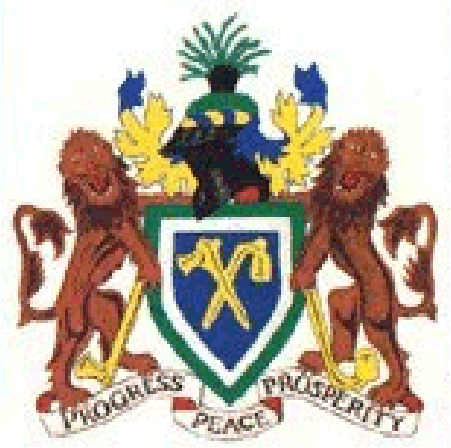
HEALTH FINANCING POLICY 2017 – 2030:
Resourcing the Pathway to Universal Health Coverage



Ministry of Health and Social Welfare
Republic of The Gambia

Foreword

The objectives of the National Health Financing Policy are to make funding available, ensure choice of cost-effective interventions, set appropriate financial incentives for providers, and ensure that all individuals have access to effective public health and personal health care.

The NHA report constitutes a strong basis for developing a comprehensive Health Financing Policy and a Health Financing Strategic Plan. It further guides the sector towards the development of Sector Wide Approach (Common Basket Funding) and mapping out how the Government plans to realize the vision of universal coverage of health services and universal protection from potentially catastrophic and impoverishing health care expenditures in the long-term. In order to facilitate the monitoring and evaluation of such policy documents once developed, it is important to institutionalize national health accounts. The latter will require boosting of the capacities in the Directorate of Planning and Information.

Given the global focus on poverty reduction, out-of-pocket payments' status as one of the single largest sources of financing is possibly the greatest concern. Therefore, there is strong believe that the health financing policy should provide sufficient information for the reform of the health services financing in The Gambia and provide financial risk-protection for Gambians.

Mrs. Saffie Lowe Ceesay
Minister of Health & Social Welfare 2017

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Abbreviations and Acronyms

NHA National Health Accounts

NGO Non-Governmental Organisation

MOH Ministry of Health

UNDP United Nation Development Programme

GAVI Global Alliance for Vaccine Initiative

GDP Gross Domestic Product

GFATM Global Fund for HIV/AIDS, Tuberculosis and Malaria

WHO World Health Organisation

OOPS Out-of –pocket payments

THE Total Government Health Expenditure

MOHSW Ministry of Health and Social Welfare

MOFEA Ministry of Finance and Economic Affairs

LGA Local Government Authority

GBS Gambia Bureau of Statistics

GDP Gross Domestic Product

HDI Human Development Index

THE Total Health Expenditure

TPvtHE Total Private Health Expenditure

CME Commission for Macro Economics

HCRP Health Cost Recovery Programme

DRG Drug Revolving Fund

BI Bamako Initiative

PAG Programme for Accelerated Growth

ESWAp Employment Sector Wide Approaches

MCNRP Maternal Child and Nutrition Results Project

RBF Results Based Financing

5.7.1 Multi-stakeholder health financing steering committee Members:

1. Minister of Health as Chairperson
2. Permanent Secretary, MoHSW
3. Director of Health Services
4. Permanent Secretary, MoFEA
5. Director General National Planning Commission
6. Representative of Bi-lateral and Multi-lateral Donor Agencies & development partners
7. WHO Representative
8. UNICEF Representative
9. UNFPA Representative
10. NGO Representative
11. CSO Representative
12. Director of Planning & Information as Secretary
13. Gambia's Worker Union

5.7.2Health financing technical working group Members:

1. Director of Planning and Information as chairperson
2. Director of Health Services
3. Director of Social Welfare
4. Director of Pharmaceutical Services
5. Director of Nursing
6. Director of Public Health
7. Director of Budget, MoFEA
8. Representative from Chief Executives of Hospitals
9. Representative from Regional Health Teams
10. Executive Director Gambia Chamber of Commerce and Industry
11. Head, National Financing Agency as Secretary
12. Representative of the private sector health providers
13. WHO
14. UNICEF
15. UNFPA

5.7.2 Regional Health Financing Committees

1. Governor as chairperson
2. Regional Health Director of Health Services
3. Chairperson of Area Council
4. Representative of Health related NGOs
5. Representative of District Chiefs
6. Representative of CSOs
7. Regional Community Development Officer
8. Chief Executives of Hospitals
9. Senior Administrative Officer of the Regional Health Team as Secretary

Executive summary

Health financing is one of the main pillars of the health system and it is defined as the raising or collection of revenue to pay for the operation of the health system. It is a key determinant of health system performance in terms of equity, efficiency, and quality. It has three functions: revenue collection from various sources, pooling of funds and spreading of risk across larger population groups, and allocation or use of funds to purchase services from public and private providers of health care.

In The Gambia available statistics indicate that over 46.7%% of the total health funding comes from donors (international health development partners) raising challenges of sustainability and predictability of funding to the sector[1]. In addition, cost of providing health care continues to rise due to increasing demand, changes in diagnostic and therapeutic technologies, inflation and currency fluctuations. Although there is an impressive revenue collection system in place by the Gambia Revenue Authority, and opportunity for progressive economic development through local government and civil service reforms, and attracting investment in the private sector, funding to the health sector is still below the Abuja declaration of 15% of annual budget allocations.

The purpose of this policy is to facilitate resource mobilization, resource pooling and equitable distribution and efficient utilization of funds in The Gambia. Specifically the policy recommends roles and responsibilities for stakeholders in funding health and provides a framework for monitoring and evaluation. The implementation of an aid co-ordination policy that brings together development partners into the planning and budgeting process will be an important step in the search for greater coordination of resource flow and more efficient utilization of these resources. This policy will advocate for the adaption of new innovative purchasing mechanisms to ensure payment for quality health care outputs to improve health outcomes.

This policy has been developed based on orientations from international and national policies and declarations, designed for the transition to universal coverage so as to contribute to meeting the needs of the population for health care and improving its quality, reducing poverty, attaining the Sustainable Development Goals (SDGs).

