economic developments and the return of over 90 per cent of the refugees that fled the country prior to the war. Currently, there is an active donor community in Sierra Leone, which in the field of health care consists mainly of the World Bank, which is running a major programme to strengthen the health infrastructure and national health accounts, UNICEF and the WHO, which are focusing on maternal and child health and public health activities with the Ministry of Health, the Global Fund and GAVI. Besides these, many NGOs and bilateral donors are active in facility- or community-based activities, such as public health campaigns, facility upgrading, etc.

Recently the MoHS commissioned a review of health financing and the development of policy options by consultants[1]. The study concluded that transition to lower cost services

[1] Ensor, T., Lievens, T. & Naylor, M. (2008). Review of Financing of Health in Sierra-Leone and the Development of Policy Options, Final Report submitted to the Ministry of Health and Sanitation, Freetown, Sierra-Leone, June 2008. Oxford Policy Management

for the population is a key factor and suggested a facility-based approach. However, the question of financing mechanisms for this suggestion remained open and included a range of domestic funding (including both tax and premium/contribution funding) and external donor sources.

Against this background, the ILO project on the assessment of health insurance options in Sierra Leone conducted a mission in order to address the low health status of the population and the impoverishing impacts of ill health in Sierra Leone.

Sierra Leone: the country and its socio-economic and health background

The country and its economy

Sierra Leone is presently recovering from a brutal decade-long civil war, which displaced about one-third of the population. The economy has been rebounding strongly since the ceasefire despite a recent drop in growth rates − but 2007 still saw 6.8 per cent growth.

Many indicators point to very low development: the UNDP's Human Development Index shows Sierra Leone as one of the least developed countries in the world; Transparency International ranks the country at 158 out of 180; the Doing Business ranking lists Sierra Leone at 148 out of all countries surveyed.

The country became independent of British colonial rule in 1961. The administrative system is split into a central government, 19 local councils and 149 chiefdoms. Local governments are almost entirely dependent on allocations from the central government (>95 per cent) with very little leeway for local initiatives.

Sierra Leone is one of the poorest countries in the world with a per capita GDP of around 310 US$ (2004). Seventy per cent of the population live below the poverty line, with a vast difference between Freetown and the rural areas (15 and 79 per cent of the population living below the poverty line, respectively). Over 50 per cent of the population is undernourished.

Infrastructure was severely disrupted and underfunded during the war, and less than 10 per cent of the roads are paved. Electricity supply is erratic and per capita consumption of public power is negligible at 6kWh per capita/year. Unemployment is high, especially amongst young people, where the combined rate of underemployment and unemployment reaches 70 per cent (ILO report on the employment situation in Sierra Leone, 2008).

The current poverty reduction strategy paper (PRSP) for the period of 2008-2012 includes a priority on improving access to social services such as healthcare. They key strategies outlined in the PRSP include generating more financial resources for the health sector, achieving universal coverage of essential health services and improving the quality of providers and services. The PRSP contains a commitment of the government to setting up a "National Social Health Insurance Scheme that will ensure access and affordability of quality health care services to all Sierra Leoneans[2]"

Fiscal space is limited with revenues estimated at 10.8 per cent of GDP compared to a programme target of 13.6 per cent.

[2] Government of Sierra Leone (2008). An Agenda for Change. Second Poverty Reduction Strategy (PRSP II). 2008-2012. Freetown, Sierra Leone

However, the country has nevertheless undergone two peaceful transitions of political power following elections. Some progress in regulatory reforms, human development and adherence to the rule of law have led to cautious optimism amongst foreign observers. For example, the country's strong economic recovery is now in its seventh year and exports are picking up. In addition, a recent "doing business" survey found significant improvement in Sierra Leone as regards setting up and running private enterprises as well as trading in goods and services with other countries.

Poverty and health indicators

Health and nutrition indicators are amongst the worst in the world. Life expectancy is around 40 years and the infant mortality rate (165/1,000), under-5 mortality rate (286/1,000) and maternal mortality rate (1,300–2,000/100,000) are dire. Prevalence of tuberculosis (847 per 100,000) and malaria is high, causing 3 per cent and 7 per cent of all deaths respectively. HIV/AIDS prevalence is relatively low, the latest study showing 1.5 per cent country-wide.

Vital registration is seriously underdeveloped, 25-30 per cent of all births probably never being registered. Strong family ties, family support systems and developed local social networks play a central role in managing risks in daily life.

Table 1: Country and health data Sierra Leone

Population (2008)	5.1 million
Annual population growth rate	2.3%
Per capita gross national product (2004)	310 US$
Per capita GDP (PPP, Int. US$, 2004)	790
Economic growth (2006)	7%
Gini coefficient	0.63
Life expectancy at birth (m/f, 2004)	37/40 years
Infant mortality rate (per 1,000 live births)	165
Under-5 mortality (per 1,000 live births)	286
Maternal mortality rate (per 100,000)	1300-2000
% living in extreme poverty (less than 2,700 calories/day)	26
Underweight prevalence (%)	31
Health expenditure per capita (2007)	7.5 US$
Health expenditure from development partners	5.9 US$
Total health expenditure (2007)	2.4 % of GDP
TB incidence (per 100,000 pop.)	628
HIV prevalence (% of pop.)	1.5 - 4.9

Sources: DFID, World Bank, WHO, Ensor et al. (2008)[3]

[3] Ibid.

A comprehensive national reproductive health policy has been developed but is far from being rigorously implemented. Thus, fertility rate remains high at around 6.5 children per woman and an annual population growth of 2.3 per cent.

The ILO Decent Work Country Programme for Sierra Leone and the President's Agenda for Change

However, in times of global food crisis, fuel crisis, and financial and economic crisis, achieving progress in health proves to be particularly challenging. Impacts observed in Sierra Leone − such as high unemployment particularly amongst young people – and the expected downturn in economic growth are aggravating existing financial constraints and people in Sierra Leone will need a safety net more than ever before to cushion the impacts of the crisis.

The ILO's Decent Work Country Programme for Sierra Leone and the Joint UN Vision for Sierra Leone are designed to address these challenges. Both aim to strengthen the efforts undertaken by the government in the context of the Government's Agenda for Change and to maximize synergies in order to accelerate progress. These programmes bear in mind that health and poverty are interlinked. Addressing gaps and deficits therefore requires a wider protective social policy approach necessitating the formulation of national social floor policies. It is important to provide social security and decent work with wages that take the real costs of healthy living into account.

Low wages for the health workforce are an issue that needs to be urgently dealt with in order to develop decent working conditions and to improve the quality of health services for the benefit of the whole population. The first and most important layer of social floor policies should relate to providing universal access to health services. It should include at least essential benefits at the primary and secondary level. And it is also indispensable to cover catastrophic health care costs, for example for women in need of operative delivery.

The clear and strong commitment of his Excellency the President provides a particularly good starting point for innovative and thorough initiatives towards an economically strong, social and healthier Sierra Leone.

2.2. Activities

The first part of the ILO project was conducted between 1 August and 25 November 2008 with a total input of 70 man-days. Initial preparation was done between 1 August and 13 September. A mission to Sierra Leone was conducted between 14 September and 26 September. The remaining weeks were used to write up the findings and draw up a detailed assessment of the health insurance options.

The mission team was able to speak to a broad range of stakeholders in Freetown as well as in different parts of the country. In addition, they visited medical institutions and discussed the status of health and health care in the country with practitioners and politicians.

Once the preliminary report had been submitted, several regional consultative meetings were held to validate the contents, receive comments on core elements of the proposal and suggest alternatives and amendments. These SLeSHI consultative meetings were held simultaneously in Bo (South), Kenema (East), Makeni (North), and Western Rural (Waterloo) on 11−12 May 2009 and in Western Urban (Freetown Municipality) on 14−15 May 2009. In addition, two task forces were set up to follow through the national discussion on the draft report. The Sierra Leone parliament also debated the report.

The meetings were followed by a National Consultative Conference held in Freetown on 24−25 June 2009. The ILO team participated in this conference during their second mission to the country and an intensive exchange of ideas helped to further refine the plan as well as inform decisions on numerous options that had been set out in the draft report.

2.3. Methodology

The methodology consisted of:

- initial research (books, scientific articles, internet sources) on Sierra Leone, its health system and modes of paying for health services;
- obtaining information on local needs and discussing the gaps in the current provision and financing of care with local stakeholders;
- interviews with MoESS, MoFED, MoHS and NASSIT at the central level and with major donors as well as representatives from development partners and civil society institutions which would play an important role in shaping the mode of sustainable health care financing in the country;
- a document review of existing studies on health and health care in Sierra Leone;
- developing an Excel-based actuarial formula to calculate the impact of different modes of financing and coverage.

The ILO mission was also fortunate enough to have the opportunity for an audience with both **His Excellency the President** as well as **His Excellency the Vice-President**. Both Excellencies pointed to the need for a national comprehensive programme to help in developing the country and to provide the services needed for the people. Annex 8.4 provides the schedule of activities. Details are available on request.

The ILO recommended that the draft report should have national ownership − it should be presented to all stakeholders through consultative meetings for their comments and input. Extensive **regional meetings** were held in May 2009 for the purpose of validating the draft ILO study report. Detailed validation reports were produced which formed a basis for the national conference. The regional meetings were followed by a **National Consultative Conference**, held in Freetown on 24–25 June 2009. The composition of the participants during the consultative meetings was broad-based and diverse. They were drawn from:

- the cabinet, parliamentarians, academia, the judiciary, government ministries, departments, and agencies (MDAs);
- private sector employees, employers, informal economy workers, trade unions,
- administrators of private insurance entities, private health service providers,
- traditional and religious leaders as well as opinion leaders,
- district hospital and health management teams,
- health students and workers' associations, health research institutions,
- development partners, NGOs in health service delivery,
- professional regulation boards (medicine, dentistry, nursing, midwifery, pharmacy, etc.),

- the Private Hospitals and Maternity Homes Board,
- local councils, the chiefdom administration, and civil society.

The feedback, comments and suggestions obtained during these meetings and the conference have been included in this final report.

3. Conceptual Remarks

Possible Options for Financing Health

Health Financing in Africa has emerged from a long and winding history. The following list illustrates the numerous concepts and discussions:

- post-colonial development optimism; free market vs socialism; "third way" (exemplified by Julius Nyerere's Ujamaa);
- basic needs approach, Conference on Primary Health Care (Alma-Ata);
- neo-liberalism, institutions, new public management;
- dependency & adverse aid reactions;
- results-based aid;
- global initiatives: achieving the MDGs;
- disease control, vertical programmes (initially maternal and child health, later HIV/AIDS);
- integrated (area-based) development programmes – health districts;
- health sector reform, user fees, privatization, decentralization.

None of these different approaches has proved to be the magic bullet; indeed, some have arguably exacerbated problems rather than solving them. Increasingly, there is a move towards a less ideological debate, driven by better coordination of policies and aiming at embedding social health protection in a broader social protection floor that addresses poverty in various life cycles. This approach is resulting in a rather sober view of "What works, what doesn't, and why"[4]. In addition, holistic thinking is being applied increasingly, taking into account the effects of financing arrangements on provider payments and incentives for doctors and nurses to stay in the country, the capacity of the administration to effectively manage a programme, and the need for timely and adequate monitoring and external evaluation.

3.1. The ILO strategy on social health protection

The ILO strategy on achieving universal access to health care provides insights and advice based on long-standing experience. The strategy goes beyond the various approaches described above and is based on a rights-based approach to universal coverage of social health protection involving principles such as equity, solidarity and a strong role by government. It aims to achieve nationwide access to affordable health services and to close the deficit in access to health services. In Sierra Leone, the access deficit is currently estimated at 88 per cent of the entire population.

[4] The subtitle of a publication by Gwatkin, Wagstaff, and Yazbeck: Reaching the Poor. (World Bank, 2005).

The denial of access to medically necessary health care not only has a negative impact on health and poverty, but also affects the labour market and income generation and thus overall economic growth and development. Social health protection is an essential prerequisite for a healthy workforce and a dynamic economy.

Universal social health protection ensures that all people in need have effective access to at least adequate care. It is designed to alleviate the burden caused by ill health, including death, disability and loss of income. Social health protection coverage also reduces the indirect costs of disease and disability, such as lost years of income due to short- and long-term disability, care for family members, lower productivity and the impaired education and social development of children due to sickness. It thus plays a significant role in poverty alleviation.

The traditional view that social protection is a form of consumption and can only be afforded once a certain level of economic development has been reached is increasingly being challenged by the notion that social protection should be seen as a vital contribution towards building human capital and thus yielding economic profits through productivity gains.

Social protection is embedded in the ILO's *Decent Work Agenda*, which rests on four pillars:

1. employment – the principal route out of poverty is through work and income;

2. rights – a precondition for empowering people to escape from poverty;

3. social protection – a safeguard of income and financial support in case of sickness;

4. dialogue – the participation of employers' and workers' organizations in shaping and ensuring appropriate and sustainable government policies for poverty reduction.

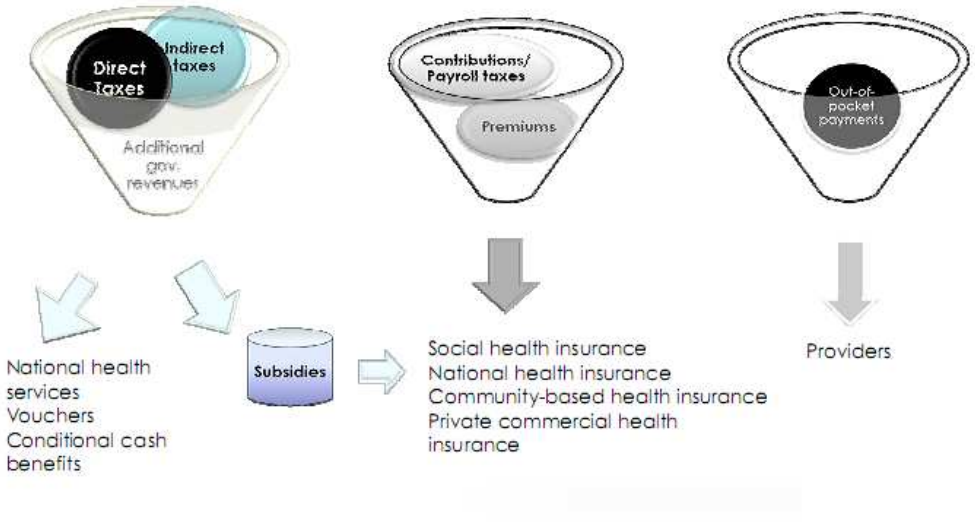
> "What is social health protection?
>
> Social health protection is a series of public or publicly organized and mandated private measures against social distress and economic losses caused by the reduction of productivity, stoppage or reduction of earnings or the cost of necessary treatment that can result from ill health."[5]

This concept is based on the core values of equity, solidarity and social justice, and a central objective is to achieve universal coverage – defined as effective access to affordable quality health services and financial protection in the event of sickness.

It is important to point out that in the ILO's view the financing of social protection is not restricted to a single measure, i.e. only taxes or only social insurance, but rather comes from a multitude of mutually enhancing and complementary sources. Figure 1 gives a graphical overview.

[5] International Labour Organization (2008), Social Health Protection: An ILO strategy towards universal access to health care. Social Security Policy Briefing Paper 1. ILO, Geneva

Figure 1: General flow of funds



Source: ILO 2008

Each mechanism – except out-of-pocket payments, which are not considered to be a source of funding for social health protection − is characterized by the three functions of

(i) revenue generation: the ability to raise sufficient funds;

(ii) pooling: the appropriate sharing of risks and management of funds;

(iii) purchasing: the active purchase of quality services from health-care providers.

All of these functions need to be fulfilled, the criteria of efficiency, equity, feasibility and sustainability thereby being taken into consideration.

In shaping the specific social protection scheme in a country, the ILO refers to the core mechanism of *social dialogue*, a mechanism through which the social partners can express their specific interests and concerns. Social dialogue in improving health services is based on certain values and principles to which all social partners subscribe.

Coverage, access and affordability are at the core of the concept

Coverage is the extension of social health protection to the size of a population that in case of need can access care without financial barriers. Whereas universal coverage is the ultimate goal, it does not preclude national health policies from (at least temporarily) focusing on certain priority groups.

Coverage relates to *effective* access to health services that medically match the morbidity structure and needs of a population. Beyond formal legal access there are the notions of geographical, cultural and financial access.

Affordability is defined as the absence of financial barriers to effective and necessary health care for individuals, groups or society as a whole. Affordability aims primarily to avoid health-related poverty and refers to the share of cost for necessary care in comparison to available household income. Fiscal affordability relates to the fiscal space of

a country that can be made available for financing health care at a level that ensures universal access to services.

This briefly described strategy will form the theoretical basis for the development of a comprehensive social health protection strategy for Sierra Leone.

3.2. Beyond "pure" financing mechanisms

In the past, discussions have sometimes degenerated into the simple question of whether a country should adopt a social health insurance scheme or a tax-funded system or whether it should rely on private market forces to provide optimal insurance and care. Such a simple presentation of alternatives does not capture the many possible options for *combining* elements from a health-insurance-based and a tax-based system and private insurance. In addition, there is the issue of providing care beyond some form of "basic package" of care that any type of general health financing system will be able to provide.

So far, none of the "pure" approaches exists in any country or has been shown to be feasible in a development setting. Purely tax-based financing requires inputs from public budgets which often exceed the possibilities of developing countries. Selected co-financing by users with exemptions for the poor and needy has not worked because the group of exempted people has been very large and/or the mechanism for identifying the poor and needy has been flawed and has resulted in fraudulent eligibility claims.

Social health insurance requires clear and strong support from the government, since the small percentage of formally employed persons in a country cannot cross-subsidize the large informal sector, which by its very nature usually cannot (or will not) contribute on a regular basis to any scheme. Thus, financial support has to come from the State in order to make SHI sustainable.

Private for-profit health insurance has its merits in providing high-quality and comprehensive care for those who can afford it. However, the problem of equity, adverse selection and the need for differential pricing and risk premiums for the chronically ill and the aged in a non-mandatory insurance runs counter to the very core ideas of universal social health protection.

Further, it is important to bear in mind that health is determined by various social factors ranging from education, income status and environmental aspects. The ILO therefore suggests that social health protection be incorporated into a broader social protection floor, i.e. a basic and modest set of essential social guarantees realized through tax- and insurance-based social protection mechanisms, such as transfers and benefits in cash and in kind that could ensure:

- universal access to essential health services for all people that live in a given country,
- income (or subsistence) security for all children through child benefits; and
- modest income support for the poor in active age who cannot earn sufficient income on the labour market, combined with employment guarantees through public works programmes[6],

[6] including women during the last months of a pregnancy and during the month immediately following delivery

- income security through basic tax-financed pensions or insurance for the old, the disabled and those who have lost the main breadwinner in a family.

3.3. The goals of health-care financing

The connection between ill health and poverty has been clearly demonstrated in quantitative studies, and the link between the economic "asset" of good health and poverty can be depicted as shown in Figure 2.

Figure 2: The health and poverty trap

Source: ILO 2008

Providing quality services at the point of delivery

Good and reliable quality at the point of delivery can significantly improve uptake and use of services. In addition, where hospital-based care is covered, a clearly limited co-payment/user fee protects against catastrophic health care expenditure, which can push a family into poverty.

Alleviating fears

As stated above, health care expenditure can be catastrophic and the 2007 "Pilot Survey on Social Security Priorities and Needs" in Sierra Leone clearly shows that sickness and work-related injuries are two of the three most dreaded threats for income and business. Eighty-nine per cent of the respondents indicated that sickness was a major threat, whereas 60 per cent said this about old age and 45 per cent cited occupational injuries. The concept of social health protection aims to optimize access to and affordability of health care in order to prevent such threats from materializing.

Improving quality

There is adequate proof that people are willing to pay for health if they receive value for money. Thus, in order to gain confidence and lasting support from those paying into a health care financing scheme, a social health insurance system or indeed any type of third party payer should nowadays no longer act as a mere administrator of funds but as an active purchaser of goods and services for its clientele. This entails elements of efficiency and quality. Accreditation and regular internal and external controls are two of the cornerstones of quality management on the part of the health insurer.

However, it is still unclear how much upfront investment will be required to build up a level of reasonable quality in order to convince people of the positive effects of a comprehensive and mandatory health financing scheme.

Improving health status

In comparison to public health measures such as sanitation and immunization, the evidence that health insurance improves the health status of a population is not very strong. However, a focus on mothers and children in designing a benefit catalogue (e.g. oral re-hydration and emergency obstetric care) will ensure maximum effect for the most needy.

A reform of national health financing has been included as one aspect of the PRSP 2008-2012.

Building trust

An often neglected but very important element in the implementation and building up of social health insurance is the tremendous opportunity for creating a trusted institution. This is often all the more important since in many developing countries central institutions are weak and plagued by large-scale corruption. PhilHealth, the national social health insurer in the Philippines, provides a convincing example: in a country that has seen immense corruption and misuse of money at the highest level, the general public now places trust in a centrally run agency which has accumulated reserves of well over 100m US$.

3.4. Rational use of pluralistic financing mechanisms

There is no single "right" way for providing social health protection or achieving universal coverage. Each country, depending on its history, economic context and preferences has to find its own very specific mode of providing and financing health care. This is where the concept of "path dependency" comes in, i.e. the theory that a set of decisions an individual, a business or a society faces for any given circumstance is limited by the decisions the individual, business or society has made in the past, even though past circumstances may no longer be relevant; in other words: institutions and socio-economic and legal frameworks are self-reinforcing and long-lasting.

ILO suggests a three-step strategy to rationalize the use of the various existing financing mechanisms in a country:

(i) take stock of all given mechanisms;

(ii) assess the remaining coverage and access deficits;

(iii) develop a coverage plan that fills gaps in an effective and efficient way.

Eventually, such a strategy should accelerate the achievement of universal coverage and appropriate access. Once the coverage gap and the access deficit have been assessed, a comprehensive "national coverage plan" could be developed which would include:

a. developing a coverage map;

b. developing a national health budget and outlining the funds available;

c. improving health financing mechanisms and addressing the strengths and weaknesses of the various financing forms;

d. building rational linkages between sub-systems;

e. designing adequate benefit packages;

f. creating institutional and administrative efficiency.

