



**Government of Sierra Leone**

# **HEALTH FINANCING SITUATION ANALYSIS**

**Ministry of Health and Sanitation**

**January 2020**

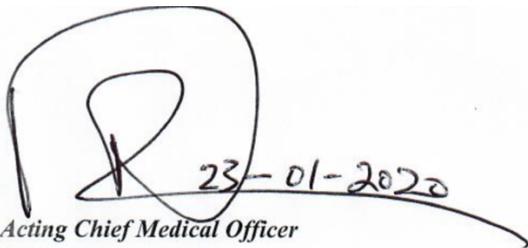
## FOREWORD

The conduction of the Sierra Leone Health Financing Situation analysis is guided by the current dynamics in the health sector. With the Government of Sierra Leone's (GoSL) commitment to reach Universal Health Coverage (UHC), there is an urgent need to think about how to finance it. Addressing the health financing issues of raising more revenues in an equitable way and spending them efficiently will direct resources towards improving the quality and coverage of health services; help reduce the financial burden on people; and improve health outcomes, thereby moving the country towards UHC. To this end, the GoSL will embark on the development of a health financing strategy, outlining clear steps on how to address health financing issues, and move towards UHC.

In order for a Health Financing Strategy to be useful, it was imperative to diagnose the current problems of the health system of the country, and identify their underlying causes. To this end, the Health Financing Unit, under the Directorate of Policy, Planning and Information and other health partners developed the Health Financing Situation Analysis.

On that note, the situation analysis has been conducted using a consultative approach involving all the key stakeholders in the health sector and Ministry of Finance, while taking cognizance of other relevant ministries, departments and agency (MDAs). The analysis provides a detailed description of funding arrangements from various sources and services that the funds were utilised for.

The Ministry of Health and Sanitation is thankful to its staff, development partners and other health stakeholders who contributed to various efforts in shaping this report. The Ministry is also committed to the full realization of recommendations in this report. The report will be used as one of the relevant documents to guide the development of the health financing strategic plan for Sierra Leone. We look forward to working collaboratively across the health sector, partners and all stakeholders to ensure the development of the health financing strategic plan come to actualisation.

A handwritten signature in black ink, consisting of a large, stylized 'D' followed by a smaller 'R' and a horizontal line extending to the right. The date '23-01-2020' is written in the middle of the horizontal line.

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Dr. Donald Bash-Taqi  
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## Table of Contents

<b>FOREWORD</b> .....	<b>2</b>
<b>Table of Contents</b> .....	<b>3</b>
<b>Table of Figures</b> .....	<b>4</b>
<b>Table of Tables</b> .....	<b>5</b>
<b>ACRONYMS AND ABBREVIATIONS</b> .....	<b>6</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>7</b>
<b>SECTION I: INTRODUCTION</b> .....	<b>9</b>
I.    Background .....	9
II.   Methodology.....	11
<b>SECTION II: Organization of health services in Sierra Leone</b> .....	<b>13</b>
III.  Public Administrative Structure (focus on health) .....	13
<b>SECTION III: Contextual factors that impact on health financing policy</b> .....	<b>15</b>
IV.   Fiscal capacity of GoSL .....	15
<b>SECTION IV: Public Financial Management</b> .....	<b>23</b>
I.    Overview of PFM in Sierra Leone .....	23
II.   Planning and public budgeting processes in health .....	26
<b>SECTION V: Review of health revenue and expenditure</b> .....	<b>33</b>
I.    Government expenditure on health .....	35
II.   Donor expenditures .....	42
III.  Household expenditure on health.....	46
<b>SECTION VI: Review of existing health financing arrangements</b> .....	<b>49</b>
I.    Resource mobilization.....	49
II.   Pooling.....	52
III.  Strategic purchasing.....	53
<b>SECTION VII: Financial protection and equity in finance</b> .....	<b>55</b>
I.    Equity in distribution of resources .....	57
<b>SECTION VII: Research gaps</b> .....	<b>63</b>
<b>Annexe 1: Out of pocket expenditure</b> .....	<b>64</b>
I.    Consulting for illness .....	64
II.   Hospitalisation for illness .....	64
III.  Vaccination.....	65
IV.   Ante-natal care.....	65
V.    Contraceptives .....	66

## Table of Figures

Figure 1: Map of Sierra Leone .....	9
Figure 2: Annual % change of real GDP growth, 1991-2018.....	15
Figure 3: Domestic revenue and expenditures as % of GDP.....	16
Figure 4: Domestic revenue by source, 2008-2019 .....	17
Figure 5: Inflation rate, annual percentage change, 2008-2018 .....	19
Figure 6: Nominal and real exchange rate.....	19
Figure 7: UHC Maximising Fiscal Space Financing Gap (in million USD) .....	22
Figure 8: Timelines of MoHS budget development .....	27
Figure 9: Schematic overview of GoSL funds flow from the central government to the districts.....	29
Figure 10: Fund flows and budget execution within the health sector, 2017 figures .....	31
Figure 11: GoSL Payment process flow.....	32
Figure 12: Health outcomes vs health spending in Sub-Saharan Africa .....	34
Figure 13: Total Health Expenditures in Sierra Leone (2006-2016).....	35
Figure 14: GoSL revenue and MoHS expenditures over ten years .....	35
Figure 15: Annual growth rates of domestic revenue, GDP and MoHS expenditures.....	36
Figure 16: Government health expenditures as % of GGE, domestic revenue, GDP (2010-18) .....	37
Figure 17: Regional comparison of government’s contribution to health.....	37
Figure 18: Total health expenditures of GoSL, 2008-2018 .....	38
Figure 19: MoHS budget execution rates (2015-18).....	39
Figure 20: Non-salary expenditures by level of health care, 2015-2018 .....	40
Figure 21: MoHS recurrent expenditures (2010-2018) .....	40
Figure 22: The GoSL wage bill has grown faster than the MoHS wage bill.....	41
Figure 23: Health receives the largest support from donors, on average a third of total support goes into the health sector. ....	43
Figure 24: GoSL and donor support in 12 key sectors, 2017 .....	44
Figure 25: GoSL and donor support across key sectors, 2013-2017.....	45
Figure 26: Incidence of OOP expenditures, by region and wealth quantile .....	47
Figure 27: Out of pocket payments by region and wealth distribution.....	47
Figure 28: Out of pocket payments by district .....	47
Figure 29: Out of pocket expenditures in Sierra Leone and West Africa.....	48
Figure 30: Non-food household expenditure .....	55
Figure 31: Non-food household expenditures (in %).....	55
Figure 32: Catastrophic health expenditures bigger than 40% of non-food consumption .....	56
Figure 33: Catastrophic health expenditures bigger than 10% of total consumption.....	57
Figure 34: Urban vs. rural distribution of the health workforce compared to population.....	58
Figure 35: Distribution of health workforce by district. ....	59
Figure 36: Distribution of all public facilities by district. ....	59
Figure 37: Findings of Spot Check of health worker attendance at facilities.....	60

## Table of Tables

Table 1: Tabular overview of domestic revenue by source, 2008-2019.....	18
Table 2: Diseases and services included in the SLeSHI benefits package. ....	51
Table 3: Summary of costs and contributions of current SLeSHI scheme. ....	52
Table 4: Up to 52% of the population would be exempt from premium payments under SLeSHI. ....	53
Table 5: Deployment efficiencies of nurses in hospitals.....	61
Table 6: Overview of resources in supply chain, 2019. ....	62
Table 7: Cost of consultation, medicines, supplies and tests by type of facility.....	64
Table 8: Cost of consultation, medicines, supplies and tests by most common illnesses .....	64
Table 9: Cost of hospitalization by facility type .....	64
Table 10: Cost of vaccination by facility type .....	65
Table 11: Cost of ante-natal care by facility type .....	65
Table 12: Cost of most commonly used contraceptives.....	66
Table 13: Cost of contraceptives by facility type .....	66

## ACRONYMS AND ABBREVIATIONS

AfDB	African Development Bank
BCC	Budget Call Circular
CDC	Centers for Disease Control
DFID	Department for International Development
DHMTs	District Health Management Teams
DACO	Development Assistance Coordination Office
DHRH	Directorate of Human Resources for Health
EU	European Union
FHCI	Free Health Care Initiative
FMR	Financial Management Regulations
GoSL	Government of Sierra Leone
GDP	Gross Domestic Product
GST	Goods and Services Tax
HMIS	Health Management Information System
HRIS	Human Resources Information System
HFAC	Health For All Coalition
HRH	Human Resource for Health
HRMO	Human Resource Management Office
HSC	Health Service Commission
IMF	International Monetary Fund
IFMIS	Integrated Financial Management Information System
IHPAU	Integrated Health Project Administration Unit
ILO	International Labour Organization
LGFD	Local Government Fun Department
MoHS	Ministry of Health and Sanitation
MoF	Ministry of Finance
MoPED	Ministry of Planning and Economic Development
MTEF	Medium-Term Expenditure Framework
MDAs	Ministry Departments and Agencies
NEER	Nominal Effective Exchange Rate
NGOs	Non-Governmental Organizations
NASSIT	National Social Security and Insurance Trust
OOP	Out of Pocket
PFM	Public Financial Management
PBF	Performance Based Financing
PHUs	Peripheral Health Units
REER	Real Effective Exchange Rate
RMNCH	Reproductive Maternal New-born and Child Health
SLIHS	Sierra Leone Integrated Household Survey
SLeSHI	Sierra Leone Social Health Insurance
THE	Total Health Expenditure
UHC	Universal Health Coverage
WHO	World Health Organization

## EXECUTIVE SUMMARY

Sierra Leone has relatively high total expenditure on health, but poor outcomes. In 2013, the Total Health Expenditure (THE) per capita in Sierra Leone was USD 82 (compared to USD 20-57 in Ethiopia, Mozambique, Rwanda and Uganda)<sup>1</sup>; yet there were 1,460 maternal deaths per 100,000 births (compared to less than 550 in the other countries)<sup>2</sup>. Resources are also distributed inequitably; a large proportion of the THE is directed towards hospitals, rather than PHUs whereas it is known that primary services are more cost-effective, and spending at primary level would be more efficient.

With the Government of Sierra Leone's (GoSL) commitment to reach Universal Health Coverage (UHC), there is an urgent need to think about how to finance it. Addressing the health financing issues of raising more revenues in an equitable way and spending them efficiently will direct resources towards improving the quality and coverage of health services, help reduce the financial burden on people, and improve health outcomes, thereby moving the country towards UHC. To this end, the GoSL will embark on the development of a **health financing strategy**, outlining clear steps on how to address health financing issues, and move towards UHC.

In order for a Health Financing Strategy to be useful, it is imperative to diagnose the current problems of the health system of the country, and identify their underlying causes. To this end, the Health Financing Unit, under the Directorate of Policy, Planning and Information, developed the **Health Financing Situation Analysis**. Data and inputs were accumulated other Directorates, Ministries (especially Ministry of Finance) and key partners. The main findings are summarized below:

1. **Limited government contribution:** While the government's revenues has grown over the last 10 years, expenditure on health has on an average remained 6% of the general government expenditure. Sierra Leone is the smallest public spender on health in ECOWAS. To close the health financing gap for Universal Health Coverage by 2025, raising government expenditures to meet the Abuja target would have a significant impact – this requires widening the tax base and further increasing domestic revenues.
2. **Donor dependency:** External partners have contributed 6.5 times more than GoSL for health in the last five years, explaining considerable differences in decision-making power. Even if the Ebola years – which saw an influx of donor money to the health sector – are not considered, the average amount of external support going to health is 25%, making it still the most supported sector.
3. **Burden on the population:** Between the two rounds of SLIHS surveys (2011 and 2018), out-of-pocket expenditure in absolute terms has decreased. However, the burden of health care still largely falls on the population – bore two thirds of the THE in 2018. 68% of what they spend goes into drugs, where there are huge inefficiencies due to irrational prescription and counterfeit drugs. 9% of the population incurred catastrophic spending on health (i.e. more than 40% of their non-food expenditure was on health)

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<sup>1</sup> WHO Global Health Expenditure Database 2013

<sup>2</sup> World Development Indicators 2013

4. **Weak health financing arrangements:** There is virtually no risk pooling, financial protection for patients, and very limited strategic purchasing.
5. **Primary health care is woefully underfunded,** indicating a sluggish way ahead towards UHC. Peripheral Health Units – the main vehicles of primary health care in Sierra Leone – have very limited funds at their disposal, with most expenditure directed towards hospitals.
6. Strengthening **Public Financial Management** (in health, as well as broadly) can overcome inefficiencies in spending, and thereby increase the fiscal space for health. Processes to access Government of Sierra Leone funds are bureaucratic and time-consuming, and funding is not made regularly available by MoF. Budget execution rates of MoHS vary widely, from 41%-127% within the last ten years. Budget predictability is low.

#### **ACKNOWLEDGMENTS**

The Health Financing Situation Analysis was developed under leadership of the Principal Health Economist, Directorate of Policy, Planning and Information. The Government of Sierra Leone acknowledges and appreciates the financial and technical support of UK Aid through the Saving Lives in Sierra Leone Project Phase II.

## SECTION I: INTRODUCTION

### I. Background

#### A. Geography, Demography and Governance

Sierra Leone is a small West African country of approximately 7 million people<sup>3</sup>, bordered by Guinea, Liberia and the Atlantic Ocean. The country is subdivided into four administrative regions – the North, East and Southern provinces, as well as the Western Area, where the capital city of Freetown is located. Roughly 21% of Sierra Leoneans live in the geographically small Western Area; 35% in the North; 23% in the East; and 20% in the South<sup>4</sup>. These regions are further subdivided into 14 districts. Freetown, the capital, is located in Western Area. The districts are further subdivided into 152 chiefdoms. The Government of Sierra Leone (GoSL) has been attempting to devolve many functions to the district and chiefdom levels since the Local Government Act was passed in 2004, with mixed results across its various sectors. The country has roughly fifteen different ethnic groups<sup>5</sup>. The official language is English, and most individuals also speak Krio, the most common local language.

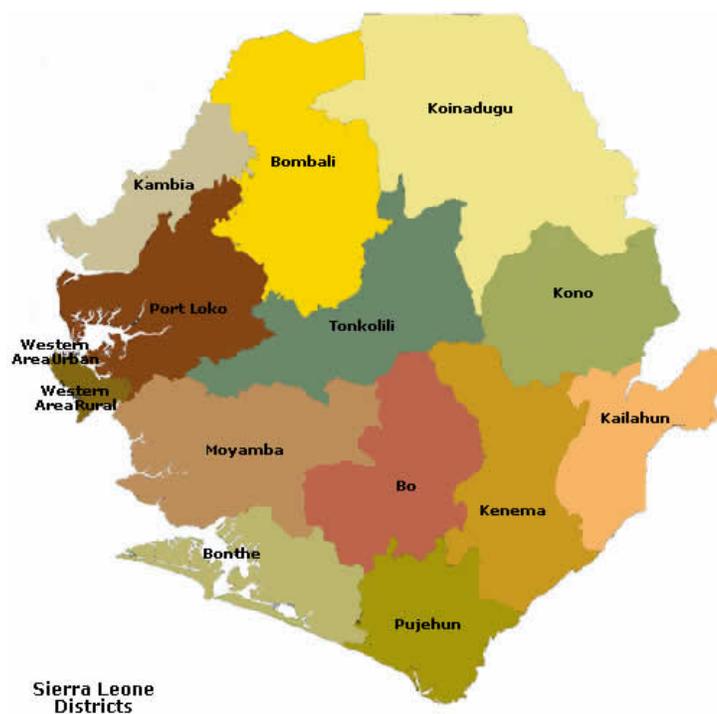


Figure 1: Map of Sierra Leone

#### B. Economics, Human Development and Humanitarian Crises

Sierra Leone was thrown into chaos during its decade-year long civil war, which began in 1991 and was ended only in 2002. Tens of thousands of Sierra Leoneans were killed during this period, while the war also destroyed the infrastructure and systems on which any government relies. The after-effects of the

<sup>3</sup> Statistics Sierra Leone, 2015 Population and Housing Census Summary of Final Results, 2016, [https://www.statistics.sl/wp-content/uploads/2017/01/final-results\\_-2015\\_population\\_and\\_housing\\_census.pdf](https://www.statistics.sl/wp-content/uploads/2017/01/final-results_-2015_population_and_housing_census.pdf)

<sup>4</sup> Ibid

<sup>5</sup> Statistics Sierra Leone, Sierra Leone Demographic and Health Survey 2013, 2014, <https://dhsprogram.com/pubs/pdf/FR297/FR297.pdf>

conflict can still be felt today. Roughly 52%<sup>6</sup> of Sierra Leoneans live below the poverty line, and life expectancy for an average Sierra Leonean citizen is 50 years of age<sup>7</sup>.

Nevertheless, Sierra Leone has a reputation for resilience for good reason. The country's leaders and its citizens began to develop its economy, government and civil society once more during the decade between the civil war and the beginning of the Ebola epidemic. For the health sector, this culminated in the promise of the Free Healthcare Initiative – launched in 2010 – which would deliver free care to all pregnant and lactating women, children under five, and other select at-risk groups.

However, once again, the government and people of Sierra Leone faced a terrifying disaster. The Ebola epidemic arrived in Sierra Leone in 2014, after crossing the border from rural Guinea. The epidemic would go on to become the largest Ebola epidemic ever recorded, and one that would paralyze much of West Africa during 2014 and 2015. However, through the courage of the Sierra Leonean people, their Liberian and Guinean neighbours, and their international partners, the epidemic was stopped and Sierra Leone declared Ebola-free in November 2015.

Even so, the epidemic did tremendous damage to the country. Between deaths that were directly a result of the Ebola virus – and others that were caused as a result of Sierra Leoneans not accessing care during the epidemic – Sierra Leone suffered yet another crushing loss of life, with more than 14,000 total cases and nearly 4,000 deaths<sup>8</sup>. Conservative estimates suggest that as many as another 2,819 individuals perished from malaria, HIV/AIDS, and tuberculosis alone due to the lack of accessible medical care for other issues during the time of the epidemic<sup>9</sup>.

Today, Sierra Leone is at a crossroads. The Government of Sierra Leone – and the Ministry of Health and Sanitation in particular – has the difficult task of trying to get Sierra Leone's health sector back on track. The country still has some of the worst health indicators in the world – in particular on maternal and child mortality – but a keen interest in leveraging the resources and experience of the Ebola epidemic to make significant strides forward in the health sector.

### C. Sierra Leone, the Sustainable Development Goals and other global/regional commitments

The 2030 Sustainable Development Agenda has the potential to play a key role at this pivotal moment in the trajectory of Sierra Leone's health sector and overall development. The Sustainable Development Goals (SDGs) comprise a broad range of objectives that integrate several dimensions of sustainable development around people, planet, prosperity, peace, and partnership (WHO, 2015). Sustainable Development Goal Three (SDG 3) seeks to ensure healthy lives and promote wellbeing for all at all ages.

Prior to the introduction of the SDGs, Sierra Leone demonstrated its commitment to achieving progress towards targets outlined in the Millennium Development Goals (MDGs). The United Nation's summary

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6 The World Bank, World Development Indicators, 2011, <http://databank.worldbank.org/data/home.aspx>.

7 World Health Organization, Global Health Observatory, 2015, <http://apps.who.int/gho/data/node.cco>

8 Centres for Disease Control and Prevention, "2014 Ebola Outbreak in West Africa – Case Counts," 2016, <https://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html>

9 Alyssa S. Parpia, Martial L. Ndeffo-Mbah, Natasha S. Wenzel, and Alison P. Galvani, "Effects of Response to 2014–2015 Ebola Outbreak on Deaths from Malaria, HIV/AIDS, and Tuberculosis, West Africa," *Emerging Infectious Diseases* 22, no. 3 (2016): 433-441. <http://doi.org/10.3201/eid2203.150977>.

report of adaptation of the goals reported that the poverty headcount has declined from 70% to 53% from 2003 through 2013, access to safe drinking water increased from 37% in 1990, to 63% in 2015, and the ratio of girls to boys in primary school was close to 100% (United Nations, Sustainable Knowledge Platform). However, the shock of economic and health crises that struck the country towards the end of the MDG timeline undermined and, in some cases, reversed progress made towards achievement of MDGs.

As Sierra Leone continues to recover and return to pre-Ebola health system priorities, there is a renewed call for long-term, sustainable, and equitable progress towards achieving universal health coverage (UHC) and improving health for all Sierra Leoneans. The government of Sierra Leone can harness the focus and intent of the SDGs to deliver on this promise. The SDGs recognize the importance of partnerships within and across sectors, as well as the crucial priority of focusing on systems to improve health and wellbeing. Especially within the context of a low-income country like Sierra Leone, increased recognition of the importance of synergies across other sectors and a commitment to health systems strengthening and capacity building will be critical to the achievement of meaningful change. These principles are reflected in the objectives and activities found in this document.

Specifically, for the SDG 3, the Government of Sierra Leone, and in particular the MoHS, has been working actively to develop interventions aimed at achieving the adapted targets. This has entailed ensuring that programmatic and sub-sector strategies such as the RMNCAH strategy and Human Resources for Health (HRH) strategic plan take into account the required investments and resources to reach SDG 3 targets by 2030. Additionally, determinants of health, which are covered under other SDGs (such as education, water, food security) will have an impact on policies in the health sector and beyond. Considering that the under-five mortality and maternal mortality will decrease, it will be even more important to ensure that people not only survive but live long and healthy lives.

In addition to the Sustainable Development Goals being a main driver for the sector in the coming years, Sierra Leone is also a key partner in the UHC2030 (formerly known as the International Health Partnership IHP+). The country's active engagement in this initiative speaks to the government's commitment to strengthening the country's health system towards universal health coverage.

Furthermore, Sierra Leone is signatory of the Abuja Declaration, pledging to set a target of allocating at least 15% of its annual budget to improving the health sector, while also committing to several other global requirements such as the International Health Regulations and the Framework Convention on Tobacco Control and regional initiatives such as the Ouagadougou Declaration on Primary Healthcare and Health Systems.

## **II. Methodology**

This situation analysis for health financing was conceptualized and initialized by the Health Financing Technical Working Group, under the leadership of the Health Financing Unit in the Directorate of Policy, Planning and Information. Building on existing reports such as two public financial management reports

completed by consultants<sup>10</sup>, as well as accumulated reports from the last six years of technical staff in the health financing and financial resources units, the writing team was able to build this situation analysis with reviewing existing data, and fill knowledge gaps with various data requests from government, research and civil society organizations. In-depth analysis was completed with the Sierra Leone Integrated Household Survey 2018 dataset, tailored to the questions that were posed by the Technical Working Group for the purpose of this exercise. In addition, data sources were received from the following stakeholders:

- ❖ the Accountant's General Department
- ❖ the Budget Bureau of the Ministry of Finance
- ❖ the Local Government Finance Department
- ❖ the Public Investment Directorate of the Ministry of Planning and Economic Development
- ❖ the Development Assistance Database (<https://dad.synisys.com/>) of the Ministry of Planning and Economic Development
- ❖ the Human Resources Management Office
- ❖ the Attendance Monitoring System of the Ministry of Health and Sanitation ([www.hrhsl.org](http://www.hrhsl.org))
- ❖ the SABI project led by Christian Aid (Social Accountability Building Inclusion)
- ❖ the Public Financial Management and Anti-Corruption consortium, led by Christian Aid
- ❖ Statistics Sierra Leone

All data were cleaned, analysed and cross-compared to answer various questions posed during the development of the situation analysis. Extra resource mapping was conducted for supply chain specific functions, and the National Health Accounts Database provided all other relevant resource statistics.

There was a writing team that split tasks and also reviewed paragraphs, before sharing them with the wider technical working group. Comments were addressed and incorporated.

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<sup>10</sup> Both studies were funded by the World Bank Group. One focused on the Macro Public Financial Management Situation (*Understanding Public Financial Management (PFM) in Sierra Leone: A Health Sector Perspective*) and was written in November 2018, the other one was focusing on district Public Financial Management (*Sub-National PFM Issues from Sierra Leone*) and was written in July 2018.