This policy was developed through a very elaborate and consultative process involving all stakeholders and Government at the highest level. The process started with the constitution of a drafting team from Government

departments, International agencies, and the private sector. National consensus meeting and validation process was carried out through which the draft was revised before the submission of the policy document to the formal government approval process.

The policy components are developed with the aim of strengthening: the stewardship of health financing; the three functions of health financing (revenue collection; revenue pooling and risk management, resource allocation and purchasing); the development of human resources for health financing; research and development; and monitoring and evaluation.

The Government of The Gambia through relevant departments and agencies will create the enabling environment for the participation of all stakeholders in the public and private (for- profit and not-for-profit) sectors to play their respective roles for the successful implementation of the National Health Financing Policy. The Government will facilitate, support and promote the development and strengthening of the relevant key implementing bodies.

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1 NHA report for The Gambia (2013)

CHAPTER 1: INTRODUCTION

Financing health care requires collaboration of Government, donors, other partners and the beneficiaries. In The Gambia available statistics indicate that over 46.7% (NHA, 2013) of the total health funding comes from donors (international health development partners) raising challenges of sustainability and predictability of funding to the health sector[2]. In addition, cost of providing health care continues to rise due to increasing demand, changes in diagnostic and therapeutic technologies, inflation and currency fluctuations.

In 1988 a Cost Recovery Program was started as part of the National Health Development Program. This established the Drug Revolving Fund and the introduction of user fees as a form of health financing. Bamako Initiative (BI) was introduced in 1993 as a strategy to further develop the Cost Recovery Program. In 2014 the Government of The Gambia and Ministry of Health and Social Welfare with support from the World Bank, WHO, UNICEF and UNFPA introduced Results Based Financing with the overall objective of improving health and nutrition outcomes among women and children with the aim of increasing the utilization of community nutrition, maternal and child health services in selected regions. Results Based Financing was recognized as a financing mechanism that could scale-up the PHC service delivery system, including the village health system and also fill the financing gap for high impact maternal and child health interventions as outlined in the Investment Case for Health 2013 to 2015. Results Based Financing is defined as a cash or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken unlike the traditional health financing mechanisms that provide input financing (www.rbfhealth.org). Results Based Financing makes a clear distinction of institutional arrangements that separate the functions of fundholding, purchasing, service provision, regulation and verification and counter-verification of results outside and within MOHSW. This ensures transparency and accountability in utilization of health care resources.

Although some successes have been registered with these financing strategies, universal access and coverage still remains a major challenge.

A concern of policy-makers is to protect people from financial catastrophe and impoverishment as a result of use of health services. When people have to pay fees or co- payments for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household. Such high expenditure can mean that people have to cut down on necessities such as food and clothing, or are unable to pay for their children's education.

Current funding for the health sector is less than optimal and the available resources are inadequate to provide the required quality of health care services for the population. In addition donor inputs are not well coordinated while issues of efficiency and equity in the use of funds continue to be a challenge. It is against this background that this policy has been developed.

1.2 Justification Global, Regional and National Health Policy commitments

This policy has been developed with clear orientations from The Fifty-eighth World Health Assembly resolution 58.33 (explain the resolution 58.33) on Sustainable health financing, universal coverage and social health insurance. Also, the Health Financing Strategy for the African Region which emphasizes that the manner in which health system is financed affect both the performance of its functions and the achievement of its goals has been utilized in fashioning this document. This policy is designed for the transition to universal health coverage so as to contribute to meeting the needs of the population for health care and improving quality of health care, reducing poverty, attaining the health related Social Development Goals (SDGs) and implementing the Paris Declaration on Aid Effectiveness. Furthermore, it is believed that the implementation of this policy will contribute towards the achievement of the Abuja declaration of 2001 which request countries to progressively move towards allocating 15% of their National budget to health; and the recommendation of the Commission for Macroeconomic and Health (CMH) of $34 - $40 per capita expenditure on health for a package of basic health services.

The Policy also draws insight from national policies such as the Poverty Reduction Strategy Paper (PRSP II) and most recently the Program for Accelerated Growth and Employment Two (PAGE II) which identifies adequate financing of health as means of social development through the introduction of Sector Wide Approaches (SWAp) and the operation of Mid-

Term Expenditure Framework (MTEF). The National Health Policy, advocates for the need to secure the required financial resources for the health sector and improving the management of available financial resources in the health sector.

1.3 Purpose of the health financing policy document

The purpose of this health financing policy document is to provide all stakeholders in the health sector with the guiding philosophy that governs health financing in terms of governance, resource mobilization, distribution and use of funds in The Gambia. In more details, the policy will recommend roles and responsibilities for stakeholders in funding health services and provide a framework for monitoring and evaluation.

1.4 Policy development process

This policy has been developed through a very elaborate and consultative process involving key stakeholders and Government at the highest level. The process started with the establishment of a drafting team from Government departments, International agencies, and the private sector. Thereafter, stakeholders meetings were held at regional levels and included NGOs and CBOs. National consensus meeting and validation process was carried out through which the draft was revised and validated.

1.5 The Organisation of remaining chapters

The remaining part of this policy document is organized as follows:

- Chapter two focuses on the situational analysis, providing the economic, disease burden and epidemiological as well as the current health funding context for the development of the policy.
- Chapter three elaborates the vision/goals of the policy while also providing the guiding principles and philosophy on which the policy is premised.
- Chapter four looks at the policy content while chapter five is devoted to the implications of the policy in terms of implementation and monitoring and evaluation.