(Source: ILO 2008)

Each country will need to work on its national capacities as well as embark on a broad national dialogue in order to steer this long-lasting technical and political process through the vicissitudes of democratic decision-making and political power games.

Given that there will, at all events, be a definite need for timely feedback and relevant data on the effects of reforms and its impact on the population, patients and providers, an astute and thorough evaluation balancing parsimony with producing meaningful data must be put in place.

3.5. Evaluation

Measuring, benchmarking and showing evidence will be crucial elements in developing a new mode of health-care financing. This is a powerful approach for steering activities and gaining political support but also for terminating activities that are detrimental to the goals pursued. A mix of qualitative and quantitative approaches should be found which captures the most important aspects when implementing any fundamental change in financing health care.

Some possible quality indicators are listed below. It is suggested that a common understanding be developed on which indicators to use, how to measure them and how to use them. Furthermore, the extent to which such evaluation can make use of existing instruments such as the Health Management Information System, Household Studies, Sentinel Surveys, Integrated Disease Surveillance Projects, and the information systems of the existing vertical disease programmes needs to be explored.

(I) Coverage

- Who is covered by which type of scheme?
- Geographical/socio-economic distribution of coverage
- Coverage for specific groups (children, mothers, …)
- Cost of care borne by those covered

(II) Access

- Geographical access (e.g. percentage of the population living within 5/10 km from a health post)
- Utilization by socio-economic status, by current need
- Outputs (at various levels) and outcomes
- Births attended by skilled personnel
- Density of health-care providers and staff-related access deficit (ILO)

- (Health indicators)

(III) Affordability and financial burden

- National health accounts and financial flows
- Total public health-care expenditure
- Total out-of-pocket payments
- Catastrophic health-care expenditure at household level; risk of impoverishment

(IV) Quality

- Structures – processes – outcomes
- Geographical / administrative comparisons
- Role of incentives; pay-for-performance

4. Service Provision, Health Financing and Perceptions in Sierra Leone

The following is largely based on the first-hand impressions gained by the consultants during their visit to the country. It is complemented, where appropriate, primarily by the comprehensive "Health Sector Review" (Gibril et al, 2004) and the data and internal studies received from the MoHS and others.

4.1. The health care system

The national health policy is based on the Primary Health Care concept. Following the implementation of several pilot primary health care initiatives, including the Bamako Initiatives, a broad-based health sector policy was developed in 1993 and revised in 2002. Primary health care is the main thrust of the policy.

With respect to cost recovery policy, the MoHS concludes the following in its 2006 Revised Health Services Cost Recovery Policy Guidelines for Sierra Leone":

> "In 2002 the government made an attempt to re-introduce the medicines cost recovery scheme (Bamako Initiative), which was operational in all districts before the war escalated. The target for cost recovery was 80 per cent recovery on medicines at all levels. However, there were no clear policy guidelines on cost recovery of other health services, exemptions and financial management. Moreover, shortly after its re-launching, the scheme ran into difficulties, when government pronounced as a policy that provision of treatment and medicines would be free to all vulnerable groups, who constitute over 60 per cent of the users of the health facilities. The target rate for cost recovery was later reduced to 40 per cent. However, this policy was not only impracticable, but also grossly misused."

In 2002 the MoHS published the latest comprehensive health policy paper. It starts with the notion of the severe disruptions caused by the civil war and the changing patterns in the demographic composition of the country as well as in the morbidity and mortality patterns. In addition, the Ministry adopts a broad approach to the major factors influencing health and explicitly recognizes the importance of water, sanitation, and health promotion, amongst other factors.

NGOs, private providers and traditional birth attendants are seen as valuable additional inputs for achieving adequate service provision in the country. However, the MoHS wants stricter regulation from government and professional bodies to improve overall standards.

Decentralization and de-concentration are seen as major moves towards local responsibility and acceptance and capacity-building is a critical element in keeping up professional levels. In general, human resources are devastatingly scarce and the Ministry sees a mix of approaches with a focus on national training in primary care and management as the way forward.

It is of interest to note with respect to financing that the MoHS states that it will investigate the possibility of a national health insurance scheme in the medium term. Strong emphasis is placed at all events on providing free services for the most vulnerable population segments: school-going children, under-fives, pregnant women, lactating mothers for up to 12 months and citizens over 65 years of age.

There are referral hospitals in Bo, Makeni and Kenema as well as the central referral hospital in Freetown (Connaught Hospital). In addition, there are four specialty hospitals, all of which are in Freetown. The MoHS is responsible for all tertiary care.

Sierra Leone has embarked on a devolution process in the health sector. Devolution is the transfer of funds and administrative power to local levels whilst the line ministry remains responsible for policies and standard-setting. Following the Local Government Act of 2004, the primary care facilities have been handed over to the District Councils. The effects of devolution are not yet clear at the secondary care level, as this only came about this year. Tertiary level care remains in the hands of the MoHS and there are no plans at present to devolve these institutions.

Health system capacity indicators

Health insurance and health provision of at least reasonable quality go hand in hand. Only if the insured can experience some appropriate health care in the event of illness will they be willing to contribute to a scheme.

The major finding is the severe shortage of qualified personnel (especially doctors, see Table 2, and hospital managers) and the outdated and procrustean administrative rules and regulations governing health care management.

Health personnel are probably the most important input factor for an efficient health care system. There is an extremely critical shortage of qualified staff outside Freetown and the WHO's recommended doctor-to-population ratio of 1:12,000 is nearly 25 times below this in Kailahun District.

Current staff numbers are nowhere near even the rather modest staffing requirements proposed. Out of ten newly trained physicians around eight will leave the country after graduation. The country's only medical school has an average annual output of eight doctors. Post-basic training is haphazard and there is no concept of systematically improving skills and using them in practice.

The majority of new doctors trained in the country leave very soon after graduation. There has been an initiative to bring Cuban doctors to the country for a fixed period, but this has proved to be very costly in terms of accommodation.

Apparently there is a policy for requiring doctors to perform some period of mandatory service, but this does not seem to be properly implemented.

Table 2 shows a disconcerting ratio of skilled medical personnel to population and a highly skewed distribution towards Freetown – important aspects that need to be addressed in further discussions on introducing a new mode of health care financing.

The status of the hospitals visited was deplorable: although some institutions had recently been refurbished, the overall appearance was still bleak in most instances: leaking roofs, dismal order in the pharmacy store, unused equipment and bare patient beds were common.

Table 2: Number of staff by specialty and distribution (selected)

Specialty	Total no. in Sierra Leone	Of whom in the Western Area (Freetown)
Cardiologist	1	1
Dentist	5	3
Gynaecologist / obstetrician	11	8
Lab technician	64	35
Nurse anaesthetist	17	9
Orthopaedic surgeon	1	1
Paediatrician	8	7
Public health specialist	20	13
Psychiatrist	1	1
Surgeon	12	9
Total	328	209

Source: MoHS

The level of equipment is very poor. Even in the tertiary referral hospitals a functioning X-ray or ultrasound machine is rarely to be found.

The publicized case of high-ranking politicians and administrators leaving the country for some basic health care (i.e. giving birth) has not helped to restore confidence in the quality of care in the country.

Traditional medicine still plays an important role in the country. Several interview partners pointed out that in rural areas in particular herbal medicine and healing rituals are deemed superior to “western” medicine especially in “native diseases” such as insanity, accidents, allergies, animal attacks, and so on. It is important to monitor peoples' wishes in terms of treatments and forms of healing covered in order to keep the emerging financing scheme in line with local preferences and needs. Policies need to be developed that allow for regular revision of the benefit catalogue to see where additional needs exist and/or where the services proposed are no longer suitable.

Public Health

Taken as a whole, the data and our impressions were dire. Preventable infectious conditions are a major burden of disease: malaria (35.1 per cent), acute respiratory infection (21.7 per cent) and watery & bloody diarrhea (8.1 per cent) are the topmost causes of out-patient attendance, together accounting for about 65 per cent of those patients. These three diseases together with malnutrition account for about 75 per cent of under-five consultations.

Figure 3: Some impressions from the hospital visits

A comparison between a public hospital pharmacy (left) and the pharmacy of St. John of God (right).

Deplorable situation in Bo: Operating theatre and open fire used to sterilize instruments.

Health care planning

The health sector planning follows the government planning cycle, and is based on the mid-term expenditure framework (MTEF). There is an MoHS three-year plan including a budget spanning the period from 2006 to 2008, which covers both government and the major donor funding and indicates an annual shortfall of about 50 per cent in most cost facilities at the national level.

Table 3: Public health output indicators

Measles immunization (%)	62
Children fully immunized at 1 yr (%)	54
Contraceptive prevalence (%)	5
Skilled attendant at delivery (%)	43
Use of improved water sources (%)	46
Use of improved sanitation facilities (%)	30

Source: MoHS

The primary strategies of the MoHS reflected in the plans are in three main areas:

(i) expanding and strengthening health services in a decentralized health system;

(ii) building partnerships with all stakeholders;

(iii) improving disease prevention and control as well as maternal and child health.

The Decentralization Act was brought into force in 2004: Primary Health Centres (in 2005) and some secondary level hospitals (in 2008) have been devolved and are now managed by District Health Management Teams (DHMT). However, personnel is still hired and paid by the MoHS; devolvement is planned for a later stage. Government funding for the functions ceded to local councils is no longer reflected in the central plan, and local planning is not (yet) fully developed.

Although the provision of drugs can still be an issue, the management of resources seems to have become much easier and hospitals can make use of their budget much more simply and more quickly than before.

4.2. Health care financing

Sources of revenue / Paying for health

All "vulnerable groups", i.e. children under five, schoolchildren, pregnant and lactating women, the disabled and those over 60 years of age are supposed to receive free services, but the policy is not clearly implemented – we therefore found many examples of patients having to pay for "registration" before seeing a doctor or a nurse.

User fees and access

In 2005, Médecins Sans Frontières (MSF) carried out a survey in four districts of the country to measure mortality rates, collect information on income and expenditure patterns and compare levels of access with three different payment systems: (i) cost recovery, (ii) all-inclusive low flat-fee system and (iii) subsidized free health care for all. The cost-recovery scheme (operated in the public sector), whereby patients have to pay for drugs at a mark-up price, led to exclusion from public structures, failed to exempt appropriately, led to impoverishment and pushed people into unemployment.

Payment systems (ii) and (iii), operated in MSF's facilities brought the following results: the low flat-fee system already substantially increased use of services but also showed that even a small fee can constitute a significant obstacle to accessing health care. The "free health for all" approach produced a sudden and dramatic increase in consultations.

Despite some conceptual limitations, this study clearly shows the effects of mandated payments at the point of care. The simple, easy to market and medically appropriate approach of "free care at the point of service" should be kept in mind as one of the major goals to be attained.

We held intensive discussions on the ability to pay for health care. Whereas the vast majority of Sierra Leoneans from all walks of life said that some contribution of 10,000 or even 20,000 Le (EUR 2,5 / EUR 5) would not pose a real problem to anyone in the population, foreign observers pointed to the various studies and personal impressions that led them to seriously doubt such an assumption.

The 2008 "Review of financing of health in Sierra Leone"

A recent and very comprehensive "Review of financing of health in Sierra Leone and the development of policy options" paints a sobering picture indicating the very low overall spending and the high degree of out-of-pocket expenditure:

> "Health care in Sierra Leone is principally financed through private, out-of-pocket payments (69 per cent) – most of these on medicines. Public spending is financed partly through the consolidated fund (22 per cent) and partly by external project based assistance (78 per cent). Consolidated funding per capita has fallen since 2003 from around $4 to just over $1.5."

Cost recovery and user charges remain an important source of income for health care facilities, despite the fact that the official system has virtually broken down due to lack of drug supplies. The exemption system does not work due to the large number of persons officially exempted. Despite the clear international evidence that any payments at the point of care have a substantial negative effect on the use of services, the major advantages of user fees and co-payments should not be forgotten and need to be addressed by any comprehensive financing scheme: regular cash revenue for facilities, incentives for staff, performance-based payments.

The authors point out that the following are the six most important factors contributing to the present financial access barriers:

(i) erratic financing of the public facilities: non-salary items in particular may only be paid for late in the year or not at all;

(ii) uneven allocation of funds from external sources: donors do not have country-wide allocative efficiency in mind when financing specific projects; money thus does not necessarily follow need;

(iii) low productivity of services: due to low utilization, unit costs are high;

(iv) health-worker incentives are inadequate and skewed: here, the problem of "ghost workers" is mentioned, and it seems to the authors that only user fees come anywhere close to an activity-related payment;

(v) the charging of services remains unclear: despite tariffs, households often have little idea of the overall cost of care;

(vi) the distribution of skilled health-care workers is highly skewed towards urban areas, especially Freetown.

Ensor and colleagues then go on to review various targeting mechanisms in order to adjust to the fact that at present only a selected approach to health care financing will be possible. They discuss service targeting (cost-effective services), individual targeting (the poor), characteristic targeting (groups with high needs), facility-based targeting and geographical targeting (areas with particularly high needs) and conclude:

> "To address the acute disease burden composed of persistently high communicable disease incidence, poor maternal health and a growing burden of non-communicable disease requires dramatic action. Much of the disease burden at PHUs and secondary hospitals can be classified as priority health problems for which cost-effective treatments exist. We **recommend** a facility-based approach that directs funding to primary care and district hospitals to provide most of these services and supports a pragmatic essential package approach while at the same time helping to protect against the catastrophic costs of ill health.[7]" (**authors' emphasis**)

4.3. Public perceptions and fears

As previously mentioned, NASSIT conducted a milestone report in 2007, the "Pilot Survey on Social Security Priorities and Needs" (Cleeve, E.A. 2007). The following are its major findings:

1. Social security coverage is low in the country, less than 10 per cent of the workforce, and mainly limited to government employees and a small number of those in larger enterprises.

2. The household income in the informal sector is extremely low: more than 90 per cent of the respondents report an income below 400,000 Le/month (130 US$/month). In addition, there is a high level of dependents (the vast majority have 5-14 dependents).

3. Ninety per cent of respondents felt threats to their business, and "sickness" was ranked first by all age and gender groups.

4. "Sickness" (by 89 per cent of respondents), "Becoming Old" (60 per cent) and "Occupational Injury" (45 per cent) were the most common risks mentioned.

5. Social protection needs were "Sickness", followed by "Old Age" and "Health Care".

6. The vast majority of informal sector workers would like to join the NASSIT scheme.

7. The respondents revealed their willingness to pay either 5 per cent or 10 per cent of their monthly income as a social security contribution. This pattern was found in all groups of respondents.

These results indicate (a) the predominance of health as a threat to business, (b) the willingness to contribute to some form of social protection and (c) NASSIT's strong brand amongst the population in the informal sector.

[7] Ensor, T., Lievens, T. & Naylor, M., op.cit., p.46

4.4. Discussions and interviews at central level

4.4.1. Government institutions

In his keynote address delivered to the National Consultative Meeting, His Excellency President Dr Ernest Bai Koroma, was quite clear about the need for a national unified approach and the importance of a pre-paid approach.

> "Our support for a health insurance scheme is a vital component of our strategy for increasing accessibility and affordability of medical services in the country. […] The study report we are about to deliberate on seeks out the various options for including the struggling worker, trader and ordinary citizen in a national health insurance scheme. […] The framework of a National Health Insurance Scheme envisages citizens and consumers paying for medical services through regular deposits of small amounts of money. […] I am also instructing the Ministry of Local Government to initiate discussions with local councils on harmonizing their health-care programmes with the National Health Insurance scheme."

The President also suggested the slogan "Well-Bodi-Osusu" (Health is Wealth) for SLeSHI making explicit the notion that good health is a vital ingredient for economic development.

During the meeting with the ILO mission, His Excellency the President emphasized the revolutionary nature of the approach and applauded ILO for the work done so far and the results achieved.

His Excellency Vice-President Sam Sumana was receptive to the idea of an independent institution that would channel and coordinate financial contribution to curative care. He suggested looking into the option of taxing alcohol and tobacco consumption as an additional means of paying for health care.

The MoESS pointed out that a number of very senior politicians in the current administration have an insurance background, including His Excellency the President. The Minister strongly argued in favour of an institution independent of NASSIT that would be solely concerned with health financing matters.

The MoFED as well as the National Revenue Authority (NRA) indicated the general willingness to channel some of the additional taxes gained via the goods and services tax (GST − essentially a VAT, soon to be introduced) to the health sector, if politically so mandated. The NRA assumes that the first year of introducing this tax will be budget-neutral as it will require substantial up-front investments.

The Minister of Health and Sanitation emphasized the need to generally strengthen public services and the need for additional funding. He welcomed the planned separation between public health and curative health, the latter being financed by an independent institution. The devolution of staff is a logical next step in providing local public providers with the necessary autonomy for effective management.

4.4.2. Local politicians and administration

Discussion with local politicians revealed that at present the experience with devolved health care is very limited. All managers and doctors agreed that the facilities receive only a fraction of their official budget − assumptions ranged from 25 to 40 per cent. We could not verify these claims against the official data from the MoFED or MoHS, but we were under the impression that further detailed analysis is certainly warranted.

Staff salaries are perceived as inadequate, with a doctor earning the equivalent of around 150 US$ per month and some health aid workers only being able to afford one 50kg sack of rice on their monthly salary.

The recent shift of financial responsibility from central level to the local District Health Management Teams (DMHT) involving consultations with the Council Health Committees was eagerly awaited and all interview partners place great hope in an improved and timelier flow of the budgeted funds to the institutions. The District Medical Officer will now be reporting to these local bodies and this should allow better coordination and quicker responses. Instead of the historical budgeting approach, local need-based planning will provide the basis for allocating resources.

LOCAL HEALTH INSURANCE SCHEMES

We were told of a rural health insurance scheme ("Kabala birth waiting homes"), but could not obtain additional information. Apart from this one scheme, no comprehensive local schemes seem to exist in the country.

In Bo, a scheme has been set up with support from the Medical Research Council (MRC) to finance transport costs. It now covers 20 Primary Health Clinics and a population of around 74,000.

Some years ago, the MRC was approached by a local chief who wanted to have some form of transport available for his constituents. A meeting with all local chiefs and the hospital led to the conclusion that transport was not the problem per se but the inability of many people to pay for it.

It was agreed that each chief would convince his people that some form of pre-payment would be the best solution towards a sustainable and donor-independent scheme. A high-profile case soon came up with a young man who had refused to pay as he deemed this unnecessary and who approached the MRC with his wife, who was seriously ill, and begged for assistance despite the fact that he was not eligible. Assistance was granted and his wife was taken to hospital and successfully taken care of. This husband then became a staunch supporter and advocate of the scheme.

The scheme is now well established. Each household pays 1,000 Le or each individual adult 500 Le per year. The money is collected and administered by local sections. If an ambulance is needed, it will be provided by the MRC and reimbursed by the local section. The cost per trip ranges from 25,000 Le to 50,000 Le. The individual still has to pay the hospital costs. Each health centre has radio equipment and external seed money had previously been granted for the purchase of two ambulances. Today, every chiefdom has one ambulance available.

The MRC pays a moderate stipend to the personnel involved at the hospital. Around 100 trips a year are being financed by the scheme – the majority of which are obstetric cases (43 per cent) and infections (33 per cent). Accidents constitute only 10 per cent of all cases. It took around 6 months for the scheme to be established and for the general population to recognize the benefits it brings.

An internal analysis indicates that about two-thirds of all potential obstetric emergency care cases (conservative estimate) are not being addressed.

From next year onwards, the contribution to the scheme will be pegged to the collection of local taxes; the timing will be just after the local harvest.

The politicians emphasized that people in general expect health care to be provided free of charge and paid for by government. Any attempt to initiate a pre-paid scheme would therefore require a great deal of information and education – and a visible improvement in quality must go hand in hand with any financial demands on the public. Apart from providing care for women, mothers and children, the need for accident services was repeatedly stressed.

Our interview partners assumed that about 70 per cent of people in rural areas would be able to afford to pay 10,000 Le per year into some health care scheme, whilst 30 per cent would not.

However, we were told in all of our discussions that the majority of people are very willing, that people want to re-build their country, and that even doctors would return from

abroad if change could be initiated and a more conducive working environment could be set up.

4.4.3. NASSIT

On the basis of the successful development of the Trust during the last six years or so, NASSIT took the initiative to explore options for health insurance in Sierra Leone. A major goal is to extend the coverage of the population as far as possible and to include workers of the informal economy and their families from the outset.

NASSIT was conceived in Sierra-Leone in emulation of a similar organization which has been largely successful in Ghana. The chairman of the NASSIT Board is appointed by the President and reports directly to him. Although NASSIT is formally under the MoESS, there is little supervision at present due to lack of qualified ministry personnel. Nor does the ministry carry out audits. The NASSIT chairman suggests an independent supervisory body similar to the body operating in the banking system.

However, there is currently intense internal debate about whether it would be preferable for the health insurance to be self-sufficient (say, 60-70 per cent revenue generation) from the outset rather than relying too heavily on State subsidies. This would mean starting a health insurance scheme in the formal sector and then gradually expanding it into the informal sector.

NASSIT has at present high administrative costs, not least due to its efforts to provide local presence. Expanding social security to health care could lead to substantial economies of scale and NASSIT is prepared to explore this option.

NASSIT has repeatedly stated that it does not propose to manage the social health insurance scheme, but rather advocates an independent new organization. However, it might make sense to explore forms of shared administration of SLeSHI and NASSIT in order to make optimal use of the experience accumulated in NASSIT so far and to somehow transfer the "culture" of the organization to SLeSHI.

A major concern is finding qualified personnel at the local level; this is aggravated by the fact that it is often politically very difficult to award job contracts solely on qualification and merit.

4.4.4. Providers in Freetown and up-country

We spoke with the managers of several public and private facilities in Freetown as well in Tonkolili, Bo, and Kenema Districts. The general experience was that 60-70 per cent of patients could not even pay modest charges under the "cost-recovery" scheme.

In most instances, people pay some form of "registration fee" of about 1,000 – 2,000 Le. In many facilities, all patients have to pay some form of user fee, which entitles them to seeing a nurse or doctor. This fee can range from 5.000 to 25.000 Le. A caesarean section costs about 700.000 Le (230 US$). There is a substantial percentage of people willing to pay extra for a private room and better service.