## SECTION II: Organization of health services in Sierra Leone

### III. Public Administrative Structure (focus on health)

#### Decentralization Act, and review of implementation

The Local Government Act (2004) describes the extent of decentralization for different levels of care: primary and secondary care falls under the jurisdiction of the local council, while tertiary hospitals remain under the jurisdiction of central level MoHS. The local council receives yearly budget allocations to ensure provision of primary and secondary care at district level. However, the decentralization has only been partially implemented; important functions such as the supply chain and HRH remain largely managed from central level.

In line with the decentralization policy adopted after the enactment of the Local Government Act 2004, Primary and Secondary healthcare services are devolved functions in Sierra Leone. The local councils oversee the District Health Management Teams (DHMTs), responsible for primary care, and the district hospitals, responsible for secondary care. The DHMTs are an extension of the MoHS, but as established by the Local Government Act of 2004, work under the local council. At council level, the Chief Administrator is a civil servant posted from central level, working together with an elected chairperson (council chairperson). Elected councilors are part of the district's health committee. One of the mandates of the health committee is to organize and lead regular health sector meetings at the council, participate in monthly meetings held at the DHMT, provide inputs in the Annual Work Plans (AWPs) of the DHMT / District Hospitals, and more broadly, monitor health activities taking place in the district. The health committee has the potential to serve as the bridge between the health sector and the council but its potential has not been realized fully.

Government funding for health services are transferred directly to the local council primary and secondary healthcare accounts by the Ministry of Finance and Economic Development (MoF). These transfers are administered centrally by the **Local Government Finance Department** of MoF. In the case of Primary Health care, the District Health management Teams are the technical wing that accesses funds available to local councils and support the operations of Primary Health Units. There is no monetary transfer to PHUs from DHMTs. In the case of Secondary Health, hospitals operate as separate accounting units and the Medical Superintendents of secondary hospitals access funds earmarked for secondary health for the respective local council. Tertiary Hospitals receive funding directly from the allocations of the MoHS<sup>11</sup>. It may also be noted that DHMTs, as well as Secondary and Tertiary Health care facilities are reported to receive funding from the central MoHS pool and from donors through accounts held separately from those associated with Local Councils.

#### Decision making responsibilities at different levels regarding HRH (hiring, transfers, etc.)

Responsibility for recruitment and deployment of health workers is split across several entities: the HR management body for the Sierra Leone Civil service, called the Human Resource Management Office (HRMO); the Health Service Commission (HSC); the DHRH and various professional directorates within MoHS. These bodies are each accountable for different steps of the process. To begin recruitment,

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<sup>11</sup> For the period 2010-2013 Tertiary Hospitals received funding through Local Council budgets

Directorate of Human Resources for Health (DHRH) announces vacancies for positions established by the annual manpower plan. Next, HSC interviews and selects the qualified candidates and forwards candidate information back to HRMO to formalise the recruitment.

DHRH must then collaborate with the relevant professional directorate to determine health worker postings: the Directorate of Nursing Services for nursing and midwifery cadre postings, the Office of the Chief CHO for CHO and CHA postings, the Office of the CMO for medical officers and specialists, and so on. After initial posting, a health worker can be transferred at the discretion of the supervising DHMT if intra-district and DHRH if inter-district.

In 2017, the MoHS appointed and trained district Human Resource Officers, based at the DHMTs, and district Human Resource Assistants, based at the district hospitals, as a first step to decentralize HR management. The HR officers and assistants are to lead performance assessments, district and hospital postings, lead planning and continuous professional development coordination. The deployment of these additional HR staff led to increased monitoring of attendance, which meant that reports of health workers spiked in the first few months, and then levelled off. In addition, the ability to process leave applications from the district level has decreased the travel times for workers from average five days to average two days, leaving them to provide services in the health facilities longer.<sup>12</sup>

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<sup>12</sup> HRH Technical Working Group October 2018, and information received from the Directorate of HRH, MoHS.

## SECTION III: Contextual factors that impact on health financing policy

### IV. Fiscal capacity of GoSL

#### Overview of the Economy

The twin shocks of the Ebola epidemic and a decline in iron ore production set back the economy, leading to difficulties in revenue raising. Inflation has been in double digit figures since the second half of 2016. Investments in agriculture are expected to give the economy a boost. Fiscal spending instruments such as the introduction of a Treasury Single Account, the elimination of subsidies on fuel, etc. are expected to improve revenues. Investments in agriculture are expected to give the economy a boost.

Historically, the allocation to health remains low. A fiscal space study finds that the most impactful way to reduce the health resource gap, is increasing the domestic budget allocation to health to 15% of general government expenditures. This warrants the need to increase domestic tax base – which could take years. In the interim, earmarked taxes may serve as short-term measure to direct more resources towards health. However, even with these measures implemented, Sierra Leone will still need to be dependent on donor financing to implement UHC.

#### Macro-fiscal context of Sierra Leone

##### GDP growth

A violent and prolonged civil conflict that erupted in the 1990s led to a downward spiral of the Sierra Leone's economy. From a low 3.5% GDP growth rate in the late 1980s<sup>13</sup>, the 1990s saw the country's economy averaging a -8.34% GDP growth rate, below the West African average of 3.4% (during this period, West Africa excluding Sierra Leone averaged an 11.8% GDP growth rate). With the end of the war and the stabilizing of the government, the growth rate bounced to 18% in 2001.

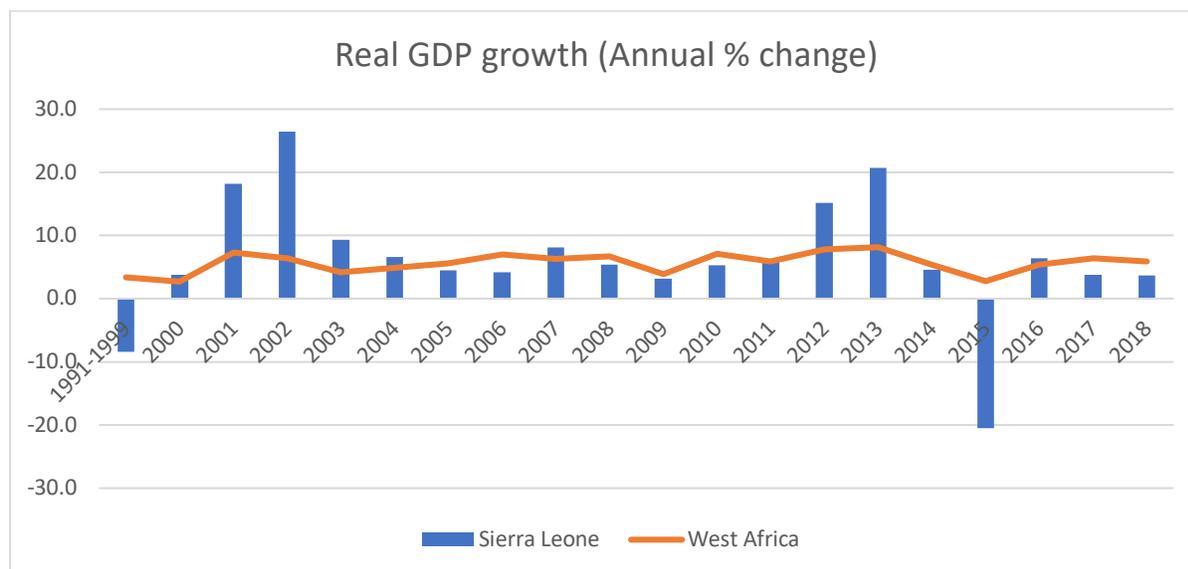


Figure 2: Annual % change of real GDP growth, 1991-2018<sup>14</sup>

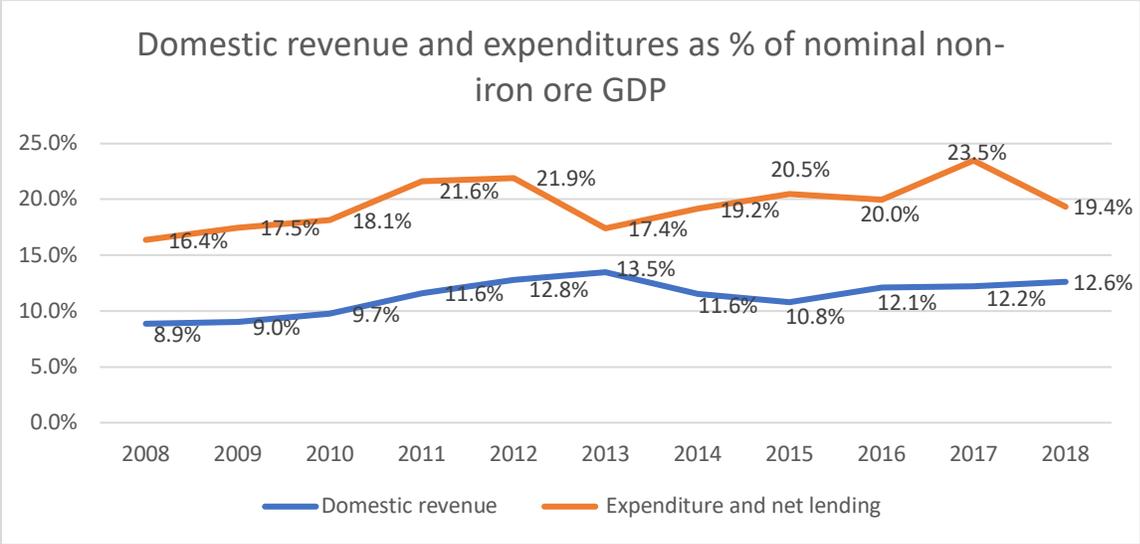
<sup>13</sup> IMF 2019

<sup>14</sup> IMF 2019

During the immediate post-war period (2001-2006), the country benefited from a substantial influx of donor resources. As aid flows reduced after 2007 and the global prices of food and fuel saw a sharp increase, the GDP grew annually at an average rate of 5% between 2008 and 2011 – falling below the West African average. Sierra Leone’s fortunes changed significantly in 2012, after the discovery of large iron ore deposits in the north of the country, and the establishment of mining operatives. This propelled a sharp rise in the country’s growth rate, from 6.3% in 2011, to 15.2% and 20.7% in 2011 and 2012. However, the growth was short-lived as the country was hit by the “twin shocks” of the Ebola epidemic and the global fall in iron ore prices. As a result, the GDP growth fell by 20.5% in 2015, but recovered to 6.4% in 2016 with the resumption of iron ore mining and the prompt action by international aid agencies and foreign assistance.

**Revenue**

Revenue collection was impacted by the contractionary effects of these twin shocks. A rise in imported fuel prices negatively affected the balance of payments and the budget revenue of the country<sup>15</sup>. Domestic revenue mobilization decreased from 13.5% to 10.8% of the GDP between 2013 and 2015 (see graph below). At the same time, public expenditures increased from 17.4% to 20.5% of the GDP, due to Ebola-related capital spending. The resulting budget deficit increased from 3.9% in 2013 to almost 10% in 2015<sup>16</sup>.



**Figure 3: Domestic revenue and expenditures as % of GDP**

The total domestic revenue (tax and non-tax) has been slightly below the average of 12 percent of GDP between 2004 and 2009, but increased to 12.8 and 13.5 percent in 2012 and 2013 respectively on account of the increase in income tax from the mining sector, signature bonuses from petroleum exploration activities, royalties on iron ore and road users’ charges.

<sup>15</sup> IMF Country Report No. 18/371 (December 2018)  
<sup>16</sup> Sierra Leone Integrated Macroeconomic Model (version: April 2019)

Grants have played a significant role, particularly in the early 2000s, representing an average of 40 percent of the total domestic revenue. However, there is a declining trend in the value of grants received by the country.

The main source of domestic revenue is from income tax, which contributes, on average, 36 percent each year. Import duties and customs have lost in importance, decreasing from 55% to 26%. The new government has cancelled duty waivers, leading to an increase from 21% to 26% in 2017 to 2018. Goods and Services Tax (GST) was introduced in 2010, contributing more than a fourth (26%), at the beginning while in 2018 the contribution of GST was 19% of total domestic revenue.

As mining activities expand and contract alongside the world market, the share of mining revenue goes up and down, from minimum 2% in 2010, to a maximum of 14% in 2011. In 2018, the sector contributed 5% to total revenue.

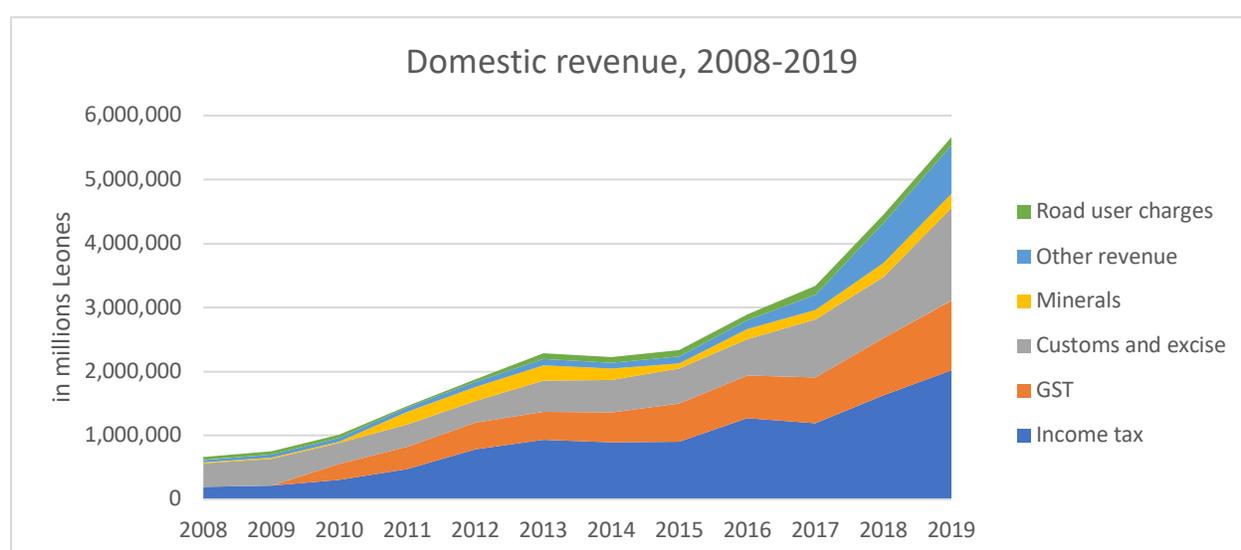


Figure 4: Domestic revenue by source, 2008-2019

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Actuals	Estimate	Budget
<b>Income tax</b>	195,611	211,901	303,026	473,150	778,038	929,294	895,672	901,691	1,269,208	1,188,596	1,626,805	2,017,842
<b>GST</b>	0	0	246,362	351,449	418,558	440,266	459,095	593,048	666,090	713,965	900,233	1,088,459
<b>Customs and excise</b>	363,064	420,503	329,931	343,735	339,667	491,191	507,816	545,811	570,057	909,768	951,706	1,450,600
<b>Minerals</b>	18,545	20,163	24,191	202,344	222,043	235,038	186,673	86,528	155,517	149,022	220,691	228,785
<b>Other revenue</b>	38,711	49,022	52,145	68,520	80,242	100,983	89,328	108,371	138,832	237,674	627,296	751,728
<b>Road user charges</b>	46,201	48,620	51,972	22,901	34,958	83,242	87,616	94,710	89,028	140,897	128,900	125,445
<b>Total domestic revenue</b>	662,132	750,209	1,007,627	1,462,099	1,873,506	2,280,014	2,226,200	2,330,159	2,888,732	3,339,922	4,455,631	5,662,859

<b>Annual growth of domestic revenue</b>		12%	26%	31%	22%	18%	-2%	4%	19%	14%	25%	21%
<b>Revenue as % of GDP</b>	11.4%	11.6%	13.3%	16.2%	12.5%	13.2%	10.3%	10.5%	10.9%	11.7%	14.3%	15.4%

Table 1: Tabular overview of domestic revenue by source, 2008-2019

## Budget gap

In 2017, there was a spike in public spending as there were overruns in all categories of expenditure – including wages and salaries, goods and services, interest payment and domestic capital expenditure<sup>17,18</sup>. The government attempted to address the budget deficit by financing through arrears. This has limited the implications of the financing shortfall on the exchange rate and the foreign exchange reserves, but has created an unsustainable situation. Corrective measures to strengthen public finances include the elimination of subsidies on fuel, the creation of a Treasury Single Account, collecting dividends from profitable state-owned enterprises, and reviewing and streamlining duty and tax wavers. Additionally, the Ministry of Finance has put into place measures to control domestically-financed capital projects and recurrent expenditures, and identifying double/ excess payments on the wage bill<sup>19</sup>.

**Inflation** remained in single digit figures till the first half of 2016, but rose to double digits in the second half of 2016, and peaking in 2017 (see graph below). This was caused by the sharp depreciation of the Leone<sup>20</sup> and rising food prices<sup>21</sup>. From 2017 to 2019, the inflation rate has been declining, mainly due to the stabilization of the exchange rate and raising the monetary policy rate by the Bank of Sierra Leone<sup>22</sup>. The first quarter of 2019 saw a slight increase in the interest rate to 17.2%, due to the weakening Leone, and increasing fuel prices<sup>23</sup>.

<sup>17</sup> Government of Sierra Leone Fiscal Strategy Statement for 2019-2023 (Draft)

<sup>18</sup> SLIMM (version: April 2019)

<sup>19</sup> IMF Country Report No. 18/371 (December 2018)

<sup>20</sup> Government of Sierra Leone Fiscal Strategy Statement for 2019-2023 (Draft)

<sup>21</sup> IMF Country Report No. 18/371 (December 2018)

<sup>22</sup> Government of Sierra Leone Fiscal Strategy Statement for 2019-2023 (Draft)

<sup>23</sup> World Bank overview of Sierra Leone (<https://www.worldbank.org/en/country/sierraleone/overview>). Accessed on 25.10.2019

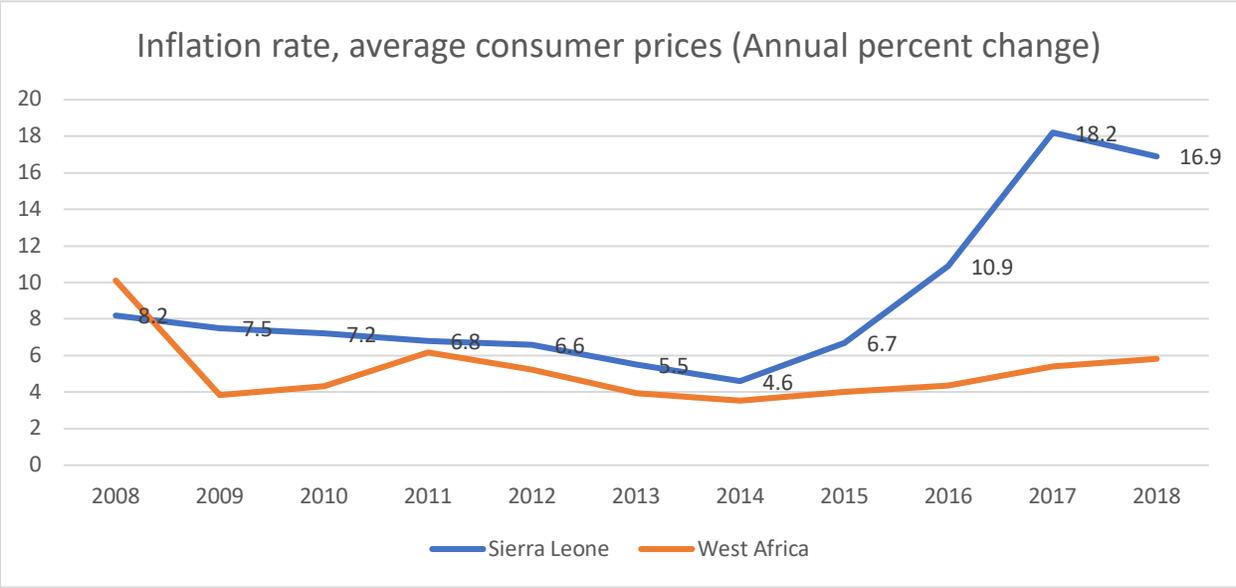


Figure 5: Inflation rate, annual percentage change, 2008-2018<sup>24</sup>

Inflation has remained consistently higher than the West African average. Since 2016, the average inflation rate in Sierra Leone is the 2<sup>nd</sup> highest in West Africa (after Liberia); between 2012 and 2016, the country had the 4<sup>th</sup> highest inflation rate in the region (after Ghana, Nigeria and Liberia)

**Exchange rate**

The graph below depicts the nominal and real effective exchange rate between the Leone and the US Dollar. The exchange rate – which was fairly stable between 2012 and 2015 – depreciated significantly against the US dollar after 2015, reflecting the impact of Ebola and the fall in global iron ore prices.

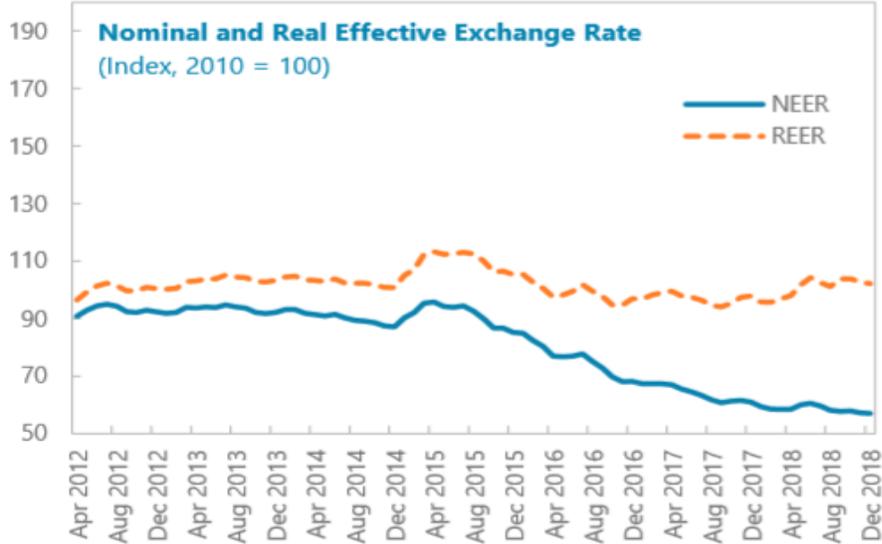


Figure 6: Nominal and real exchange rate<sup>25</sup>

<sup>24</sup> IMF 2019  
<sup>25</sup> IMF Country Report No. 19/217 (July 2019)

The nominal exchange rate has further declined due to lower revenues from iron ore exports, less than expected donor financing, and an increase in world oil prices (prompting demand for foreign exchange from fuel importers)<sup>26</sup>.

### *Fiscal space in health*

To estimate the financial resources needed to achieve UHC, an Oxford Policy Management report studied the fiscal space for health in Sierra Leone. Using international health financing norms developed by McIntyre and Meheus (2014), the authors of the OPM report project that Sierra Leone needs to invest USD 95 per capita in 2015, increasing to USD 130 by 2025, in order to provide the basic level of health services for UHC. This is USD 812 million per year, over the next 10 years (i.e. 12% of the GDP and 59% of GGE).

The funding sources for meeting these needs are broadly classified into the following – government contribution, earmarked taxes, efficiency savings and borrowings. Out-of-pocket expenditures are excluded by the authors, as they are contrary to achieving the UHC goals. The funding sources are discussed in the paragraphs below:

- **Government contribution:** This includes the annual budget allocation to health, revenues collected by Local Councils and public health facilities and subsequently spent on health, and the government's contribution to national health insurance scheme.

In 2018, 4% of general government expenditures were for the health sector. Post Ebola, there has been a decline in the proportion of government expenditures allocated to health.

As of November 2019, a health insurance scheme has not been implemented<sup>27</sup>. Additionally, there are no specific guidelines on how revenues collected by Local Councils and public health facilities should be used; therefore, they do not count as a substantial contributor to health.