CHAPTER 2: SITUATIONAL ANALYSIS

2.1 The Economy

The Gambia is amongst the Least Developed Countries (LDCs) with Gross Domestic Product (GDP) per capita of US$ 560 (IMF Staff report 2011). Agriculture forms the backbone of the economy with nearly 70% of the working population involved in the agricultural sector. However it is the services sector that is the biggest contributor to GDP, at 60%, with agriculture contributing about 30%. The economy grew by 7.2% in 2007 over the preceding fiscal year; national revenue has been increasing progressively; inflation reducing to low single digit levels and was 2.3% as at end May 2007 (PRSP II, 2007). According to MOFEA, the Gambia has been registering annual GDP growth rates of more than 5% (2008-2011) during the current global economic crisis, and has maintained a stable macroeconomic environment that is increasingly threatened by a mounting debt burden. The Gambia is ranked 168 out of 187 countries in the 2011 UN Human Development Index and the last poverty survey (2008) revealed that about 55% of the population lives below the poverty line. The Gambia has limited natural resources, and the economy is dominated by the service and agriculture sectors. Despite the global economic crisis, The Gambian economy achieved robust growth of 5.3% between 1998 and 2001, and the GDP increased 62.2% between 2004 and 2012.

The national economy is based mainly on agriculture, with groundnut as the main export crop. The recent upturn in performance of the economy has however been driven mainly by the service sector including tourism, telecommunication, construction, etc. The economy suffered a contraction of GDP to 4.3% in 2011 due to drought. This was due to a fall in crop production of around 45 per cent in that year, despite several non-agricultural sectors of the economy, such as tourism, performing well during 2011. The figures for 2012 show a rebound in GDP growth of 5.3 per cent due to a recovery in crop production and strong growth in wholesale and retail trade, and construction. The services sector saw its total contribution drop 1.8 percentage points from 16.3 per cent in 2011 to 14.5 per cent in 2012 (PAGE 2012).

2.2 Health System

The government is the major provider of health services in The Gambia. The public health care system has three tiers, based on the primary health care strategy. Presently, services are provided by seven hospitals at the tertiary level, 47 health centres at the secondary level and 634 health posts at the

primary level. The system is complemented by 41 private and NGO clinics. In The Gambia the majority of health facilities and personnel are located in urban areas resulting in inequitable access to care. There are also disparities among regions, with the Western Region having most of the resources. For most communities, the first point of contact with health care services is the informal sector through traditional healers.

Private sector health services provision includes the private for- profit and private for non- profit. These are few and small in sizes each with bed capacity less than 50. The large majority are located in the Greater Banjul Area, making choice in health services delivery point in the rural community non-existence. However, in spite of the seemingly low capacity of the private sector, the Vision 2020 aims at a fully-fledged private sector that is responsive to the development needs of the country and aims to use the private sector as an engine of growth.

The Ministry of Health and Social Welfare is responsible for the management of the health sector, which includes health services provision, regulation, resource mobilization including human resource development and health research. It is headed by a Minister assisted by a Permanent Secretary, who serves as the Chief Administrator of the Ministry. Other operations of the ministry is organized around two departments (Department of Health Service and Department of Social Welfare). The Department of Health Services has the following directorates: Directorate of Health Services, Directorate of Planning and Information, Directorate of Pharmaceutical, Directorate of Health Promotion, Directorate of Health Research, Directorate of Human Resources for Health, Directorate of Public Health Laboratory, Directorate of Public and Environmental Health, Directorate of Nursing.

The lowest level for health service provision is the community health post. This provides the very basic minimum health package to the village. The service providers are the Village Health Workers (VHW) with very minimal training and Traditional Birth Companions (TBCs) with limited additional training. The village health provider provides treatment for uncomplicated malaria, diarrhoea, minor injuries, worm infestation and stomach pain. The village health services are complemented by Village OPD clinics and the Reproductive and Child Health (RCH) trekking visits from the health centres. The RCH package includes: antenatal care, family Planning, birth registration, child immunization, weight monitoring and limited treatment for the sick.

2.3 Demographic and Health Profile of the Gambia

The population of The Gambia is estimated at 1,882450 million inhabitants, with an annual population growth rate of 3.3% (GBoS, 2013). The fertility rate is 5.6% while the population under the age 15 years comprise of 40.9%. Its high population growth rate (153 persons per square kilometer), has been recognized as one of the constraints of the country's development. The current rate of illiteracy among adults is 62.2%. Urban inhabitants make up 57.3% of the population, while rural inhabitants account for the remaining 42.7%.

The Crude Birth Rate (CBR) is 40.5 per 1000 population (GBoS 2013) and the Crude Death Rate (CDR) is estimated at 9.24 per 1000 population (World Bank Report 2010). The Infant Mortality Rate (IMR) is 34 per 1000 and Under-5 Mortality Rate (>5 MR) is reported at 54 per 1000 live births (GDHS 2013), Maternal Mortality Ratio (MMR) is 433/100,000 live births (GDHS 2013). It is among the least developed and poorest countries; ranked 168 out of 182 countries in the Human Development Index of 2011 with a per capita Gross National Income (GNI) of about $US 1,282(UNDP, 2011). 61.2% of the population lives below the poverty line with a marked variation between urban and rural populations. About 60% of the population lives in the rural area; and women constitute 50.5% of the total population. The high fertility level of 5.6 births per woman (GBoS 2013) has resulted in a very youthful population structure. The annual population growth rate is 3.3% (GBoS 2013).

The health sector despite remarkable achievements registered in the past still under great pressure due to a number of factors: high population growth rate, increasing morbidity and mortality, insufficient financial and logistic support, deterioration of physical infrastructure, inadequacies of supplies and equipment, shortage of adequately and appropriately trained health personnel, high attrition rate as well as inadequate referral system. Poverty, traditional beliefs and low awareness have led to inappropriate health seeking behaviours thus contributing to ill health (NHP 2012-2020).

Indicators of child and maternal mortality are improving, however more work need to be done in the following areas: poverty, low literacy, prevalence of communicable and non- communicable diseases such as Malaria, Diarrhoea, Pneumonia, Tuberculosis, Accidents, Hypertension, Cancers, and Pregnancy related conditions, and malnutrition and HIV/AIDS and its spread. Most of these diseases can easily be prevented if appropriate environmental and lifestyle measures are taken, with more attention paid to

development of health promotion and prevention actions than merely focusing on curative care alone.

2.4 Health expenditure patterns and trends

Government allocations to the health sector as a percentage of the total national budget continue to improve yearly. However, it is still below the Abuja Declaration of 15% budgetary allocation to the health sector.