Whereas the private facilities complain about lack of space and generally overcrowded wards, the major problem in public facilities is the absurd and outdated management of personnel. Despite devolution, all staff is still with the MoHS and is centrally hired and paid by the Ministry. This means that a local manager does not have any hold on his staff, rendering him basically powerless – a central issue in all discussion with hospital doctors and directors of public hospitals. The consultants frequently observed that only a fraction of the staff on the payroll seemed to actually be physically present during their visits. Even

allowing for rotating shifts and weekends, it seemed that by far not all staff would actually report to work. The staff probably work at around 1/3 of the potential level.

Thus, in order to substantially improve quality of services, all interviewees unanimously stressed that it was absolutely essential to radically change the current HR system. Apart from additional money, incentives such as housing, schooling support, relocation of family or even simple measures like offering communal breakfast for all staff in the morning would go a long way towards improving staff morale. The planned devolution of staff is thus a move that is welcomed.

In addition, continuous medical training for nurses and doctors was mentioned as a major element of building up an enabling and satisfying work environment. For example, one option could be to rotate doctors and nurses around hospitals and to organize regular visits of specialists who would assist in operations and teach new methods.

All hospitals operate with some form of a cost-recovery scheme (mostly a mark-up on drugs), but due to many exemptions the flow of funds remains insufficient. Payments from patients are used to buy hospital supplies.

The idea of a national insurance scheme was well received – a major concern on the provider side was the timely reimbursement of invoices.

Opinions were divided over the reimbursement of traditional healers and/or traditional medicine: some thought that this type of healing is well engrained in the Sierra Leonean culture and a large part of the population would want such care to be covered, whilst others firmly rejected the idea of paying for non-scientific medicine.

People in general prefer western drugs. The availability of drugs is insufficient, but the consultants felt that this is not anywhere nearly as serious a concern as the HR component. Although the quality of the drugs, most of which are purchased centrally, was generally considered to be good, inspection of the medicine stores revealed substantial room for improvement in the proper handling and storage of drugs: apart from general untidiness, we saw several instances of drugs being past the use-by date because they had been stacked away in some far corner.

The state of buildings and medical equipment was mixed – in many instances, however, we were told that an external donor (African Development Bank, World Bank) would be coming in to rehabilitate and upgrade. Bo Government Hospital was in a particularly deplorable condition with leaking roofs in the operation wing, no electrical sterilizer and a dilapidated X-ray facility.

Another concern that was frequently mentioned was the non-existence of a referral system with patients going to either the nearest available facility or else to the place where they felt they would receive the best care. This lack of coordination is particularly evident in Freetown, where even tertiary hospitals are flooded with standard cases, thus depriving the institution of staff and resources to deal with the more difficult conditions.

A visit to Falaba Maternal and Child Health Post (MCHP) revealed a high degree of self-sufficiency with the local nurse taking pride in the fact that in the last 3 years (i.e. around 300 births) not a single caesarean section had been necessary and not a single woman or child had died. Despite this success story, the need for supervision and referral is apparent.

4.4.5. Unions and employees

A joint meeting with unions' and employers' associations brought to light an understandable fear that any form of national health financing scheme which relies on

cross-subsidies from the formal sector would leave this group essentially worse off than they are now.

This argument is to be taken seriously and two possible responses can be put forward:

(i) the obligation for the formal sector to support those less fortunate (solidarity);

(ii) the opportunity to improve the health sector in general and therefore have better services available for everyone, including the formal sector.

In addition, employers would still be able to purchase top-up insurance for their staff such as in the mining industry or to enable senior staff to access treatment abroad. Furthermore, the generally better quality expected would eventually allow private enterprises to reduce their activities devoted to providing care on-site with the corresponding reductions in costs. At present, an amount equivalent to around 4 to 6 per cent of the wage bill is spent on medical fringe benefits for staff.

We strongly believe that further major efforts will be needed to address the objections and fears raised by employees and employers alike. Their contributions are the basis for SLeSHI and strong and unequivocal support from these social partners is very important.

4.4.6. NGOs

There were 64 NGOs (31 national & 33 international) registered with the health authorities as of December 2005.

Discussion with MSF revealed widespread discrepancy between the national views on ability to pay and MSF's experience of requesting co-payment. A study published by MSF in July 2005 indicates that even very moderate fees would have a severely detrimental effect on the health of the very poor (see 4.2):

> "Indeed, even when what may seem a very small fee is requested from patients, exclusion and further impoverishment are seen. […] In 2004, the suppression of the flat fee of 500 Leones in the MSF project in Bo resulted in a fourfold increase in curative consultations. This increase reflects the real health needs of a population, and [these consultations] are not 'frivolous' consultations …"

This experience led MSF and UNICEF to seriously question any approach where each and every individual is requested to contribute to a national health scheme. The consultants held intense discussions with members from these NGOs on the ability to pay of subsistence farmers or of the destitute in the urban areas. Perceptions differed substantially amongst interview partners as to how many of the adult population could not even afford 10.000 Le per year for health care. Exemption schemes, although very difficult to operate and rarely successful, need to be taken into consideration.

In addition, there is the question of geographical access: although the vast majority of Sierra Leoneans live reasonably near a facility, interview partners from NGOs pointed out that a substantial number of births still go unattended due to inability to reach a facility within a reasonable period of time.

CASE STUDY: THE SUCCESSFUL HOSPITAL OF ST. JOHN OF GOD

In all of the facilities but one we sensed a high degree of demotivation and lack of initiative. Although some successes were reported, such as improved cleanliness in one hospital or upgraded infrastructure, the overall comment was generally very negative. The inability of local managers to control their personnel in conjunction with a practically non-existent work environment has demoralized staff. There is no joy or sense of ownership when one has to operate in an operating theatre with a leaking roof, no surgical consumables available, frequent power cuts in the middle of operations coupled with a sense of large-scale corruption and fraud that is taking money from the facilities.

A notable exception is the successful hospital "St. John of God", a privately-run mission hospital. When we visited the facility, we were impressed by highly motivated staff – which to us seemed to form the basis for all subsequent success:

- the patients come from all over the country;
- the facility is well stocked and organized;
- no patient will be rejected if unable to pay.

The hospital operates a cost-recovery scheme and is supported by the Catholic Church. A major element of its success is the very efficient management and the successful external fund-raising, which make it possible to waive fees if a patient is unable to pay. In addition, due to its cooperation with international bodies a number of foreign specialists work free of charge at the hospital, helping to develop local capacities and to attract wealthy patients.

The staff motivation stems from the spirit/attitude adopted by the hospital leadership coupled with tangible benefits for those who work there. While it is easy to feel this atmosphere it is very difficult to replicate it and it will probably require a mixture of approaches (such as a selection process for hospital management, extra funding, autonomy of operations, supervision, exchange programmes, continuous learning) to try to achieve this kind of positive spirit and attitude.

4.4.7. Private health insurers

A meeting with the three insurers operating in Sierra Leone − Reliance, NIC, and Aureolm− showed a clear understanding and acceptance of some form of National Health Insurance on the part of private insurers. At present, an average of 4-6 per cent of gross income is spent additionally on medical fringe benefits, most of which are managed by the private insurers. There is full coverage usually up to 500 or 1,000 US$; due to the huge potential for fraud (often by providers), a lump sum is paid directly to employees in many instances.

The introduction of NASSIT created huge distortions in the private life-insurance market with many people requesting cancellation of their existing life insurances and forcing the industry to quickly find huge sums of cash for pay-outs. The introduction of some form of national health insurance should be more gradual and should be carried out in closer cooperation with the private sector.

It might make sense to pass on the private companies' experience to the emerging national scheme in the form of training sessions and hiring of staff. The insurers' representatives stressed their willingness to cooperate. There will most probably still be a market for private firms in topping up health insurance, for example, in dangerous workplaces or for treatment abroad.

Despite the initial positive feedback, the proposed shift from a private to a publicly managed health insurance scheme will create some distortions, and the consultants can see a clear need to further discuss matters with representatives from the industry, not least to possibly draw on the tremendous experience that these companies and their staff have amassed.

4.4.8. Donors

A Health Care Financing Task Force has been set up under the auspices of the Health Economics Department of the MoHS. It includes members from World Bank, UNICEF, DFID, and MSF, amongst other organizations.

A large-scale Reproductive and Child Health Project is about to start, funded by the World Bank, the DFID, UNICEF and Irish Aid. It comprises measures concerning public health and facilities as well as equipment for primary- and secondary-care facilities in selected districts. Five districts are to be covered and substantial focused investments will be made in order to support Millennium Development Goals (MDGs) 4 and 5. The consultants see this initiative as a potential opportunity to combine various donor initiatives in order to systematically improve health care facilities and thus provide the basis for introducing a nationwide unified health financing scheme that can deliver value for money to its members.

The discussion with the Health Care Financing Task Force revolved around possible modes of cooperation and synchronization of activities. Most importantly, as any national health financing scheme will have to rely heavily on good quality of the care provided in order to gain public acceptance, the current initiatives to upgrade facilities should be dovetailed with such efforts. It was also pointed out that there are a number of well-developed national health policies (e.g. “Child and Reproductive Health Programme”, providing free health care for the under-fives and pregnant women) which have not yet been appropriately implemented, mainly due to lack of funds and expertise.

The possible positive effects of conditional cash transfers were discussed. Any such scheme would focus primarily on public health measures such as immunization rates among children.

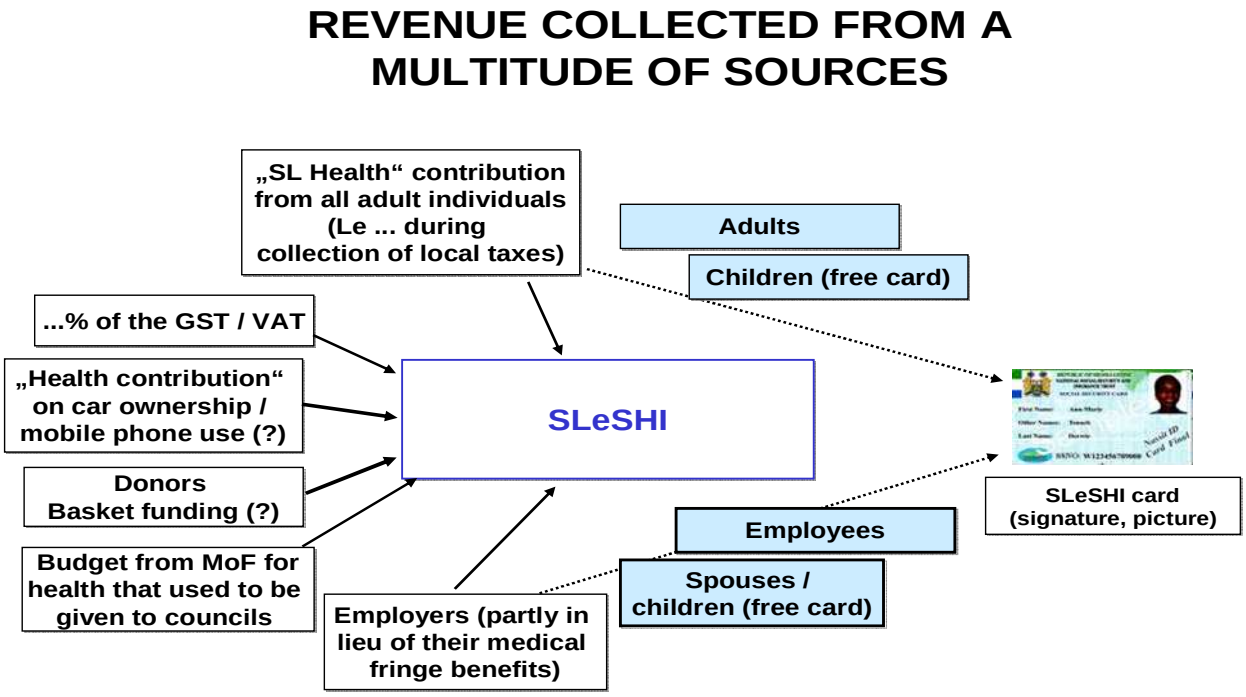
In general, there was strong willingness amongst all partners to further coordinate efforts to explore options for cooperation and joint approaches.

5. A Plan for Health-Care Financing in Sierra Leone

This chapter describes some preliminary elements of an overall plan for the national social health insurance (SLeSHI), which emerged from the numerous discussions we held during our mission in Sierra Leone. It should be stressed here that this is a proposal with many (crucial) options still to be decided upon. The consultants believe that only wide-ranging national ownership will allow a balanced approach that can address the country's most pressing social security and health-care needs.

The following must be the overall objectives of any scheme: (i) there must be generally free service at point of delivery with, if any, only very limited user fees/co-payments, (ii) the poor / destitute and women and children must be prime target groups for quality services, and (iii) services must be substantially improved in general. Figure 4 provides a graphical overview of financing sources and membership cards in SLeSHI.

Figure 4: Overview of financing sources and membership cards in SLeSHI



1

National management with local ownership of SLeSHI is the key for the further technical, political and funding processes. It is hoped that the overall proposal will be approved by the authorities and supported by the people and the donors, although details need to be further discussed and refined. The proposed plan will build strongly on a micro/community-based approach, since it rests on local oversight, local information and education, and local identification of those exempted. It allows for full community participation, peer review, and responsiveness to local needs whilst harnessing the positive aspects of central management, i.e. nation-wide pooling, subsidies for the very poor, technical knowledge and support.

The proposal takes account of the results of recent or on-going studies and programmes and any implementation will be in close cooperation with donors as well as bi- and multilateral agencies working in the health sector.

There is a clear need for significant political and financial (donor) support to further develop, fine-tune and implement the proposal. Only a joint approach involving all of the relevant stakeholders will ensure the lasting success of such a major undertaking.

5.1. The advantages of the proposed approach: combining a community-based approach with national technical pooling and capacities

As has already been stated, none of the "pure" approaches has been shown to be feasible in a development setting. A much-debated alternative is community-based health insurance (CBHI). CBHI has been defined as an insurance scheme which is aimed primarily at covering informal economy workers and formed on the basis of the local pooling of health risks, and in which the members participate in management.

CBHI is also referred to as a micro-insurance scheme managed by community members, a community-based organization whereby the term community can be defined as the members of a professional group, the residents of a particular location, a faith-based organization, etc[8].

The key characteristics of CBHIs have been identified as:

- being locally initiated small-scale health insurance schemes that are specially designed to meet the health-care needs of poor families;
- being formed on voluntary basis;
- being based on concepts of mutual aid and social solidarity;
- having established a pre-payment mechanism for health care expenses; and
- being designed to assist those in the rural and informal economy for whom other forms of health insurance are not appropriate.

The policy holders are the owners and managers of CBHIs. One or two managers, who work on a voluntary basis, are elected among the policy holders. The level of contributions to be made and the rules for enjoying benefit packages are determined through participatory approaches. Agreements are made with health-care providers through negotiations concerning payments to be made for benefit packages. Such benefit packages need to cover for both high-cost and low-incidence health events (such as emergency operations), and frequent low-cost health events. The provision of transport services for health emergencies is also an important issue to be considered.

Pre-payment is one of the most important determining factors for developing sustainable health-care financing. Pre-payments could promote the achievement of equity goals based on the social solidarity concept due to their risk-sharing and fund-pooling potential as well as their potential to translate out-of-pocket health expenditure into pre-payment schemes.

[8] World Health Organization Regional Office for the Western Pacific (WPRO) (2005). Strategy on health care financing for countries of the Western Pacific and South-East Asia Regions (2006-2010).

CBHIs are playing an increasing role in developing countries these days. They are particularly prevalent in Sub-Saharan Africa and have also developed in Asia and Latin America.

Reviews of CBHIs have looked at resource mobilization capabilities, financial protection and measures to combat social exclusion[9]. Analysis of the factors associated with successful resource mobilization and financial protection is based on technical design characteristics, management characteristics, organizational characteristics, and institutional characteristics.

The reviews concluded that community involvement in resource mobilization increases access to health care for those covered by the CBHIs, and financial protection is also provided through the reduction of out-of-pocket spending. At the same time, it was indicated that they still exclude the poorest and perhaps those most in need. Findings also showed that poor people were often willing and able to pay where:

- their payments were subsidized − which at the same time also ensured their access to good quality health-care services;
- community members were directly involved in designing and managing the CBHIs;
- the benefits included easy access to a network of health-care providers.

The weaknesses of CBHI are as follows [10]:

Limited protection for members. The ability of CBHI schemes to raise adequate resources is limited by the low overall income of the community. CBHI remains within a community and cannot rely on subsidies from the better-off communities. In short, it is a question of "the poor financing health care for the poor".

Sustainability is questionable. The small size of the pool makes many CBHI schemes vulnerable to failure. Indeed, the materialization of one single large risk could cause bankruptcy.

Limited benefit to the poorer segments of the population. The very poor cannot participate in such schemes as they simply do not have the cash means to contribute and in-kind contributions are very difficult to manage.

Limited effect on the delivery of care. As CBHI often lacks technical expertise and these schemes have limited purchasing power, their leverage with providers to demand high-quality services at a reasonable price is low.

[9] The following publications form the core literature here:
Preker, A.S., Carrin, G., Dror, D., Jakab, M., Hsiao, W. & Arhin-Tenkorang, D. (2002). "Effectiveness of community health financing in meeting the cost of illness", in Bulletin of the World Health Organisation 2002, 80 (2), pp. 143-50.
Jakab, M. & Krishnan, C. (2001). Community involvement in health care financing: a survey of the literatures on the impacts, strengths, and weaknesses. HNP discussion paper, The World Bank.
Ekman, B. (2004). "Community-based health insurance in low-income countries: a systematic review of the evidence" in Health Policy and Planning, 19(5), pp. 249-270.
Gottret P. and Schieber G. (2006). "Community-based health insurance" in Health Financing Revisited. A Practitioner's Guide (Washington, World Bank, pp. 96-103. The pdf version can be downloaded from the World Bank website.)

[10] Based on Gottret P. and Schieber G. (2006). "Community-based health insurance" in: Health Financing Revisited. A Practitioner's Guide (Washington, World Bank, pp. 96-103. The pdf version can be downloaded from the World Bank website).

In conclusion, CBHI schemes face very difficult issues affecting both their effectiveness and their sustainability. ILO's STEP (Strategies and Tools against social Exclusion and Poverty) has set up a website that provides numerous studies and tools for microinsurances and social health protection initiatives.

All in all, CBHI is a useful and highly visible instrument, but certainly not a panacea. It clearly has its limitations and when run inappropriately or with lack of management expertise it can severely backfire and destroy people's confidence in any form of pre-payment scheme.

The plan therefore now proposes a careful mix of community-based elements and national technical support. In addition, national pooling will allow much greater stability and potential for cross-subsidization than do single, locally confined schemes. Moreover, national pooling allows general fund transfer from other sources to the scheme. The proposed mix of national and local elements tries to integrate the clear strengths of CBHI while at the same time alleviating the well-known risks.

5.2. SLeSHI governance and management

The new institution will be called SLeSHI – the Sierra Leone Social Health Insurance. SLeSHI will act as an independent institution. The MoESS or some institution designated by the Ministry will supervise SLeSHI. SLeSHI will be established by an Act of Parliament, and relationships between SLeSHI and NASSIT as well as other relevant agencies will be governed by Memoranda of Understanding (MoUs).

Governance

A Board of Trustees will govern the Senior Management. This Board should be broadly composed to reflect important stakeholders in the scheme. It should have eleven (11) Board members, and its composition should be gender-sensitive. The members of the Board should be drawn from the following bodies:

- the National Social Security and Insurance Trust (NASSIT),
- the Ministry of Finance and Economic Development (MoFED),
- the Ministry of Employment, Labour and Social Security (MELSS),
- the Ministry of Internal Affairs and Local Government (MIALG),
- the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA),
- the Ministry of Health and Sanitation (MoHS),
- civil society,
- the Medical and Dental Association or the Nurses and Midwifery Board,
- health-related NGOs,
- inter-religious councils,
- the Employers' Federation and trade unions, and
- the Insurance Commission.

The Board should be elected for three (3) years.

Pro-active transparency and accountability measures should be implemented from the outset. In order to mitigate negative developments an independent unit will be set up, the Complaints and Investigations Bureau (CIB), dealing with issues such as fraud with a direct link to the SLeSHI Director-General. This independent unit should also report directly to the Board and to the relevant ministries and institutions (MoHS, MoFED, Auditor-General) and should be required to publish an annual report to be made available to the public. In addition, the consultants suggest than an ombudsman be appointed, whom the insured and patients can contact direct and who will look into any complaints and possible mismanagement.

Management at the central level

SLeSHI's central-level management would work on all issues pertaining to general aspects of the scheme, e.g. financing, quality control, accreditation standards, and benefit package amongst others. Central-level management would also be responsible for maintaining close contacts to politics and central-level government. In addition, central management would also supervise and support the local level, e.g. via central controlling and book-keeping. Close coordination with relevant national bodies (such as the Pharmacy Board and the Standards Bureau) is important for technical management.

Management at the local level

It has been agreed that strong local management and clear visibility must be ensured by setting up an office in each district. The district offices should have a local supervisory board, manage core daily business (claims management, membership administration, complaints management, and so on) and should enjoy some degree of regional independence, for example in defining additional benefits to be provided, specific local measures to reach disadvantaged populations, IEC measures and so on. This anchoring at the local level is an essential component of SLeSHI and will help to gain trust and responsiveness.

The proposed mix of central and local responsibilities complements the current process of devolution/decentralization in Sierra Leone.

Figures 5 and 6 provide graphical overviews of the structure.