- **Earmarked taxes:** A Free Health Care tax<sup>28</sup> of 0.5% on the sale of all goods and services has been enacted since in 2016. The revenue from the tax goes to the Treasury Single Account and not to a separate account earmarked for health<sup>29</sup>. It is not known whether the annual GoSL budget that is allocated to the health sector includes the revenue from this tax, or if it is over and above the tax. Since no costing of the FHCI was done, it is difficult to say exactly how helpful the tax is. However, rough estimates produced by the authors of the OPM report show that the tax will raise USD 0.7 million a year, covering only 1.6% of the financing gap for FHCI over the next 10 years. Indeed, estimates from the National Revenue Authority show that the amount collected through the tax was approximately SLL 3.046 billion in 2018. This would have financed only 0.2% of the total resource needs of the Free Health Care Scheme – which was estimated by the OPM report to cost USD 150 million in 2018.

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<sup>26</sup> IMF Country report No. 18/371 (December 2018)

<sup>27</sup> Please see the section on SLeSHI for a detailed explanation of the feasibility of the scheme in its present form

<sup>28</sup> Section 36(1), The Finance Act 2017, Sierra Leone – “(There is hereby imposed a National Free Health Care Levy of 0.5% on all payments made to contractors, both local and foreign, for the supply of goods and services which shall be payable on or before the 15th day of the month following the transaction.)”

<sup>29</sup> Source: Interview with Accountant at the Accountant General Department, Ministry of Finance

There have also been discussions between the World Bank, the NRA and Ministry of Finance, on earmarking the tobacco tax for health. Such taxes on tobacco and alcohol, also known as ‘sin taxes’, have the added benefit of potentially improving the health of the population, by decreasing the demand for these goods. While it is commonly argued that such taxes can be regressive, evidence suggests that such a tax actually benefits the health of the poor, as they are most likely to give up smoking, and therefore avoid paying high associated healthcare costs<sup>30</sup>. In Sierra Leone, tobacco taxes have been collected since 2016. In 2018, roughly 67 billion Le<sup>31</sup> was collected in tobacco tax revenue.

The OPM report proposes various taxes that could be earmarked for health, of which an airline tax is the most highly ranked. The authors argue that it is a luxury tax levied mainly on international population (and therefore will not burden the poor of Sierra Leone), easy to administer, and would not significantly reduce the demand for tickets. The report estimates that USD 4 million could be raised a year over the next 10 years, filling 9.4% of the FHCI resource gap. However, the GoSL 2020 budget speech proposes the elimination of GST on aviation related charges, in order to boost tourism. Adding an additional tax for health would require discussions between the MoHS, the MoF, the Ministry of Tourism and Cultural Affairs, and the Sierra Leone Civil Aviation Authority.

- **Efficiency gains** refer to interventions that aim to increase the value of every unit of currency spent, such as effective governance, pooling of resources, strategic purchasing, reduced fragmentation in spending, and prioritizing the delivery of services. While it is difficult to estimate the gains brought about by these measures, the World Health Organisation estimates that 20-40% of all investment on health is wasted.

As of November 2019, there are no interventions in Sierra Leone for risk pooling and strategic purchasing. SLeSHI would serve as a mechanism for risk pooling, but it is yet to be set up. A revised Performance-based Financing (PBF) scheme, which would be a mechanism for strategic purchasing, has been under discussion in the MoHS since 2017, and may be launched as a pilot in 1 district in 2020. **Error! Reference source not found.** of this report discusses the public financial management challenges in health in Sierra Leone in detail.

- **Borrowings:** The OPM report estimates that an average of USD 178 million per year would be needed in borrowings, in order to close the UHC resource gap by 2025. These borrowings would mainly be used to finance recurrent expenditures, and not just capital expenditures which have the potential of generating financial returns in the future, which could then be used for repayments. Given that the borrowings are needed very year, and not for a one-off programme, it is evident that there are structural problems in health financing in the country. As such, the OPM report strongly advises against borrowings to finance the UHC gap.

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<sup>30</sup> Saved off, W., & Alwang, A. (2015). The single best health policy in the world: tobacco taxes. *Washington: Center for Global Development*.

<sup>31</sup> National Revenue Authority

Figure 7 below is extracted from the OPM report and charts the impact of the above measures on closing the resource gap. The red bar represents the financing gap as per the ‘business as usual’ scenario. The orange bar shows how the gap can be reduced by increased government funding (such as increasing budget allocation to health to 15%, and developing SLeSHI). The gold bar shows the additional impact of earmarking taxes for health. Finally, the yellow bar shows the impact of efficiency savings. If all the recommended actions are followed, the financing gap can be filled in 2025. In order to close the gap completely over this period, and meet UHC needs, the government would need to rely on external assistance.

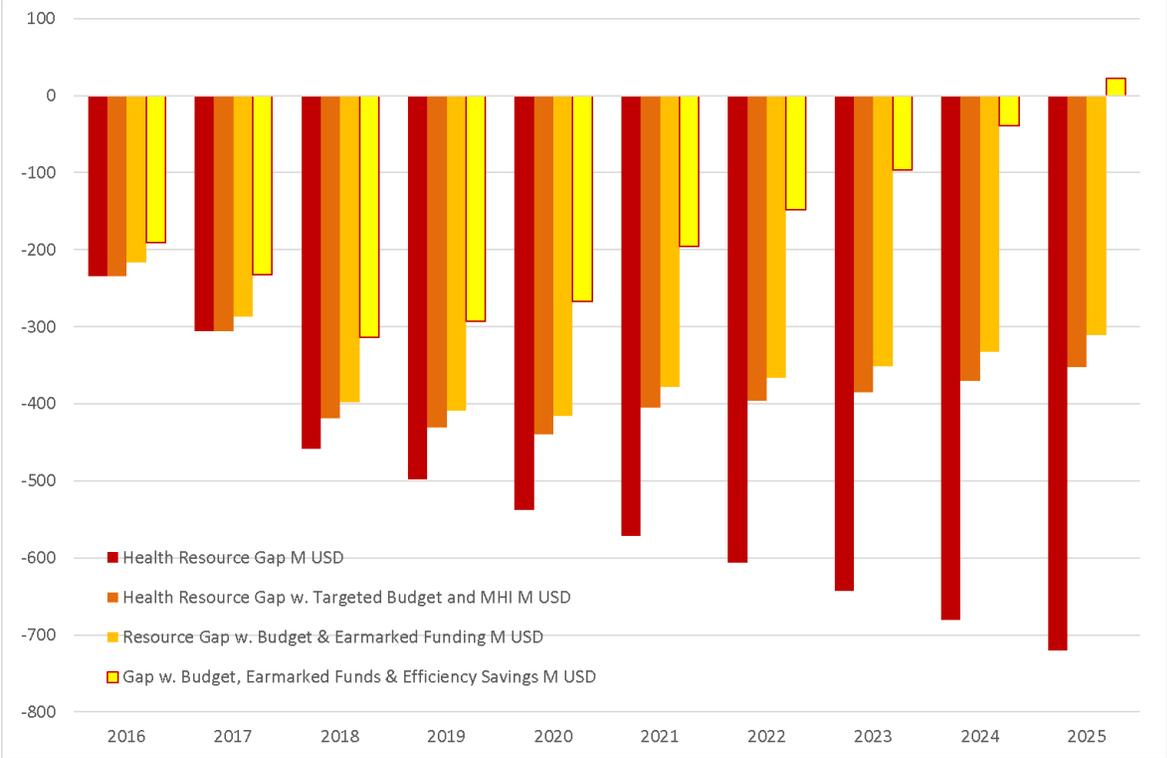


Figure 7: UHC Maximising Fiscal Space Financing Gap (in million USD)

To conclude, the OPM report advocates that allocating 15% of the government budget to health (as per the Abuja target), will have a significant impact in the long-term. However, this first warrants general taxation measures to widen the tax base – which take time to implement. In the short-term, earmarking a tobacco tax for health can serve as a sustainable revenue stream. Measures to improve efficiency (PFM reforms, strategic purchasing, risk pooling) can free up more of the existing resources for health.

However, even if the above measures are implemented, Sierra Leone would still need to be dependent on donor assistance to provide UHC. To attract more donor funding, the MoHS would need to strengthen PFM to inspire confidence in its transparency and efficiency, and lay out clear strategies and costing plans. At the same time, a health financing strategy should be designed that reduces donor dependency over the years, and increases domestic ownership.

## SECTION IV: Public Financial Management

### Overview

The budget allocated to the various MDAs is significantly lower than the amount announced in the annual budget, and is subject to delays, making it difficult to plan. This also discourages senior staff in the MoHS from taking the budget process seriously. Late disbursement of funds leads to delayed and unpredictable execution – over the last 6 years, MoHS budget execution has ranged from 23% - 171%. Overspending is often due to payment of arrears, or unregulated expenses such as overseas medical treatment. Underspending is often caused by bureaucratic payment processes – a request for drug payments, for instance, must go through 35 signatories before being approved.

At the district level, problems such as dissonance between Local Councils and DHMTs/DHs, weak documentation practices, lack of comprehensive internal auditing at Local Councils, and meager funds at the PHUs plague the effective implementation of funds.

### I. Overview of PFM in Sierra Leone

With the introduction of a number of regulations and frameworks since the early 2000s, Sierra Leone has made notable progress in strengthening its PFM system. With financial and technical support from African Development Bank (AfDB), Department for International Development (DFID), European Union (EU), the World Bank, and other partners, the country has been able to introduce several reforms and initiatives. It introduced the Medium-Term Expenditure Framework (MTEF) in 2001, Integrated Financial Management Information System (IFMIS) in 2005, Government Budget and Accountability Act (GBAA) in 2005, Financial Management Regulations (FMR) in 2007, and the phase I of the IFMIS over 2005-2006 period. With the passage of the PFM Act in 2016<sup>32</sup>, the country has committed to addressing existing gaps while further strengthening and institutionalizing the progress made till date.

*Despite a plethora of PFM regulations and frameworks, much remains to be done to ensure their effective implementation.* For example, MTEF has been used by the MDAs to prepare their budgets but its effectiveness is compromised since there is a significant difference between the amounts included in the MTEF and the final amounts disbursed to the MDAs. Similarly, activity-based budgeting exists but in practice, MDAs strongly prefer not to disaggregate their budgets at the level of every single little activity. The disconnect between the theory and practice of how PFM are implemented further worsened in 2014 when the country was hit by the twin shocks of Ebola outbreak and a significant decline in mineral prices. The resulting macroeconomic crisis severely affected both the size and the distribution of public funds.

#### Financial management capacity at different levels

A few key issues pertaining to the central government are found to influence PFM issues and practices at the district level. First, there are severe delays before the GoSL funds reach the councils, and ultimately, the DHMTs and the DHs. The delays occur largely because the central government is unable to release the first-quarter funds until after 6 (to 8) months into the fiscal year. Moreover, the amounts that are

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<sup>32</sup> Note that the 2016 PFM Act replaces the GBAA.

eventually released and transferred are significantly lower than the approved amounts, and the health sector is not an exception in this regard. Second, budget ceilings indicated in the Budget Call Circular (BCC) dictate and limit the size of the budget for the MDAs (including the health sector). This means that there is somewhat limited opportunity during budget preparation process to ensure that the budget adequately captures the priorities and the needs. Third, directors and program managers at the MoHS are not always sufficiently engaged in budget preparation. Quite frequently, it is the junior officers with relatively limited understanding of the programs/directorates that attend budget discussions. This limits the extent to which the budget is realistic and reflective of the sector's priorities.

In detail:

*MoF is constrained in its ability to make realistic macro-fiscal projections. MoF team responsible for modeling and making revenue/expenditure projections suffers from a high staff turnover and faces a dearth of sector-specific experts.* Making projections in certain sectors (for example, mining) requires sector-specific knowledge. In the absence of such experts, projections are not realistic. The lack of latest tools and software packages also limits MoF's ability to make accurate projections. For example, the projection team still uses Stata version 6 even though the latest available version is Stata version 15. Data-related challenges further restrict the ability to make correct projections - on the one hand, a significant amount of latest data in Sierra Leone is the most up-to-date and on the other, some sectors are especially reluctant in complying with MoF's data requests. Since the projections for overall budget as well as sector-specific budgets rely on macro-fiscal projections, the accuracy (or lack thereof) of the macro-fiscal projections directly impacts the extent to which prepared budgets are realistic.

*Sometimes, donor practices also pose a hindrance in preparing realistic budgets. This can happen in a few ways.* First, donors do not provide a detailed breakdown of the support that they are going to provide for the next year (or the next few years), and instead, they provide an aggregated budget. Second, donors do not always live through their commitments, i.e., they do not disburse all the funds that they initially committed. Sometimes, they do not disburse any of the committed funds citing fiduciary risks. In such situations, government is forced to make unanticipated adjustments to its funds.

*Within the MoHS specifically, directors and program managers are not sufficiently engaged in the budget preparation process.* The managers and directors typically attend the first few meetings but let their junior officers to attend subsequent meetings. Some of these officers know their programs and priorities well but others have only limited knowledge. Many senior officials do not attend because they simply do not believe that the discussions will lead to something substantive (i.e., an increase in funds allocated / released). Other senior officials do not attend these meetings because they are busy with important works, which often involves travelling abroad for trainings or attending donor-led workshops that often provide sitting allowances.

*The absence of senior officials in budget formulation meetings at the MoHS means that the prepared budget may not accurately and sufficiently reflect the priorities.* The tendency of the junior officers is to use the previous year's budget as the basis and propose an increment in the overall budget. The lack of adequate engagement by the senior managers is partly linked to the timing and amounts of funds released. Because of their experience of receiving significantly smaller amounts of funds in the recent years, the managers and directors feel that budget discussions are mostly a waste of time.

*Indicative budget ceiling provided in budget call circular (BCC) dictates and limits the size of the budget for the MDAs (including the MoHS and the district health). Typically, MoF sends a BCC to all the MDAs in late June / early July of the current fiscal year to kick-start the budget formulation process for the upcoming fiscal year. To initiate the process in the districts, MoF sends the BCC to the councils which then communicate to the devolved sectors (including the health sector) on behalf of the central government. The BCC indicates a ceiling amount for each devolved sector (for e.g., district health sector) within which the sector is supposed to work. This means that the sectors do not have much freedom in terms of how much / what to include in the budget.*

*There are severe delays in transferring funds to the MDAs, and the actual amounts transferred are significantly lower than the budgeted amounts. This has especially been the case since 2014. In 2017, for example, councils received funds for the first quarter in August, nearly 6 months after they were scheduled to do so, and the amount that they received was less than 30 percent of what they were supposed to receive for the first and second quarter combined. The delay in the transfer of funds is largely caused by the lack of funds in the central government treasury. An additional delay occurs during the transfer process. This is because the process of sending funds to the councils is preceded by (and sometimes almost simultaneous to) an allocation advice. However, sometimes, there can be a time lag (of several weeks) between when the allocation advice arrives in the council and when the GoSL transfers funds to the councils' accounts.*

At the district level, a number of PFM practices were found to be salient. First, ineffective communication between the DHMTs / DHs and the councils has created inefficiencies in the management of the GoSL funds. Poor communication is manifest, for example, in the fact that DHMTs/DHs are not always fully aware of when precisely the GoSL funds arrive at the council. Protocols on formal communication (via phone or email) do exist but they are not systematically followed in practice. Second, DHMTs/DHs suffer from weak and/or inadequate documentation practices. Specifically, the DHMTs/ DHs do not always attach the required details when they send their requests for funds to the councils. This leads to unnecessary back and forth between the DHMTs/DHs and the councils, adding a layer of inefficiency in the process. Third, key staff members (CCs and the CAs in the case of the councils, and the DMOs and the MSs in the case of the DHMTs/ DHs) are frequently absent. The absence of key staff translates into untimely approval / release of the GoSL funds, thereby negatively affecting activities that may be time-sensitive.

The fourth issue affecting the management of GoSL funds in the district is the lack of comprehensive internal auditing at the councils. Councils' in-house internal auditors do not enjoy an unfettered access to council's financial transactions. Councils are supposedly the "most audited government entities in the country" and yet, the auditors have restricted access to the details of the councils' finances. Fifth, councils' view of what is important and necessary for the health sector in the district does not always match with those of the DHMTs/DHs. Councils almost always prefer to spend on capital expenditures while the DHMTs / DHs prefer to spend on recurrent expenditures. The difference in spending preference can become a bone of contention between the councils and the DHMTs/DHs. Sixth, PHUs have virtually no funds at their disposal. As a result, they are not able to address even the most basic operational needs.

## II. Planning and public budgeting processes in health

### GoSL Budgeting

In line with the institutional arrangements, the budgeting for health expenditures is done at three levels:

MoHS Budget: This includes budgets for centrally coordinated programs (including drugs and medical supplies), technical and administrative directorates, regulatory bodies and public investments of the Ministry of Health and Sanitation.

Local Council Budget: This includes operational and administrative expenses on Primary and Secondary Health

Payroll Budget: This includes budgeting for salary costs of all health workers on GoSL payroll as well as administrative, managerial and other technical employees of the MoHS.

### MoHS Budgeting

The budget process of MoHS programs begins with the issue of a budget call circular by MoF, usually in June, wherein the budget ceiling is set in line with the projected macro-economic trends for the year. The Permanent Secretary, MoHS calls for a Budget Committee meeting where Program Managers, Directors and the Budget Officer of MoF attached to MoHS, prepare a draft budget submission. These are consolidated by the Directorate of Financial Resources of the MoHS. The Permanent Secretary, through the office of the Minister of Health and Sanitation, presents the consolidated draft budget to the Financial Secretary, MoF, at public budget hearings.

The Financial Secretary through the Budget Bureau director consolidates the budget submissions from all MDAs of the GoSL. This budget is subsequently presented to stakeholders, including the Civil Society by the MoHS around October where expenditures for previous financial year are presented and the draft budget is discussed. This is then approved by the Parliament in the final budget reading, usually in November or December.

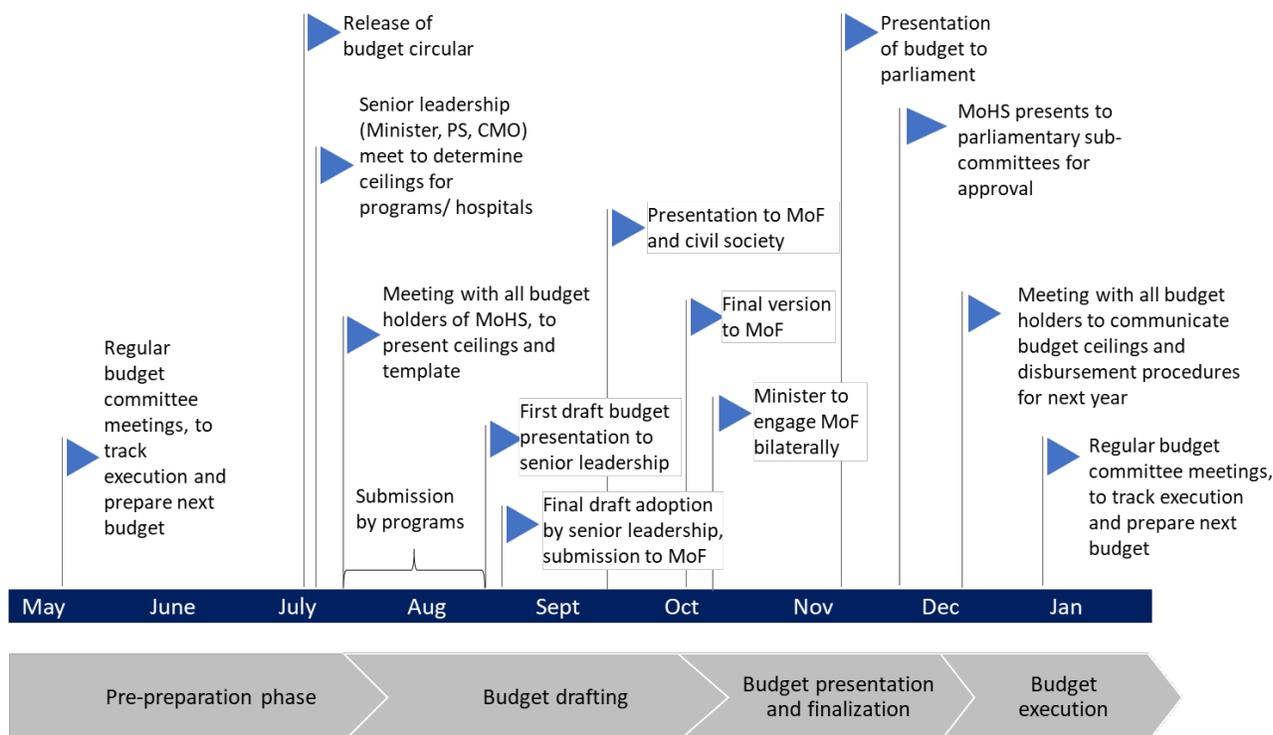


Figure 8: Timelines of MoHS budget development<sup>33</sup>

The deployment of budget officers in MDAs, including the MoHS in 2018 has improved the accuracy, efficiency and effectiveness of the budget process. The budget officer in the MoHS advises the Permanent Secretary on timelines, necessary meetings, and acts as secretary to the budget committee. He inputs all submissions into the final template and prepares the senior management for the public budget hearings. Delays result from the program managers delaying the submission of their activity-based budgets, due to competing priorities.

The allocation of funds occurs in quarterly or half-yearly rounds by the Budget Bureau. The allocation circular is provided to the Permanent Secretary, who decides on final allocation with advice and secretarial support from the budget officer and the Directorate of Financial Resources. Allocations can vary from the annual budget, as the MoF is re-calibrating individual ceilings based on actual revenue forecasts. Given that allocations for a quarter usually come during the middle of the quarter, the actual budget execution and cash withdrawal are only taking place in the following quarter. Hence allocation for quarter 1, reflects in the expenditures of quarter 2, for example. The later allocations are released, the more delayed execution becomes. This highlights the fact that MoHS budget execution is difficult to attain 100%, due to the fact that there is no budget execution for quarter 1 that follows an allocation. The new administration has also instituted the fact that all expense requests that are not paid (yet processed) before the end of the year, will be taken off the new annual budget.

### Local Council Budgeting

The budgeting process of primary and secondary health care programs begins with the issuance of a Budget Call Circular (BCC) by the Budget Bureau, MoF, usually in June, wherein an indicative budget ceiling

<sup>33</sup> Source: After Action Review report of budget committee, 6<sup>th</sup> November 2018, Ministry of Health and Sanitation

is set for each of the devolved functions. This ceiling is an overall amount for primary and secondary healthcare.

The LGFD coordinates a consultation process with all stakeholders associated with Primary and Secondary Health, including Local Council members, District Medical Officers, Medical Superintendents and MoHS directorates and program officers, to determine indicators for horizontal allocation i.e. amounts to be allocated to each council from the consolidated budget for devolved functions received from the Budget Bureau (including that for primary and secondary health). This leads to a grants distribution formula<sup>34</sup>, by which the amounts for each council for various devolved functions is determined and is published publicly.

Based on the amount allocated, the local councils seek work plans and budgets from DMOs in the case of primary health, and Medical Superintendents (MS) in case of Secondary healthcare. During this stage the MoHS provides policy guidelines to ensure that the plans of the councils are aligned to the overall plans for the health sector. These are consolidated into the overall local council budget with technical assistance from the LGFD. This budget along with work plans are then submitted through the LGFD to the Budget Bureau for approval.

There have been allegations of rent seeking of councils for release of health funds, as well as micro-managing the DHMTs and hospitals on what they can and cannot spend money on. In general, councils, especially its political leadership has an incentive to invest in 'visible' projects, hence spending more on capital, while it is difficult for DHMTs to get funding approved for vital monthly in-charge meetings, for example.