In 2007, the first National Health Accounts (NHA) for The Gambia was conducted covering the fiscal years 2002 – 2004 and a subsequent one in 2013. The results revealed marginal increase in Total Health Expenditure (THE), moving from approximately D1,185,223,103.00 in 2002; D1,682,323,673 in 1.9 billion GMD in 2013. As a percentage of GDP, the total health expenditure (THE) has decreased from 16.1% in 2002, 14.9% in 2004 and 5.63% in 2013. Per capita health expenditure was D895 in 2002, D1203 in 2004 and 1013 in 2013. This ranges between US$33 and US$40, almost matching the WHO Commission for Macroeconomics and Health (CMH) recommendation of US$ 34 per capita expenditure for a package of essential health services. It is instructive that a significant amount of funding comes from donors. Over 46.7% of the total health funding came from international health development partners (source).

Government of The Gambia's contribution to Total Health Expenditure grew from 18% in 2002 to 24% in 2004, and a further increase to 28.18% in 2013. OOP declined from 2002 (12%) to 2004 (9%) but has worryingly increased to 21.21 % in the 2013 NHA. Total Out-of-pocket expenditure on health as 21.21 % of private expenditure on health is estimated to be consistently high at 70% for 2004, 2005 and 2006 signaling the heavy burden of funding health on households.

2.5 Brief descriptive analysis of the existing health financing in The Gambia

Health financing system in The Gambia is organised through Government tax revenue, allocated by the Ministry of Finance and Economic Affairs to various financing agents, e.g. Ministry of Health and Social Welfare, Education, Defence, Interior and Foreign Affairs. The contribution from direct out-of-pocket payments (OOPs) for health goods and services do not go through any resource pooling and risk-sharing mechanism. Current trends have shown that some private sector operators (Banks and NGOs) do provide medical cover for their employees, either through self-operated health clinics (e.g. Gambia Ports Authority (GPA) Clinic) or by paying premiums into private health

insurance schemes. However there is no social health insurance in the Gambia. Other innovation has been for the private sector to adopt hospital wards in health facilities for funding.

Presently the funding from international donors (e.g. bilateral and multi-lateral agencies, World Bank, WHO, UNICEF, UNFPA, UNDP, Global Fund for AIDS, Tuberculosis and Malaria, WAHO and GAVI) is channelled directly to the intervention programmes through the Ministry of Health and Social Welfare. The Government of The Gambia in 2014 secured a grant amounting to Eight Million, Six Hundred and Eighty Thousand US Dollars (US$8,680,000.00) from the World Bank to implement a Maternal and Child Nutrition and Health Results Project (MCNHRP) using Results Based Financing (RBF) for Health approach. To further compliment the efforts of the project, and to address the Food and Nutrition Security (FNS) situation and likely Ebola crisis in the country, an additional funding of Five million US Dollars (US$5.0) million was approved to scale up the Community Nutrition and Primary Health Care services, and strengthen the Ebola Response. To mitigate social impact at household level of the fiscal crisis, another US$7.5 million was approved in January 2017.

To a lesser extent the Local Government Authorities also contribute to health financing in the area of environmental sanitation and the employment of auxiliary health workers. User charges for services are being made as part of cost recovery programme introduced in 1988 to supplement the high Government expenditure in health. This was part of the Economic Recovery Programme / Structural Adjustment Programme of the eighties.

Formal community health insurance schemes do not exist in The Gambia. However, as part of community contribution to the health sector, some communities do construct health facilities or donate ambulances. This shows the vast opportunities available at that level to be harness to fund the health sector.

2.6 Challenges in Health Financing

Revenue Generation and Resource Mobilization

- The current GDP per capita of $560 is way below the per capita GDP of $1900 needed to achieve UHC according to international standards and calls for a diversification in economic productivity of The Gambia
- The current per capita level of government funding at $7.8 (NHA, 2013) is well below the Chatham House estimated $86 needed to provide an essential benefit package in low and middle-income countries. This represents a serious challenge in the face of rising

health needs that have to be met if the country is to reach the Sustainable Development Goals (SDG) targets.

- Health as a share of government budget allocation 10.56% and actual spending of 764,796,000.00 (2016 Estimates of Revenue and Expenditure) have remained below the Abuja Declaration commitment for domestic spending, reflecting to some extent fiscal pressures and downward adjustments given declining external funding

- The rise in the share of total external funding of 46% increases donor dependency risk.

- An increase in OOP over the years from 9% in 2004 to 21% in 2013 highlights the lack of financial protection and equity of access to healthcare services.

- Earmarking of non-government funds to specific diseases also reduces universality and equity. Vertical funding arrangements are able to raise funds for certain priority programmes but undermine equity and service provision for other disease areas.

Pooling of Risk and Financial Protection

- The proportion of the population that is covered by private health insurance schemes is very small hence the rest of the population is not able to benefit from the risk pooling function of health insurance. Therefore voluntary nature of medical insurance in The Gambia, and the current pooling mechanisms that are fragmented result in inadequate risk pooling and does not allow for cross-subsidization across various income and population groups (healthy/sick and working/non-working).

- The Gambia has a national pool of resources as it provides a set of publicly funded services to all Gambians. However, current purchasing arrangements, limited resource availability and underutilization of the Drug Revolving Fund reduces the ability of the pool to impact financial protection and equity on a national scale.