Figure 5: Overview of the SLeSHI management structure

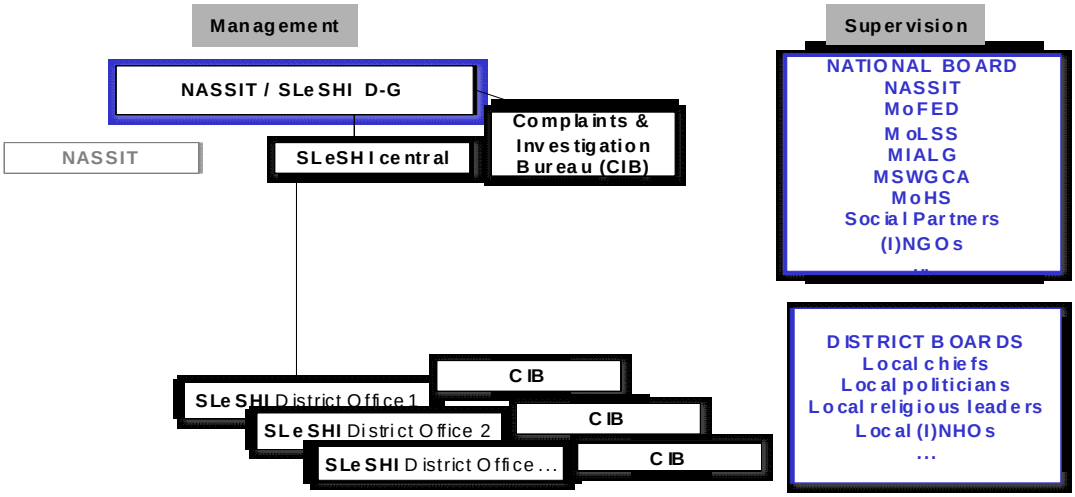
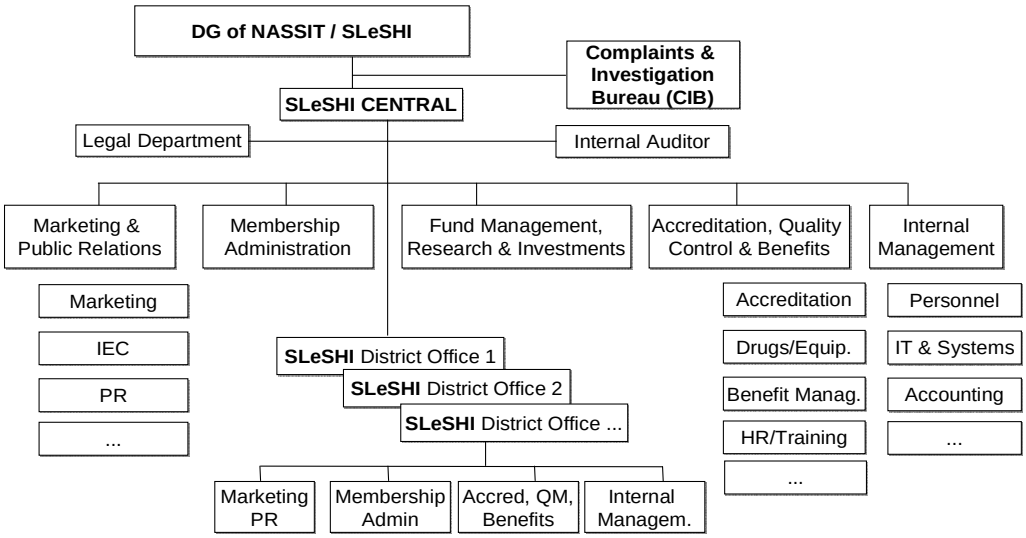


Figure 6: Management structure at the central level



Collaboration and institutional arrangements between SLeSHI and NASSIT

NASSIT has accumulated a wealth of experience over the past few years and it would make perfect sense to make use of this knowledge as much as possible. In addition, such additional work for some of NASSIT's departments could harness economies of scale.

It is suggested that initial stocktaking and internal discussions between NASSIT and the evolving new scheme be envisaged in order to identify capacity-building needs and to see where NASSIT staff could play an initial role and to what extent NASSIT rules and regulations could be copied. Furthermore, staff from the private health care industry might play an important role in teaching and on-the-job training and could even fill central positions in the new scheme.

Starting within NASSIT

It was widely agreed that the scheme should be started by using NASSIT's well-developed capacities. A Department of Social Health Insurance within NASSIT would make it possible to use the institutional environment to the full and then gradually develop administrative, financial and operational capacity for SLeSHI. The Department would have a Charter and defined autonomy in decision-making, as well as financial, contractual and operational autonomy. It would, however, work under the auspices of the NASSIT Director-General and the NASSIT Board and would use the NASSIT infrastructure (district offices, headquarters, accounting and other services, until it gradually develops its own capacity based on the results of the pilot studies. Funds management would be run completely separately right from the outset and would be audited by independent external auditors.

Although NASSIT has developed into a trusted and technically competent institution, it is clearly not well-versed in running a health insurance scheme. The complexity of risk management and the task of prompt administration of claims, proper negotiations with providers and monitoring quality in a large number of institutions go well beyond NASSIT's current mode of operation. Therefore, although SLeSHI will be initially an integral part of NASSIT, competencies need to be developed and established before operations are rolled out.

In addition, there should be a specific Memorandum of Understanding (MoU) between NASSIT and SLeSHI before operations are launched. This MoU should outline responsibilities, reporting structure, financial agreements and hiring of personnel. Given the complexity and crucial role of this MoU in setting up SLeSHI as well as preparing for the separation of the two entities in the foreseeable future, this MoU should be a major focus in the coming months. It was agreed at the National Consultative Conference that SLeSHI will be separated from NASSIT after 5 years of operation. The MoU needs to reflect this, and provision should be made for a smooth and non-disruptive transition phase.

Legal framework

A fully independent SLeSHI will require a National Law (and possibly a Charter as well as Executive Orders). It is suggested that the legal framework be made as simple and functional as possible. Intense political lobbying is thus a major prerequisite for further action (see 5.11). At all events, specific legal expertise is needed to translate political will into a coherent legal framework while at the same time allowing SLeSHI to be relatively independent of changing political governments and goals. The legal framework should be specific enough to allow for productive continuation of SLeSHI's core business, but at the same time leeway is necessary to reflect the political will of any government in SLeSHI's operations, such as allowing specific benefits to be included in the benefit catalogue or allowing extra money to be channelled into SLeSHI for generally improved care. A paragraph allowing for piloting innovative schemes and approaches would be most helpful, enabling SLeSHI to test new forms of provider payment, revenue collection, and so on.

5.3. Division of labour between SLeSHI, the MoHS, and local institutions

As stated above, the goals of public health and health insurance are quite different. The proposed split between public health and curative services should therefore be very clear and stringent at all levels.

All public health services should remain with the MoHS at the central level and with the DHMT/DMO at the local level. These services would include (amongst others) public screening measures, immunization, water and sanitation control, ante- and post-natal care, and child growth monitoring. SLeSHI would carry out all activities related to its function as a provider of social health insurance under the supervision of the MoESS.

Figure 7: Overview of the setup involving MoHS, SLeSHI and local institutions

Local hospital boards would be responsible for the management of facilities. These local boards should eventually have overall and independent responsibility of their facilities. Only local political supervision can ensure adequate response to the local needs of the population. The current untenable situation where local staff are centrally hired, paid and managed will hopefully soon be overcome with further devolvement of functions, funds and responsibilities.

Administrative and management support could come from the MoHS and also to some extent from SLeSHI. Ideally, SLeSHI and the MoHS would conduct regular supervisory visits to each and every facility with the aim of re-accreditation and quality control. See Figure 7 for an overview of the setup.

5.4. Population coverage and benefit package

When SHI is introduced, it very often occurs as a natural option to start with the formal sector since this sector can easily be reached and contributions to SHI can be taken at the source, Furthermore, the formal sector is normally used to contributing a certain

percentage of its income to insurance schemes and able to do so. The benefit package in turn is often quite comprehensive.

However, the major drawback of this approach is the limited population effect. In many developing countries the formal sector comprises 10 or perhaps 20 percent of the population – 80 per cent is essentially left out of the scheme. It becomes extremely difficult and tedious to extend the existing SHI to the informal sector. In a recent conference in Manila (2006) a multitude of extension approaches were presented, none of them fully convincing or readily applicable in all settings.

According to the 2004 Labour Force Survey, about 2 million individuals in Sierra Leone were working in the informal sector (nearly 92 per cent of total employment). The gender distribution shows that 94 per cent of women and 85 per cent of men are in that sector. The picture is almost the same across the working-age population. In terms of occupation, the informal sector in Sierra Leone covers a diverse range of economic activities. The vast majority of workers (81 per cent) are in the agricultural sector (subsistence crop-farming, animal husbandry, fishing and hunting). About 12 per cent of workers in the informal sector are in sales (traders), while others are in small production units such as shoe-making, clerical work and so on. Only 1 per cent of workers are classified as professional informal sector workers.

Finally, in terms of cash earnings, informal sector workers earn on average just under one-third of what their formal sector counterparts earn.

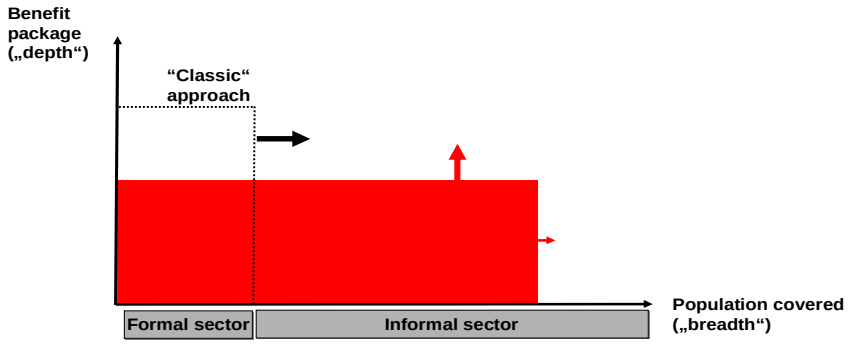
It is thus proposed that the insurance should cover the whole population from the outset with a limited benefit package of primary and secondary care; phased implementation, however, is needed and possible. As Ensor et al.[11] rightly point out:

> Comprehensive, universal care in Sierra Leone is not currently affordable. It is, therefore, necessary to develop selective approaches to health financing.

As discussed by Ensor et al., several targeting mechanisms are possible and we agree with this group's recommendation of focusing on institutions. This will complement the idea of trying to cover as broad a population as possible right from the beginning.

[11] Ensor, T., Lievens, T. & Naylor, M., op.cit., p.10

Figure 8: Benefit package and population covered in various approaches



Coverage of traditional healers and medicines is an important issue, which needs to be dealt with at some point. We suggest two approaches to initially defining the benefit catalogue:

- close cooperation with providers and communities in defining the benefit scheme
- focus on group discussions with members of the public.

Figure 8 illustrates the classical approach of a more comprehensive benefit package for the formal sector versus a more modest benefit package for the entire population.

Closely related to the benefit package is the issue of contracting options with providers and suppliers. This is examined in detail in section 5.7.

5.5. Revenue: sources and collection

The contributions from the formal sector will not allow cross-subsidization of the large informal sector in the country. We therefore propose a multitude of revenue sources, some of which are quite similar to a tax-based system. However, we think that an independent body like the SLeSHI should govern and manage all these contributions because of its visibility, the clear separation from the MoHS and the chance to build up a trusted institution. The collection should be done at source whenever possible.

A percentage from the salaries of the formally employed

At present, NASSIT contributions are 10 per cent of salary from employees plus an additional 5 per cent from employers. The tax rate ranges from 20 per cent to 30 per cent. It has been agreed that 2 per cent of the gross income of all formal sector employees should go to SLeSHI irrespective of level of income. This would be complemented by a 4 per cent contribution (4 per cent of the gross salary) from the employer.

As the formally employed will contribute substantially more than the average adult Sierra Leonean, we propose some advantages for those contributors, most importantly the possibility to access secondary care direct without the need for referral.

A contribution from ALL economically active adult Sierra Leoneans

The idea of insurance is to contribute on a regular basis in order to be eligible for benefits. We think it is paramount to have each and every economically active adult individual in the country contribute to the scheme.

The rather positive and encouraging results of the local tax led us to the idea of "piggybacking" the local tax collection mechanism.

A "health contribution" of 10.000 Le (around 2,50 EUR) per adult has been agreed on. This needs to be carefully timed to harvest cycles because it will be easier at that time for subsistence farmers to contribute. January to May each year will be the collection time.

> The conceptualization and measurement of poverty in Sierra Leone was based on access to a range of assets and other resources. These assets included the physical condition of housing, type of roofing material, type of flooring and type of wall of the house. Further, the list also included the sources of cooking and lighting energy, the main source of drinking water, the type of toilet facility, and the means of rubbish disposal. Finally, the list included the number of head of livestock owned by a household.
>
> The Statistics Sierra Leone constructed a poverty index using weights derived from each type of asset. For each household, ownership of an asset determined its "mean poverty score" or economic status score. These scores were then used to categorize all households into one of five groups classified as very rich (16 per cent), rich (17 per cent), poor (17 per cent), moderately poor (16 per cent) and very poor (34 per cent).
>
> Such a method of measuring household wealth has advantages in a country such as Sierra Leone, where cash incomes may not be the only indicator of economic status. It also avoids problems of measuring income or expenditure directly in a survey in a developing country.

We therefore suggest that contribution waivers be introduced for the very poor as well as possibly other groups, e.g. the handicapped. Children and minors up to the age of 18 will also be excluded from payments. These groups will be identified at the district level. Further intense and widespread discussions are needed on the detailed definition and execution of such a waiver scheme. A committee will look into this once appropriate feasibility studies have been carried out.

Family members of the very poor who are better off might be quite willing to pay if they can be assured that membership with SLeSHI prevents the poor relatives from asking for support in the event of illness – this should also be taken into consideration.

A percentage from the GST / VAT

In the near future a goods and services tax (GST; VAT) is to be introduced in Sierra Leone in order to broaden the government's tax base. It has been suggested that 2 to 3 percentage points of this be used for health insurance purposes.

At present, 12.2 per cent of GDP is channelled via the government, some of which is off-budget. Sixty per cent of all State revenue currently comes from customs and excise. In general, the level of compliance is rising. VAT is expected to bring in another 3 to 5 per cent of GDP, thus considerably broadening the fiscal space. In the first one or two years

the introduction of this tax will be budget-neutral, since substantial up-front investments are needed.

The budget allocated by the MoF to local councils for curative health care

At present, as a result of devolution, the MoF allocates an annual budget for public health and for curative health to the local councils and District Health Management Teams (DHMTs). Whereas the budget for public health measures should remain in the hands of the DHMTs and should be spent in consultation with the MoHS, it is proposed that the budget for curative care be allocated to SLeSHI to pay for curative services.

A percentage of the funds of the Social Safety Net Fund

The MoESS manages this substantial fund and, since health financing is clearly one element of a functioning social safety net, some of these funds could be diverted to SLeSHI.

Additional funding from consumption taxes

As the flat contribution from all adults will place a heavy burden on the destitute and very poor, we propose that additional funding be considered in order to achieve more equitable financing. The two most promising levies could be a "health contribution" on the ownership of motor-cars and on the use of mobile phones. The latter in particular has a huge potential for revenue and, for example, a modest 5 per cent "health contribution" on all user charges could very well be seen as an acceptable contribution to the health of fellow Sierra Leoneans.

A suggestion made by His Excellency the Vice-President concerned taxing tobacco and alcohol consumption as an additional means of paying for health care. A contribution could also be levied on environment-polluting machines such as generators, ships and aircraft. Such contributions are relatively easily levied, but their reverberations on the economy need to be carefully analyzed and monitored.

A major element of future work will be to focus on the collection of contributions from the various sources, making sure they arrive in a timely and uncompromised manner. Moreover, the exact level of contributions and input from various sources needs to be defined during the process of refining the key elements of the proposal.

5.6. Types of care covered and referral

SLeSHI would cover only primary and secondary care. The limited budget available does not allow for more expensive tertiary care such as hemodialysis and cancer care. This type of care will be left to the referral hospitals and national specialist hospitals under the MoHS. A division of this nature would allow state-of-the-art medicine to be tested at the national level and this type of care to be kept for education and training purposes.

The numerous vertical schemes currently operated in the country (such as HIV/AIDS, malaria, tuberculosis, mother and child care) need to be integrated and aligned with the SLeSHI benefit package. For the time being it might be best to leave these programmes as they are and build additional SLeSHI-financed services around them. Some important and potentially impoverishing services such as caesarean section or casualty services need to be included.

Referral scheme and gate-keeping

We suggest the introduction of a referral scheme based on the idea that reimbursement of secondary institutions will only be made if (a) a referral slip from a primary institution is attached or (b) the patient comes as an emergency case. The technical details need to be discussed.

The possible role to be played by traditional medicine needs to be carefully considered. Although its potential should not be neglected, the often rather informal setting makes any payments difficult and prone to fraud. Despite this risk, some selected traditional forms of care are being tested (for example, some forms of traditional care that should come under the benefits package).

Table 4: Coverage in primary and secondary care

Primary care	Secondary care
Most common conditions defined	Diagnostic procedures
Drug list	Internal medicine
Basic equipment	Obstetric care
Standard treatments	Paediatrics
Other	Surgery

Since confidence in the scheme is paramount, conservative actuarial calculations and a focus on the quality of services is strongly recommended.

A referral scheme is a central element in managing the flow of patients and preventing people from flocking to the seemingly better institutions. International experience shows that referral systems only work if they are (i) simple, (ii) clearly communicated and (iii) coupled with incentives. Again, a detailed description of the referral mechanism is beyond the scope of this report but a working group composed of the relevant stakeholders could develop an integrated model that is both feasible and robust. The encouraging results of the local scheme for supporting transport costs (see the text box in chapter 3.4.2) should be taken into account.

SLeSHI members would only be able go to a secondary facility in an emergency or if they have a referral slip; otherwise such patients would be responsible for full payment for care.

5.7. Eligibility and identification

Only SLeSHI cardholders would receive benefits, non-cardholders would have to pay for services. Two different types of SLeSHI cards would be issued. A SLeSHI Card (with signature and photograph) for everyone who has contributed 10,000 Le to the insurance or has been formally exempted.

Exemption has been thoroughly discussed but not yet finally agreed on. While the very poor need to be exempted, an initial move to also exempt pregnant women met with the concern that this would also exempt some rich people. However, all children up to the age of 18 will be exempted. It has been suggested that the details of exemption be further discussed in a special committee in addition to local consultations. Any exemptions require clear and easy identification of who should be exempted. There also seems to be concern that exemption might stigmatize people and hence efforts should be made to avoid this. It

was further suggested that the local District Board should determine who benefits from the waiver.

When accessing an institution non-cardholders could pay the annual SLeSHI contribution (plus some extra charge) upfront to make them eligible for SLeSHI benefits. Incentives could also be created to increase compliance in paying the annual contribution for SLeSHI.

It was suggested that foreign nationals could be eligible for access the scheme. To obtain this eligibility they would have to register with SLeSHI and pay 50 US$ per year. Sierra Leoneans working abroad and not permanently residing in the country could register with the scheme and pay 50 US$.

In order to build up a sufficient reserve with SLeSHI, a 3- to 6-month waiting period after obtaining the SLeSHI card has been suggested before access to services via SLeSHI can be obtained.

5.8. Active purchasing and quality management

As previously stated, SLeSHI will not confine itself to the role of a passive payer, but will act on behalf of its insured population to obtain effective and high-quality care for the insured.

Accreditation

Accreditation plays a major role in ensuring good services. Accreditation should not be understood as a bureaucratic measure but as a dynamic process – the constant dialogue between the accredited institution and the accrediting authority should ideally lead to a learning environment. Both public and private providers (including faith-based organizations) can apply for accreditation. SLeSHI should make optimal use of the available manpower and institutional competence. There are numerous guidelines available internationally and it should pose no problem to use one of the standard formats (e.g. from the WHO) as a basis for a national approach. We strongly suggest, however, that an accreditation authority be set up carefully with massive input from providers and the MoHS in order to access maximum technical expertise and gain acceptance. Uniform prices and clear quality standards should be mandatory. The local management team of the SLeSHI District Office should be closely involved here, but guidelines should come from the central level. “Secondary” issues such as water, sanitation and power supply should also be part of this process, since major disruptions in service provision were frequently observed due to inadequacies in these areas.

Human resources

Human resources are of course the very backbone of any quality service. SLeSHI may need to take the lead in the medium term to develop and support initiatives to draw qualified personnel to rural areas. Better wages are only one element here. Equally important are a conducive working environment, housing and appreciation of medical and nursing work (in the form of bonuses, for example).

Costing

Costing plays a vital role in keeping expenditure at bay. The consultants suggest that a comprehensive costing study be carried out at an early stage in the establishment of SLeSHI. It is important to do so at that point, since once prices are set it can be very difficult to adjust them downwards.

Equipment

The National Health Insurance Fund (NHIF) in Tanzania has recently launched an innovative approach whereby the Fund gives out loans for selected equipment and the loans are to be paid back by forfeiting reimbursement claims. Initial experience is very encouraging. SLeSHI might consider a similar scheme for improving and upgrading facilities. This, however, might not be feasible during the initial period of operation.

Provider payment, reimbursement and claims administration

In principle very many different forms of reimbursement are possible, all with pros and cons. For administrative reasons, simple-case payment in primary care has been agreed upon: this can be done relatively easily and, given the limited diagnostic and therapeutic options, it seems realistic to assume that there is comparatively little leeway for cream-skimming and sub-optimal service provision. The role of communities is emphasized and has been dealt with before.

As regards secondary care, we think a strong incentive should be given to improve the quality of services, and we therefore propose a fee-for-service scheme. It has been well proved that such a form of reimbursement, if done properly, will lead to investments from providers and will generally propel an institution in terms of structural quality and a conducive working environment. However, there is a clear need for careful pilot studies in order to avoid uncontrolled rise in expenditure.

Any additional or substantially more complex form of provider payment should be rejected at present since it is imperative to keep administration as simple as possible at the beginning. In addition, pay-for-performance, for example, may focus only on a limited number of outcomes and has a strong effect on providers to provide services that will affect their assessment and pay. However, innovative options should nevertheless be considered in order to create incentives for providers to improve services.

The administration of claims for primary care will be comparatively simple. However, it will be important to check whether a billed patient has actually visited the facility (and received medication) e.g. by signing or thumb-printing. Handling claims for secondary care with fee-for-service is much more complex. Here, national and international experience should be sought and structured training initiated in order to build up a skilled workforce.

Monitoring and quality control

Although we are unable to flesh out details at present, a number of measures are available to encourage proper record-keeping and discourage perverse incentives leading, for example, to fraud:

- patients must sign their attendance (primary care) or itemized bills (secondary care);
- providers must record the number of the SLeSHI card;
- procedures must be computerized at the district level with the option of analysing reimbursement patterns.