Given that the DHMTs have a direct reporting line to the MoHS for programmatic issues and implementation, the budgeting and planning process omits the MoHS due to decentralization laws. This sometimes leads to dis-connected district plans not fitting into overall health sector strategies. Furthermore, health partners implement at district level through and with approval of the MoHS, often leaving out the councils and LGFD in their planning and financing of activities and items at district level.

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<sup>34</sup> In 2019, the grants distribution formula for primary health divided 35% of the funds equally across Local Councils, and 65% of the funds were divided across Local Councils based on their population weighted by the average utilisation rate of PHUs in the area. For secondary health, 20% of the funds were divided equally across Local Councils. The weights given to the remaining factors was as follows: bed capacity at hospitals (20%), population (30%), and service utilization at hospitals (20%).

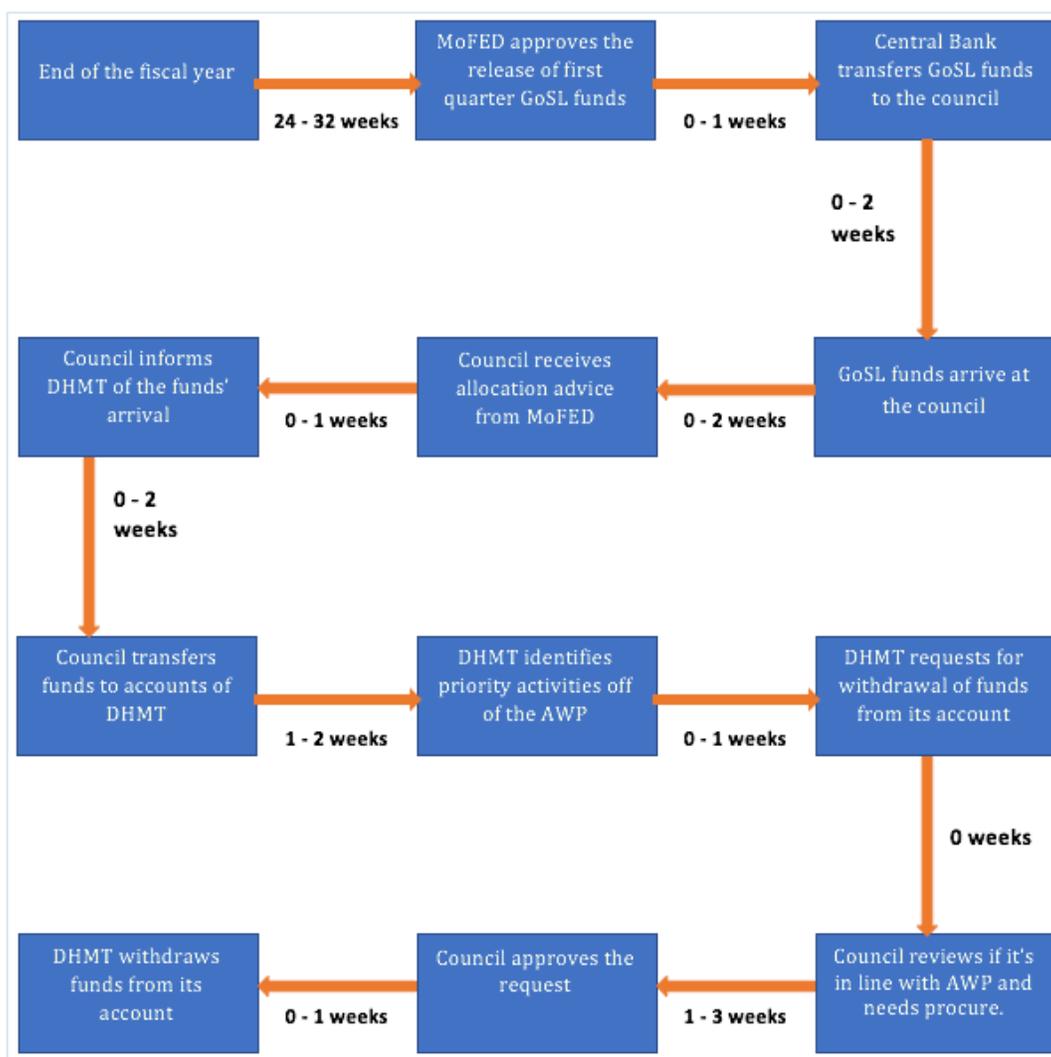


Figure 9: Schematic overview of GoSL funds flow from the central government to the districts<sup>35</sup>

The creation of the National Medical Supplies Agency in 2017 by an Act of Parliament mandates all public entities of Sierra Leone to procure medical equipment and supplies, including drugs, solely through the new agency. In 2019, local councils continue to procure drugs on their own.

### Payroll

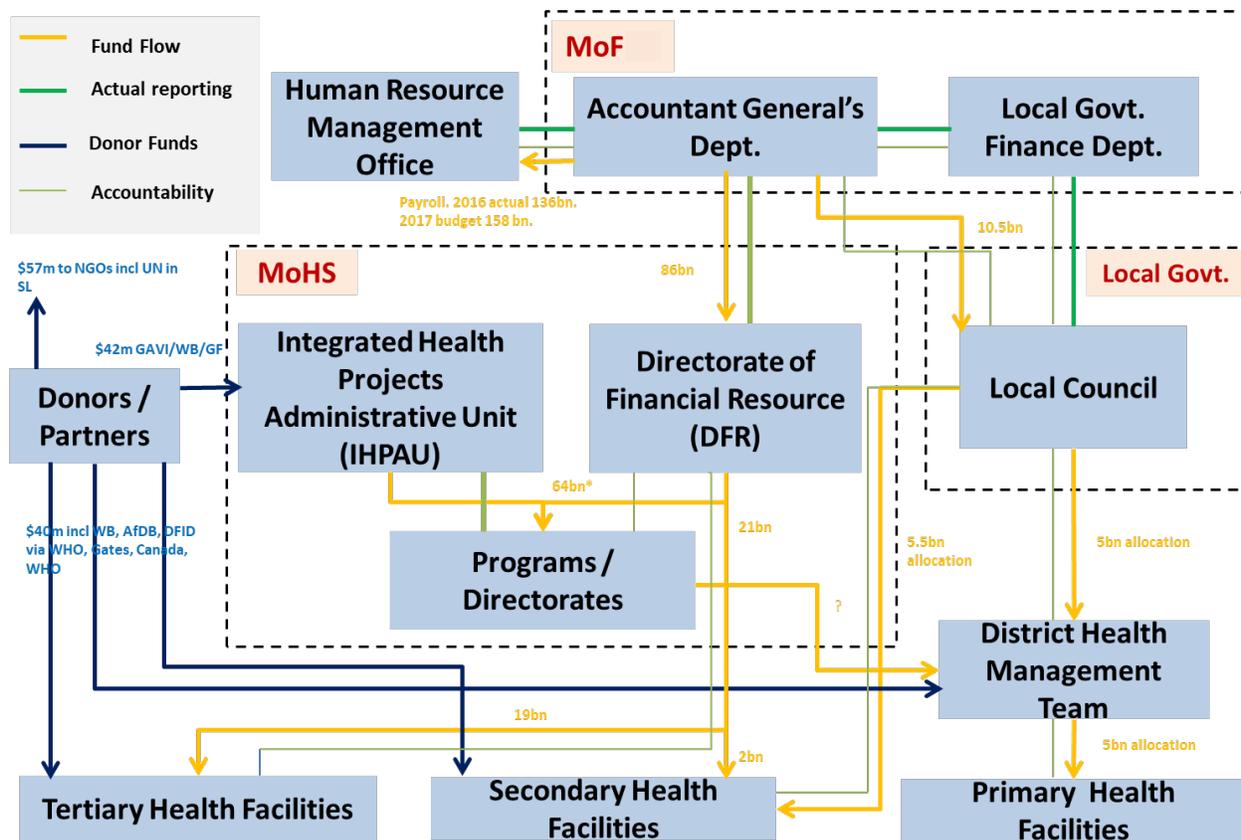
The budgeting process begins with the issue of budget call circular by the Budget Bureau, MoF which seeks payroll budgets from all MDAs of GoSL. The HRMO communicates the budget call circular to the Directorate of Human Resources for Health (DHRH) of the MoHS for manpower plans for the health sector. Currently there are no annual budget ceilings for health workers, largely due to the disconnect of the manpower planning process and the general budgeting process.

<sup>35</sup> Also, included in the schematic is the approximate amount of time it takes between each step. The time shown in the schematic is merely indicative and most closely reflects the situation since 2015.

The DHRH calls for manpower requests from the various agencies of the MoHS which is subsequently analyzed, discussed and collated. The consolidated manpower plan is submitted to the HRMO which then conducts a manpower hearing exercise where the manpower plan is scrutinized and is defended by the MoHS. Subsequently the agreed manpower plan is submitted to the Budget Bureau for approval and inclusion in the annual appropriation. Upon receipt of approval, recruitment of health workers (if any) is initiated by HRMO in conjunction with the Health Service Commission (HSC). It is to be noted that the funds for all health worker salaries remain within the Consolidate Revenue Fund (CRF) from which it is disbursed on a monthly basis. Due to the lack of budget ceiling, the submitted manpower plans for health regularly ask for double the current manpower, effectively doubling the wage bill. The need for additional staff is justified with data and minimum staff requirements, but the later allocated payroll ceiling for health cannot accommodate all the additional required staff. Furthermore, there are not enough health workers available to hire to fill all the gaps, and not enough health workers are being trained annually.

**Budget execution:**

Figure 10 shows the flow of funds within the health sector and contains figures for actual 2017 disbursements. Budget execution varies from year to year. Districts have not achieved full budget execution in the last decade, while the MoHS budget execution has ranged from 23%-171% in the last six years, averaging 85% (see Figure 10 for more in-depth breakdown of execution rates). Execution rates are marred by arrears that have been accumulated and are being paid off over three to six years, impacting the amount of new activities that can be undertaken. Arrears are poorly planned for and then take up large portions of allocated funding when executing the budget.



2017 data. Actuals unless otherwise stated. All figures in Leones. \* of this 64bn, 47bn is for drugs, labs and diagnostics

**Figure 10: Fund flows and budget execution within the health sector, 2017 figures**

Some of the delay and mismatch in budget execution could be due to the payment process for government being bureaucratic, with a request for drug payment for example going through 35 hands before payment is being effected (see Figure 11).

Figure 19 in *SECTION V: Review of health revenue and expenditure* presents budget execution rates for the Ministry. In 2015 and 2016, the recurrent expenditure of the Ministry exceeded the budget, largely due to arrears from Ebola (the Ministry incurred high expenditures on drugs and ambulances, paying for contracts signed during the Ebola outbreak). In 2018, however, only 41% of the recurrent health budget was spent. This was due to a delay in the processing of PET forms<sup>36</sup>, as well as insufficient allocation being made available by the Ministry of Finance (see section *Budget execution*: for more details on the budget execution process).

The Public Investment Programme – which finances capital projects for health – consistently under-spends as well (In 2017 and 2018, only 5% and 4% respectively of the budget was executed). Underlying reasons are poor understanding of the required paperwork for final approval and disbursement, as well as lack of planning<sup>37</sup>. In 2019, for example, a total of eleven new projects were added for health, while only two of the projects had a concept note or project proposal. The other projects were unplanned, and no detailed budget was available. Furthermore, eight of the new projects were anchored within one single directorate, which had only one technical staff apart from the Director. Since the architect of the MoHS died in 2015, there has been no replacement for her position, and all construction and architectural work has to be overseen by one engineer – for the whole Ministry nationwide.

In addition to the execution of the GoSL budget, the MoHS also operates an Integrated Health Project Administration Unit (IHPAU), which manages donor funds running through the government. This includes Global Fund, the World Bank, GAVI, CDC, the Islamic Development Bank and the Kuwaiti Funds. IHPAU operates annual budgets of between USD 30-50 million -- 1.5 to twice as much as GOSL is allocating for MoHS annually, meaning that de facto, IHPAU is financially stronger than the MoHS. IHPAU is responsible for ensuring that all donor guidelines and reporting requirements are followed. IHPAU has a separate team operating from a different office than the MoHS, yet they are linked with approvals to senior management of the MoHS. This has historically led to delays, miscommunication and low burn rates of programs<sup>38</sup>.

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<sup>36</sup> Interviews with Directorate of Financial Resource, MoHS; and, Budget Bureau, MoF

<sup>37</sup> Interviews with Directorate of Financial Resources, MoHS, PS, MoHS, project officer in charge of health at MoPED

<sup>38</sup> For example, the last round of Global Fund financing could not be fully utilized, and USD 12 million had to be returned after the deadline passed. This equals to about 13% of the total funding committed.

## GoSL payment process: from request to payment

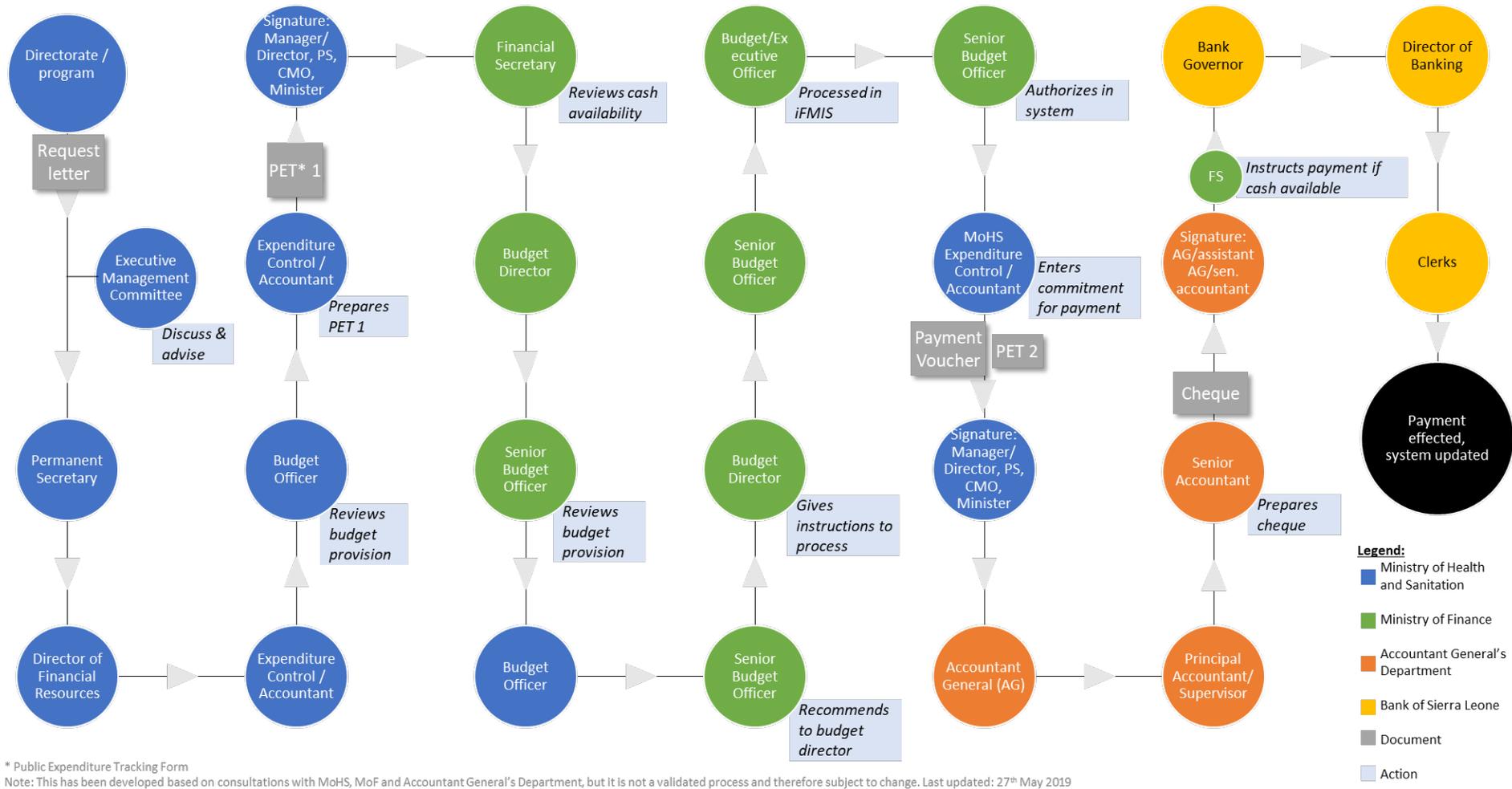


Figure 11: GoSL Payment process flow

## SECTION V: Review of health revenue and expenditure

While the fiscal envelope of Sierra Leone has expanded significantly in the last 10 years, a commensurate increase in health spending government has not occurred. Ebola saw an influx of donor resources, and government spending took a back seat. Households bear a large proportion of the total health expenditure, while government spending has remained below 2% of the GDP. Government spending as a proportion of the THE is the lowest in the West African region.

Delayed disbursement of funds, complex PFM practices and ineffective communication between different departments have resulted in low budget execution. The wage bill for health workers has grown at a much slower rate, compared to the rest of the government work force. Transfers to Local Councils for spending on primary and secondary health care has historically constituted the lowest proportion of the total health sector allocation, reducing the effectiveness of decentralization. In general, spending on tertiary health care is much higher than that on primary health (excluding salaries). Given the strong advocacy for investing in primary health as a means to achieving UHC, the government needs to prioritise accordingly. The resource gap for attaining Universal Health Coverage will reach USD 720 million by 2025, which is 6.6% of the GDP<sup>1</sup>. Therefore, there is an urgent need for the government to increase its commitment to health.

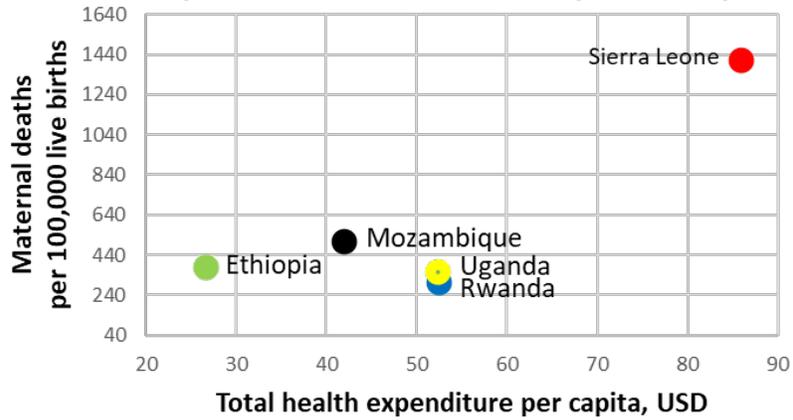
### Overview of Total Health Expenditure in Sierra Leone

During the Ebola outbreak, government spending took a backseat as donor resources poured into the country. Government increased their health expenditures in years after the outbreak, when donors subsequently reduced their funding. Households bear a large proportion of the THE. The National Health Accounts 2013 reported that out of pocket expenditures constituted 61% of total health expenditures before the Ebola outbreak. This decreased slightly during Ebola, due to increased donor funding and limited availability of services, but has now increased again. The following chapters discuss each source of funding in depth.

Mapping the Total Health Expenditures against outcomes (mortality rates), shows that Sierra Leone has disproportionately bad outcomes for the amount of funding spent (Figure 12). In other words, the value for money is poor, compared to other Sub-Saharan African countries. This has several possible explanations: 1) the high out of pocket expenditures are inefficiently spent (e.g. informal payments for services that are paid for by donors or government, ineffective drugs, traditional treatment, etc.); 2) the donor and government funding are overlapping and paying for the same things; 3) general rent-seeking across the different sources. The first one is supported by reports from citizens, collected as part of the SABI (Social Accountability Building Inclusion) project. Free Health Care eligible clients were asked if they paid for services, and if so, what for. 46% of eligible clients had to pay for supposedly free services in 2018, and of those, the majority of payments (61%) was for drugs<sup>39</sup>. That means that every third FHC eligible client paid for drugs – and those drugs were already paid for by donors and government.

<sup>39</sup> Source: <http://sabi-sl.org/>, report for 2018

### Maternal mortality rate versus Total health expenditure per capita



### U5 mortality rate vs Total health expenditure per capita

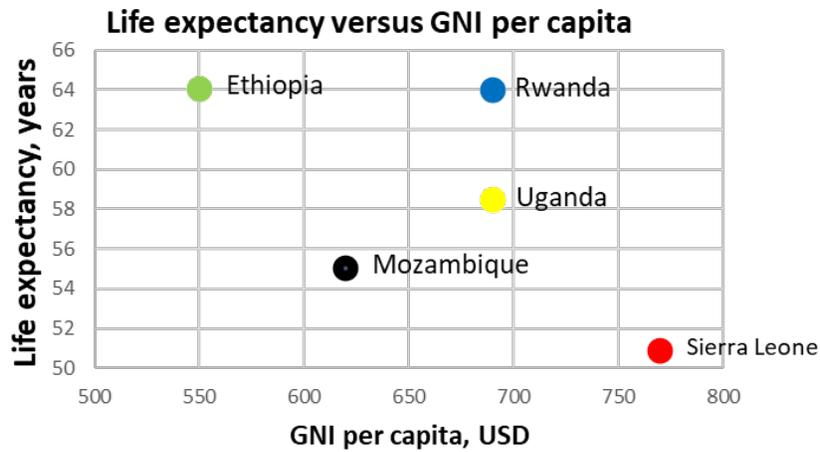
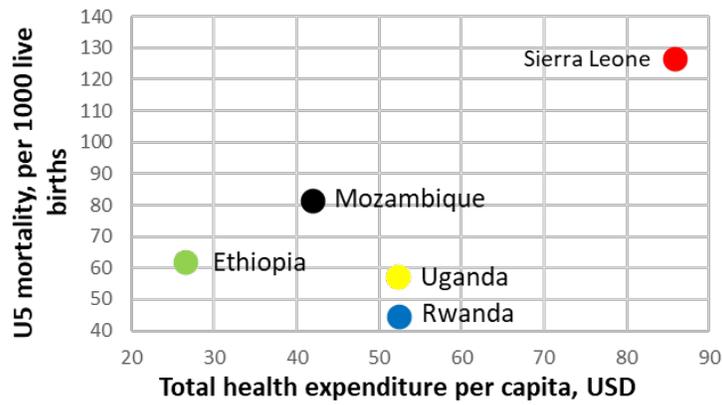
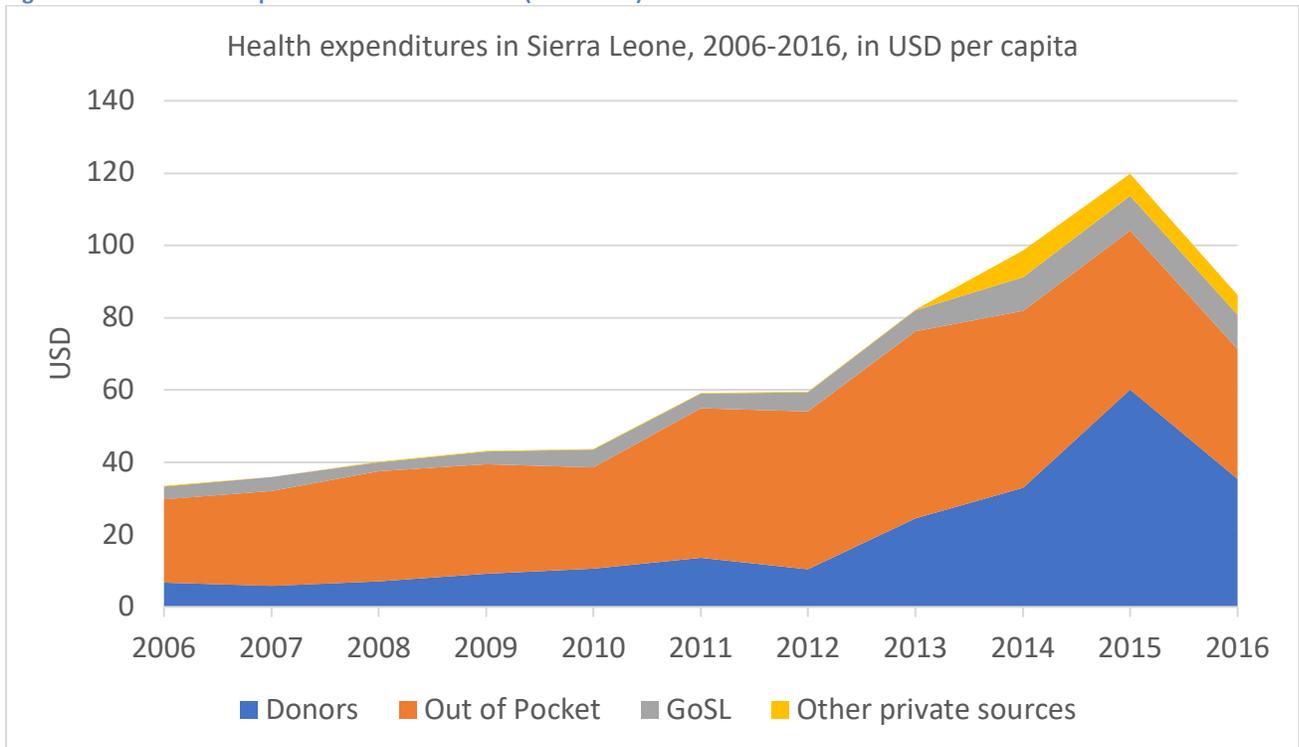