2.7 Equity in Health Financing and Universal Health Coverage

To achieve universal health coverage, there is need to address equity in the collection, allocation and provision of health resources and services. Inequality remains a determining feature of socio-economic wellbeing and addressing equity is key to achieving health goals under the SDGs for The Gambia. Addressing equity in health financing implies mobilizing revenue according to ability to pay through progressive financing; allocating resources according to health need; pooling funding for income and risk cross subsidies; analyzing key determinants of health equity across various socio-economic and demographic factors that pose barriers to access and effective coverage of health care; and ensuring financial protection. Equity challenges for health financing for universal health coverage that need to be addressed in the policy include:

Financial protection when accessing health services remains low, especially for the low-income groups. Access to health services remains primarily dependent upon highly regressive OOP payments. According to the GDHS 2013, forty-three percent of women age 15-49 reported that they have at least one problem in accessing health care. Thirty percent of women reported getting money for treatment as a problem, and 28 percent noted that distance to a health facility is a concern. Furthermore, 10 percent of women cited not wanting to go alone for treatment as a problem in accessing health care, and 5 percent reported that getting permission for treatment is a hindrance. Recent efforts, such as the introduction of Results Based Financing (RBF) mechanism for essential services, have contributed greatly in creating demand for health care.

CHAPTER 3: VISION, GOAL, OBJECTIVES AND CORE VALUES

3.1 Vision

Achieve sustainable universal health coverage (UHC) for every one living in the Gambia by 2030

Mission

To establish integrated health financing mechanisms that promotes and protects the health of the population through equitable provision of quality health care and ensuring that no one suffers financial hardship in accessing healthcare.

Goal

To ensure adequate and sustainable financing of health care services to protect the population from financial hardship particularly the poor and vulnerable

3.2 Objectives

1. To increase access to quality health care service to the whole population by 2030
2. To establish a mechanism for revenue mobilization for the payment of health care services.
3. To ensure all financial resources available for health care delivery are pooled in a common basket by 2020 and allocated for both inputs and outputs financing.
4. To ensure choice and purchase of evidence based, high impact, cost-effective interventions, as well as give appropriate incentives to providers.
5. To ensure equity regarding distribution and access in the use of financial resources throughout the country.
6. To ensure health services financial risk protection for all.
7. To improve efficiency in administration of the health financing system.

3.3 Core Values or Guiding Principles

The core values and guiding principles for this policy are aligned with the national core values and guiding principles espoused in other national documents like the National Health Policy and PAGE.

In particular:

3.3.1 This policy is premised on Country ownership driven by the patriotic principles of government's responsibility to the welfare of the citizenry

3.3.2 This policy framework shall give due cognizance fostering equity in access among all population groups; with special attention to vulnerable groups (e.g. the poor, the elderly, disabled, women and children).

3.3.3 This policy shall ensure equity in financing; making sure that contributions to the funding of the health system are made according to ability to pay and long before health care is needed in order to protect families from impoverishment.

3.3.4 Within this policy, efficiency shall be given due consideration; ensuring that maximum health benefits are derived from scarce available resources, with particular attention to both immediate operating expenditures and the long-term recurrent cost implications of major human resources and capital investments

3.3.5 In line with Government Policy a high degree of transparency and accountability shall be demanded in all financial procedures and mechanisms.

3.3.6 This policy shall amplify risk sharing mechanisms in the spirit of solidarity and cross subsidization, expanding the proportion of the health budget that is pooled and reduce the proportion that comes as out-of-pocket payments.

3.3.7 Implementing this policy shall be on evidence-based decision-making, practiced on a day-to-day basis, harmonized with health financing reforms, rely on best practices, and be economically viable.

3.3.8 Implementation of this policy shall require partnerships involving all health- related sectors, various levels of government, the private sector, NGO community, international development organizations, communities and civil society. There shall be improved coordination of funding leading to SWAp.

3.3.9 Accessibility to twenty-four hour quality essential services for the population

3.3.10 Devolution of financial and managerial responsibilities, in line with the Government decentralization programme.

3.3.11 Help patients feel more confident in the health care system by enforcing the patient bill of rights. It assures that the health care system is fair in terms of universal coverage. The policy will work to meet patients' needs; gives patients a way to address any problems they may have; and encourages patients to take an active role in staying or getting healthy.

4. POLICY COMPONENTS

The policy components are developed with the aim of strengthening: the stewardship of health financing; the three functions of health financing (revenue collection; revenue pooling and risk management; and resource allocation and purchasing); the development of human resources for health financing; research and development; and monitoring and evaluation.

4.1 Stewardship for health financing

Government through relevant departments and agencies will pursue the following strategies and legislations to strengthen health financing:

. 4.1.1 The development of a holistic health financing mechanisms legislation which secures statutory protection for health financing including but not limited to an allocation of at least 15% of the national budget to the health sector and; increase financing of health related interventions such as access to safe water, improved sanitation and household nutrition.

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. 4.1.2 The development of a National Health Financing Strategic Plan (NHFSP) with a clear roadmap for achieving the vision 2020 and Sustainable Development Goals (SDGs) and eventually universal coverage and indicators for monitoring progress of achievement of the health financing policy objectives.

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. 4.1.3 Ensure that the NHFSP is incorporated into national development frameworks such as PAGE, PAGE successor plan and MTEF/PBB.

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. 4.1.4 The strengthening of the health sector stewardship, oversight, transparency, accountability through separation of functions of fundholding, strategic purchasing of services, provision of services, regulation and verification and counter-verification of results within and outside MOHSW and through the enforcement of existing rules and regulations to prevent wastage of health resources.

. 4.1.5 The maximization of inter-sectoral collaboration and actively pursuing all relevant forms of technical cooperation with other countries and international organizations (eg; WHO, World Bank, UNICEF,

GFATM, GTZ, ILO) in the implementation of the National Health Financing Policy (NHFP).

4.2 Revenue generation and collection

Policy Objective

The overall objective is to mobilize adequate resources for sustainable funding of the health sector and to coordinate the use of these resources for improved ta targeting of budget allocations.

Government through relevant departments and agencies will pursue the following strategies for revenue collection to support financing of health services:

4.2.1 Developing a mandatory mix of prepayment mechanisms including social health insurance, tax- based and non-tax based financing of health care to achieve the Universal Health Coverage goal.

4.2.2 Establishment of a Primary Health Care Fund, through the share of 25% of the levy on tobacco and alcohol, contribution from Social Security and Housing Finance Corporation and introduction of a levy on the sale of all hazardous products.