Quality control is another wide-ranging area to which at present only some preliminary remarks can be made. Some simple measures such as monthly reports and regular

supervisory visits will go a long way in encouraging a culture of quality-awareness and constant improvement in service delivery.

SLeSHI should take the lead, cooperating closely with the MoHS and providers in working for some mode of continuous quality improvement. Examples of best practices from various countries are available, which could form the basis for national quality benchmarks and quality assurance reference manuals. Such benchmarks could include standard treatment guidelines, quality measures and ways and means of improving the quality of care in general.

5.9. Provider capacity nationwide

An important component in the assessment of the feasibility of a national insurance programme involves looking at the institutional capacity within a country. An insurance scheme can only succeed if there is capacity within a health system to deliver at least a decent package of benefits to the insured population. This assessment considers the distribution of physical health infrastructure, availability of equipment, staff, and other systems. It also involves looking at capacity utilization and the services provided in existing facilities. Capacity is important in order to address concerns regarding possible overcrowding under an insurance scheme. Some basic information is available in Sierra Leone. In this section, we report on key indicators that describe the capacity of the Sierra Leonean health care system.

Infrastructure

Although physical access is a problem in Sierra Leone, two key indicators of physical access, namely the population-to-bed ratio (see Table 5) and the percentage of the population within one hour of a health facility (see Table 6) are not out of line with Sub-Saharan African standards. More physical infrastructure is clearly needed in specific regions of the country. For instance, there is some reason for concern about the tight supply of hospital beds. Also, the time taken to reach a facility needs to be reduced significantly if SLeSHI is going to win acceptability and offer the benefits to the intended population in an effective way.

Furthermore, as we learnt during our up-country field visits, these ratios in the table mask an important aspect of the poor quality of infrastructure in many cases. Many public hospitals and health centres, particularly in rural areas, will need some refurbishment before or soon after accreditation by an insurance agency. In some countries such as Tanzania, the challenge of rural infrastructure and equipment is being addressed using the reserves that have been built up over the years. It seems that in Sierra Leone, public providers will be the major provider group under SLeSHI.

This assessment of hospitals is somewhat contradicted by the report of a survey of PHUs conducted by Statistics Sierra Leone in 2006 (the IRCBP reports). According to that survey, virtually all PHUs in the country were judged to be in good physical condition (only 1 per cent of PHUs were assessed as being in need of repair). Unlike hospitals (where we focused our attention), the PHUs are portrayed as being in a relatively good state of repair.

Table 5: Distribution of health facilities, hospitals and beds per district population

	Population	Population/Health facility	Population/hospital	Population/ bed
Bo	463,668	5,269	231,834	699
Bombali	408,390	4,439	68,065	878
Bonthe	139,687	3,676	69,844	582
Kailahun	358,190	6,396	358,190	1,312
Kambia	270,462	6,440	270,462	1,276
Kenema	497,948	5,472	248,974	1,245
Koinadugu	265,758	6,180	265,758	3,127
Kono	335,401	4,861	335,401	1,048
Moyamba	260,910	3,143	130,455	1,165
Port Loko	453,746	4,776	151,249	1,371
Pujehun	228,392	4,758	228,392	1,842
Tonkolili	347,197	4,692	173,599	911
Western Area	947,122	8,770	59,195	450
TOTAL	4,976,871	5,375	127,612	855

Source: MoHS

Table 6: Time taken to reach a district hospital from health centre

Time to nearest district hospital	% of PHUs
Less than 30 mins	11
Between 30 mins and 1 hour	16
Between 1 hour and 2 hours	18
Between 2 hours and 3 hrs	17
Between 3 hours and 5 hours	25
More than 5 hours	13

Source: Institutional Reform and Capacity Building Project (IRCBP) Report 2007

The report points out, for example, that 17 per cent of PHUs in the country had reported using piped water, 54 per cent used water from a mechanical well, and 17 per cent used an ordinary well. The remaining 12 per cent relied on water from a river or stream. About 80 per cent of PHUs had some source of power: 76 per cent used solar power, 10 per cent operated a generator and only 4 per cent were on the national electricity grid. Three-quarters of the PHUs sampled had a refrigerator, and 86 per cent of those refrigerators were in working order at the time of the survey.

An effective referral system is a key aspect of the benefit package under the insurance arrangement. This requires that patients can be transferred from one level to the next with relative ease, which in turn requires that health facilities are within a feasible distance of one another. To assess this, we examined the average time taken to reach a District Hospital from a PHU (see Table 6). As can be seen, there is a cause for concern for a significant number of geographic localities where it takes more than 3 hours to reach a

referral district hospital from a PHU. The study estimates that the average time is about 3 hours. This confirms that many PHUs are isolated.

Human resources

When we evaluated health system capacity, the most disconcerting issue was the dismal population-to-staff ratios (see Table 7). This assessment suggests that critical human resources would need to be recruited beforehand, particularly in rural areas, where human resources are even scarcer and there are fewer private provider options.

Table 7: Staff-to-population ratios

Cadre	Ratio	Cadre	Ratio
Medical officers	1:78,125	Psychiatrists	1:5,000,000
Paediatricians	1:1,000,000	Midwives	1:57,471
Dentists	1:625,000	Nurses (all grades)	1:22,222
Obstetricians & gynaecologists	1:714,286	Nurse anaesthetists	1:454,545
Public health specialists	1:238,095	MCH aides	1:4,072
Surgeons	1:625,000	Pharmacy technicians	1:38,462
Medical specialists	1:714,286	Pharmacists	1:294,118

Source: MoHS

Reasons cited for high attrition in the public health sector

As we went round, we interviewed health workers about the possible reasons for the low levels of staffing and the high attrition rates of health staff particularly in the public sector in Sierra Leone. The notable reasons included the following:

- poor conditions of service (i.e. low salaries, lack of basic work tools, highly centralized decision-making structure);
- undefined career path for medical personnel coupled with irregular or no promotion;
- lack of opportunities for further training;
- slow absorption of new graduates into the civil service.

Throughput and other indicators

As shown in Table 8, there are variations in all indicators across hospitals. These variations can be partly explained by geographical location. The nature of referrals handled may also affect throughput and other indicators. About half the hospitals already operate with relatively high occupancy rates, notably Connaught, Magburaka, Makeni and the PCMH. The other hospitals have quite low occupancy rates. Connaught also has a much longer average length of stay (ALOS) and reports by far the highest death rate per admission amongst all hospitals. ALOS seems to be within a reasonable range by international standards.

However, the authors caution that ALOS and bed occupancy may be disproportionate since district hospitals are likely to admit patients requiring shorter stays than those in Freetown. The variability in throughput is also indicative of potential capacity in some hospitals to deliver extra output or handle any surge in patient volumes that might occur once insurance is put in place without compromising the quality of service.

It seems that some facilities are busier than others. An assessment of overall throughput in primary health care units also suggests that on the whole there is room to increase the productivity of public facilities (Review of health financing in Sierra Leone 2008).

All in all, we think that improvements in the existing hospital facilities and the construction of more PHUs will be needed in order to bring the paying population closer to health service and to reduce transport costs. It is hoped that with World Bank support for upgrading infrastructures the current programme might provide an opportunity to address this issue. The shortage of basic equipment in these facilities also needs to be addressed. Human resources remain the greatest challenge that needs to be addressed before the scheme can start. On a positive note, most of these issues could be effectively addressed with some seed money. Resolving the human resources issue, however, requires additional political and administrative will to change existing structures and procedures.

Training and capacity-building

SLeSHI will require a number of well-qualified staff – staff that might not be readily available in the country. The issue of the (internal and external) "brain drain" is particularly relevant here, and we propose a very careful analysis of the needs and the currently available personnel. It might be possible to hire some key persons from the private insurance industry, as it seems likely that the health insurance business will shrink, and it might also be possible to develop some form of exchange or "buddy-buddy" approach with NASSIT, whereby NASSIT staff will take on a coaching role for counterparts in SLeSHI.

But there will nevertheless be a need for a well-structured and well-executed training programme. Some of the expertise could come from within the organization and from NASSIT but external help should be sought. Numerous donors have developed excellent training schemes, which could be tailored to SLeSHI's needs.

Human resources are the single most important factor determining the performance of an organization. Staff development and continuous training should therefore be a top priority right from the outset. Special emphasis should be put on finding and developing staff at the local level as there is a strong tendency for the better qualified to leave for the capital or even to go abroad. The next step should be to make human resources a top priority and to carry out a thorough review of capacity and training needs.

Table 8: Capacity and throughput statistics for selected hospitals

	Beds	Bed days	Admissions	Deaths	Occupancy rate	ALOS	Deaths/admissions
PCMH	130	28,083	2076	101	59%	13.53	4.9%
Ola During Children's Hospital	124	25,388	3273	178	56%	7.76	5.4%
Connaught	83	27,287	1931	408	90%	14.13	21.1%
Rokupa Govt Hosp	45	8,109	1428	12	49%	5.68	0.8%
Kingharman Road	25	3,991	636	20	44%	6.28	3.1%
Lumley Govt Hospital	35	715	122	-	6%	5.86	0.0%
Magburaka (Tonkolili)	300	79,576		-	73%	NA	NA
Bonthe	60	-	44	2	2%	-	4.5%
Kabala (Koinadugu)	100	-	787	48	20%	-	6.1%
Port Loko	75	-	312	30	11%	-	9.6%
Bo	450	17,747	-	-	11%	-	-
Makeni (Bombali)	62	13,887			61%	NA	NA

Source: Ensor et al (2008)[12]

5.10. Refining key elements of the emerging SLeSHI and feasibility study

Given the complexity of the scheme one would be well advised to take a phased approach to implementation i.e. by starting in several selected districts. These districts should be very carefully selected as the technical, socio-economic and political environment is vital for the success of such a highly visible, emotionally charged and potentially contentious scheme.

Some aspects to be considered when choosing the first implementation district(s)

(I) Are the facilities of the district(s) in good condition or about to be refurbished (?)

(II) Is there political support and political as well as administrative strength?

(III) Is the geographical accessibility from Freetown good?

(IV) Can support for the pilot be secured from donors?

Apart from selecting a district, some general work needs to be done first of all

(I) the possible cost of the pilot study should be ascertained;

[12] Ensor, T., Lievens, T. & Naylor, M., op.cit

(II) internal support should be secured − GoSL, MoHS and NASSIT;

(III) external support should be secured − multilateral institutions, bilateral donors, NGOs;

(IV) a dedicated task force will be needed to develop concrete detailed tasks, procedures and solutions and to oversee all operations;

(V) if seed money is needed, from whom could this be obtained? (NASSIT, GoSL, donors).

With respect to the cost of running a pilot project, some initial figures could be estimated

(1) The cost of upgrading an 80-bed hospital. The MoHS estimates that it would cost **3.1 billion Le**. Items included are:

Admin building

Clinical wards / surgical wards / private ward

Medical equipment

Theatre in maternity

Doctors' quarters (2) / Matron's quarters (2) / Nurses' quarters (4)

NB. This was based on needs and costs at Muyamba Hospital. Information obtained from MoHS. One could assume that the cost of upgrading a PHU would be 5 per cent of that of a hospital.

(2) Human resources numbers and salary costs can be calculated as follows:

4 additional MDs (1 per ward − Maternity, Internal Med, Surgical, Paediatrics) at a salary of 1,000 US$ all-inclusive per month = ***4,000 US$.*** *Which is approximately 5 times the current salary.*

Plus 2 nurses for each MD = 8 nurses at 250 US$ per month = ***1,000 US$*** *per month*

Plus 1 lab technician, 1 pharmacist and 1 radiographer at 350 US$ = ***1,050 US$***

This works out at 6,050 US$ per month = ***217,800,000 Le*** *per annum*

(3) In addition, the cost for drugs needs to be included.

In general, very careful preparation is needed and support from the relevant administrative bodies and stakeholders must be secured as early as possible. Moreover, very careful monitoring should be set up and we advise external monitoring and quality control in order to obtain unbiased results and recommendations.

Choosing districts for the inception phase

Intense discussions with the MoHS and external donors should be sought when choosing districts for an inception phase. It is strongly recommended that a start be made in regions where donor activities for upgrading facilities and services are already taking place or are about to start. This will help to build the necessary good-quality facilities that are needed by SLeSHI to show that it can deliver value to its members. Some proximity to Freetown should also be considered due to the numerous visits and consultations required.

An outline for a forthcoming analysis could be based on four components for further work as well as several cross-cutting issues.

Component 1: Legal framework

Ownership. Should SLeSHI be a private company, a public agency, a quasi-public agency or a government agency? SLeSHI should initially be part of NASSIT and should stand on its own after 5 years of operations.

Governance and government supervision

Transparency and accountability

Relations between SLeSHI and employers, collection of contributions, service provision.

Assessing fiscal requirements and use of different revenue sources.

Component 2: Administrative setup

Strategy and business plan. SLeSHI is a financial institution. As such it needs a clear and comprehensive strategy and sound business planning

Corporate culture; separating SLeSHI from NASSIT.

Financial management and control

Actuarial analysis. This will remain a somewhat "moving target" as it needs to reconcile the available financial means with the needs of the population covered and the cost of the suggested benefit catalogue.

Component 3: Technical components

Eligibility and definition of the poor

Designing the benefit catalogue

Accreditation and contracting

Medical personnel and delivering value for money

Provider payments and incentives

Quality management

Controlling costs.

Monitoring and evaluation. What is the effect of SLeSHI on patients and providers? Possible indicators include:

- household-based incidence of catastrophic health-care expenditure;
- institution-based death rates due to emergency obstetric cases;
- public perception of unmet need for specific health care;
- percentage of births attended by a skilled birth attendant;

- rate of caesarean sections;
- number of women from different income strata seeking care at the hospital;
- changes in health-seeking behavior (household-based);
- data on structures and processes, e.g. number of nurses trained, amount of continuous medical training provided, number of operations performed, percentage of post-operative complications and so on.

A baseline should be established before operations commence.

Component 4: Connecting with the field

Any public health insurance scheme will have to inform the population on how it works and what it can do for people and it also needs to make sure it delivers what people want. To this end, different approaches need to be used that put the emerging scheme in close and regular contact with the insured, the patients and the providers. In addition, politicians also need to be informed, and the mechanisms of policy formulation and implementation need to be understood in order to influence them effectively.

Information campaigns

Local workshops with providers

Identifying local needs

Policy advice and lobbying

Cross-cutting issues

All four components require intensive efforts to develop knowledge, international exchange and capacity development. It also requires reliable data for development, calculation and monitoring purposes. These could be dubbed "cross-cutting issues" that need careful attention and substantial effort. It will be helpful to put special emphasis on these issues and foster intense exchange between the groups.

Knowledge development and international exchange

Building capacities for effective and efficient management for the implementation of the National Social Health Insurance

Data gathering

Coordination with external development partners

5.11. Getting the message across: IEC and general training needs

Although NASSIT has paved the way to some extent, the general idea of insurance is not well established in remote parts of the country. In addition, there are a number of people and institutions that benefit from the current system – one should anticipate passive or even active resistance and obstruction.

In general, though, the willingness to change and to work for the social and economic development of the country seems to be very high and we felt an enthusiastic and "can do"-spirit when talking to various stakeholders.

The *general public* should be thoroughly and properly informed. If possible, the concept of "change agents" or "champions" should be employed: selected members of the public act as promoters and living proof that the system is working. An instructive example was given by the MRC: a young husband had initially refused to pay into the transport insurance scheme, but when his wife needed emergency obstetric care after prolonged labour he literally begged the scheme managers to allow his wife to use the car going to the nearest facility. This was granted at no cost and the wife successfully underwent caesarean section. The husband has been an ardent supporter of the scheme ever since. Personal rendering of the story provides a authentic entry point into many audiences. SLeSHI will work closely with the MoHS on prevention and other public health measures.

Politicians need to be convinced that such a scheme could benefit their political ambitions and is worth pushing for. The examples of SHI in the United States or Kenya indicate that theoretical and technical superiority do not necessarily lead to successful implementation.

Providers can constitute a major hurdle in implementing a nationwide financing mechanism. They often feel that such an institution might inappropriately infringe on their professional autonomy or might also curb income from private practice. These aspects need to be taken into serious consideration from an early stage. Consultations and input from relevant and respected leaders in the field should allay these fears to a large extent. After all, professional ethics in the medical and nursing staff are high throughout the world.

The employers raised the important objection that the present medical fringe benefits they grant their employees by far exceed any possible SLeSHI benefit catalogue. Similarly, the *trade unions*, which often act primarily on behalf of their constituents − those in (formal) employment −, expressed concern about the excessive strain on formal workers' net income. These concerns also need to be taken very seriously, as unduly taxing formal workers' pay in order to finance national schemes could estrange this important segment of the population from the scheme.

National social dialogue

The concept of a "national social dialogue", an open dialogue between social partners and other stakeholders with the aim of mutual learning and understanding is probably the most effective approach for achieving common understanding of the value of social security and its importance for decent work and a thriving economy. At all events, it is believed that information-sharing and participatory decision-making should be a core element when implementing a programme which affects all segments of the population. The "voices of the poor" need to be listened to in particular, especially when it comes to the mode of contributing to the scheme.

In addition, there is a considerable need for capacity-building at all levels. As has already been mentioned, SLeSHI will need extensive training support in order to have the right staff available – otherwise this complex technical scheme will not function optimally. It has also been said that providers should receive extensive post-graduate training and continuous medical education to improve the quality of care. While this might not be possible immediately, relevant plans should be developed. SLeSHI will be measured by the amount of care people receive and will also be held responsible for the quality. Thus, the scheme must have a clear understanding and policies on how to go about such provider-centered training efforts. Other segments of the population should also be taken

into consideration: politicians could receive specific training on core elements of health care financing and social security in general at a high level.

5.12. Limitations and open questions

Although the study team enjoyed full support from NASSIT and had a number of well-designed studies and excellent reviews at its disposal, and although the team believes that appropriate care was taken, including the employment of conservative assumptions, the sheer magnitude and complexity of the task may well have resulted in some important aspects being overlooked or not being properly assessed.

In particular, some of the data used on costs (SLeSHI administrative costs by type of service), on the anticipated demand for care under SLeSHI and on the capital costs for refurbishment should be regarded as preliminary and some margin of error should be allowed for.

The degree of *institutional preparedness* has not been fully assessed. A detailed analysis of the abilities of various stakeholders to actively support the creation of SLeSHI is recommended.

Closely related to this are the *human resources* issues concerning the ability of the new scheme to attract, train and retain enthusiastic and well-qualified staff.

6. Preliminary Actuarial Assessment of SLeSHI

A preliminary actuarial assessment of SLeSHI has been carried out for the year 2008 based on the data available.

6.1. Country macroeconomic context

Macroeconomic conditions in Sierra Leone: recent trends

Sierra Leone has a per capita GDP of 310 US$, with nearly half its population considered to be living in poverty (Statistics Sierra Leone 2007: Analytical Report on Poverty 2004). Social conditions are still quite dismal as is reflected by the fact that Sierra Leone ranks lowest in the Human Development Index (HDI) world ranking. Agriculture accounts for some 50 per cent of GDP. Sierra Leone still has a relatively small industrial base. Electricity, water, construction and manufacturing still account for 10 per cent of the total economy of the country. About 90 per cent of the Sierra Leonean labour force is employed in the informal sector. However, recent trends in key indicators of economic performance suggest that the economy of Sierra Leone has started to improve after years of protracted destabilization. For example, real GDP growth has accelerated since 2002. Recent trends indicate that key sectors of agriculture and mining have continued to show strong performance in recent years. The government of Sierra Leone has kept inflation at bay through monetary and fiscal control, although recent global increases in food and oil prices have put upward pressure on inflation.

The measures to restructure the tax system have continued with the introduction of a goods and services tax (GST). There has also been recent focus on improving the capacity and efficiency of tax collection and administration through the creation of the National Revenue Authority (NRA). Furthermore, the country is making progress in introducing several institutional reforms aimed at attracting private investment into the economy, after years of economic decline. Gross domestic capital formation has shown steady growth from a low of 7 per cent of GDP in 2000 to 17 per cent in 2007 (see Table 9).

Table 9: Key macroeconomic indicators − selected years

	2000	2001	2002	2005	2006	2007
GDP growth rate	3.8	5.4	6.3	7.3	7.4	6.5
Inflation, GDP deflator	6.1	6.1	3.9	12.9	11.6	11.4
Domestic revenue	11.4	13.0	12.1	-	11.6	10.7
Agriculture, forestry and fisheries	-	39.2	42.3	46.4	48.6	-
Industry	-	7.9	9.1	9.1	8.6	-
Services	-	47.7	45.6	41.6	40	-
Financial intermediation services	-	0.8	0.9	1.6	1.4	-
Net indirect taxes	-	5.9	3.8	1.6	1.4	-
Gross capital formation	7	7.6	10.1	17	15	17

Sources: Ministry of Finance, SL; World Bank World Development Indicators. All indicators as a percentage of GDP, unless otherwise stated

Fiscal situation and the structure of the Sierra Leonean tax system

In this section, we assess the key sources of revenue for the Sierra Leonean government. The success potential of a health insurance scheme can be assessed by considering how robust the structure of the tax system is. In other words, the capacity of the government to collect revenue is often a good indicator of the potential to successfully collect insurance contributions. The regressiveness of a tax system (i.e. a tax system which imposes a greater burden on the poor, compared to their income) could also have adverse effects for insurance. We present a summary of the principal taxes available to the Sierra Leonean government below (see Table 10).

There is clearly a structural weakness in public finance in Sierra Leone. Total domestic revenue is only able to cover about half of total expenditure, the rest having to be covered by project and programme grants and other forms of foreign assistance. External budget support covers more than 40 per cent of total government expenditure. Such a degree of dependence on donors is a cause for concern, particularly if the government has to be the final financial guarantor of SLeSHI in the first few years of operation. Furthermore, our impression from the persistent public budget deficits in the Sierra Leonean national treasury is that there is very limited fiscal space. This viewpoint was expressed to us during our meetings with both the Ministry of Finance and the National Revenue Authority. From a revenue projection perspective, this also suggests that there is little room for increasing the salaries of public service workers. This is mainly why we have proposed new alternative financing mechanisms for SLeSHI.