Figure 12: Health outcomes vs health spending in Sub-Saharan Africa<sup>40</sup>

<sup>40</sup> Source: Global Health Expenditure Database, World Development Indicators, 2014

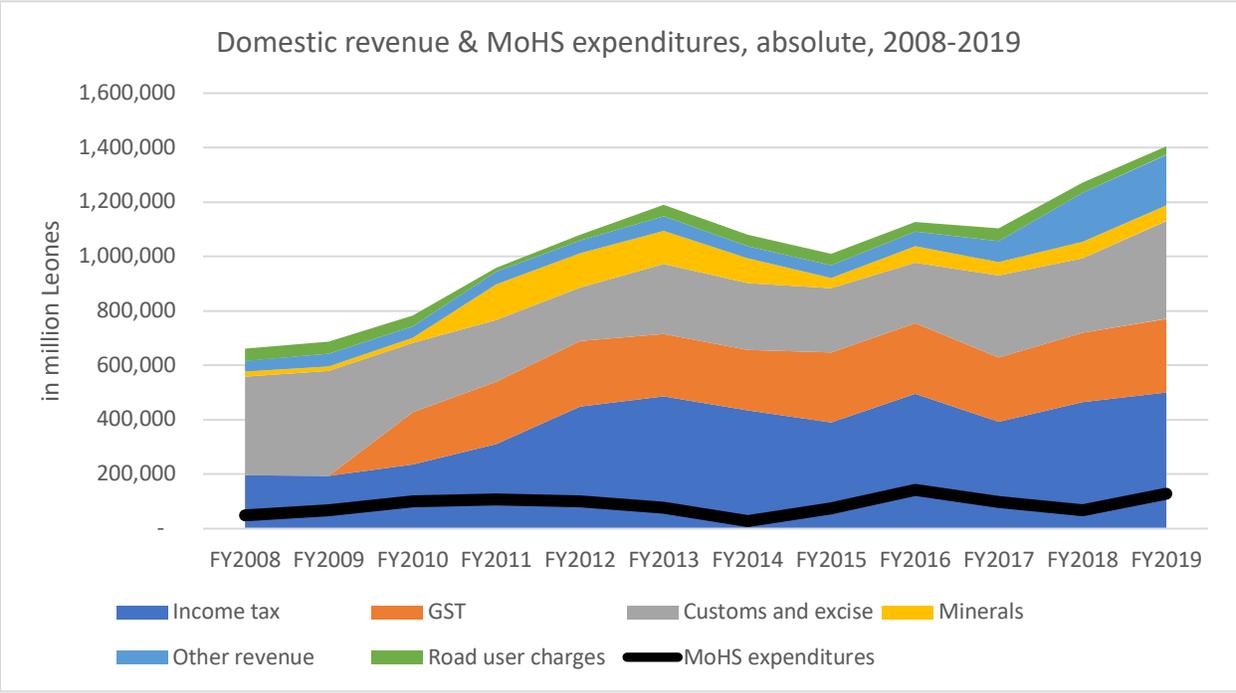
Figure 13: Total Health Expenditures in Sierra Leone (2006-2016)



### I. Government expenditure on health

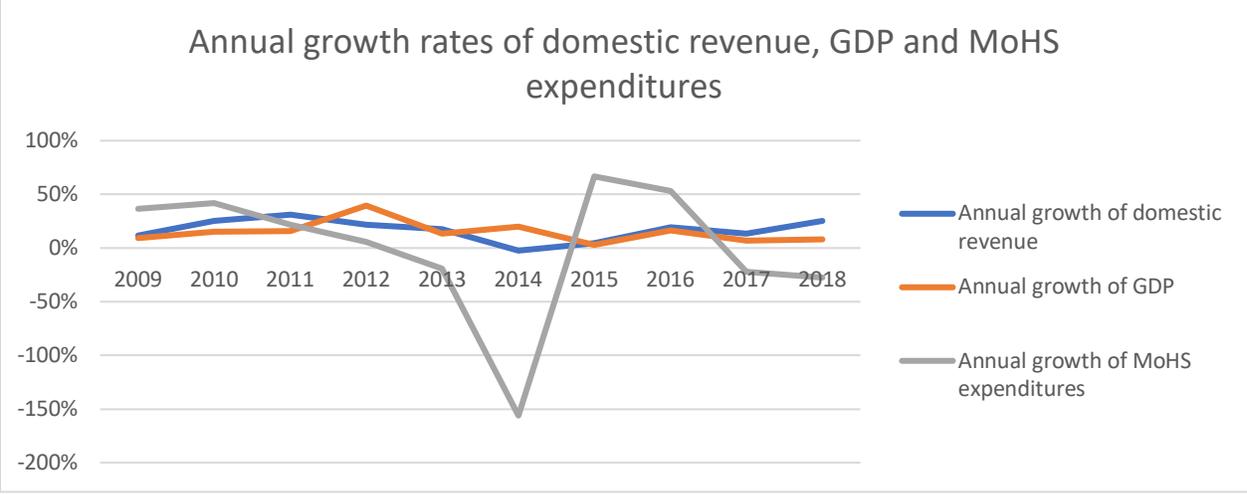
Absolute (corrected for inflation, keeping 2008 prices) domestic revenue has more than doubled in the last ten years, while the absolute allocation to health has less than doubled, as shown in Figure 14. Absolute revenue is expected to reach SLL 1.4 billion in 2019, while the budget for MoHS stood at SLL 128 million, an 89% increase within ten years. In fact, Figure 15 shows that the annual change in the MoHS expenditures are not aligned with general growth of the GDP or revenue (the latter two are interdependent though).

Figure 14: GoSL revenue and MoHS expenditures over ten years



In years where MoHS expenditures grew faster than GDP or revenue (such as 2009, 2010, 2015, 2016), they usually came from a low base in the previous year.

Figure 15: Annual growth rates of domestic revenue, GDP and MoHS expenditures



The general government expenditure on health has remained less than 2% of the GDP and has declined over the last few years (Figure 16). While there is no official benchmark as to what percentage of a country’s national income should be spent on health<sup>41</sup>, Sierra Leone’s government contributes the least to health, when compared to the rest of West Africa (Figure 17).

<sup>41</sup> A commonly cited figure is 5% of GDP<sup>41</sup> – an apparent WHO recommendation – however, this was never formally adapted by the organization (Source: World Health Organization, 2003. *How much should countries spend on health?* (No. EIP/FER/DP. 03.2). Geneva: World Health Organization)

Figure 16: Government health expenditures as % of GGE, domestic revenue, GDP (2010-18)

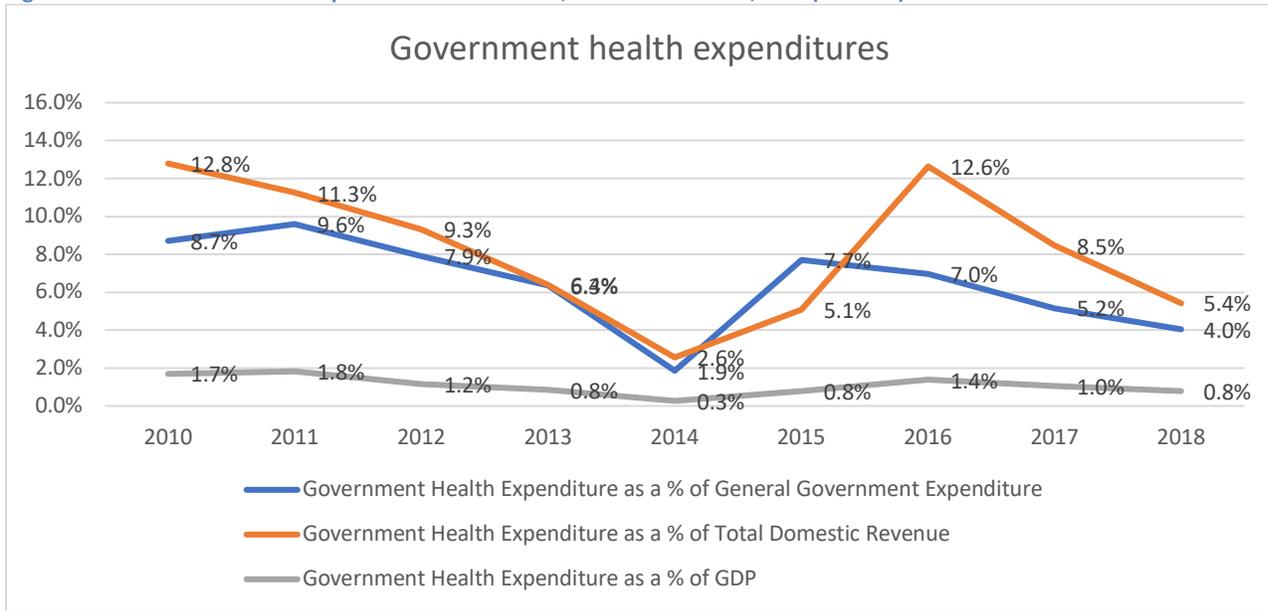
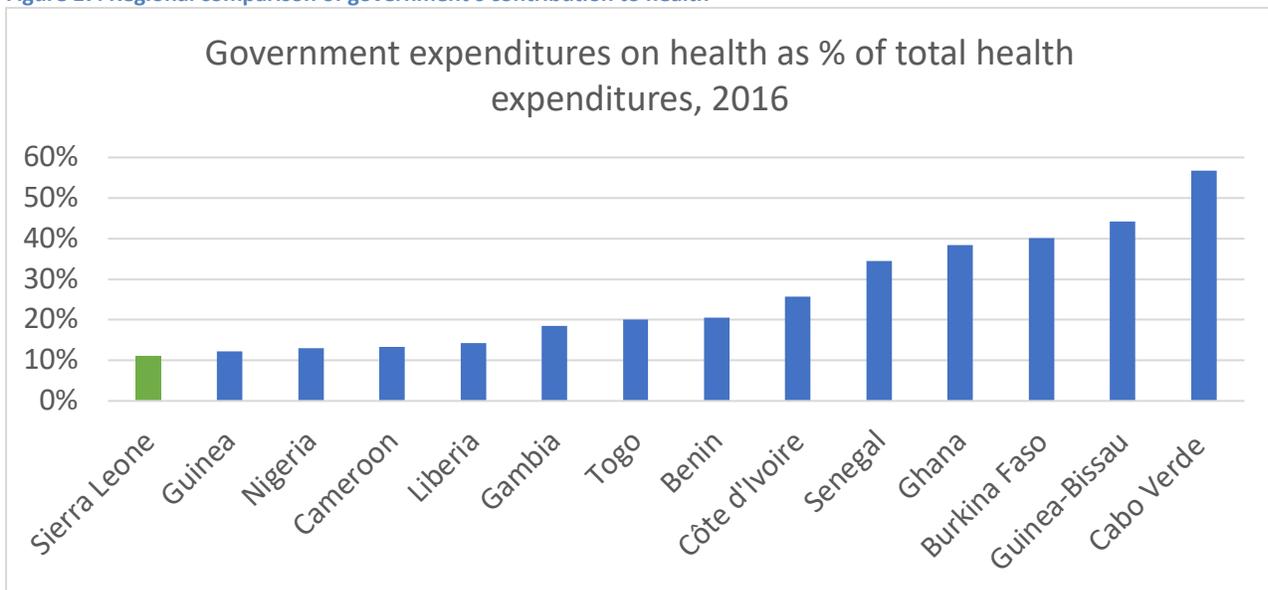


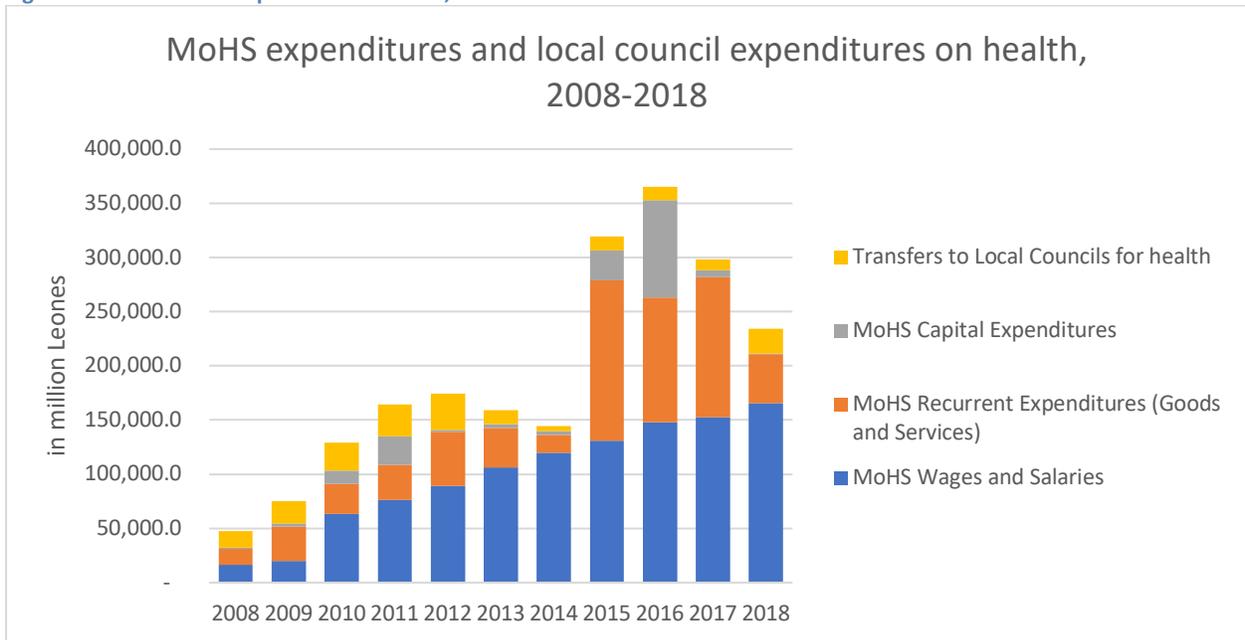
Figure 17: Regional comparison of government's contribution to health<sup>42</sup>



GoSL expenditure can be broadly classified into 4 components: recurrent, capital, salaries, and transfers to local councils (for spending on primary and secondary health care) (see Figure 18 below). Most of the expenditure is incurred on salaries; on average 51% over the last 11 years, ranging from 26% to 83%. Capital expenditures fluctuate a lot, indicating the project type nature of these expenditures. They average around 7% for ten years, ranging from 0% to 25%. Local council transfers have decreased, from 33% to currently 10%, with an average of 14%.

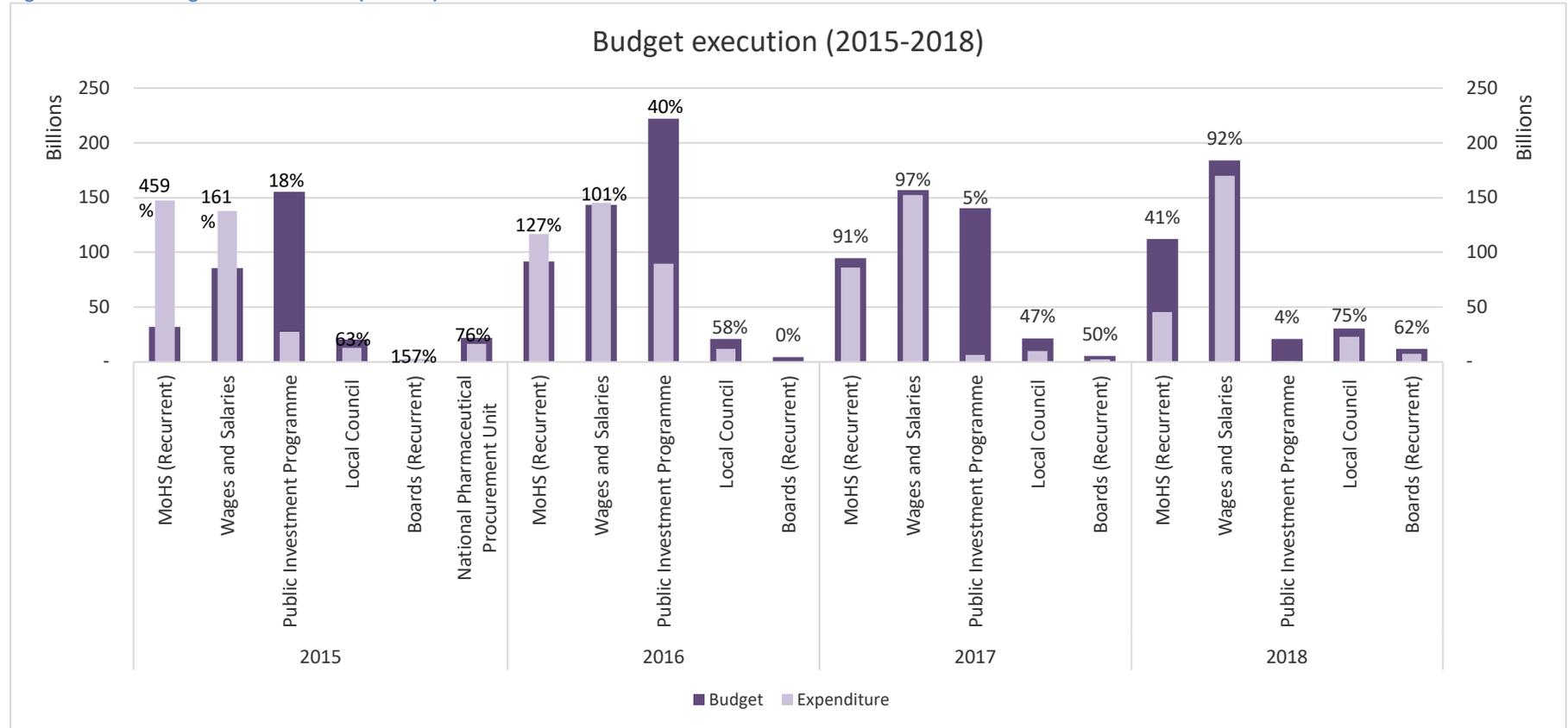
<sup>42</sup> Source: Global Health Expenditure Database

Figure 18: Total health expenditures of GoSL, 2008-2018



Juxtaposing the expenditures and budget allocation, as is done in Figure 19 below, highlights a point of concern – while the recurrent budget allocation has been increasing over the last few years, the actual spending has been declining. This is due to delays in processing PET forms, as was explained in the section on *Budget execution*:

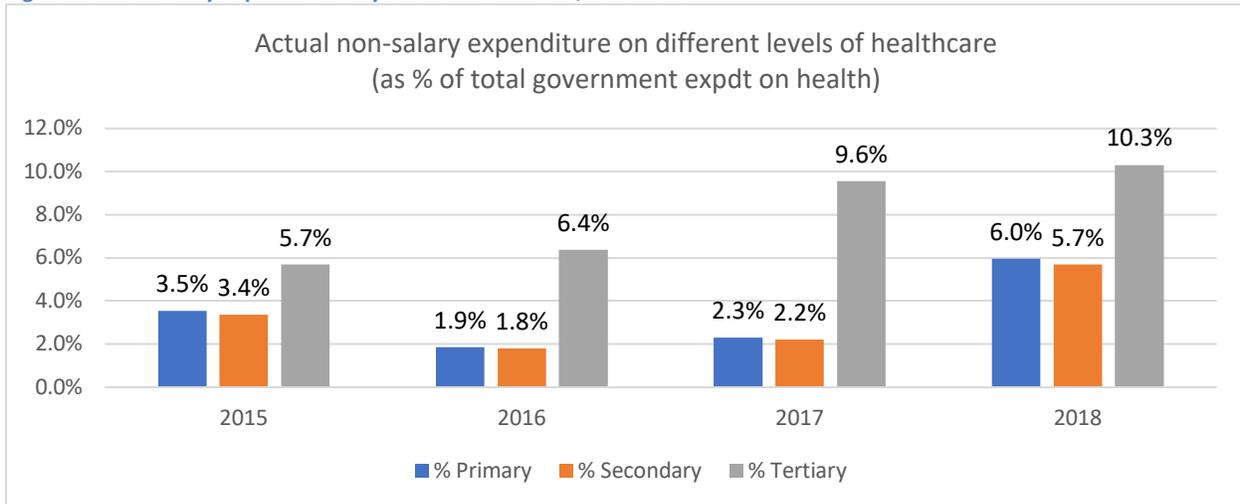
Figure 19: MoHS budget execution rates (2015-18)<sup>43</sup>



<sup>43</sup> 'Boards (recurrent)' refers to recurrent expenditures by the Dental and Medical Board, Health Service Commission, National HIV and AIDS Commission, Teaching Hospitals Complex Administration, and Pharmacy Board Services (for the applicable years)

In general, tertiary care receives the largest share of funding, if salary expenditures are not considered (Figure 20). This might be due to the fact that tertiary hospitals are directly under the MoHS, while the funding for secondary and primary facilities flows through the councils, therefore including another level of negotiation and administration. Given the advocacy for investing in primary health care in order to achieve UHC<sup>44</sup>, the government needs to prioritise accordingly.

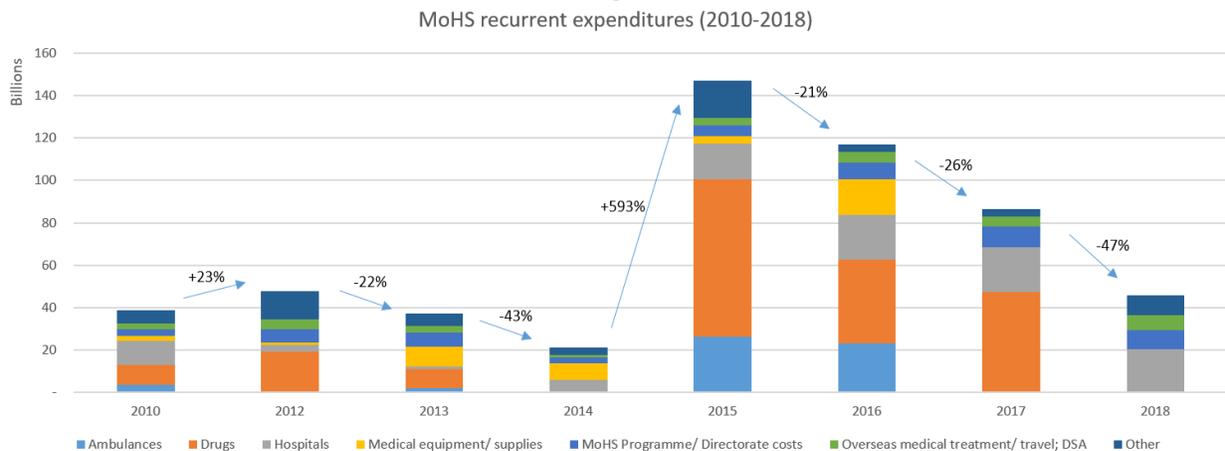
Figure 20: Non-salary expenditures by level of health care, 2015-2018<sup>45</sup>



The following sub-sections briefly explore trends in the 4 components of government health expenditures:

#### Recurrent expenditures

Figure 21: MoHS recurrent expenditures (2010-2018)



<sup>44</sup> Binagwaho, A., & Ghebreyesus, T. A. (2019). Primary healthcare is cornerstone of universal health coverage. *BMJ: British Medical Journal (Online)*, 365.