4.2.3 Taking the necessary steps to ensure that the approved health budget is fully executed.

4.2.4 Closely monitoring multi-donor budgetary support to ensure that the shift from sectoral to general budgetary support does not decrease donor contribution to the health sector.

4.2.5 Ensuring an alternative source of financing is available to continue providing high quality services in the event of removal or reduction in out-of-pocket payments.

4.2.6 Improve efficiency in revenue collection mechanisms from both the formal and informal sectors and minimize wastage by putting regulations on levels of administrative and operational costs.

4.3 Revenue Pooling

Policy Objective

To enhance the adequacy of health financing and financial protection of households and ensure that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector

Government through relevant departments and agencies will pursue the following strategies to support revenue pooling for health financing:

4.3.1Strengthening prepayment systems, where funds collected through taxes, levies, special funds and insurance contributions are used to protect citizens from financial catastrophe by reducing out-of-pocket spending.

4.3.2 Strengthening the national health financing system, including financing structures, processes and management systems as well as building (or strengthening) prepayment systems (include health insurance) with community participation.

4.3.3 Establishing a health financing agency to manage the complex links between risk management and revenue collection and purchasing of health services.

4.3.4 During the transition to universal Health coverage, the Government will use a combination of mechanisms (exemptions, subsidies, compulsory insurance for specific groups, voluntary insurance, domestic philanthropies and charities) to effectively manage financial risk and provide social safety nets to protect the poor

4.4 Resource allocation and purchasing

Policy Objective

To ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services.

4.4.1 Government will ensure financial resource allocation in the health sector guided by needs assessment and priority setting supported by policy objectives.

4.4.2 There will be use of a mix of provider payment mechanisms that promote optimal provider performance while containing costs, such as providing inputs, capitation, fee for service and Results Based Financing and any other mechanisms that may prove to be effective.

4.4.3 Government shall ensure that there is transparency and accountability in resource utilization through the establishment of a body that will guarantee quality assurance for the services purchase and periodic reporting on health expenditures

4.4.3 Government will create the necessary enabling environment, suitable policy and legislative frameworks to allow contracting of service provision to Non- governmental and private providers especially in areas where they have comparative advantage.

4.4.4 Government shall use appropriate financing incentives to promote referral systems, quality of services, institutionalized equity and efficiency monitoring, health sector coordination mechanisms (e.g. SWAps), and delivery of an integrated essential service package based on priority setting and choice of interventions agreed by society.

4.4.5 A frame work will be developed for regular evaluation of benefit and cost of intervention and technologies to ensure optimal choices and cost containment.

4.4.6 The government will reform provider payment mechanisms to create incentives for greater productivity, efficiency and equity.

4.5 Development of Human Resources for Health Financing

The human resources for health is far from having the required number and the health financing personnel represent one of the most under staff cadre in the sector. The human resource policy and strategy plan laid emphasis on staff training, motivation and retention. Having the required number of

personnel to implement the health financing policy is critical in overcoming the other challenges facing the health sector. Therefore Government through the various departments and agencies shall under take the following measure:

4.5.1 Allocation of funds for both domestic and external training of health economists, health planners, and accountants,

4.5.2 Allocate funds to strengthen the capacity of local training institutions for training of health economists, health planners, and accountants,

4.5.3 Organise regular in service short term training in new developments in health financing, negotiation and resource mobilization for staff of the Ministry of Health &Social Welfare and Ministry of Finance and Economic Affairs with the main goal of developing adequate capacity for the National Health Financing Agency.

4.5.4 The Ministry of Health and Social Welfare and Ministry of Higher Education Research Science and Technology (Directorate of Planning, Budgeting and Policy Analysis) and the University of the Gambia will actively participate in the review of curricular for the schools of economics, medicine, public health and nursing to incorporate modules on health financing and health economics.

4.5.5 To promote health economists and health planners association as an umbrella organization for sharing of information, experiences and promotion of networking with other regional and global associations

4.6 Research and Development

As part of generation of evidence to support implementation, Government will reinforce capacities for health financing (including cost) evidence generation, dissemination and utilization in decision-making.

4.6.1 The Ministry of Health and Social Welfare in collaboration with MOHERST and other relevant government and non-government institutions, private and civil society will institutionalize national and sub-national intervention specific health accounts.

4.6.2 The Ministry of Health and Social Welfare in collaboration with other relevant government institutions will fund and institutionalize monitoring of economic efficiency of the national health system.

4.6.3 The Ministry of Health and Social Welfare will evaluate different practices in health financing, including collection of revenue, pooling and purchasing (or provision) of services as well as evaluate cost-effective health interventions and services the country moves towards universal coverage.

4.6.4 Ministry of Health and Social Welfare, in collaboration with other relevant government institutions, will institutionalize monitoring of equity in health finance and equity in the use of health services and distribution of health systems resources.

4.6.5 The Ministry of Health and Social Welfare will identify and support other priority areas of health financing research that will foster the implementation of the NHFP.

4.6.6 The Ministry of Health and Social Welfare will mobilize support for participation of national health economists and health planners at national, sub-regional, regional and international health economics associations for continuing education and sharing of experiences.

4.7 Monitoring and Evaluation

The Government will institute mechanisms for monitoring and evaluation to ensure the successful implementation of the National Health Financing Policy. This shall be achieved through the following:

4.7.1 The Ministry of Health and Social Welfare will ensure that the national health financing strategic plan includes a monitoring and evaluation framework based on sources of financing (level, distribution and execution rates), pooling (population coverage through pooling mechanisms) and spending (expenditure tracking and benefit incidence of spending)

4.7.2 Conducting regular National Health Accounts and Public Expenditure Reviews and support the integration of the results into the Health Management Information System. Efforts shall also be made to ensure regular publication and dissemination of the reports.

The Ministry of Health and Social Welfare will create and maintain a monitoring and evaluation capacity at all levels of the national health system.