A recent study that reviewed the public funding situation for health in Sierra Leone found that the disbursement of budgeted resources (mainly for non-salary recurrent or operational budgets) by the Ministry of Finance to health institutions is very erratic (Review of health financing in Sierra Leone 2008). This study concurs with the information we gathered during our field visits to the effect that in many cases only half of the resources actually reach the intended institutions. The study found furthermore that allocations for drugs are

almost always made only in the second half of the year, and were not made at all in 2007. This epitomizes the challenges that remain for public funding in Sierra Leone.

The only positive development is that the economy has started to register substantial improvements and the government of Sierra Leone is managing to keep fiscal discipline. More time will be required before the public treasury is in a position to invest more resources in health. Importantly, it is hoped that new reforms aimed at improving the efficiency and capacity of the Sierra Leonean tax system will provide additional resources in the near future.

Table 10: Contribution of various revenue sources to total revenue and fiscal deficits in Sierra Leone 2002-2007

Year	Company taxes (of total)	Personal tax (of total)	Excise duty on goods & services (of total)	Import duty (of total)	Other taxes (of total)	Total revenue in m Leones	Total expenditure in m Leones	Overall fiscal balance in m Leones	Deficit as % of expenditure
1998	9.5%	8.6%	24.7%	55.6%	1.6%	67,689	149,427	(72,267)	-107%
1999	11.1%	17.8%	17.0%	53.9%	0.2%	76,014	235,940	(150,126)	-197%
2000	11.8%	17.2%	14.4%	56.2%	0.4%	135,162	301,830	(149,656)	-111%
2001	10.4%	17.6%	17.5%	54.2%	0.4%	192,745	354,940	(146,877)	-76%
2002	13.0%	14.6%	17.8%	54.0%	0.6%	223,469	474,827	(236,141)	-106%
2003	14.4%	12.9%	18.0%	53.8%	0.9%	267,960	483,355	(195,695)	-73%
2004	14.9%	14.5%	17.4%	52.0%	1.2%	319,267	555,045	(198,079)	-62%
2005	17.6%	13.8%	18.2%	49.2%	1.2%	350,419	620,728	(204,745)	-58%
2006	15.5%	13.9%	19.4%	47.5%	3.7%	416,800	911,783	(416,081)	-100%
2007	11.3%	16.3%	12.4%	55.4%	4.6%	454,684	826,163	(289,878)	-64%

Source: Bank of Sierra Leone (2008)

The introduction of the GST is planned for 2009 and is designed to boost revenue collection for the government in order to address the current imbalance between income and expenditure. All in all, the economic outlook for the future is positive on the whole (IMF 2008 Staff Joint Assessment Report July 2008).

6.2. Population, insured persons, contributors and contributions

The population base for the purpose of calculating contributions to SLeSHI will involve multiple sources including formal sector employees, private citizens and public funding. This has been necessitated by the desire to extend population coverage as much as possible in an economy where formal employment is only just above 10 per cent of total employment and incomes are low. The population of Sierra Leone was 5,969,000 in 2008 according to UN World Population Prospects (the medium variant, 2006 Revision). The rate reported in the 2003/4 Integrated Household Survey, namely 68 per cent of the population between 18 and 64 years of age (55 per cent of the total population) was used in order to estimate the volume of the labour force. With an assumed unemployment rate of 3 per cent, employment is estimated at 97 per cent of the labour force, which is further split

into formal sector employment (10 per cent of total employed persons) and informal sector employment based on 2004 Sierra Leone Labour Force Survey.

Contributors and contributions

The contribution rate for formally employed workers is 6 per cent of their salaries, 2 per cent of which is to be paid by the employees and 4 per cent by their employers. This contribution rate of 6 per cent for formal sector employment is based on interviews with stakeholders in the National Revenue Authority, Ministry of Finance and NASSIT, in which it was established that private sector employers currently spend around 4 per cent of their wage bill on health-related fringe benefits and that an additional payroll deduction of not more than 2 or 3 per cent would be politically feasible.

Since SLeSHI is designed to cover all Sierra Leoneans, in both the formal and the informal sector, the funding base for SLeSHI should extend beyond formal sector employees. In particular, in addition to the contributions of formal sector employees, the following revenue sources are assumed: the local tax, a levy of 3 per cent of the GST to be earmarked for SLeSHI and a 5 per cent levy on mobile phone use amongst Sierra Leoneans.

The local tax currently levied amounts to 5,000 Le for each Sierra Leonean of at least 18 years of age. At this point, there is no systematic basis upon which to base a suitable and affordable flat contribution rate for the informally employed as a "health contribution" to be collected along with the local tax. A new study commissioned by NASSIT is eliciting willingness to pay for health insurance which could be used for revisions of the assumed amount of contributions. It emerged in consultations with local councils in Freetown, Makeni, Kenema and Bo, that anything between 10,000 and 20,000 Le per year per employed person would be appropriate as long the benefits were assured to the paying public. We have thus based our calculations on a contribution of 10,000 Le.

Compliance is a big issue with this financing mechanism. A variety of mechanisms exist for collecting local tax. In rural areas, collection is done through the institution of local chiefdoms throughout Sierra Leone. Marshalls conduct door-to-door inspections as well as roadblocks for enforcement of local tax payment. There is a local tax department in the Freetown City Council that collects local tax from the informal sector. For example, this department uses market representatives to collect from all traders operating in the markets. In the case of public employees (except military personnel), the government of Sierra Leone writes a cheque to the Freetown City Council for the amount covering the local tax of all Freetown-based public service workers.

We estimated compliance on the basis of the total local tax revenue collected as of September 2008 and divided it by the estimated relevant population (i.e. at least 18 years of age) of Freetown. There were some problems with this method. Although the official total population of Freetown City is 800,000 Le, we assumed it to be 1,200,000. The total collections were reported as 1.3 billion (although the Department of Local Tax claimed that this figure could rise by an additional 200-300 million Le by the end of the year). Collections and compliance rose sharply each time the City Council mounted their campaigns. However, our estimate suggests that only 38 per cent of residents had paid their local tax. On that basis, we apply a national compliance rate of 30 per cent.

Assuming a 100 per cent compliance rate for formal sector employees and a 30 per cent compliance rate for the local tax, the formal sector contributors are estimated at 216,543 and the local tax contributors at 816,380.

A study on willingness to pay for health insurance protection that was being conducted at the time of our visit might provide a stronger basis for making more precise estimates.

The salary base for the contribution is estimated at 606,106 Le per month in 2004 based on the Sierra Leone Integrated Household Survey 2003-4 and subsequently inflated by 20 per cent to adjust to the value in the year 2008.

Table 11: Earnings in the formal and informal sector by occupation

OCCUPATION	FORMAL SECTOR	INFORMAL SECTOR
Professional, technical and related	860,477	668,358
Managerial and administrative workers	1,575,747	343,639
Clerical related workers	709,092	-
Sales and related workers	638,917	270,843
Service-related workers	651,201	313,352
Agricultural, animal, forestry, fishing, hunting workers	695,623	130,150
Production-related workers	587,439	473,038
Shoemakers and related workers	625,225	502,504
Weighted average earnings	606,106	174,739

Source: Sierra Leona Integrated Household Survey 2003-4

Public Financing: MOF to MoHS

Taking NHA estimates of allocations from MOF to MoHS for 2004-2006 as a basis, 2006 estimates are adjusted to 2008 by 20 per cent. In order to cater for problems of erratic execution of MOF budgets, it is assumed that only 40 per cent is actually disbursed and it is further assumed that only 40 per cent of resources disbursed by MOF to MoHS are dedicated to curative primary and secondary health care. This assumption means that the remaining 60 per cent goes to preventive programmes, sanitation projects and other purposes except health care.

GST

The GST is estimated to be an equivalent of 3 per cent of Sierra Leonean GDP. The revenue for SLeSHI was based on 2 per cent of the total GST revenue.

Mobile use tax

It is assumed that 850,000 mobile phones are in active use in Sierra Leone with an average expenditure of 7,500 Le per mobile phone per month. A 5 per cent tax is assumed to be imposed on this amount.

The total income for the scheme is estimated at 166 billion Le in 2008, composed of separate contributions of 113 billion Le, 36 billion Le, 4 billion Le, 8 billion Le and 4 billion Le from formal employees, Ministry of Finance (MoF) budget allocations, GST for health, local tax and GSM tax respectively.

6.3. Expenditure assessment: various scenarios

Benefits and expenditure

Three major cost items, namely (i) out-patient visits, (ii) in-patient care and (iii) administrative costs, are estimated separately and then totalled. Out-patient costs are estimated by multiplying the average number of visits per insured person, the average cost per visit, utilization rate and the number of persons covered. The cost for in-patient care is

derived in a similar manner. The administrative costs were assumed to be 10 per cent of the total revenue collected.

Estimation of population coverage

The coverage of the Sierra Leonean population under SLeSHI is constructed as follows:

- all formal employees will be covered through their employment;
- the dependents of formal sector employees (up to 5 per family, including the spouse, assuming a family of up to 6) will be covered;
- the informal sector will be covered on a voluntary enrolment basis;
- all children under school age and minors up to the age of **18 years** will be covered;
- all citizens identified as indigent for the purpose of receiving free health benefits will be covered;
- all persons over 60 years of age will be covered.

We apply national statistics on the proportion of persons in the above demographic and income groups, and we take note of the following: first, we identify all minors under the age of 18, regardless of the income level of the household from which they come. These children represent 50 per cent of the Sierra Leonean population. This also means that all dependents of formally employed workers are covered by default.

Second, SLeSHI will provide free coverage to all persons over 60 years of age, again irrespective of income level. All retirees will also be covered under this criterion. Demographic estimates show that this population group makes up 5.1 per cent of the Sierra Leonean population as indicated in Table 12.

Third, in view of the above, income-based exemptions would have to target individuals in the informal sector who belong to the 18 to 60-year age group; membership will depend on payment of the local tax. Since this demographic group accounts for about 47 per cent of the population of Sierra Leone, inclusion of both the poor and very poor would mean that half of the population would be exempted, and this could undermine the financial sustainability of the scheme. The scheme is therefore designed to cover exemptions for those identified as very poor. According to official poverty statistics, at a national level this group constitutes 34 per cent of the Sierra Leonean population (Sierra Leone Statistics 2007). For the sake of simplicity, we assume that this ratio also applies to this age group. By definition this group includes the destitute.

Table 12: Various population coverage scenarios

Scenario	Estimated population coverage	Coverage as % of total SL population
Scenario I: All under 18 years; above 60 years; very poor	5,055,779	84
Scenario II: Under 6 years; above 60 years, very poor	3,205,389	53

Source: authors' own calculations

Costing medical services

Utilization rate

There are very limited data on service utilization in Sierra Leone. In an ideal situation, projecting population utilization rates under an insurance scheme requires modelling health care demand and estimating the price elasticity of demand. In the absence of data for such an exercise, assumptions based on available data on patterns of service utilization and the utilization rates, and some reasonable adjustment for increased utilization, may be the only way forward. This is the approach we adopted in this report.

A new project by the MSF has recently experimented with eliminating user fees at the point of use, offering incentives to staff and providing needed supplies at facilities in two districts in Sierra Leone, Bo and Pujehan. They report that out-patient utilization has increased to 1.21 contacts per person per year. This estimate represents an increase of more than 400 per cent over recent estimates of per capita utilization of 0.25 at public primary health care centres (SL PRSP 2004). When visits for preventive care and immunizations are included, per capita contacts in Sierra Leone are estimated at about 0.5. This is substantially higher than the "utilization rate" factor used in Ghana to assess the differential increase in health care from an uncovered population to a covered population, which was 2.5.

The Ensor report uses 1.5 in estimating the costs of their options, a doubling of the current utilization rate. And it is assumed that 1.5 per insured is a reasonable assumption.

As for in-patient admissions, the present utilization rate is assumed for the estimate, namely 0.06 per person per year.

Unit cost

There is very limited data on which to base accurate estimates of the cost of health care in Sierra Leone, but, given the importance of cost information, we dedicated a fair amount of time to obtaining as much information as possible. However, there are challenges for using budget or actual spending figures as a basis for estimating cost. Budget figures are rarely realistic. On the other hand, actual expenditure provides a serious under-estimation of what the cost might be under an insurance scheme. For instance, salaries for all staff cadres are so low as to be untenable under an insurance scheme. We found that hospital staff such as medical doctors operate private clinics within public hospitals in order to supplement their salaries. Unfortunately there is no data on how much extra they make from this scheme.

We made an attempt to obtain cost data from existing private insurance schemes (most of them employer-based) in Sierra Leone. These data are rife with problems of excessive moral hazard and downright fraud between providers and the insured. The average utilization rate was 5-6 per person per capita. The drugs prescribed at those clinics are not subject to any regulatory oversight and not the cheapest (anecdotal information obtained at a meeting with Private Medical Insurance Schemes at NASSIT).

We made use of unit cost information compiled by the Ensor report[13] which estimated unit costs for both hospital and primary health care. This cost exercise assumed a 500 to 600 per cent increase in staff remuneration in line with our expectation that improved salaries will be a key to implementing an insurance scheme in Sierra Leone.

[13] Ensor, T., Lievens, T. & Naylor, M., op.cit

Unfortunately these costs are consolidated, making it virtually impossible to tease out specific components of costs such as personnel contact time, drugs, investigations and so on. Nonetheless, the benefits covered under these costs include the following:

- registration;
- out-patient consultations;
- investigations (medical examinations);
- in-patient care services, including drugs, investigations, board;
- surgical services (including caesarean sections);
- pharmaceutical services (medicines);
- deliveries.

The consolidated cost at primary health care level is 15,000 Le (very similar to the data used by Ensor et al.), while the estimated hospital cost (adjusted for the proportion of in-patient care that is surgical and medical and length of stay) is 330,000 Le per person.

The second Disease Control Priorities project (DCP2) has done some comprehensive costing analysis for health care from primary to tertiary levels, for all regions of the world. We apply estimates for Sub-Saharan Africa. These are consolidated costs including personnel, equipment, capital buildings, drugs, medical examinations, materials and other overhead costs (DCP2 project: wwww.dcp2.org). These estimates represent a meta-analysis based on various international costing estimates and provide a reasonable source of cost information. The caveat is that these data are based on regional rather than country-specific estimates. We have compared this cost information with the costs used in our report.

We converted the 2001 prices to 2008 prices by using average CPI values available from the US Bureau of Labor Statistics. According to that source, the value of 1 US$ in 2001 was 1.24 US$ in 2008. This implies that in terms of 2008 prices, the unit costs for primary health care visits and hospital visits and bed days estimated by the DCP2 are as follows:

- health centre visit: 1.77 US$ or 5,310 Le
- district hospital visit: 2.64 US$ or 7,924 Le
- district hospital cost per bed-day: 7.65 US$ or 22,952 Le
- secondary-level hospital cost per bed-day: 10.00 US$ or 30,000 Le.

We observe that our estimate of 15,000 Le for each visit to a health centre is nearly three times the cost estimated by the DCP and WHO. This would compensate for any underestimation of utilization rate. Similarly, the cost per day of 30,000 Le at a secondary hospital is in line with the 329,000 Le cost for the duration of admission even if we assume an ALOS of 11 days.

Table 13: Cost of care per capita at various levels of care

Health care level	Number of contacts per year	Cost per contact (in Le)	Cost per capita (in Le)
Primary care contacts	1.5	13,000	19,500
Secondary care contacts	0.06	329,000	19,740
Total			39,240

Source: authors' own calculations

Table 12 shows the assumed number of medical contacts at primary and secondary care level based on the population covered and the average contact rates as well as the cost per capita.

Administrative costs

The administrative costs are assumed to be 10 per cent of the total revenue collected, taking into account some of the experiences of other countries such as 8 per cent in Tanzania and a maximum of 12 per cent of PhilHealth in the Philippines.

Additional costs occurring during the initial phase (which might lead to total administrative costs as high as 30 per cent) could be covered by a grant from the national government or from an external donor. NASSIT was set up with a similar scheme, which has worked well so far.

Total cost estimate in 2008

It is estimated that the total cost of SLeSHI is 215 billion Le and 142 billion Le according to Scenarios I and II (see Table 12)

Start-up costs

Based on the experience with establishing SLeSHI, the start-up costs can be estimated at around 3-5 million US$, which could be shouldered either by the GoSL and/or via grants/ loans from the international donor community.

A detailed study will certainly be required here with special emphasis on cash flow, human resource intake and development costs.

6.4. Overall assessment of SLeSHI in 2008

By comparing the estimated income of 166 billion Le, Scenario II − with coverage for all children under 6 years of age − can be financed, while Scenario I − with coverage for all minors under 18 years of age, cannot be met within the proposed fiscal envelope.

Within the SLeSHI coverage and benefit framework proposed in this report, the greatest challenge to affordability is the ability to commit the required public funding on a predictable basis. In particular, our estimates suggest that extra funding in the region of 33-50 million US$ is required to make SLeSHI financially sound from the start. Ultimately, the assessment of affordability involves policy and political value judgement.

The other challenge to affordability involves whether the private citizens of Sierra Leone are willing and can afford to pay the required premium or other contributions (local tax and mobile phone tax) for improved health coverage and greater risk protection. As has been indicated, there is evidence that such willingness might exist but will need to be nurtured

with very aggressive information and education campaigning and political mobilization. SLeSHI affordability hinges on both public commitment and continued citizen willingness, perhaps more so on the former.

The authors would like to stress again that poor quality of cost information could present a problem for actuarial analysis. However, it was not possible to gather more detailed cost information in the time available. We recommend that once the proposals are under serious consideration, NASSIT be requested to conduct a detailed costing exercise that should generate the desired level of detail. This analysis could easily be updated with better cost information.

6.5. Institutional framework for targeting and contribution collection

Our options for a general targeting mechanism will involve a district-oriented system using local institutions with close supervision from headquarters. Community-level data on poverty and livelihoods will be used to guide exemption targets. This will be done prospectively and SLeSHI certificates will be issued to deserving persons. All patients who turn up at facilities will be treated. Follow-up investigations will be carried out to determine their eligibility for exemption.

As outlined above, the collection of contributions should be done at source whenever possible. Substantial efforts should be made to ensure as extensive participation as possible in any of the different contribution modes.

7. Next Steps

The reform debate in Sierra Leone is characterized by the full political support and untiring commitment of major stakeholders. The National Consultative Conference was a major success and a step forward towards a feasible and sustainable health insurance scheme.

After this initial groundwork, a political decision will be needed in order to determine whether, in principle, the approach should be pursued further and whether sufficient funds will be made available to proceed. Concrete steps must be taken with regard to the following:

1. the inception and phased implementation of the agreed SLeSHI concept in two carefully selected districts in close coordination with on-going (upgrading) programmes and projects such as those run by the World Bank, UNICEF and others; ensuring seed money for additional external advice and support, start-up outlay, drugs (possibly drug funds), limited scaling-up of health facilities, contribution waivers, etc.;

2. commissioning technical work (refining and inception phase) to accompany the country-wide application of the scheme's features in one or two districts covering topics such as:

   - disposable incomes, mechanisms for collecting contributions from the population and transferring them to the district and the national level; measures to improve collection efficiency;

   - the feasibility of starting initially with only the formal sector or starting with all segments of the population;

   - the availability of quality services and drugs and the definition of benefit packages which can be scaled up – through either national or donor funds, for example; close cooperation with the MoHS, donors and a broad public consultation is very important: a thorough initial assessment is clearly needed here.

   - the possible devolution of staff coupled with more flexible HR management − this needs to be investigated;

   - payment mechanisms for providers incorporating incentives for quality improvements; we suggest substantial upfront discussion with various providers (State, private for-profit organizations, FBOs) on the possibility of loans from SLeSHI to improve facilities upfront;

   - an assessment of the extent of initial over-consumption and how to mitigate this;

   - IEC for the general public to develop knowledge, confidence and compliance (especially as regards paying the contribution); these efforts should be massive in scale and scope and should make it clear that local governance coupled with central technical expertise is a key to an efficient scheme;

3. developing a training and capacity-building programme enabling staff and scheme managers to adapt to the scheme's modalities and monitor scheme performance;

4. setting up a legislative process (please see annex 8.2 for a draft outline of some key features for legislation on SLeSHI should the proposal meet with approval).

The ILO team has developed a more detailed proposal entitled “Refining key elements of the emerging SLeSHI – a study in the rapid implementation of policies and plans”, in the annex, which describes issues nos. 2 and 3 in more detail. In general, many concrete aspects will have to be determined during the forthcoming phase, and it will therefore be mandatory to obtain highly qualified national and international expertise, e.g. in health system design, health economics and health financing, and legal matters, amongst other fields.

At the end of the study and implementation phase, which might be after about 18 months, a viable and efficient national health insurance could start to provide services (quality health care and financial protection against health-related costs) for the population in the selected districts (please see annex). Further, the methodology and institutional capacities within the project area will be developed and can be used by the government and other national and international actors for other districts.

Finally, it should be stressed that the transition to a sustainable and rationally financed system will take considerable time − somewhere between 10 and 20 years. Hopes and expectations are high, and this prevailing “can do” spirit should remain and be used to push for radical changes. However, it should be very clear to those responsible for the change and to those politically supporting it that change in the field of health care takes time and if the proponents are hesitating between speed and careful (slower) adjustment, precedence should always be given to caution. The term “kick-start” can (and should!) only be used with respect to further refining and fine-tuning the scheme in selected districts; it is impossible to kick-start such an ambitious undertaking without due precautions and careful deliberation.

8. Annexes

8.1. Actuarial calculations and key assumptions

Please refer to the Excel sheets:

i. "Actuarial calculations and key assumptions"

ii. "Econ pop and Labour force data"

8.2. SLeSHI: Suggested key features for legislation

Related legislation could start with the definitions of the terms used: benefit package, beneficiary, contribution, dependent, employee, and so on.