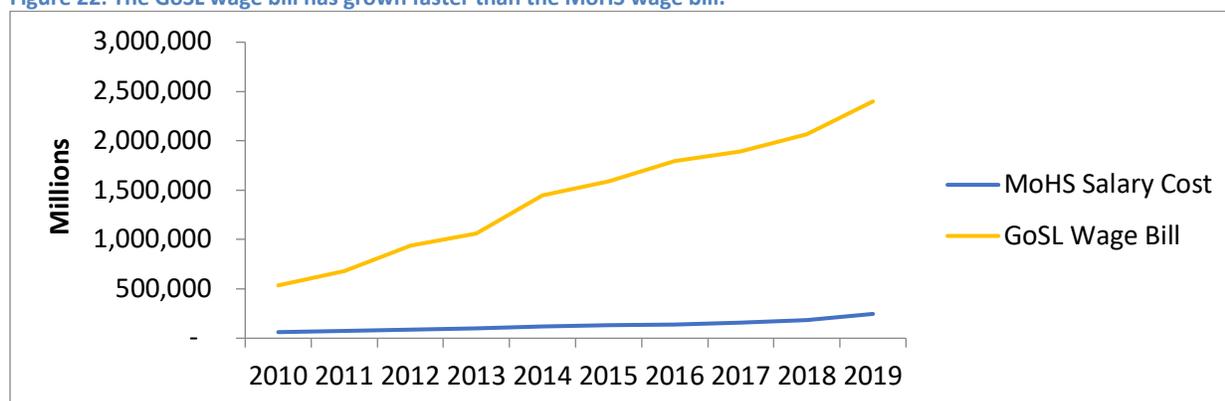
<sup>45</sup> Source: Local Government Finance Department (MoF); Accountant General's Department (MoF). Note: The remaining shares of funding could not be clearly allocated to a type of care, therefore the sum does not add up to 100%.

Before Ebola struck in 2014, recurrent expenditures were around 40 billion Leones, and appeared to decrease between 2012 and 2014. Post Ebola, there was a significant increase in expenditures in 2015, and has been on a decline since. The large increase in expenditures after 2014 can be attributed to drugs and ambulances, as is visible on the graph. However, it is worth noting that both types of payments were towards arrears, and there was no actual procurement of drugs and ambulances in 2015 and 2016. There has been a steady decrease in recurrent expenditures since 2015. In 2018, only 45.7 billion Leones was spent, compared to 86.3 billion Leones the year before.

### Salaries

Salaries for health workers have been low, until they received a blanket 100% increase in 2010 with the introduction of the Free Health Care initiative. In 2019, three extra allowances were added, increasing salaries between 50% up to 150%, depending on grades, location and work schedules. However, despite the health workforce constituting half of the civil service (10,000 out of 20,000), and 16% of the total government workforce (10,000 out of 78,000), the wage bill for health workers only constitutes 8% of total government payroll. Over the last nine years, the overall government payroll has grown faster than the health payroll, indicating that other agencies have either increased their salaries more, or hired more staff compared to health (see Figure 22).

Figure 22: The GoSL wage bill has grown faster than the MoHS wage bill.<sup>46</sup>



### Capital expenditures

The budget allocation for Public Investment Programmes (PIP) – which finances capital projects for health -- fluctuates each year, and the execution is generally low. In 2017 and 2018, only 5% and 4% respectively of the budget was executed. As detailed in the section on *Budget execution*: the underlying reasons are poor understanding of the required paperwork for final approval and disbursement, as well as lack of planning<sup>47</sup>. Inefficient communication between IHPAU – which is responsible for managing the majority of PIP funds – has also contributed to underspending.

<sup>46</sup> Source: Accountant General’s Department (MoF)

<sup>47</sup> Interviews with Directorate of Financial Resources, MoHS, PS, MoHS, project officer in charge of health at MoPED

### Local transfers

The allocation to Local Councils for primary and secondary healthcare is done through a resource allocation formula developed by the Local Government Finance Department, at the Ministry of Finance (see the section on *Local Council Budgeting* for more detail). Historically, this amount has always been low – ranging from 4% to 9% of the total health sector allocation<sup>48</sup> between 2015-19. The amount that is eventually disbursed from the MoF to Local Councils is lower than what is declared in the annual budget, and the Local Council ultimately divides the received funds between the various sectors (health, education, waste management, etc.) by their own discretion<sup>49</sup>. The money that eventually reaches district hospitals and PHUs is delayed, and much lower than the budgeted amount.

## II. Donor expenditures

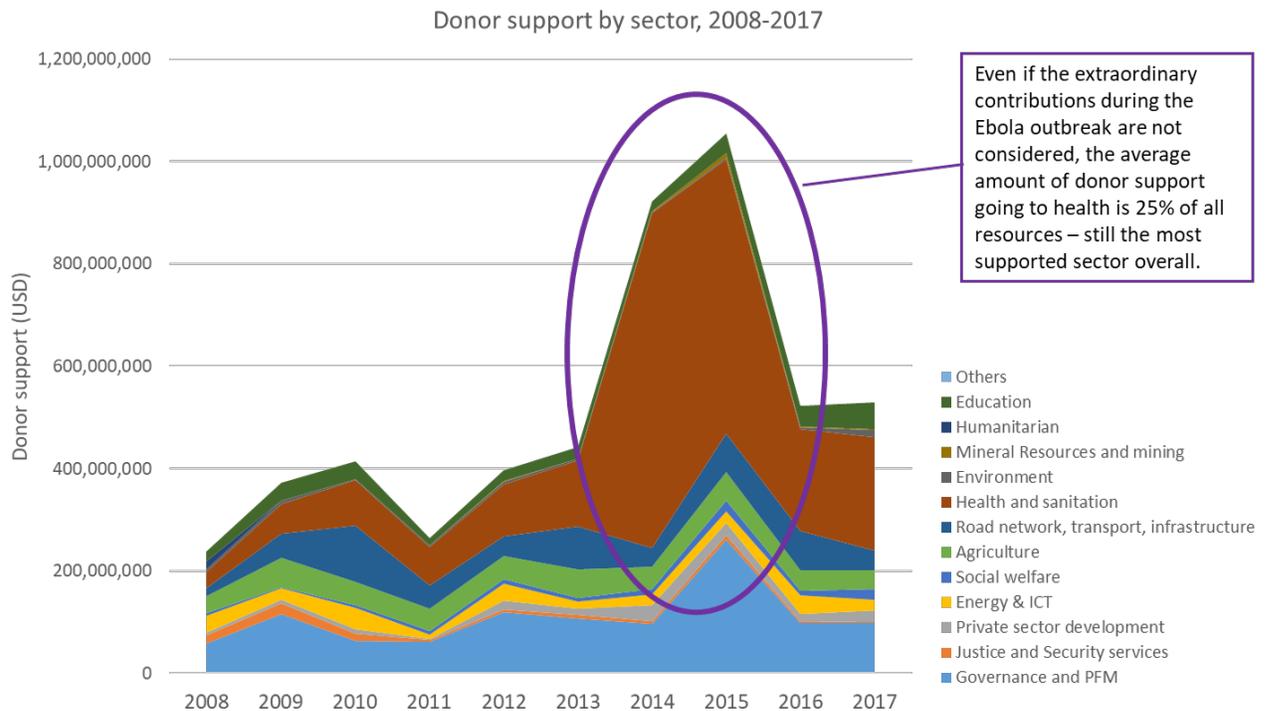
Donors have historically contributed significantly to the health sector, compared with their support to other sectors. On average, over the last ten years, a fourth of all donor funds went into health – and this is not considering the massive increase during the Ebola outbreak (see Figure 23 below). If the Ebola contributions are accounted for too, the percentage increases to a third of all donor funds flowing into Sierra Leone. The second most supported sector is governance and PFM, while education is increasing in importance.

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<sup>48</sup> This does not include allocation to the various boards

<sup>49</sup> Source: Interview with Senior Economist at the Local Government Finance Department, MoF

Figure 23: Health receives the largest support from donors, on average a third of total support goes into the health sector.<sup>50</sup>



In total, donors contributed USD 2 billion from 2008-2017 to the health sector in Sierra Leone. The years of the Ebola outbreak had the highest contributions – USD 1 billion within two years. This still leaves USD 113 million per year on average without the Ebola expenditures, and nearly double this (USD 209 million per year) if Ebola funding is counted towards the contribution. This means that donor funds always outweigh Government contributions to health, an indication towards who is driving the agenda, and how difficult it can be for Government to coordinate the influx of funds. Both Figure 24 and Figure 25 show the distribution of donor and GOSL funding across twelve key sectors in the last five years and for 2017 respectively. Overall, the health sector received the most funding – combined more than USD 2 billion in the last five years.

<sup>50</sup> Source: DACO, MoPED

Figure 24: GoSL and donor support in 12 key sectors, 2017

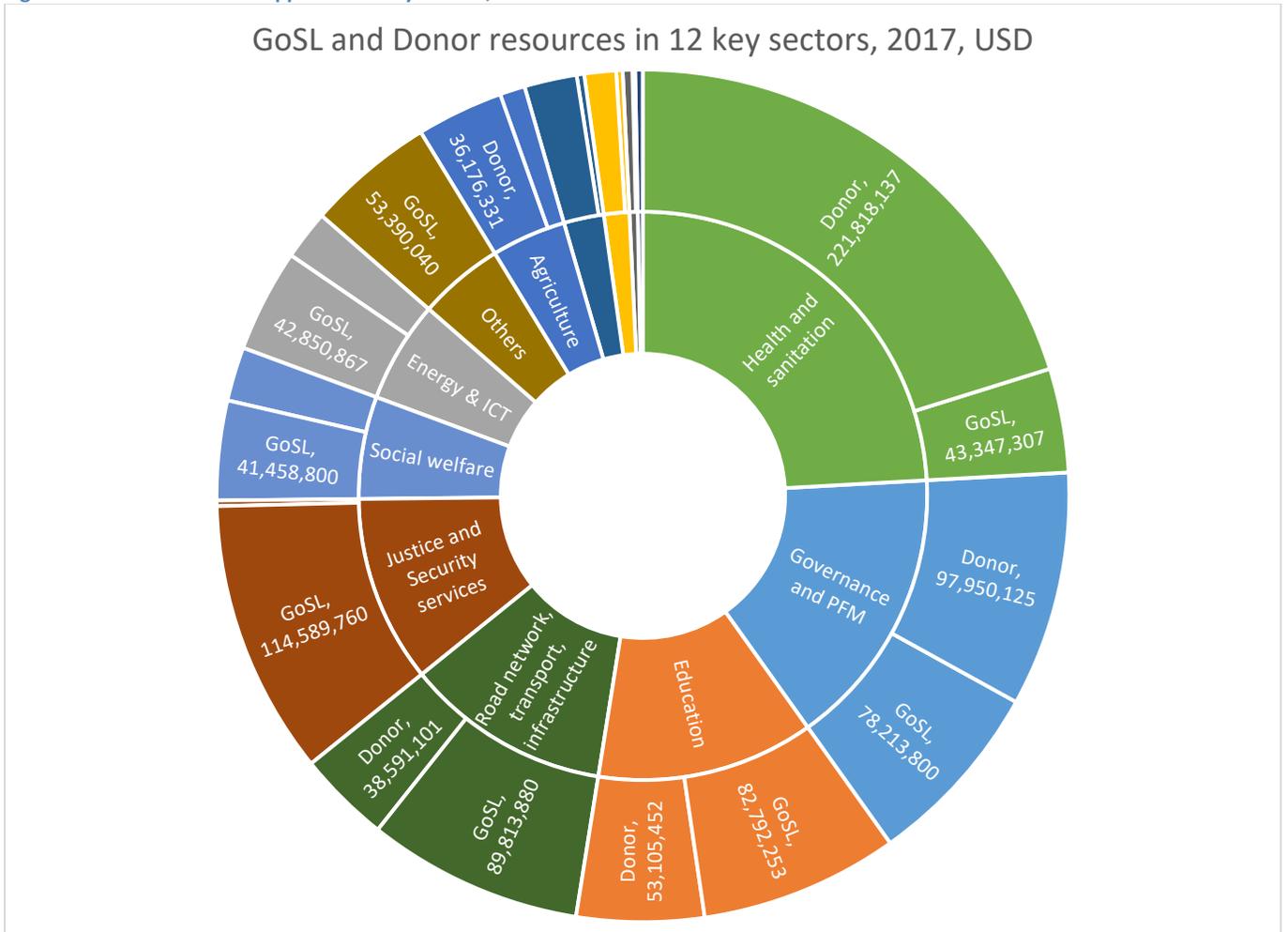
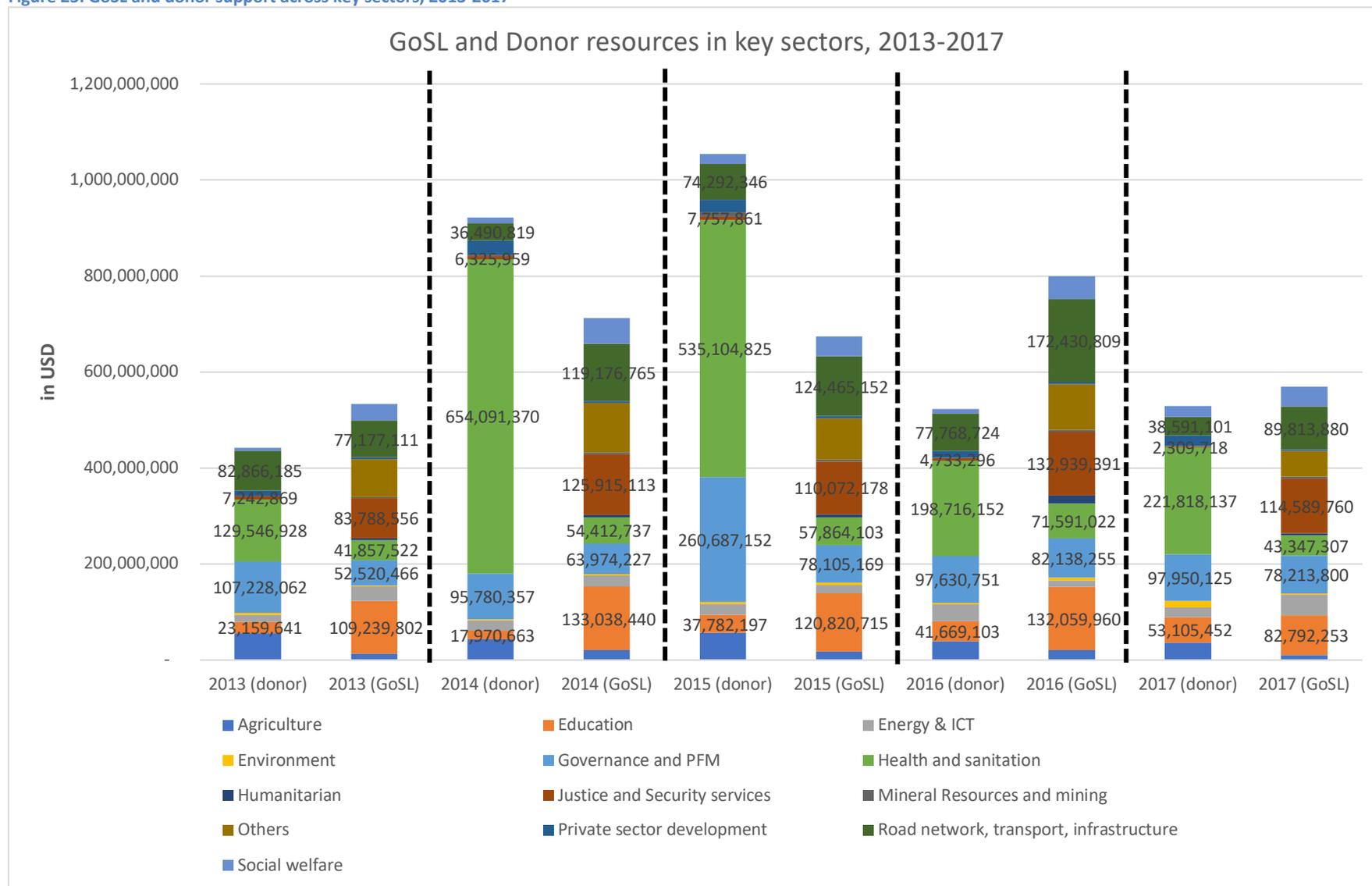


Figure 25: GoSL and donor support across key sectors, 2013-2017



### **III. Household expenditure on health**

In Sierra Leone, data on out-of-pocket expenditures on health is collected during the Sierra Leone Integrated Household Survey (SLIHS), a household income and expenditure survey conducted periodically. In the survey, households are asked about their expenditure on various health services, such as consultation/ admittance fees, medicines, vaccinations, etc. Additionally, information is collected about expenditure on other aspects – education, housing, food, durables, etc. – allowing us to view health expenditures against the total household consumption.

#### **Breakdown of OOP expenditure in Sierra Leone**

In 2011, OOP expenditure was SLL 250,569 per capita; or SLL 1,400,278 per household. As per our estimates from the latest SLIHS – conducted in 2018 – OOP expenditure increased to SLL 303,616 per capita, or SLL 1,696,722 per household.

Most spending occurs on drugs – 45%-47% of costs during consultations and hospitalisations are spent purchasing drugs (See Table 7 and Table 9 in Annex 1). Malaria is the most common illness reported in the survey, and medication to treat it (which should be free at government facilities) can set families back by up to SLL 711,989 per year. Most households prefer to visit government clinics, presumably due to convenience, where the average cost of drugs is cheaper than in government hospitals and private facilities.

Households paid an average of SLL 1,357 per year on vaccinations (Table 10), but the majority (95%) got the vaccination for free.

An average of SLL 11,023 was paid per household availing of ante-natal care services. Government clinics were the most commonly frequented for such services, where the average cost of care was SLL 7,943 (Table 11).

The most commonly used contraceptives were injections (Costing an average of SLL 61,163 per household reporting to use them), implants (SLL 51,220) and pills (SLL 39,950); see Table 12. Government clinics were most frequently visited to buy contraceptives (Table 13).

#### **Regional incidence of OOP expenditure in Sierra Leone**

As is evidenced in Figure 26 below, out-of-pocket expenditures in Sierra Leone are progressive – i.e., they rise with an increase in the wealth of the household. This is in line with global trends<sup>51</sup>, which find that out-of-pocket expenditures tend to be progress, when assessed relative to consumption.

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<sup>51</sup> Wagstaff, A., Eozenou, P.H.V. and Smitz, M.F., 2019. Out-of-Pocket Expenditures on Health: A Global Stocktake. *World Bank Policy Research Working Paper*, (8808).

Figure 26: Incidence of OOP expenditures, by region and wealth quintile

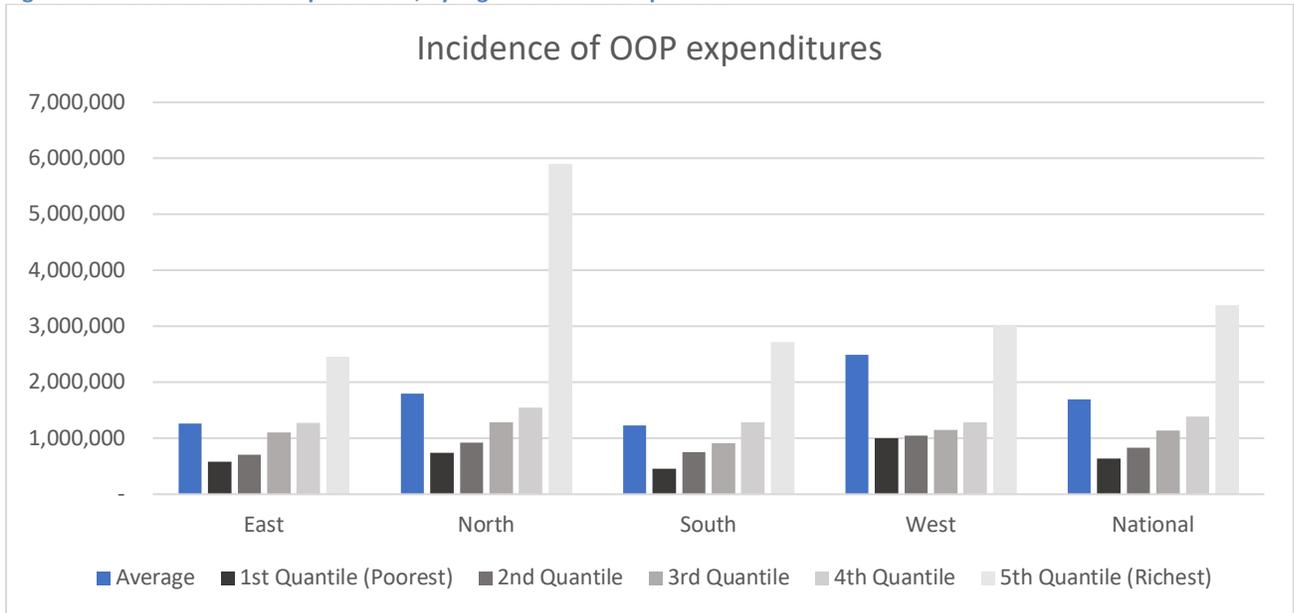


Figure 27: Out of pocket payments by region and wealth distribution

As can be seen, the Northern and Western regions of Sierra Leone incur a higher than average out-of-pocket expenditure. This can be further broken down in the graph below, which shows that Tonkolili in the North drives up the average of the region. The higher OOP incidence in the Western Area may also be explained by the higher levels of welfare.