5. POLICY IMPLEMENTATION

The Government through relevant Ministries and agencies will create an enabling environment for the participation of all stakeholders in the public and private (for-profit and not-for-profit) sectors to play their respective roles for the successful implementation of the National Health Financing Policy. The Government will facilitate, support and promote the development and strengthening of the relevant key implementing bodies. These are:

5.1 National Assembly

Enact the appropriate legislations that put into effect the implementation of the health financing policy. Through the various National Assembly sub-committees, National Assembly will ensure adequate budgetary provision for the health sector.

5.2 Ministry of Finance and Economic Affairs

Ensure that the approved health budget matches actual expenditure and core principles of the NHFSP are incorporated into MTEF.

5.3 Ministry of Health & Social Welfare

Ensure that the policy goes through the approval process, the drafting of the appropriate legislation that would put into effect the implementation of the Health Financing Policy, develop a Health Financing Strategy to operationalize the Health Financing Policy and finally the establishment of a National Health Insurance Agency.

5.4 The Directorate of Planning and Information

The Directorate of Planning and Information will coordinate the implementation of the National Health Financing Policy and the development of a Health Financing Strategy until the establishment of a National Health Insurance Agency. 5.5 Health Financing Agency

5.5 A semi-autonomous National Health Insurance Agency

The agency will be established to manage the complex links between risk management, revenue collection and purchasing of health services through capitation, fee for service or Results-Based Financing.

5.6 Ministry of Higher Education, Research, Science and Technology

5.6.1.MOHERST to ensure that UTG and related institutions in the country establish partnership with health economic training centre of excellence in the region to develop capacity and initiate studies on health financing and health economics.

5.6.2 The Department of Economics and management Sciences, And School of Medicine and Allied health Sciences at the University of The Gambia will develop the capacity and in the long run be responsible for training of health financing and health economics.

5.6.3 Government will support overseas training preferably in the sub-region of health financing professionals as an interim measure until the time such courses are available locally.

In addition, MOHERST in collaboration with Ministry of Health and Social Welfare will allocate funds for training of health economists and health planners at the Health Economics Centres of Excellence in the region including World Health Organization fellowships.

5.7 Ministry of Justice

The Ministry of Justice will provide technical advice in the drafting of the legislations including the health financing Act

5.8 Tango

Serve as a mouth piece for advocating for the increased NGO participation in Health Financing.

5.9 Ministry of Trade Regional Integration Industry and Employment

Advocate Health insurance coverage for workers and their families in the formal and informal sector. Monitor compliance with relevant policies and laws among employers.

5.10 Committee(s)

For the purpose of the implementation of the NHFP the Ministry of Health and Social Welfare will support the establishment of specific committee and working groups, which include the followings

5.10.1 National health financing steering committee.

The national health financing steering committee shall be set up with clear terms of reference. It will be chaired by the Permanent Secretary Ministry of Health and Social Welfare and will meet quarterly. Until the establishment of the agency, DPI would serve as the secretariat. The membership of the committee shall include key ministries, development partners, private sector representative, NGOs and civil society organizations, and the local government authorities.

5.10.2 Health financing technical working group

This will be chaired by the Director of Planning and Information until the establishment of the agency and will meet bi-monthly. The health financing agency will serve as the secretariat. Their functions will include monitoring of the implementation of the NHFP and the strategic plan, give feedback to the steering committee and the tracking of inflow and out flow of funds.
The membership of the committee shall include senior staff of the Ministry of Health and Social Welfare, central and regional levels, representative from key government sectors and donor partners, head of the health financing agency.

5.10.3 Regional Health Financing Committees

The regional health financing committee will be set up with clear terms of reference. It will be chaired by the Regional Governor/Chairperson and will meet monthly. The Regional Health Team will serve as the secretariat. The functions of the committee will include the monitoring of the quality of service delivery within the region, resource needs against allocation and revenue collection within the region.

The membership of the committee shall include staff of RHTs, private and NGO of health related institutions, senior staff of government departments in the regions, chairpersons of hospital management boards and community representatives.

5.10.4 National Health Economists and Health Planners Association

The Ministry of Health and Social Welfare will advocate for the establishment of a vibrant National Health Economists and Health Planners Association to help generate and disseminate the evidence that underpins the implementation of the NHFP and advocate for support for the policy.

6. REFERENCES

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7. Glossary of Technical Terms

Adverse selection: The tendency of purchasing health insurance benefit packages by individuals with high health risk affecting health expenditure increases more than people with low health risk.

Benefit package: A minimum set of services that are offered to an insured person within a level of contributions.

Capital cost, Capital expenditure: Cost of inputs whose useful life is usually longer than one year. In terms of health investments, refers to expenditure on physical assets such as hospitals, beds, health centres, medical and diagnostic plant and equipment, etc.

Catastrophic health expenditure: A situation where a household spends on health more than 40% of its income after paying for subsistence needs, e.g. food. It can be caused by catastrophic illness, either high cost but low frequency event or by low cost and high frequency events.

Contracting: The process in which a legal agreement between a payer and a subscribing group or individual such as purchasers, insurers, takes place which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions.

Co-payment: A fixed amount of payment, which must be paid by a beneficiary for each service at time of service use.

Cost: Resources in monetary terms expended in carrying out activities.

Recurrent cost: Costs of inputs whose useful life is less than one year.

Cost-effectiveness analysis: A form of economic evaluation where costs are expressed in money terms but consequences are expressed in physical units. It is used to compare different ways of achieving the same objective.

Costing: The techniques and processes of ascertaining the expenditures the amount of expenditure incurred on particular products and services.

Debt stock: Total value of borrowings of an entity such as a sovereign country or a firm, which constitutes a liability of the entity, measured at a given point in time.

Decentralization: Transfer of administrative power from a central to a local authority, also referred as “devolution of power”.

Demand: The level of consumption preferred by consumers at different prices.

Deferral and Exemption: Deferral and Exemption scheme aims at guaranteeing access to quality health care to the mass population of the poor in the society. It tends to encourage those who temporarily lack the capacity to pay cash immediately for the treatment or other health service to have the service and later come back at a specified period for payment (deferral). Those who permanently lack the money to pay for the service can also

access the service without personally paying for it (exemption). These are the unemployed and others unable to pay for economic and social reasons

Earmarked tax: Contribution dedicated to health or particular function. Earmarked taxes sometimes reduce flexibility over time in allocating public funds to the best possible use. It may also reduce accountability of agencies to which funds are allocated when those revenues are determined by factors independent of the number or quality of services provided.