1 Establishment and functions of the SLeSHI

1.1 Aim and functions of the SLeSHI : a description of the purpose of the SLeSHI, along with the responsibilities involved in achieving that purpose (supervising the operations of the scheme, accrediting health care providers, advising the Minister, …)

1.2 Membership and composition of the SLeSHI Board: the composition of the Board (chairman and members: representatives from the different ministries, employers, unions, health-care providers, civil society and private industry), Director-General

1.2.1 Incompatibilities of the (other) functions of the board members, disclosure of interests, procedure in such cases

1.2.2 Tenure of members : designation procedure, duration of membership, number of terms for which re-appointment is possible, replacement in the event of death, resignation, removal, removal procedures, allowances, appointment of the chairman and Director-General…

1.2.3 Tasks of the board/ Director-General/secretary

1.3 Meetings of the board: frequency, quorum and voting, extraordinary meetings if they are planned, …

1.4 An option could be to set up committees to prepare the work, vision and policy of SLeSHI.

1.5 Supervision of SLeSHI (the SLeSHI Board) by the MoESS or an institution designated by the Ministry

1.6 Financing of the trust:

1.6.1 Contributions : 2 per cent of payroll from employees, 4 per cent from employers, (see point 4 for the contributions of the persons covered).

1.6.2 General tax revenue of MoHS

1.6.3 3 per cent of the General Goods and Service Tax

1.6.4 Part of the tax on cell phones (5 per cent), tobacco, car ownership (to be discussed)

1.7 Investments: possible provision concerning how investments of the fund are approved, conditions, decision-making and control bodies

1.8 Annual reports: timing, procedures for submitting to the government and parliament, procedure for special reports if a request is formulated by the Minister

1.9 Cooperation with NASSIT: organization of cooperation, level and responsibilities

1.10 District offices: structure of the SLeSHI with regard to the various district offices, assignment of responsibilities to the different levels and the allocation of the funds, the boards of the district offices, supervision of the (boards of the) district offices

2 Financial provisions

2.1 A description of how the accounts, books, records are to be kept

2.2 The timing and planning of the financial year

2.3 Organization of audits; this can be done by the NASSIT Auditor-General. Description of the means at the disposal of the Auditor-General, follow-up of reports (the report of the Auditor-General is delivered to the Board and Ministers and then handed over to the parliament.)

2.4 Expenses of the members of the Board: Board approval of expenses, members' accounts, sanctions if the regulations/procedures are not complied with

2.5 A description of how the reserves are to be managed

3 Who is covered?

3.1 A list of the various categories of persons covered by health protection

3.2 A description of whom the law can be applied to (all citizens of Sierra Leone, based on place of residence, nationality, …)

3.3 Enrolment of foreigners/Sierra Leoneans living abroad

3.4 Information about registration and the issuing of the SLeSHI card

4 Contributions

4.1 A summary of who should pay contributions

4.1.1 Formal economy workers: 2 per cent of their salary

4.1.2 Self-employed, non-working population: 10,000 Le

4.1.3 the very poor, children and minors up to the age of 18 and other groups to be defined : waived (distinguishing characteristics of the poor/very poor, how they are to be identified at the district level, the yearly revision if provision is made for this)

4.2 Timeframe and how contributions are to be paid

4.3 The consequences of non-payment/paying too late:

4.3.1 A contribution with or without interest and/or a penalty

4.3.2 Procedure for taking legal steps (reminder, notification, …)

5 Benefit package

5.1 A summary of the benefit package

5.1.1 The distinction between primary care (procedures/diseases covered) and secondary care (procedures/disease covered), the referral system

5.1.2 The place of tertiary care and public health in the scheme, which level of care this falls under, the explication that this is not included

5.2 Quality of health care:

5.2.1 A description of the minimum standards and accreditation for providers

5.2.2 Terms of registration of private providers with the Professional Council.

5.2.3 Reference to the Essential Drug List if it is included

5.3 Modalities of provider payments:

5.3.1 Simple case payments in primary care

5.3.2 Fee for service in secondary care

6 Appeals of SLeSHI decisions

6.1 Role and responsibilities of the Complaints and Investigation Bureau

6.2 The authorized court, composition, disclosure of interest of court members, scope of judgements, …

7 Criminal provisions / institutional provisions

7.1 Regarding insured persons/providers

7.1.1 Penalty for evading payments

7.1.2 Penalty for making false statements

7.1.3 Penalty for providing false documents (if any documents are used)

7.1.4 Penalty for (attempted) bribery

7.2 Regarding members of the Board

7.2.1 Protection for actions which members of the Board undertake ("in good faith")

7.2.2 Criminal provisions

Transitory provisions : when the law will come into force, mention of the waiting period (3-6 months), phased implementation?

8.3. ToR for the team of consultants

a. Joint tasks of the project team

Assessment mission

- to carry out the assessment mission in September 2008;
- to develop, collect and review qualitative and quantitative data for the production of the report, in close cooperation with NASSIT.
- to work together with NASSIT to identify suitable areas for the field trip to take place during the first week of the mission with a view to assessing health protection needs and the socio-cultural/political environment in rural areas, issues in reaching out to the informal economy, and health infrastructures and/or to assessing where a limited amount of upgrading would suffice for subsequently testing suggested options; meetings and discussions might include cooperatives, microfinance groups, health facilities, NGOs working on health issues, and donor-funded health protection projects;
- during the second week of the mission, to hold discussions focusing on the socio-political and economic environment in the capital; they should include representatives from NASSIT, the Ministry of Labour, the Ministry of Health, the Ministry of Finance, trade unions, employer associations, a health care facility/hospital, NGOs, the donor community, and academia;
- on the basis of the data and information received, to develop and assess various options based on insurance mechanisms and to outline the draft report.

b. Specific tasks of the team leader

The tasks of the team leader will focus on the socio-political and the institutional environment, on developing and assessing options for extending social health protection and on discussing financial aspects with the team members including scenarios, costing and other specific tasks assigned to them.

- In discussions with stakeholders, they will consist of developing and evaluating the socio-political, institutional and administrative environment for extending social health protection through various health financing mechanisms based on insurance principles such as pre-paid financing.
- The team leader will develop, assess and review qualitative data relevant for options for extending social health protection and related stakeholder interests, taking the overall socio-economic and political situation in the country into account.

Debriefing mission

- In preparation of the mission, the team leader will revise the report according to the feedback from NASSIT and will prepare a presentation for discussion of the report.

- He/she will carry out the debriefing mission in January 2009.
- He/she will contribute to the preparation of the debriefing conference with NASSIT and stakeholders in social health protection.
- He/she will present and discuss the report with NASSIT and stakeholders in Sierra Leone.
- He/she will revise the report according to feedback from the discussions.
- He/she will ensure delivery of the final report to the ILO in due time.

c. Specific tasks of the external collaborator

- Working in close cooperation with the team leader, the external collaborator will develop data and information on quantitative aspects of the project. This will include in particular the financial framework, modelling costs and actuarial valuations. The external collaborator will support the team leader in assessing the enabling social, economic and institutional environment and developing related options for extending social health protection on the basis of insurance principles.
- He/she will analyse the data and information collected prior to and during the first mission according to the tasks outlined above.
- He/she will evaluate the current health financing system / social health protection coverage and will also develop options based on health insurance principles such as prefunding (SHI, various CBHI models, vouchers, etc.) concerning financing, entitlements, efficiency, effectiveness, sustainability, coverage, fairness, responsiveness, health outcomes, impact on poverty; he/she will further identify possible linkages with State or donor-funded health protection projects.
- For each of the options developed, he/she will calculate the costs based on various assumptions, benefit packages, the subsidies needed, contributions or premiums, the prevailing health status and health risks, and the ability and willingness to contribute.
- He/she will develop a short - and long-term costing framework and viability assessment for the various options (if the data allow) taking the economic context, demographic trends and labour market dynamics into account.
- He/she will draft the inputs for the report according to the general and specific tasks outlined above.
- He/she will ensure that the inputs are delivered to the team leader in good time.
- In coordination with the team leader, he/she will revise the report on the basis of comments from peer reviewers.

Timeline, activities and outputs

The project will be implemented according to the timeline outlined below :

Activities/output	Timeframe
1. Preparation of the first mission: literature, data and document review	
Outputs:	
- Outline of data needs to be submitted to NASSIT	20 August 2008
- Mission schedule jointly developed with the team leader and NASSIT	8 Sept 2008
2. Production of the report:	
Outputs:	
- Costing of the various options developed	
- Submission of inputs for the report to the team leader	10 October 2008
- Final draft of joint report submitted to the ILO	26 October 2008
3. Revision of the report according to feedback from peer review	
Outputs:	
- Second draft of the report submitted to the team leader	November 2008
- Final draft of joint report submitted to the ILO	December 2008

8.4. Schedule of mission to Sierra Leone

Date	Time	Activity	Location
14 September	(Sunday)	Arrival of Konrad Obermann in Freetown	
15 September	a.m.	Meeting with the NASSIT D-G, initial discussion with research team	Freetown
	p.m.	Meeting with the Commissioner General and senior officials, National Revenue Authority	Freetown
16 September	a.m.	Meeting with Local Government Finance Director Meeting with Armand Thomas, demographer	Freetown
	p.m.	Arrival of Felix Masiye, first discussions	
17 September	a.m.	Visit to the Ministry of Health & Sanitation, Health Economics Department Visit to Princess Christian Maternity Hospital Meeting with the Secretary of the Ministry of Finance	Freetown
	p.m.	Visit to Children's Hospital Visit to Connaught Hospital	Freetown
18 September	a.m.	Visit to St. John of God Hospital	Mabesseneh
	p.m.	Visit to Makeni Government Hospital Meet to Mayor and Senior Officials Visit to Magburka Hospital	Makeni Magburka
19 September	a.m.	Visit to Moyamba District Hospital	Moyamba
	p.m.	Visit to Falaba Maternal and Child Health Primary Care Journey to Bo	Falaba
20 September	(Saturday)	Visit to Kenema Government Hospital; visit of PHU Visit to Bo Government Hospital	Kenema Bo

		Visit to MRC (Medical Research Centre) to study their Community Referral System	Bo
21 September	(Sunday)	Return journey to Freetown	
		Conceptual discussions	Freetown
22 September	a.m.	Internal discussions, preparation of presentation	Freetown
23 September	a.m.	Meeting with representatives from all private insurance companies	Freetown
	p.m.	Discussion on structure of actuarial work sheet Meeting with Freetown City Council	Freetown
September 24	a.m.	Presentation to NASSIT Director-General and senior staff Courtesy call Chairman of the Board of Trustees Joint session with representatives from World Bank, WHO, UNICEF, DFID, MSF	Freetown NASSIT
	p.m.	Meeting with the Health-Financing Task Force Meeting with Statistician-General	MoHS
September 25	a.m.	Presentation to the Board of Trustees	Freetown, NASSIT
	p.m.	Meeting with the Minister of Employment and Social Security Meeting with the Minister of Health & Sanitation	Ministries
	evening	Wrap-up dinner	
September 26	a.m.	Courtesy call on H.E. the Vice President Meeting with trade union and employer federations	Freetown
September 27 – October 27		Preparation and submission of the final report	Göttingen, Lusaka

8.5. List of persons met

Family	First	Agency	Function	Location
Allieu	Andrew M.	NASSIT, Research and Actuarial Department	Head	Freetown
Amara	Michael	MoHS	Health Economist	Freetown
Cappelaere	Geert	UNICEF	Representative	Freetown
Costain	Juan	World Bank	Lead Financial Sector Specialist	Freetown
Dao	Bro. Peter	St. John Hospital	Director	Lunsar
Duada	Michael C. H.	Institutional Reform and Capacity Building Project	Director, Local Govt. Finance Department	Freetown
Dogbe	Estelle	MSF Belgium	Health Liaison Officer	Freetown
Fox	Sarah	MoHS	Economic Adviser	Freetown
Gaima	Emmanuel A.R.	Institutional Reform and Capacity Building Project	Director	Freetown
Gondoe	Mohamed	NASSIT, Operations	Director	Freetown
Jalloh	Cyril	NASSIT, Research and Actuarial Department	Research Officer	Freetown
Jalloh-Vos	Heidi	Medical Research Centre	Health Programme	Bo

			Manager	
Jalloh	Sam	NASSIT, Informal Sector Unit	Head	Freetown
Johnson	Leonard	Employers' Federation	Executive Secretary	Freetown
Kabia	Soccoh Alex	MoHS	Minister	Freetown
Kamara	Dr Adikali	Makeni Gov. Hosp.	Senior Medical Officer	Makeni
Kamara	Prof. J.A.L	Statistics Sierra Leone	Statistician General	Freetown
Kandeh	Dr Joseph	Moyamba Govt. Hosp.	District Medical Officer	Moyamba
Kanneh	L.V.	MoESS	Permanent Secretary	Freetown
Kanu	Jacob S.	NASSIT	Chairman of the Board	Freetown
Kargbo	John A.	MoESS/NASSIT	Liaison/Consultant	Freetown
Koby	David	Medical Research Council	Manager	Bo
Kortu	M. Droogleeves	UNICEF, Child Protection Unit	Project Officer	Freetown
Macauley	Raymond H.S	Aureoal Insurance	Senior Underwriting Manager	Freetown
Mansaray	Minkailu (Hon.)	MoESS	Minister	Freetown
Ndoeka	Amadu B.	Safecon Petroleum	Managing Director	Freetown
Ngayenga	Sahr	NASSIT	Deputy Director-General	Freetown
Nylender	Dr F.E.	WHO, Disease Prevention & Control	Director	Freetown
Onomake	Alice	Reliance Insurance	Managing Director	Freetown
Philips	Bowenson	Freetown City Council	Administrator General	Freetown
Pratt	Dr Dudley	Magburaka Govt. Hosp.	Senior Medical Officer	Magburaka
Saccoh	Gibril	NASSIT	Deputy Director-General	Freetown
Sahina	Peter	UNFPA	Reproductive Health Adviser	Freetown
H.E. Sam-Sumana	Sahr	Government of Sierra Leone	Vice-President	Freetown
Sesay	Sheku S.	MoFED	Financial Secretary	Freetown
Sesay	Moses	Makeni City Council	Mayor	Makeni
Stevens	Georgiana	NASSIT, Public Affairs	Director	Freetown
Stevens	Dr	Govt. Hosp. Bo	Senior Medical Officer	Bo
Stevens	Mrs.	Govt. Hosp. Kenema	Hospital Matron	Kenema
Thomas	Dr Armand	Private Consultant	Demographer	Freetown
Yaskey	Arthur N.	National Insurance Co	Managing Director	Freetown
Yayah	Dr Francis	Govt. Hosp. Moyamba	Senior Medical Officer	Moyamba
Yillah	Kandeh	Trade Union Congress	Secretary General	Freetown

8.6. Activity Plan for National Social Health Insurance Scheme

	ACTIVITIES	DATES
1	Finalization of budget for SLeSHI Activities	14.04.
2	Finalization of training manual for facilitators	15-16.04
3	Identification of facilitators	15-16.04
4	Identification of stakeholders by socio-economic group	15-16.04
5	Distribution of invitation letters to stakeholders for Regional and National Conference by NASSIT & DMOs	20-25.04
6	Presentation of draft ILO report to parliamentarians	22.04
7	Training of facilitators for the conferences	02.05.
8	Dispatch of facilitators	04.05.
9	Running of the Regional Conference (North, South East, Western Area and Western Rural)	11-12.05
10	Report Writing for findings of the Regional Conferences	13.05.
11	Arrival of ILO consultants	23.06
12	Running of the National Conference	24-25.06
13	Presentation of final ILO report to government	July 2009

8.7. Refining key elements of the emerging SLeSHI – a study in the rapid implementation of policies and plans

The "NATIONAL CONSULTATIVE MEETING FOR THE ESTABLISHMENT OF A NATIONAL SOCIAL HEALTH INSURANCE IN SIERRA LEONE" has shown wide-spread political and stakeholders' support and provided important feedback and suggestion for the further development of the Social Health Insurance scheme for the country.

What is needed now is the transformation of broad ideas, concepts and political goals into concrete legal and administrative arrangements and procedures. What form of legal entity should SLESHI have? Who should administer the scheme? How are funds collected and allocated? Which funds can go into the scheme on a sustainable basis?

Also, technical aspects need to be further defined for making the scheme viable and effective. Eligibility and exemption from contributions are major considerations. Detailed actuarial analysis is needed as well as procedures to define the benefit catalogue, to manage quality, to pool funds, to pay providers and to have a timely and relevant monitoring and controlling plan in place. The scheme will act as an active purchaser of services for its constituents.

Finally, the scheme needs to connect to enrolees, patients and providers alike. It should establish strong working relationships that allow obtaining timely feedback and constructive criticism leading to continuous improvement and effectively serving the needs of the people. Essentially, the scheme is a service provider, which manages pre-paid contributions and buys effective and high-quality health care on behalf of the enrolees.

It is suggested that the above-mentioned aspects be tackled in four components, each of which will be dealt with in a Working Group.

While Social Health Insurance can be helpful in pooling funds, purchasing quality care for the people, improving equity and preventing catastrophic health expenditures, there are bound to be shortcomings and caveats, which are well documented (Hsiao and Shaw 2007). These need to be taken into consideration and innovative mechanisms are always welcome to alleviate the shortcomings of any health care financing system.

It should be stressed here that both process and content are of fundamental importance and neglecting one of these two aspects would prove fatal for the scheme. Developing and implementing SHI is a social and political process and not a technical "pushing the button". A mixture of flexibility, persistence, adaptation, and frustration tolerance is clearly needed in this process.

1. Description of the four components

Component 1: Overall approach

Ownership. Should SLESHI be a private company, a public agency, a quasi-public agency or a government agency (the latter option was not received favourably during the national consultation)? If some form of public-private entity is planned (the most likely option), it needs to be worked out in detail what form such an arrangement could take, which would allow the necessary flexibility but also conservative thinking and adherence to the political goals set by the government. At all events, the proposed mandatory scheme will require a legal and institutional framework that provides clear and simple accounting and procurement standards based on transparency, comprehensiveness and timeliness. It should also have effective supervision and auditing systems in order to improve fiscal oversight

and ensure the effective enforcement of rules and sanctions for (financial) misconduct. SLeSHI should initially be a part of NASSIT and should stand on its own after 5 years of operations. This will require an act of parliament and appropriate executive orders.

Governance and government supervision. The government will want to have strong control over SHI for two reasons: the desire for political control and the fact that is the principal funder. Business, labour, and public representatives should also serve on the scheme's board, and the extent of their influence needs to be clearly defined. Although a clear plan for the composition of the board must be spelt out in the course of the stakeholders' meetings, the mechanisms and defined roles of government supervision need to be developed. A Memorandum of Understanding (MoU) could guide the relationships between SLeSHI, NASSIT and the various government institutions.

Anti-corruption measures. Corruption in the health sector reduces the resources effectively available for health, lowers the quality, equity and effectiveness of health care services, decreases the volume of services and increases the cost of providing them. It discourages people to use and pay for health services, demotivates staff and ultimately has a corrosive impact on the population's level of health. It is therefore important to prevent abuse and reduce corruption in order to augment the resources available for health, to make more efficient use of existing resources and, ultimately, to improve the general health status of the population. SHI can accumulate large funds – especially in its initial phase. These need to be prudently managed and the temptation to divert funds to other, even fraudulent, causes is strong. Forms of monitoring therefore need to be put in place, such as independent outside audits, professional (international) actuarial certification, regular legislative hearings, full public disclosure of funds and stakeholder meetings.

Relation to employers, collection of contribution, service provision. A frequently voiced important concern is that SHI contributions are de facto a tax on labour which could impede economic growth. This needs to be taken very seriously, and every effort should be made to follow-up on this concern in the Sierra Leonean context. Experience has shown that it is feasible to enrol and collect premiums from public institutions and private companies with more than 10 employees. Evasion is a minor problem, which, however, can become substantial in smaller private companies, as some companies may evade contributing altogether, while others may under-report salaries.

Assessing fiscal requirements and use of different revenue sources. It is well known that any form of social health insurance will require substantial subsidies from the State for those segments of the population which cannot pay for themselves. The fiscal capacity of Sierra Leone thus needs to be assessed in relation to the additional financing needs of the scheme. The success of an SHI system depends largely on its ability to enrol and collect premiums from the population and the government's ability to subsidize premiums for the poor. A thorough assessment of the labour market and the incidence of various forms of poverty are paramount here. The different forms of taxes (mobile phone use, alcohol/cigarette consumption, car ownership, etc.), as discussed in the report, need to be analyzed in terms of feasibility, sustainability and also public acceptability.

Component 2: Administrative setup

Strategy and business plan. SLeSHI is a financial institution. As such it needs a clear and comprehensive strategy and sound business planning. A "strategic plan" of some sort might not alone prevent serious financial risks and the ultimate failure of the organization.

Strategic planning is an organization's process of defining its strategy, or direction, and making decisions on the allocation of its resources, including its capital and people, with a view to pursuing that strategy. Strategic planning is the formal consideration of an organization's future course. All strategic planning deals to some extent with three key questions:

1. "What do we do?"
2. "For whom do we do it?" and (less relevant here)
3. "How do we excel?" or "How can we beat or avoid competition?"

> A business plan is a formal statement of a set of business goals, the reasons why they are believed attainable, and the plan for attaining those goals. It may also contain background information about the organization or team attempting to reach those goals.
>
> The business goals may be defined for profit-making or for non-profit organizations. For-profit business plans typically focus on financial goals, such as profit or creation of wealth. Non-profit and government agency business plans tend to focus on an organizational mission, which forms the basis of their governmental status or their non-profit or tax-exempt status respectively -- although non-profit organizations may also focus on optimizing income. In non-profit organizations, tensions may develop in the efforts to balance the mission with financial goals.
>
> Business plans may be internally or externally focused. Externally focused plans target goals that are important to external stakeholders, particularly financial stakeholders. They typically provide detailed information about the organization or team attempting to reach the goals. External stakeholders of non-profit organizations include donors and the clients receiving the non-profit organization's services.

In short, whereas a strategic plan is primarily an internal document for discussing and planning an organization's future prospects and possible courses of action, the business plan is an internal or external document describing a business goal in formal (and financial) terms and the plan for achieving it. Since SLeSHI will rely heavily on community support it will be mandatory to have all key elements of a sound strategy and comprehensive business plan ready for communication. Although the business plan is of course a value in itself, the process of developing it is more important as it will create a spirit amongst the people involved that will help to achieve the desired outcome and will contribute towards an attitude that will help to overcome the numerous obstacles along the way.