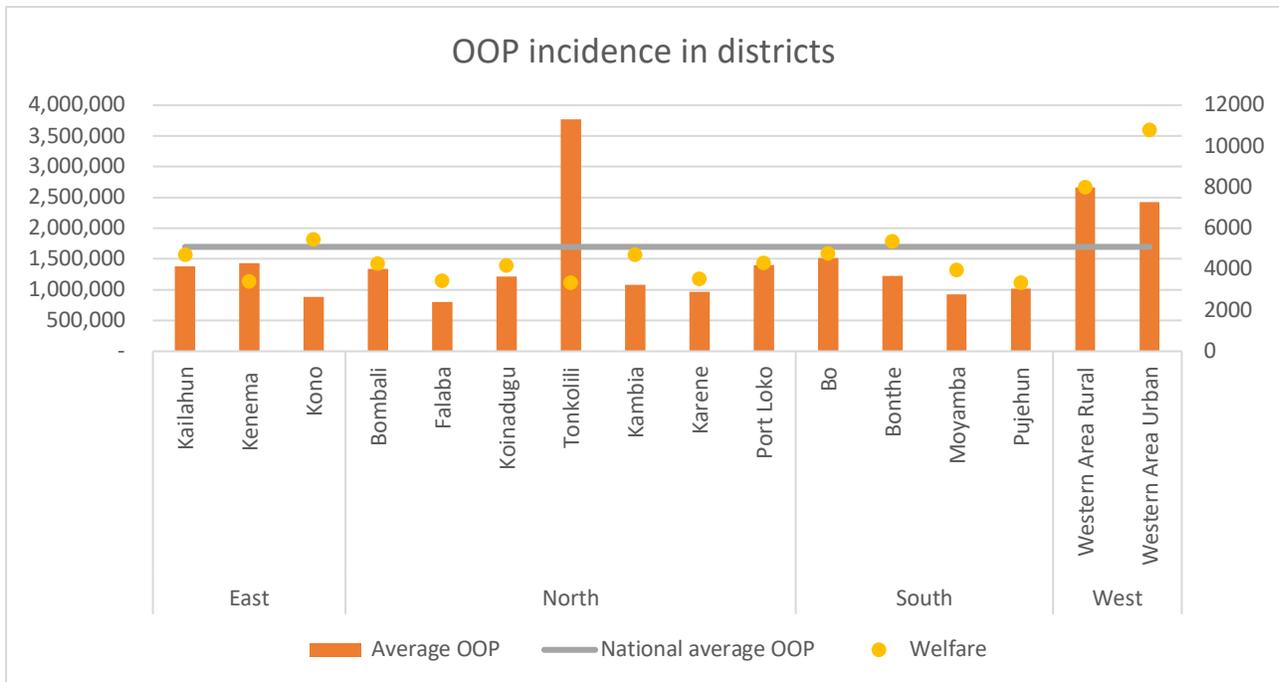
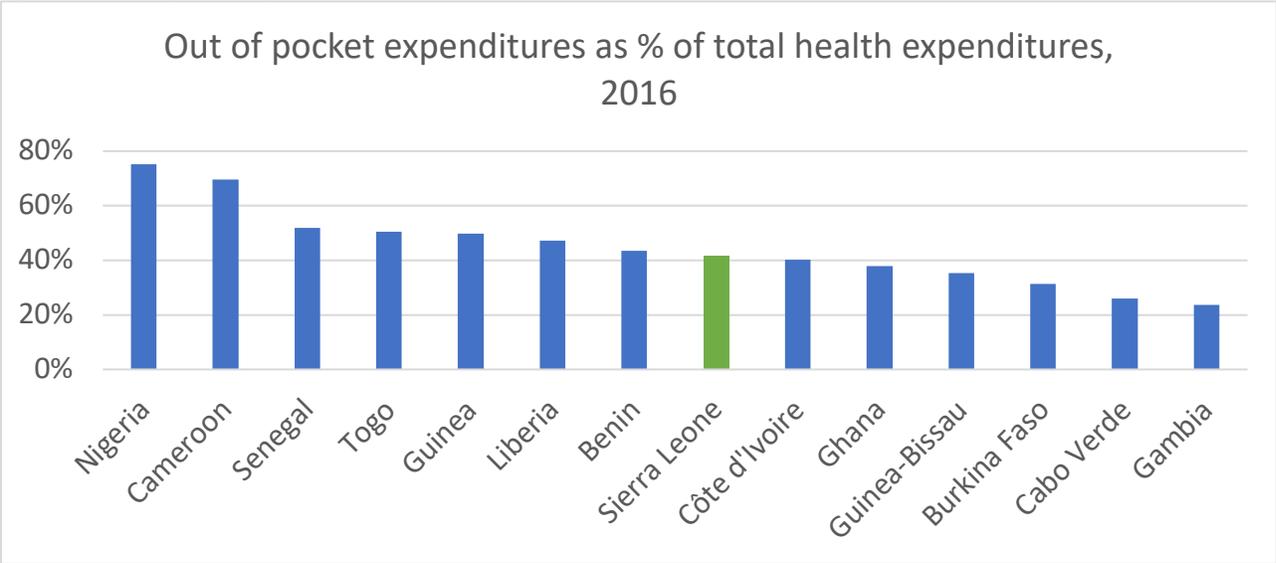


Figure 28: Out of pocket payments by district

Regionally, Sierra Leone ranks among the middle with regards to the share of total health expenditures paid out of pocket.

Figure 29: Out of pocket expenditures in Sierra Leone and West Africa.<sup>52</sup>



<sup>52</sup> Source: Global Health Expenditure Database, WHO

## SECTION VI: Review of existing health financing arrangements

Resource mobilization in Sierra Leone is largely voluntary (with spending by households at the point of service outweighing compulsory contributions through taxes), and donor dependent. There are no mechanisms operational for risk pooling. In the past, PBF – which is a mechanism of strategic purchasing – was implemented, but the schemes stopped running in 2016. A new PBF scheme and a social health insurance scheme are being developed by the Ministry at the time of finalizing this report (November 2019).

### I. Resource mobilization

Revenue raising mechanisms for the health sector usually include general revenues of the government (such as taxes levied on individuals and firms, revenues earned by government-owned assets), earmarked taxes for health, social health insurance contributions, voluntary prepayment for insurance schemes, household out-of-pocket spending, and foreign assistance<sup>53</sup>. This section examines resource mobilization for the health sector in Sierra Leone, through the key WHO criteria.

**Sierra Leone is largely dependent on voluntary payments, paid at the time of use of services:** Reaching UHC requires a predominant share of compulsory pre-payment for health. Compulsory payments include taxes (including personal income taxes and value-added taxes), or premium payments for a compulsory health insurance scheme. In Sierra Leone, four major taxes are collected: a goods and services taxes, personal income tax (progressive), pay as you earn tax, and a corporation tax<sup>54</sup>. There is only one tax levied specifically for the health sector. A Free Health Care tax<sup>55</sup> of 0.5% on contracts for all goods and services has been enacted in 2017. Although this tax is implemented, its revenue goes to the Treasury Single Account and not to a separate account earmarked for health<sup>56</sup>. The amount collected through the tax was approximately SLL 3.046 billion in 2018 and SLL 10 billion in 2019. This has financed only 0.2% of the total resource needs of the Free Health Care Scheme – which was estimated to cost USD 150 million in 2018<sup>57</sup>.

A growing number of countries around the world have used revenues generated by tobacco excise tax on health activities<sup>58</sup>. The World Bank conducted a modelling assessment in Sierra Leone, to estimate the impact of tobacco excise tax increases on prices, consumption, and domestic resource mobilization.

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<sup>53</sup> McIntyre, D., Kutzin, J. (2016). *Health financing country diagnostic: a foundation for national strategy development* (No. WHO/HIS/HGF/HFDiagnostics/16.1). World Health Organization.

<sup>54</sup> National Revenue Authority (2016). Domestic Taxes Business Brief 8: An Introduction to Sierra Leone’s Major Taxes and Taxpayer Obligations. (DTBB/008/2016)

<sup>55</sup> Section 36(1), The Finance Act 2017, Sierra Leone – “(There is hereby imposed a National Free Health Care Levy of 0.5% on all payments made to contractors, both local and foreign, for the supply of goods and services which shall be payable on or before the 15th day of the month following the transaction.)”

<sup>56</sup> Source: Interview with Accountant at the Accountant General Department, Ministry of Finance

<sup>57</sup> OPM Fiscal Space projections

<sup>58</sup> World Health Organization. (2010). *WHO technical manual on tobacco tax administration*. World Health Organization.

Tobacco tax collected in 2018 was roughly 67 billion Le<sup>59</sup>. This was well below the World Bank estimates of 160.7 billion Le<sup>60</sup>. This tax is currently not earmarked for health in Sierra Leone.

The Sierra Leone Social Health Insurance (SLeSHI) Scheme was passed as an Act in December 2017 but is yet to be implemented. Therefore, there is no mechanism for pre-payment for health expenditures. According to the 2016 National Health Accounts, 60.3% of the Total Health Expenditure is financed by Out-of-pocket payments at the time of service delivery.

#### *Sierra Leone Social Health Insurance (SLeSHI)*

In 2008 the GoSL commissioned the International Labor Organization to conduct an assessment on health financing and provision of health services in Sierra Leone. Several discussions were held with regional and central stakeholders on current gaps in health financing and on possible ways of establishing a health insurance scheme. In 2009, a second ILO mission conducted a National Consultative Conference, which also focused on establishing a national health insurance scheme in the country.

In March 2017, the Government of Sierra Leone officially launched a mandatory and Universal Social Health Insurance (SLeSHI) scheme. SLeSHI is envisaged as an autonomous corporate body with legal, administrative and financial autonomy.

The benefits package under SLeSHI includes a list of 35 diseases and services. Those services are currently being provided at all levels of health care in Sierra Leone (e.g. fever in MCHPs (primary care facility) to cataract surgeries at Connaught (tertiary care facility)). Some of the services listed are currently not provided in the public health facilities (e.g. snake bite treatment / anti-venom). Few of the services (e.g. Malaria, TB, HIV, for example) are currently fully donor funded and supposedly free to the patient. It is unclear if donors would channel their funds through the SLeSHI agency. See Table 2 below for an overview of all services that are included as per current SLeSHI act. The actuarial assessment of SLeSHI completed in 2017 also costed the benefits package. The actuarial experts estimated the total costs of delivering those services at USD 192 million a year.

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<sup>59</sup> National Revenue Authority

<sup>60</sup> Revenue Impact of Proposed Tobacco Excise Tax Increase Scenarios in Sierra Leone. World Bank Group Mission, Freetown, Sierra Leone, November 2017.

<b>Services</b>	<b>Outpatient</b>	General curative consultations, ancillary services, small/minor surgical procedures, laboratory examinations, essential generic drugs, immunizations, family planning service,
	<b>Inpatient</b>	Hospital stay for 3 days per incident, laboratory examinations, small/minor surgical procedures, essential generic drugs.
	<b>Maternity</b>	Prenatal consultations, postnatal consultations, normal delivery, caesarean section, hospital stay for 5 days, laboratory examinations, essential generic drugs.
<b>Diseases</b>	Malaria (uncomplicated), typhoid, pneumonia, common cold and cough, fever, bronchiolitis, whooping cough, sore throat/tonsillitis, diarrhea, dysentery, cholera, anemia (excluding blood transfusion), hernia, hydrocele, appendicitis, prenatal conditions, postnatal conditions, caesarean operation, tuberculosis, cataract removal, ring worm, scabies, eczema, ARI, acute asthma, wounds/accidents, UTI, snake bite, worm infection, yellow fever, sickle crisis, measles, chicken pox, malnutrition, HIV testing, TB (treatment), Oncho (treatment)	

**Table 2: Diseases and services included in the SLeSHI benefits package.**

It is proposed that the scheme is funded by contributions by formal and informal sector employees, as well as ear-marked taxes. The contribution rates proposed are 6% of salaries from formal sector employees, and LE15,000 flat rate per month for informal sector employees. The contribution from the informal sector was determined based on the findings of a willingness to pay survey, conducted in 2016. Experiences in other countries show “willingness-to-pay” surveys have a limited ability to predict real behavior in the informal sector. Mobilizing contributions from the informal sector will likely prove to be challenging in the short term in Sierra Leone due to limited capacity in targeting collections and the large and dispersed informal workforce. Similar mandatory insurance schemes, such as those in Tanzania and Ghana, have coverage rates of less than one third of the population. Low enrollment and/or collection rates will threaten the scheme’s solvency.

It is also proposed that contributions from the Goods and Services taxes (increase by 2.5 percentage points to 17.5%), a percentage of local council’s primary health care budget, licensing fees of vehicles, and contributions from non-tax revenue be used to fund this scheme. As the estimates in Table 3 indicate, the scheme will have projected annual shortfalls of USD 80 million (SLL 800 billion) with the currently proposed financing structure, not considering start-up costs. In order to achieve financial feasibility, either Government will have to contribute more, or the benefits package will have to be reduced to include less.

<b>Costs</b>	<b>USD (annually)</b>	<b>Revenue</b>	<b>USD (annually)</b>
Cost of delivering the services	192 million	2.5% of GST revenue; 2.5% of non-tax revenue;	27.8 million (maximum)
Administrative costs	24 million	0.25% of vehicle licensing; 40% of councils budget for primary health care	
Start-up costs	Minimum 21 million	Formal sector membership;	54.4 million;
<b>TOTAL COSTS</b>			<b>Maximum 52 million (which would mean a 100% enrolment rate, which no</b>

	Minimum 237 million in the first year, then 216 million annually	Informal sector membership	other similar country has achieved, e.g. Rwanda is at around 75%)
		TOTAL REVENUE	Maximum 134 million
<b>ESTIMATED GAP: at least -103 million</b>			

Table 3: Summary of costs and contributions of current SLeSHI scheme. <sup>61</sup>

SLeSHI will cost more than it generates, largely due to a generous benefits package, and will only be financially sustainable if GoSL continuously subsidizes the scheme. In its development phase, SLeSHI will take up to 10 years<sup>62</sup> before it can be relied upon as a financing mechanism for Sierra Leone. With no ICT systems and administrative systems in place to identify & collect revenue from the informal sector, revenues from SLeSHI are likely to be lower than expected.

Based on experiences from Ghana, Tanzania and Rwanda, the administration of SLeSHI would need about 311 highly skilled staff, including actuarial experts, health economists, and experts in claims, collection, costing, and accreditation<sup>63</sup>. Experience from the National Health Insurance Scheme in Ghana shows how a weak claims management system combined with a broad benefits package can threaten the viability of a social health insurance scheme. This concern is especially salient given SLeSHI's focus on primary care and the fact that administrative and management capacity is weakest within PHUs, limiting the likelihood that facilities will be able to effectively manage both claims and associated resources to improve quality of care. PHUs are supposed to receive a capitated budget under SLeSHI, which requires careful definition of catchment areas, registration of households with a specific provider, and--if not well managed--poses risk of under-provision of services. The insurance industry is still nascent, and relevant expertise is growing but still low, and not currently available in the numbers required. If a targeted program is started, the relevant experts could be ready in some years. Expertise could be bought in from other countries, which would increase administrative costs. Alternatively, GoSL could outsource areas such as collection, costing and reimbursement to the private sector.

In summary, the current design of the scheme requires some review before rolling it out, and an iterative approach to learning from challenges that other Sub-Saharan African countries experience.

## II. Pooling

The second principle to guide health financing reforms to accelerate progress towards UHC is reducing fragmentation in pooling to enhance the redistributive capacity of prepaid funds. A single pool offers greater efficiency, potential for cross-subsidisation within the population and therefore promotes equity. Fragmentation in pooling leads to system-wide inefficiencies, duplication of administrative costs and limitations on the capacity of the financing system to use strategic purchasing to support changes at the provider level<sup>64</sup>.

<sup>61</sup> Source: Own calculations, based on SLeSHI Act 2017

<sup>62</sup> Sierra Leone FHCI Evaluation Fiscal Space Analysis: FHCI and UHC (2016). Alexandra Murray-Zmijewski. Health and Education Advice and Resource Team

<sup>63</sup> Actuarial Assessment of SLeSHI: NASSIT (2016).

<sup>64</sup> Technical Brief Series – Brief No. 5 (Fragmentation in pooling arrangements), The World Health Report, Health Systems Financing, WHO 2010

To maximise the redistributive capacity (i.e., ensuring that funds flow from the rich to the poor, and from the healthy to the sick)<sup>65</sup>, pools should ideally include a large and diverse population, rather than a small pool including only a certain population group (e.g. only elderly people; only public sector employees)

Compulsory participation in a health coverage scheme leads to the formation of a larger and more diverse pool. Problems such as adverse selection arise through voluntary participation in such schemes, by way of healthy people being less likely to join the scheme, and therefore making the scheme financially unviable.

In Sierra Leone, there is currently no health insurance scheme implemented, and therefore **risk pooling does not exist**. Under the design of the proposed scheme of SLeSHI, a single and integrated risk pool would have been created. As the Scheme is proposed to be compulsory, and covers the entire population, the risk pool would have included a large and diverse population, and therefore enabling the redistribution of funds. However, the design in its current stage excludes 51.4% of the population from paying a premium, and calculations show that this will heavily impact the scheme’s financial viability. A more detailed discussion of SLeSHI is presented in the section above.

Category	Population	Data Source
Children under 12	2,630,188	Census 2015
Persons requiring ANC, child delivery, PNC	581,554	Figure in MDSR report quotes 290,777 pregnancies in 2016, x2 to include both pregnant women and those on PNC
Persons with mental disorders	102,656	Census 2015
Persons classified as disabled		
Indigents	+/- 446,771	World Bank estimates 147,000 households to be extremely poor, each with an average population of 5.6 (Census 2015), minus the already mentioned exempted categories
Persons over 65 years	260,418	Census 2015
<b>TOTAL</b>	<b>4,021,588</b>	<b>51 % of total population</b>

Table 4: Up to 52% of the population would be exempt from premium payments under SLeSHI. <sup>66</sup>

### III. Strategic purchasing

The third principle guiding health financing reforms towards UHC is a move towards strategic purchasing, which seeks to align funding and incentives with promised health services<sup>67</sup>. A passive approach to purchasing is one in which providers automatically receive funds (budget allocations) independent of their

<sup>65</sup> Pooling: Key Policy Messages, World Health Organisation ([https://www.who.int/health\\_financing/topics/pooling/key-policy-messages/en/](https://www.who.int/health_financing/topics/pooling/key-policy-messages/en/))

<sup>66</sup> Source: Own calculation using Census 2015, based on SLeSHI Act 2017.

<sup>67</sup> Strategic purchasing for UHC: Key policy issues and questions; Health Financing Working Paper No 8, World Health Organization 2017

performance, by the absence of performance monitoring, or the lack of efforts to influence the quantity and quality of health services. Shifting to strategic purchasing involves linking the payment of providers to their performance, or to the health needs of the population they serve.

In Sierra Leone, two PBF schemes have been implemented. “PBF Light” was implemented nationwide between 2011 and 2016, covering 1200 PHUs and 6 hospitals, to complement the FHCI introduced in 2010. An external verification of the scheme was conducted in 2014, and to address the shortcomings in its design, “PBF Plus” was introduced as a pilot in Bombali district. The verification of the PBF Light scheme<sup>68</sup> found that the scheme increased provider autonomy, leading to more investments in facilities in hygiene, equipment and supplies. However, the evaluation found that there was low capacity to carry out data entry and verifications, which would translate to inaccurate data and verifications. Additionally, payments were delayed (often up to a year) and sent in a lump sum, and therefore facilities were not in a position to understand why they received a certain amount. These factors dulled the intended impact of strategic purchasing, as payment decisions were not taken on accurate data regarding performance. As a new PBF is being designed, it is important to pay attention to how purchaser-provider systems can be strengthened.

The Free Health Care initiative is another way of strategic purchasing. In that case, the Government purchases the services from the service providers, and then clients that fulfill the criteria can receive the services for free. The FHC initiative has been in place for close to ten years now, and has proven to be cost-effective.<sup>69</sup> Challenges remain, largely around persisting informal fees that are still being paid, and stock out of drugs. However, the initiative has been evaluated as having achieved its aim of providing a life-saving package of intervention to a highly targeted and prioritized group of clients.

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<sup>68</sup> Cordaid. Performance Based Financing in Healthcare in Sierra Leone. External Verification - Final Report, vol. 1. Freetown and The Hague: Cordaid (unpublished report); 2014.

<sup>69</sup> Oxford Policy Management: Review of the Free Health Care initiative in Sierra Leone. 2016

## SECTION VII: Financial protection and equity in finance

Households spend 5.7% of their total household expenditures on health. Of all non-food expenditures, health takes the second biggest share of the household's income, after transport costs. At least every tenth household experiences catastrophic health expenditures. However, only few households were pushed below the poverty line due to catastrophic health expenditures in 2018.

### *% of HHs that incur catastrophic spending on health services*

Catastrophic expenditures on health view out-of-pocket expenditures in the context of the entire household consumption. Households are considered to incur a catastrophic expenditure on health when it exceeds a certain threshold, viz-a-viz the rest of the household expenditure. Figure 30 below shows an average household's expenditure on non-food items. Health, forming 16.3% of the budget, takes the second largest share after transport.

Figure 30: Non-food household expenditure

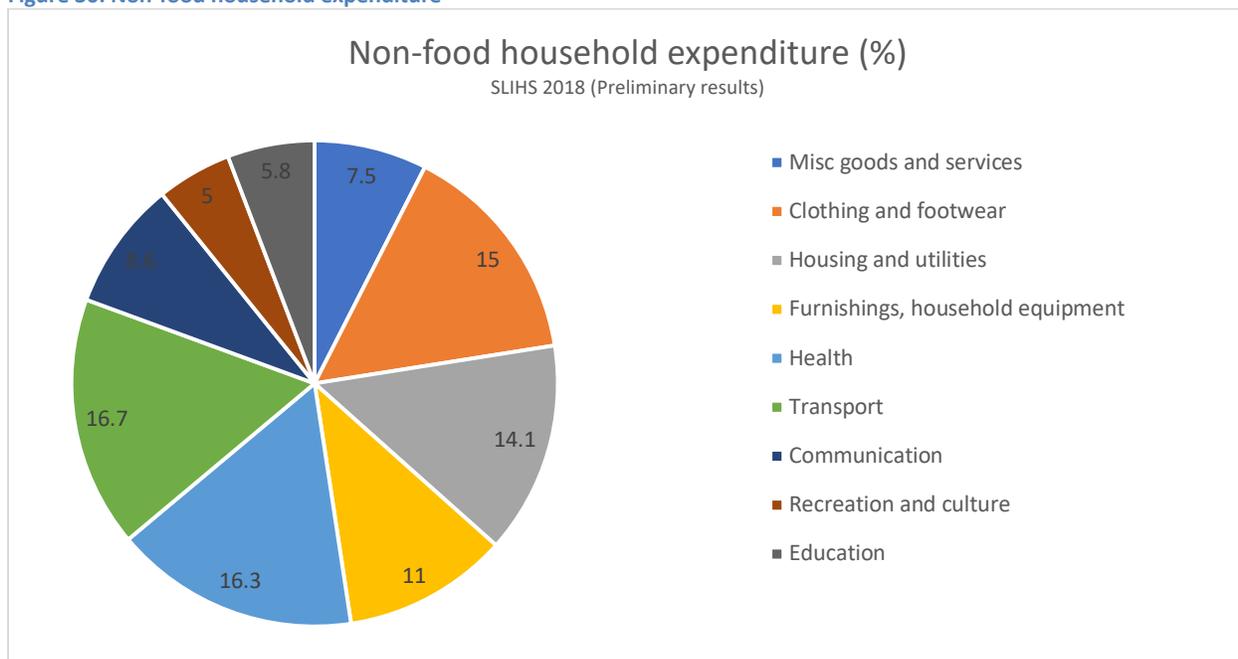
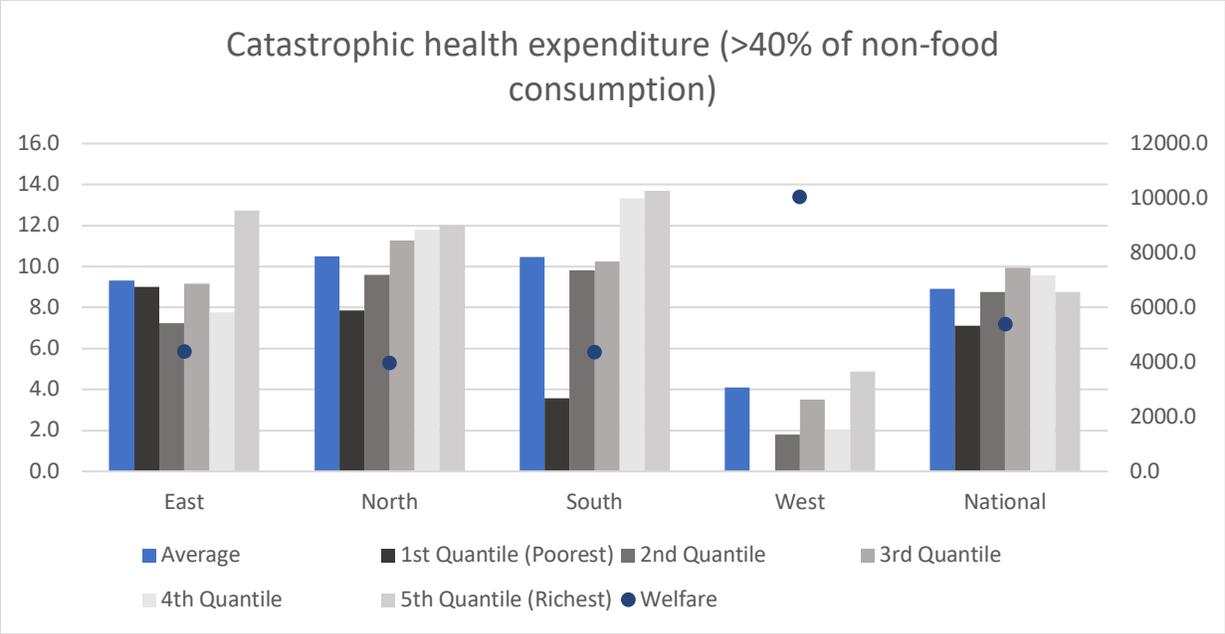


Figure 31: Non-food household expenditures (in %)

In health economics literature, the threshold for calculating catastrophic health expenditure is defined in different ways. For instance, the World Health Organisation considers a household to incur catastrophic health expenditure when it's OOP expenditure on health exceeds 40% of the household income minus subsistence needs (i.e., non-food expenditure). The World Bank, on the other hand, defines it as OOP payments on health that exceed 10% of the total household expenditure. Both calculations are presented in the graphs below:



**Figure 32: Catastrophic health expenditures bigger than 40% of non-food consumption**

When considering the WHO methodology (OOP on health exceeding 40% of non-food expenditure) in Figure 32 above, almost 9% of households across the country incur catastrophic expenditures on health. The Western Area incurs the lowest levels of catastrophic expenditure, and interestingly, has the highest levels of welfare. Except for in the Northern and Southern regions, where catastrophic payments are progressive as is reflected in global trends<sup>70</sup> (the rich incur more), there is no clear trend in the remaining regions.

<sup>70</sup> Wagstaff, A., Eozenou, P.H.V. and Smitz, M.F., 2019. Out-of-Pocket Expenditures on Health: A Global Stock take. *World Bank Policy Research Working Paper*, (8808).

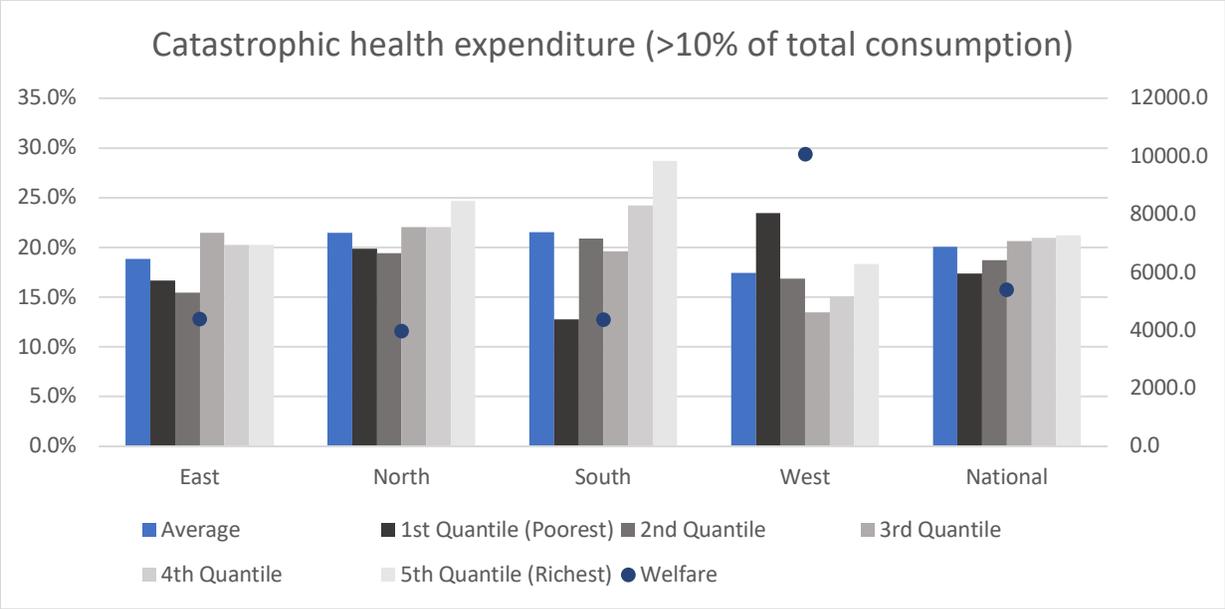


Figure 33: Catastrophic health expenditures bigger than 10% of total consumption

In Figure 33 above, the World Bank methodology of calculating catastrophic health expenditure is presented (OOP on health exceeding 10% of total expenditure). On an average, 20% of households in the country incur catastrophic health expenditures using this methodology. The incidence is lowest in the West and high in the North and South- as was reflected in the WHO methodology as well. Similar to the WHO methodology results, in the North and South, there is a clearer trend showing progressivity of catastrophic payments (they are concentrated more among the rich than the poor).

The progressivity of catastrophic payments – like the case of OOP payments – are consistent with global trends<sup>71</sup>, in that they are concentrated more among the rich than the poor.

*The number of HHs that are impoverished as a result of health care expenditure*

Indicators such as OOP and catastrophic payments on health do not tell us about whether households faced financial hardship as a result of these payments. “Impoverishing health expenditure” – an indicator that compares households to the poverty line - tells us whether incurring health expenditure pushes the household below the poverty line. In Sierra Leone, the percentage of households that incurred impoverishing health expenditure in 2018 was negligible – only 5 households were pushed under the poverty line as a result of their spending on health.

**I. Equity in distribution of resources**

Resources such as human resources, facilities or commodities are unequally distributed across Sierra Leone, with a concentration of those in urban centers (Freetown takes the majority).

<sup>71</sup> Wagstaff, A., Eozenou, P.H.V. and Smits, M.F., 2019. Out-of-Pocket Expenditures on Health: A Global Stock take. *World Bank Policy Research Working Paper*, (8808).

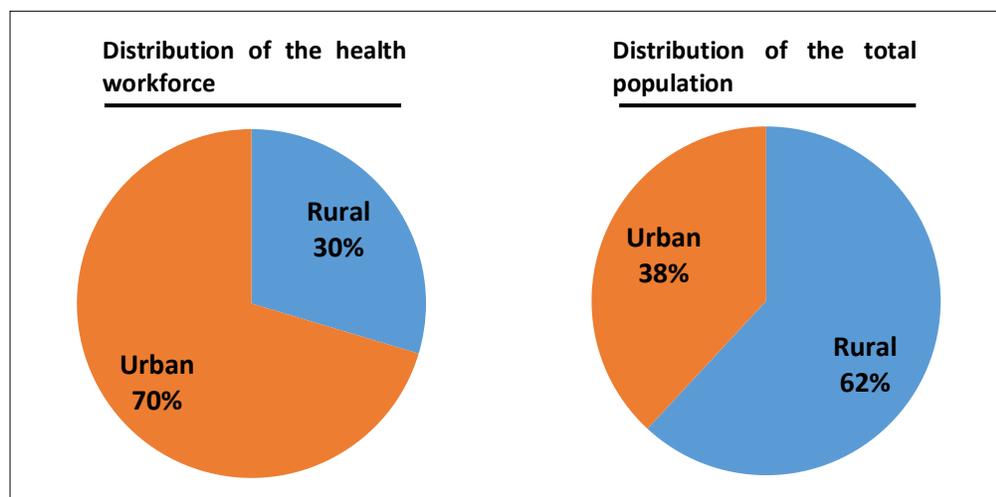


Figure 34: Urban vs. rural distribution of the health workforce compared to population.<sup>72 73</sup>

The concentration of health workers, particularly highly-skilled clinical staff, in urban areas corresponds with the general availability of advanced care, as all tertiary referral hospitals are located in Freetown and all secondary hospitals are in urban district capitals. Given the limited scope and efficiency of the current referral system, however, this distribution implies a disparity of access to health care throughout the country.

#### *Deployment efficiency*

Recent data collection efforts show that the health worker data available at the central level of the MoHS previously contained inaccuracies, particularly with regards to workstation information. As a result, the concentration of health workers in hospitals and urban areas is more significant than previously understood. Anecdotal evidence suggests that this is caused by a lack of decentralization, leading to a combination of poor record keeping, ineffective communication between district level and national level MoHS, informal transfer processes and unsanctioned transfers initiated by health workers. In addition to emphasizing the uneven geographic distribution of the health workforce, this finding also highlights the inadequacy of ongoing deployment decisions, since these are currently based on data available at the national MoHS level and not supplemented with a national deployment policy.

<sup>72</sup> Source: Sierra Leone HRH Country Profile 2016

<sup>73</sup> Urban/rural distribution of the total population is from the 2004 Population and Housing Census by Statistics Sierra Leone, as the preliminary results of the 2015 census do not include the urban vs. rural breakdown

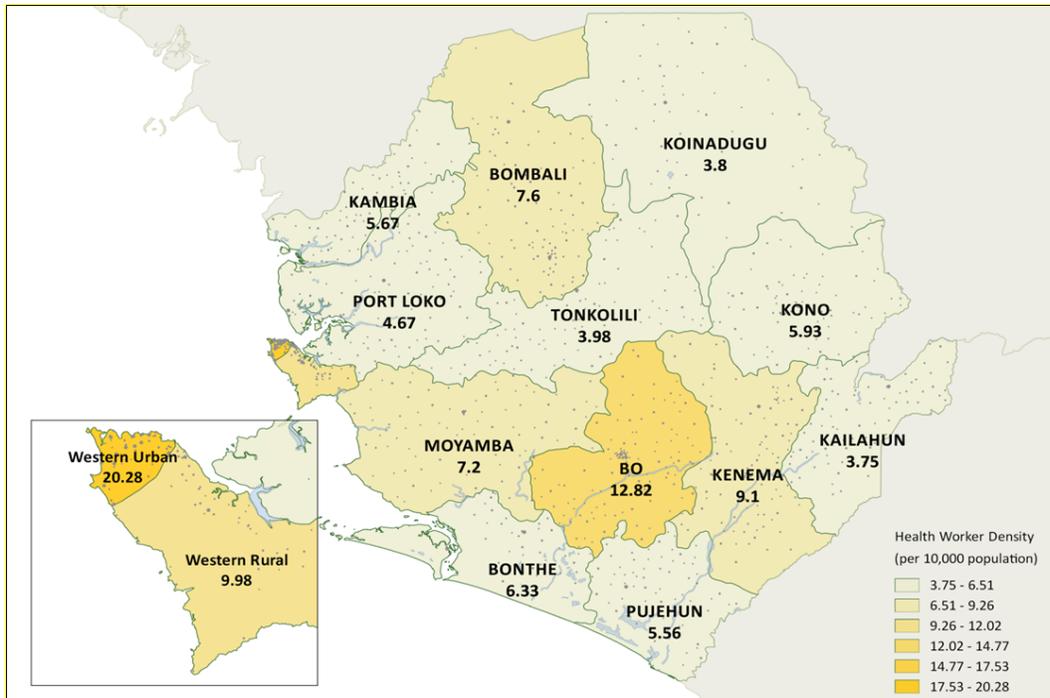


Figure 35: Distribution of health workforce by district.<sup>74</sup>

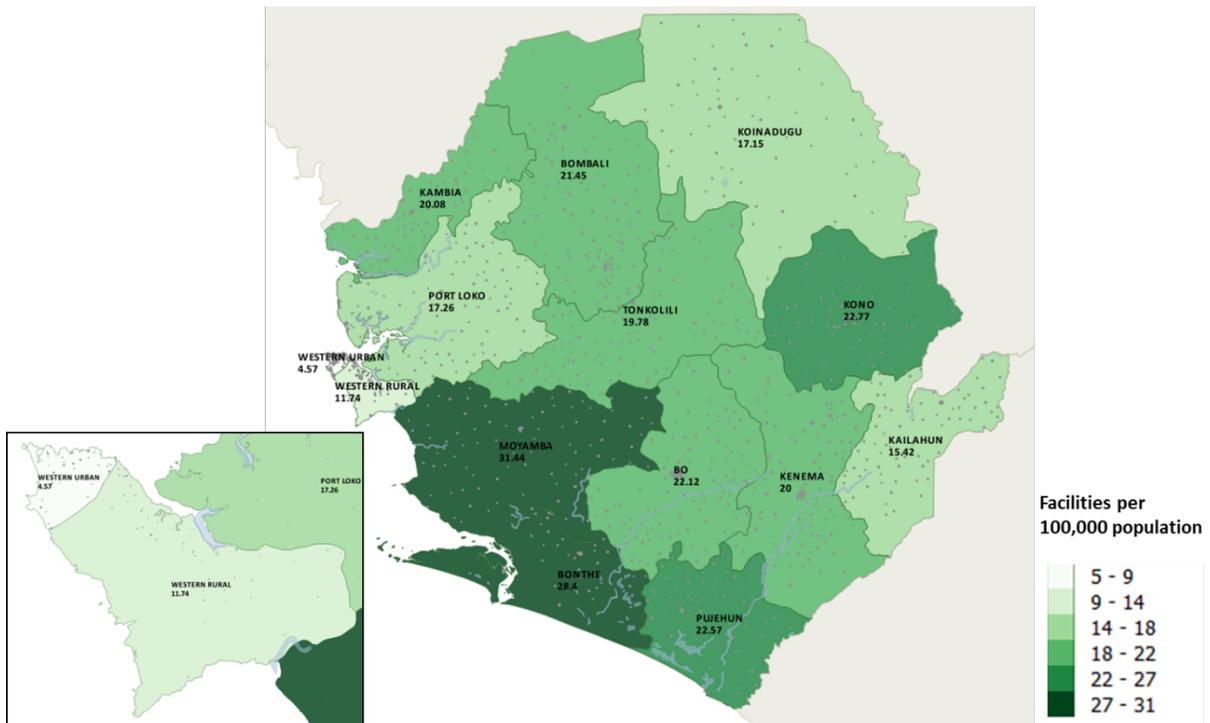


Figure 36: Distribution of all public facilities by district.<sup>75</sup>

<sup>74</sup> Source: Sierra Leone HRH Country Profile 2016

<sup>75</sup> Source: Sierra Leone HRH Country Profile 2016

There are also inefficiencies in how resources are used. For example, for human resources, there are spot checks being conducted by central level, to ascertain who is actually providing services at facilities. On average, one third of staff are absent from their duty station, while still getting paid (see Figure 37). The reasons span from family emergencies, workshops, trainings, administrative duties, sicknesses – all valid reasons. Only 38% of those absent (11.4% of total staff) are absent without authorization of the in-charge.

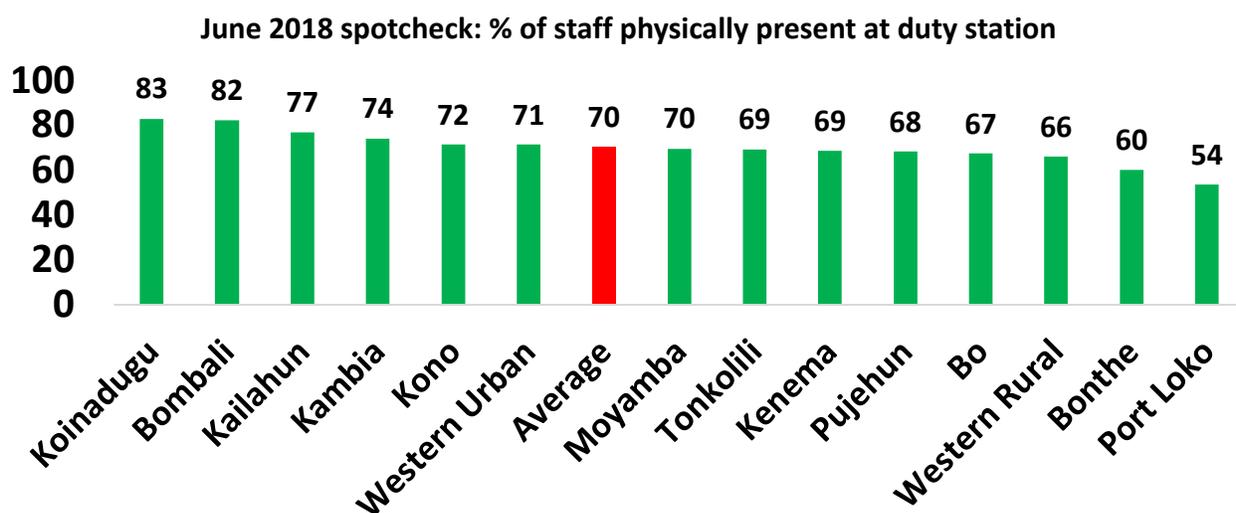


Figure 37: Findings of Spot Check of health worker attendance at facilities.

The current staffing can also be analysed against workload, to detect inefficiencies in deployment of staff. Bed capacity is a good proxy for workload, and there are international norms on how many patients a nurse can and should be able to care for. On average this is 3 patients per nurse, with varying recommendations for different types of wards. Table 5 below summarizes the situation in all public hospitals, assuming three shifts for nurses. The table shows that some hospitals are overstaffed, while some are understaffed. And again, the overstaffed hospitals are all in urban areas, while all rural hospitals are understaffed.

Name of the Hospital	Number of Authorized Beds	Current staffing: nurses	Current staffing: bed/nurse	Comparison to international standards
Kingharman Road Government Hospital	30	66	1.4	Too many nurses
Lumley Government Hospital	35	74	1.6	Too many nurses
Princess Christian Maternity Hospital	129	196	2.0	Too many nurses
Bo Government Hospital	235	319	2.2	Too many nurses
Rokupa Government Hospital	62	81	2.3	Too many nurses
Ola During Children's Hospital	186	198	2.8	Ok
Connaught Government Hospital	304	302	3.0	Ok
Makeni Regional Government Hospital	250	158	4.7	Not enough nurses
Kenema Government Tertiary Hospital	350	215	4.9	Not enough nurses
Moyamba Government Hospital	82	39	6.3	Not enough nurses

Lungi Hospital	90	29	9.3	Not enough nurses
Pujehun Government Hospital	89	25	10.7	Not enough nurses
Kailahun Government Hospital	140	39	10.8	Not enough nurses
Lakka Government Hospital	100	19	15.8	Not enough nurses
Port Loko Government Hospital	150	25	18.0	Not enough nurses
National Psychiatric Hospital	145	20	21.8	Not enough nurses
Bonthe Government Hospital	60	7	25.7	Not enough nurses

Table 5: Deployment efficiencies of nurses in hospitals<sup>76</sup>

As for supply chain resources, the distribution is unequal between different vertical programs. Donor funded programs such as Malaria, TB and HIV/Aids are nearly fully funded, while blood services for example is severely underfunded. A resource mapping was conducted, identifying needs and funding available for 2019 in all vertical programs, and across the different supply chain functions: procurement, warehousing, distribution and other functions such as reverse logistics, training, monitoring and information system. The total funding need per year is USD 49.5 million, where donors are currently funding 90-95% of it. This poses serious questions for sustainability, but also for equity – as donors are driving the agenda. Table 6 shows the full resource mapping in detail, and highlights biggest gaps in red.

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<sup>76</sup> Source: attendance monitoring system of Directorate of Human Resources for Health, accessed December 2018. Bed capacity from hospital reports.

	Free Health Care USD 25.8 m	HIV USD 4.2 m	TB USD 2.8 m	Malaria USD 8.1 m	Cost Recovery n/a	Reproductive health USD 1.75 m	Safe blood n/a	Nutrition USD 1.51 m	EPI USD 5.16 m
Procurement	USD 24 million	USD 3.4 million	USD 2 million	USD 7.5 million	Inactive, but should be cost recovering	USD 1.5 million	unquantified	USD 1.4 million	USD 4.5 million
Warehousing	USD 500,000 for rental; USD 48,000 for maintenance and running; USD 14 million for Kerry Town			USD 12,000	Inactive, but should be cost recovering	Using CMS	Using CMS	USD 100,000	USD 100,000 for Lungi; USD 52,000
Distribution	USD 960,000	USD 1.5 million			Inactive, but should be cost recovering	Integrated with FHC	n/a	Integrated with FHC	USD 400,000
All other costs*	USD 679,000	USD 405,000			Inactive, but should be cost recovering	USD 250,000	USD 80,000	USD 10,000	USD 108,000

\* Includes reverse logistics, monitoring, information system, supply chain related training

Funded Some gaps Big gaps

All information received from programs, based on their 2019 budgets/expenditures/quantifications.

Table 6: Overview of resources in supply chain, 2019.

## **SECTION VII: Research gaps**

This health financing situation analysis was completed through in-depth analysis and cross-comparison of datasets and reports at hand. However, with extra time and funding, the following knowledge gaps could be filled in the future:

- 1) What is the total health sector funding need?
- 2) Where are overlaps from different funding sources? (e.g. Government and donors funding the same input).
- 3) What efficiency gaps exist in the health sector?

## Annexe 1: Out of pocket expenditure

This section lays out preliminary analysis from the SLIHS 2018 dataset. Please note that all costs have been annualized and survey sample weights have been incorporated.

### I. Consulting for illness

Table 7: Cost of consultation, medicines, supplies and tests by type of facility

Facility	Consultation (SLL)	Medicines (SLL)	Supplies (SLL)	Tests (SLL)	Sample size
<b>Overall</b>	451,005	973,686	122,114	620,809	3495
<b>Government hospital</b>	608,459	1,352,661	703,907	212,260	991
<b>Government clinic</b>	278,710	543,339	508,770	47,538	1817
<b>Private hospital</b>	675,209	1,807,711	664,263	346,812	329
<b>Private clinic</b>	576,230	1,044,946	1,212,048	132,556	176

Table 8: Cost of consultation, medicines, supplies and tests by most common illnesses

Disease	Consultation (SLL)	Medicines (SLL)	Supplies (SLL)	Tests (SLL)	Sample size
<b>Malaria</b>	298,764	711,989	217,378	70,097	2346
<b>Cold and cough</b>	238,390	533,373	163,747	63,345	1,039
<b>No diagnosis</b>	190,897	436,977	84,704	10,690	272
<b>Typhoid</b>	423,566	997,566	839,914	130,753	434

### II. Hospitalisation for illness

Table 9: Cost of hospitalization by facility type

Facility	Stay (SLL)	Consultation (SLL)	Medicines (SLL)	Supplies (SLL)	Tests (SLL)	Aggregate (SLL)	Sample size
<b>Overall</b>	46,017	11,180	82,968	14,472	21,421	239,249	1087

<b>Government hospital</b>	54,256	12,123	101,271	8,652	21,319	262,265	563
<b>Government clinic</b>	16,886	9,472	57,248	26,281	21,691	65,209	348
<b>Private hospital</b>	85,657	9,474	77,506	3,636	20,199	539,219	172
<b>Private clinic</b>	10,726	12,159	37,092	1,126	4,442	238,940	23

### III. Vaccination

Table 10: Cost of vaccination by facility type

<b>Facilities</b>	<b>Vaccination (SLL)</b>	<b>Sample size</b>
<b>Overall</b>	1,357	4199
<b>Government hospital</b>	914	1048
<b>Government clinic</b>	1,716	2530
<b>Private hospital</b>	3,528	99
<b>Private clinic</b>	258	44
<b>Community</b>	0	15
<b>Mobile clinic</b>	82	631
<b>Other</b>	318	24

### IV. Ante-natal care

Table 11: Cost of ante-natal care by facility type

<b>Facilities</b>	<b>Ante-natal care (SLL)</b>	<b>Sample size</b>
<b>Overall</b>	11,023	1498
<b>Government hospital</b>	15,878	409
<b>Government clinic</b>	7,943	1015
<b>Private hospital</b>	34,627	51
<b>Private clinic</b>	32,171	30
<b>Traditional Birth Assistant</b>	7,231	3
<b>Home</b>	10,000	2

## V. Contraceptives

Table 12: Cost of most commonly used contraceptives

Contraceptive type	Cost (SLL)	Sample size
Injection	61,163	1289
Implant	51,220	492
Pill	39,950	570

Table 13: Cost of contraceptives by facility type

Facilities	Cost of contraceptive (SLL)	Sample size
Overall	52,229	2484
Government hospital	62,192	430
Government clinic	52,737	1015
Private hospital	67,407	158
Private clinic	64,456	188
Pharmacy	55,862	457
Other	42,439	30