Corporate culture; separating SLEHSI from NASSIT. SLeSHI will be a new institution with a cadre of young, well-trained people willing to make a difference. This enthusiasm should be matched and preserved by an administrative setup that leaves room for individuals to develop initiative but at the same time makes sure that the core functions of the scheme are working effectively and properly. A major element will be innovative and appropriate payment schemes. The administrative set-up of the scheme as broadly outlined in the report needs to be refined and amended. It was agreed upon to launch SLeSHI operations within the actual structure of NASSIT. However, it will be necessary to separate both insurance schemes (the plan is to do so after 5 years), as their goals and working procedures are quite different.

Financial management and control. A major element of any insurance scheme is financial management and control, coupled with actuarial analyses (see below). Insurance schemes are, by their very nature, conservative and need safeguards and timely financial information. Modes of collecting contributions from the various sources in a timely manner must be developed which enable adequate cash flow and ensure a safety margin. Procurement is important, and it should be analysed to what extent SLeSHI could be involved in the procurement of drugs for the facilities.

Actuarial analysis. This will remain a somewhat "moving target" as it needs to reconcile the available financial means with the needs of the population covered and the cost of the suggested benefit catalogue. The major challenge here will be to develop a robust model that enables rapid adaptation to changing values in three dimensions (finances – needs – cost).

Eligibility and definition of the poor. This is a major aspect, as a large proportion of the Sierra Leonean population is poor, if not destitute. Extensive discussions were held on whether to include that segment of the population in the mandatory health contribution similar to national taxation. At all events, in order to target the subsidy on the poor, there is a need to define who is poor and/or very poor, physically challenged, or vulnerable and then find a way to identify them fairly and accurately. Stigmatization must be avoided.

Design of the benefit package. The SHI benefit package has to achieve two social purposes: health gains and protection against impoverishment from catastrophic medical expenses. Although there is widespread agreement that given the substantial scarcity of resources, cost-benefit considerations should be the major selection criterion, a benefit package cannot at present be based entirely on cost-effectiveness studies, because this field is still at an early stage of development in developing countries. Moreover, present cost-effectiveness studies only consider one effectiveness criterion - health gains - and totally ignore protection against financial risks. Nevertheless, every effort should be made to gain reliable and accurate data on cost-effectiveness. The WHO's CHOICE database can serve as a guide here. At all events, well-proved elements, such as the coverage of maternal and child health services, must be included. A clear understanding emerged from the stakeholders' meetings that primary and secondary care should be covered by SLeSHI, but not tertiary care, which should remain in the hands of the MoHS. Also, there is a strong wish to include traditional herbalists for the treatment of selected conditions. The issue of financial protection against catastrophic health expenditures requires further investigation (what kind of accidents/ diseases cause such catastrophic expenditure?), and actuarial analyses need to identify the cost of such protection. It should be noted here that a recent study from China (W. Yip and W. Hsiao, Soc Sci Med, 2009) concluded the following:

"As chronic diseases impose a growing share of the burden on the population in developing countries, it is not necessarily true that insurance coverage focusing on expensive hospital care alone is the most effective at providing financial risk protection."

Accreditation and contracting. Any SHI scheme will have to provide value for money, all the more so since enrolment is mandatory and people will realize that they are paying directly into a specific scheme, not general taxes. The scheme will thus be held responsible for the quality of the care provided. Competition is not to be considered as a means of improving quality simply because of lack of providers, even in Freetown. Thus, alternative well-tried and tested approaches are needed. A quality management system with clear accreditation standards and rigorous control mechanisms could be developed over time and gradually implemented. The idea is to promote joint efforts on the part of providers and the scheme towards better quality health care in Sierra Leone.

Medical personnel and delivering value for money. A review in the "*Lancet*"[14] highlights the importance of knowledgeable and motivated staff in the delivery of health care in low-resource settings. It has been shown that even with the very cost-effective interventions currently available a great number of illnesses and deaths could be prevented, if these treatments were applied properly. The review also convincingly shows the differences in effectiveness of various management and training approaches to improving staff knowledge and motivation. The severe shortage of medically qualified staff in the facilities is a major concern. A recent issue of "The Lancet" (February 23, 2008) has highlighted the underlying reasons that lead to such a shortage especially in sub-Saharan Africa. On the

[14] Rowe, A.K. et al: "How can we achieve and maintain high-quality performance of health workers in low-resource settings?" in The Lancet 2005; 366, pp. 1026-35

other hand, any remedy will be complex and will need to be based on careful mid- to long-term planning.

This dearth of qualified staff is not only a problem for the facilities; it is a major concern for the scheme. People pay into the scheme and rightfully expect to receive value for money. SLeSHI can and should contribute to ways and means of overcoming this appalling situation.

Provider payments and incentives. The way providers are paid has a substantial impact on access to and the quality and cost of care. Preferred payment methods and the role that purchasing organization(s) should play in their relationships with health-care providers need to be explored, both from the demand (community) side and the supply (provider) side. There is no perfect payment mode that could satisfy the various requirements of providers. An astute mix of approaches with measures to mitigate the negative effects of the different forms of payment is probably the most promising approach. One could also explore to what extent SLeSHI should influence the staff remuneration in the different institutions in order to align it with the goals of the scheme.

Incentives are meant here in their most general form: anything a person does is driven by either internal wishes or obligations or some form of external incentive. For example, participation could be driven by the internal notion of "I am a medical doctor and I want to provide good care for my patients" as well as the external incentive "If my my facility offers health education services in addition to medical services then more patients will pay more attention to their health and access health services when necessary, thus bringing me more revenue". Both aspects should be looked at. The internal notion could be influenced by peer pressure, success stories and by a general attitude of "things can be changed and you are an important part of the process". External incentives are either financial or non-financial:

Monetary − Pay-for-performance

- Bonuses

- Raffles amongst staff that have done better than average

- Remuneration for new ideas for improving processes

- Housing, schooling, support for the employment of partner if so wished

Non-monetary−Advanced training / library / internet access

- Specific training courses

- Exchange with national / international experts

- Availability of drugs

- High-quality equipment

- Food, festivities

A well-recognized study from Benin and Kenya shows

> "that non-financial incentives and HRM tools play an important role with respect to increasing motivation of health professionals. Adequate HRM tools can uphold and strengthen the professional ethos of doctors and nurses. This entails acknowledging their professionalism and addressing professional goals such as recognition, career development and further

> qualification. It must be the aim of human resources management / quality management (HRM/QM) to develop the work environment so that health workers are enabled to meet their personal and the organizational goals[15]."

Thus, the scheme should put a major focus on working towards such an enabling work environment. One important point is the prompt and adequate payment of providers by SLeSHI.

An additional important issue here is the need to manage the supply-side subsidies for public facilities. At present, those facilities receive a budget-line item from central/local government. When SLeSHI is introduced, they are liable to receive double payment for the services they provide. The obvious solution of gradually phasing out those budget line items and replacing them with SHI payments might, however, face political difficulties and resistance from employees.

Quality management. Some form of quality management system (QM) should be installed right from the outset of operations, based on core processes of the scheme and those of providers. The basis for successful QM is an understanding at the top management and clinical level that a QM system is a tool for improving activities and results – not an external nuisance that has to be complied with in order to satisfy the someone else's demands. Accreditation and provider payment are already major tools for improving efficiency and quality in any scheme. In addition, restricting the number of drugs to be prescribed under a scheme with almost exclusive use of generic drugs from trusted sources will be another major step. This is where the specific experience and knowledge of the MoHS will play a prominent role. The standardization of treatments, the development and implementation of guidelines, the definition of essential drugs at the different treatment levels, as well as the defining of monitoring and evaluation approaches will need Ministry support. Specific tools that are available (such as EFQM, DIN-ISO, etc.) are probably not cost-effective at this stage of development.

Controlling cost. SLeSHI will become a potentially huge new source of revenue. Two major risks need to be looked at: (i) moral hazard and (ii) the rising cost of services. Both are very relevant in determining the long-term financial stability of the scheme and require careful attention. Moral hazard can come from either patients or providers, and whereas greater use of health care is a major goal of the scheme, over-utilization will always be a major consideration. The cost of services can ultimately only be controlled by a defined cost schedule. The administration of claims and reimbursements needs to be set up carefully, making sure that appropriate payments to providers is balanced with the need to protect against fraud and overcharging.

Monitoring and evaluation. The major question is the effect that SLeSHI will have on patients and providers. In order to answer it, data is needed to obtain a better understanding of the provision of services, the needs of the population and the way care is delivered, received and financed at the level of the institutions and households. It might be useful to review available data and to have just a few central indicators that are easily communicated available as well as some additional data that are important in the national and international discussion. Rather than having too many indicators that are poorly followed up and of questionable quality, fewer indicators with good reporting quality would be much more useful.

Such possible indicators include:

[15] Mathauer, I. and Imhoff, I. (2006). Health worker motivation in Africa: the role of non-financial incentives and human resource management tools, Human Resources for Health.

- household-based incidence of catastrophic health-care expenditure;
- institution-based death rates due to emergency obstetric cases;
- public perception of the unmet need for specific health care;
- percentage of births attended by a skilled birth attendant;
- rate of caesarean sections;
- number of women from different income strata seeking care at the hospital
- changes in health-seeking behavior (household-based);
- data on structures and processes, e.g. number of nurses trained, amount of continuous medical education provided, number of operations performed, percentage of post-operative complications and the like.

A baseline should possibly be established before operations are launched.

Component 4: Connecting with the field

Any public health insurance scheme will have to inform the population on how it works and what it can do for people and will also need to make sure that it delivers what people want. To this end, different approaches need to be adopted that put the emerging scheme in close and regular contact with the insured, the patients and the providers. In addition, politicians also need to be informed, and the mechanisms of policy formulation and implementation need to be understood if they are to be effectively influenced.

Information campaigns

Since the idea of a large-scale health insurance scheme is new to the country and its people, SLeSHI will need to fully inform the contributors, the insured, and patients about the work of such a scheme and its effects on individuals. Experience shows that even in well-established schemes, the members of SHI often do not feel sufficiently informed by the insurer. Misconceptions about individual rights and obligations when it comes to health care persist, for example, on such issues as whether a mother would have to bring all kinds of consumables and medicines even when attending a clinic to give birth. A massive integrated marketing campaign should be launched in order to inform the general public about SLeSHI. This will require celebrities/champions, marketing, multipliers and a host of public awareness and information approaches.

Local workshops with providers

The providers will play a major role in the strategy and expansion policy of the scheme, because it is they who give members the value for their money. If the members cannot access good-quality services, then the Fund will have a hard time justifying its existence and the need to further expand social health insurance to other segments of the population. A major thrust of SLeSHI's efforts and strategic thinking should therefore be directed towards providers. Experience has shown that providers are sceptical of a new unified scheme, which is regarded as powerful and a potential threat to professional independence. SLeSHI will need to work with providers at all levels to discuss its role and the importance of open communication and exchange.

Identifying local needs

Although a major goal of health insurance is to ensure that patients have access to effective care of high quality, efforts must be made to ascertain individual's preferences and needs and try to respond to them.

Policy advice and lobbying

The scheme will operate in a complex legal and policy framework set forth by different ministries as well as national laws and by-laws. Thus, in order to ensure successful management, any major impediments need to be identified as early as possible in order to permit lobbying and the possible removal of such hurdles. The scheme should be allowed to conduct pilot studies which would give it substantial freedom in trying out new modes of providing and paying for care. Theoretical and technical considerations, however, may not be in line with political needs and the necessary responses to demands from constituents. SLeSHI will therefore need to acquire a better understanding of the political process in order to effectively give advice, inform politicians and lobby for its cause.

2. Cross-cutting issues

In all four components there will be a need for intense knowledge development and international exchange and capacity development as well as good reliable data for development, calculation and monitoring purposes. These "cross-cutting issues" require careful attention and substantial effort. It will be helpful to lay special emphasis on these issues and foster intense exchange amongst the various groups.

Knowledge development and international exchange

Learning from international experience is a major element in developing and implementing the scheme. It is strongly suggested that a substantial amount of time be devoted to better understanding the experiences made in other countries. Countries such as Ghana, Tanzania, the Philippines, Thailand, and Colombia could provide helpful insights into the design, implementation and rollout of a scheme in a country. We suggest that one or two African and one or two Asian countries be selected for intense discussions and transfer.

In detail, the technical goals would be (i) to gain knowledge of political reform processes, (ii) to identify core successes and challenges (political and technical) as well as the enabling factors shown to be helpful in pushing through specific reform elements, and (iii) to outline ways and means of supporting and coaching reformers, improving social dialogue, and achieving sustainability.

In fact, international exchange of this nature will be most valuable for the country, since it helps not only to understand concrete issues and problems arising in the implementation of such a scheme, but also to persuade policymakers and administrators to take up advice and suggestions. Given the tremendous importance of such international cooperation, it is suggested that this element be budgeted for specifically.

Building capacities for effective and efficient management for the implementation of the National Social Health Insurance

A major prerequisite for running an SHI successfully and efficiently is well-trained people. There is a clear need for specific technical expertise such as financial management of a health insurance scheme, revenue collection and administration, reimbursement procedures, quality management and so forth. It will be necessary to identify training needs, select appropriate candidates and train them. NASSIT staff could provide training in-house, and, as far as aspects more specifically related to health insurance are concerned,

external training could be provided either by international experts in the country or through targeted training abroad. It should be considered whether NASSIT / SLeSHI could team up with an established scheme, such as the scheme in Ghana, to foster regular exchange and training.

Data gathering

Given the difficult data situation concerning some of the major elements in the actuarial calculation, institutional setup and management of the scheme, there is an urgent need to obtain comprehensive and reliable data on: (i) population and socio-economic aspects, (ii) eligibility and possible exemption, (iii) facilities and (iv) costing of procedures. In addition, information of this nature can be most valuable for better assessing the needs for selected upgrading of facilities and possible training sessions; it needs to be obtained from a multitude of sources. It will also be necessary to conduct specific surveys, conduct interviews with providers and analyse existing data.

Coordination with external development partners

Sierra Leone has close connections with a number of bi- and multilateral development partners working in various sectors of the health care system. Since these activities will need to be aligned with the emerging new scheme, a number activities will have to be discussed and coordinated with the on-going and planned initiatives of these partners.

3. Setup concerning the implementation team

Three levels are envisaged for the study:

(1) The Board will oversee operations, receive regular feedback probably on a monthly basis, provide overall guidance, liaise with relevant political forces, and will be held publicly responsible for the project. Members could include relevant ministers, the chair of the NASSIT board, and the designated CEO of SLeSHI amongst others. It could prove helpful to have an experienced international expert assisting in the undertaking.

(2) The Management Committee will be responsible for daily management and for reporting to the board, will be held responsible for achieving the targets set, and will direct the working groups. Members could include delegates from the relevant ministries, a delegate from NASSIT, and a chief technical adviser (international).

(3) The Technical Working Groups will consist of specialists in the relevant fields, will report to the Management Committee, and should prepare relevant materials and drafts that enable the Management Committee to take decisions. Each Working Group will have a head who will be responsible for output and for achieving targets. A national adviser will support each working group. The expertise of the MoHS should be sought and incorporated into the proceedings of the working groups.

In addition, external consultants will be needed to assist on specific questions and topics.

It will be essential to gain a thorough understanding of the challenges and possible pitfalls when setting up such an ambitious scheme. However, the successful development of NASSIT into a respected and trusted institution can be a source of valuable guidance.

In general, the technical and administrative components will jointly define the operating rules and will draft the manuals for the various procedures. If these rules and regulations are to be both meaningful and possible, they will need to have input from both the administrative and the technical point of view. Operations will thus also be launched

during this setup phase in the two selected districts. Concrete tasks need to be managed such as

- setting up agreements with providers
- training supervisors
- enrolment
- collecting contributions / premiums
- attending to claims administration and reimbursements
- dealing with complaints.

Such a transmission from more theoretical and organizational considerations to the operational level will provide the necessary feedback for fine-tuning and in some cases even reconsidering the approaches planned.

4. Study arrangements

The plan is to launch the initial phase of SLeSHI operations in two selected districts. One of the districts will be starting with the formal sector only, whereas the other one will try to include the entire population right from the start. This will allow better understanding of the feasibility of reaching the various segments of the population, the appropriate approaches for collecting revenue, the impact of health insurance on people's health-seeking behaviour, and the cost and subsidy implications.

The measures necessary for upgrading and developing human resources

Obviously, a major factor for the success of the new scheme is the quality of the facilities. They will have to deliver "value for money" for the SLeSHI members, and the quality of the care provided will affect people's perceptions of the scheme. Every effort will thus have to be made to look carefully at the current state of personnel, qualifications, buildings and equipment in the facilities. It is considered that several substantial upfront improvements will be needed concerning both structures and processes in the facilities.

The focus on only two districts to begin with will provide a basis for thorough analysis and scrutiny of the current state of affairs and rapid responses. It is suggested that this analysis and needs assessment be the very first step in the study.

An additional aspect is close cooperation with NASSIT on a comprehensive approach to poverty alleviation. Both schemes will be vital in the quest to establish a comprehensive social protection net which puts the vulnerable population at the centre of all effort. The needs, expectations and capacity-to-pay of the different population segments need to be explored in detail and linked to the overall strategies and policies in planning for social protection.

Concrete first steps

After due political deliberation and final approval (probably with some form of Presidential Order), the implementation team will have to adopt a very hands-on approach:

(i) it is assumed that some amount of additional surveys, data collection and analysis as well as in-depth interviews with providers will have been performed beforehand, as such data and detailed understanding will be crucial for launching operations;

(ii) the operating rules will also have to be defined upfront, and a draft manual for procedures should be available for supporting staff;

(iii) initial agreements with providers will need to be prepared, preferably within a rather short time-frame in order to enable adaptation on the basis of the initial experience gained;

(iv) supervisors and core staff will have to be trained, if only to follow proper accounting procedures and run core functions (membership and registration, issuing of membership cards, explanation of the waiting time and benefit catalogue, reimbursement, etc.);

(v) the enrolment process will start on day 1; initial strong demand should be anticipated, and the team should be prepared for a heavy workload;

(vi) the collection of contributions would start at the same time, which means that there must be a clear understanding of possible exemptions, which must be agreed upon beforehand. It is suggested that it be made very clear from the outset that benefits can only be claimed if a person is either exempted (with proof) or has a membership card. Membership cards for the informal sector should be issued as soon as payment has been received; for the formal sector, specific arrangements should be sought in cooperation with employers and unions;

(vii) the additional funds from government sources need to be secured as early as possible in the preparation process, since it should be assumed that administrative processes will not go as fast as anticipated; close coordination with the relevant ministries (MoESS, MoHS, MoFED), departments and bureaus is paramount here;

(viii) it is strongly suggested that some form of virtual health accounting be carried out, indicating the flow of funds from the different sources within government, from contributions, and from external sources; the process should be fully transparent and should follow the established Public Expenditure Tracking System standards;

(ix) the provision of coverage and reimbursement of claims will probably not start until operations have been running for 3 to 6 months; a major element here will be to explain to enrolees the need for a waiting time and the purpose it serves (i.e. building up reserves);

(x) since good public relations and communication with all stakeholders are very important right from the outset, an efficient department should be in place when operations are launched; complaints should be followed up promptly, and all of the parties involved should be invited to contribute to the solution of any deficiency that is perceived.

Provided that programmes for upgrading health facilities continue and seed money for start-up outlay, drugs, and contribution waivers is available, the above arrangements will be piloted in two carefully selected districts. This will be carried out in close cooperation with the World Bank, UNICEF and other international actors and is expected to last between one and a half to two years. It will involve the recruitment of project personnel, travel, the purchase of office equipment, and capacity-building programmes. It is estimated that the project will cost around 1.5m – 2.0m US$.

5. Milestones

Major milestones include the financial/administrative setup in the two districts; needs assessment and initial forms of support; stock-taking of the progress achieved and the challenges still to be met; launching of information, education & communication (IEC) programmes; forming of working groups; and staff recruitment and training. Progress reports on milestones will be presented to the Board at defined intervals.

6. Results framework, monitoring and estimated cost

Results framework and study monitoring

Overall goal	**Study outcome indicators**	**Use of study outcome information**
To contribute to (a) the further conceptual and technical development of SLeSHI; (b) the outlining of possible modes of implementation (c) the testing of the scheme in selected districts of the country	Satisfactory develop-ment of the SLeSHI plan on the basis of semi-annual reviews; assessment of a country-wide rollout Available data and detailed technical papers on relevant aspects of SLeSHI operations	Demonstrates the feasibility and possible sustainability of SLeSHI with respect to revenue collection, pooling and purchasing of services. Quality, financial protection and responsiveness of the services are covered.
Objective	**Intermediate outcome indicators**	**Use of intermediate outcome monitoring**
Component 1: Legal framework		
(i) Ownership (ii) Governance (iii) Anti-corruption (iv) Relations with employers (v) Assessment of fiscal requirements	Different legislative procedure initiated, drafting of relevant laws / charters / policies	Demonstrates the state of advancement of the legislative process, provides a basis for reviewing the overall setup
Component 2: Administrative framework		
(vi) Strategy and business plan (vii) Corporate culture; separate SLeSHI and NASSIT structures (viii) Financial management (ix) Actuarial analysis	Business plan and strategic plan available Controlling instruments in place Refined actuarial analysis available	Provides concrete evidence that the essential adminis-trative steps have been undertaken; basis for internal and external review
Component 3: Technical components		
(x) Eligibility, exemption of the poor (xi) Benefit catalogue (xii) Accreditation / contracting (xiii) Medical personnel (xiv) Payment of providers, incentives (xv) Quality management (xvi) Cost control (xvii) Monitoring and evaluation	Detailed technical reports on the different aspects that are written clearly and set out the underlying assumptions Monitoring plan and set of indicators available	Ensures that vital technical aspects have been dealt with, gives the underlying assumptions for regular review and adaptation
Component 4: Connecting with the field		

(xviii) Information campaign (xix) Provider workshops (xx) Efforts to identifying local needs (xxi) Policy advice and lobbying	Number of meetings / workshops / campaigns Conceptual note on effective lobbying; responsibilities	Shows the activities in the field Ensures that linking with politics is not left to chance or automatic, providing evidence for a concerted effort
Cross-cutting issues		
(xxii) Knowledge development and international exchange (xxiii) Building capacities (xxiv) Data gathering (xxv) Coordination with development partners	Countries for exchange selected, contacts made Training needs assessed and training programme developed Data structure and possible sources outlined Regular technical meetings with development partners	Demonstrates the will to tackle these issues and indicates the ways forward.