Effectiveness: The effect of the activity and the end results, outcomes or benefits for the population achieved in relation to the stated objectives. It is an expression of desired effect of programme, service intervention in reducing a health problem or improving an unsatisfactory health situation.

Efficiency: The effect or end results achieved in relation to the effort expended in terms of money, resources and time.

Technical efficiency: The production of the greatest amount or quality of outcome for any specified level of resources.

Allocative efficiency: An allocation of the mix of resources for maximal benefit, i.e. such that no change in spending priorities could improve the overall welfare.

Equity: The absence of systematic disparities in health between social groups who have different levels of underlying social advantage or disadvantage - that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged such as by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group at further disadvantage with respect to their health.

Fair financing A way health care is financed is perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status and their use of health services.

Fee for service Payments to a provider for each item or services provided.

Foreign Direct investment (FDI) Investment by firm based in one country in actual productive capacity or other real assets in another country, normally through creation of a subsidiary by a multinational corporation. Used as a measure of globalization of capital. Effects on growth and inequality in developing countries disputed.

Formal sector: Enterprises, which are registered and licensed to conduct business and whose employees earn regular salaries and wages.

Functions of health care financing The core functions of health financing are: collecting revenue, pooling of resources and purchasing:

Collecting revenue: is the process by which health systems receive money from households, companies and institutions as well as from donors. Various ways of collecting revenues are general taxation, social health insurance, private health insurance, out-of pocket payments and grant and charitable donations and multilateral borrowing.

Pooling of resources: the process of accumulation and management of revenues to ensure that the risk of having to pay for health care is borne by all the members of the pool and not by each contributor individually. Various forms of tax and social health insurance schemes aiming at sharing the financial risk and funds among the contributing members are the main focus of this function.

Purchasing: of health services is the process by which the most needed and effective health interventions are chosen and provided in an efficient and equitable manner, and the providers are paid appropriately from the pooled financial resources for delivering defined sets of services and interventions. Purchasing has three interwoven elements; "allocating financial resources", establishing "provider payment options" and "contracting" with providers. Funders Organizations contributing to the coverage of health care expenditures or providing the funding for health care through budgets, contracts, grants or donations to a health care provider. Gross domestic product (GDP) The total value of goods and services produced within a country each year. Health insurance: Financial protection against medical care costs arising from disease or injury. The reduction or elimination of the uncertain risks of loss for the individual or household, by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member. Community based health insurance (CBHI): A micro-insurance scheme managed independently by community members, a community-based organization whereby the term community may be defined as members of a professional group, residents of a particular location, a faith-based organization etc. Social health insurance: Compulsory health insurance, regarded as part of a social security system, funded from contributions – often community rated- and managed by an

autonomous yet legal entity. Private health insurance: A health insurance scheme often characterized with the following features: voluntary, managed outside the social security system where premiums are risk- rated rather than community-rated, managed by an independent legal entity (an incorporation, organization, association or foundation) not by a state/quasi state body, operating for profit or non-profit. Voluntary health insurance: Health insurance that offers benefit to its members entitled on a voluntary basis, which can be managed by a private, public or quasi-public body. Health Maintenance Organization (HMO): An organization that accepts responsibility for organizing and providing a defined set of services for its enrolled population, in exchange for a predetermined, fixed, periodic payment for each person or family unit enrolled (see also Managed Care).

Health spending: As one of the Health for All global strategy, WHO advised the Member States to spend minimum 5% of GDP on health. In many countries only one disease, such as diabetes could consume the entire amount. High level of spending may not necessarily lead to high health outcomes. At any given level of income and spending health outcome varies. Therefore, efficient use of available funds becomes critical. It is also important to correct imbalances, low spending in some areas and high spending in others.

Informal sector: Enterprises, which are not registered and licensed to conduct business but do so in an entrepreneurial, independent manner, and whose earnings are not reported or declared as part of a payroll process. Compared with wage-earning workers in the formal sector, the informal sector has more labour-intensive mode of production. Informal production units typically operate at a low level of organization, with little or no division between labour and capital on small-scale labour operations. Their existence is based on casual employment, kinship or personal and social relations rather than contractual arrangements with formal agreement.

Moral hazard: Abuse of insurance benefit by insured people which yields to an increase in health expenditure.

National Health Accounts (NHA): A framework and methodology for measurement and presentation of information on total national health expenditure including public and private sources of funds. NHA tracks financial resources from sources, to providers and functions. It is important

because, health systems are complex and policy makers need tools to analyse HCF, how and how much resources used in a health system, what resource allocation patterns, use and options exist.

Out-of-pocket payments: Payment out of private purse as opposed to public made directly by a patient to a health service provider without reimbursement.

Payer: The public or private organization that is responsible for payment for health care expenses. Payers may be insurance companies or self-insured employers or persons.

Pay roll taxes: Contributions levied against labour income. They are inexpensive to administer but easier to avoid than other forms of taxes.

Per capita income: A measure of human progress, using overall well-being to judge the level of a country's development.

Policy: An agreement or consensus among relevant partners on the issues to be addressed and on the approaches or strategies to deal with them.

Poverty gap ratio: is the mean distance separating the population from the poverty line (with the non-poor being given a distance of zero), expressed as a percentage of the poverty line.

Prepayment scheme: A method of paying for the cost of health care services in advance of their use. This is a method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions, including those contributions that are made to a health fund by employers on behalf of their employees.

Prepayment ratio: Ratio between the benefit paid by health insurance and total benefit provided to a patient.

Premium: Amount paid to a carrier for providing insurance coverage under a contract. Money paid out in advance for insurance coverage. Contributions are often defined as percentage of salary for formal sector employees or monthly level of payments for informal sector employees to health insurance fund on regular basis.

Provider payment methods: Ways or means of paying health care providers such as on a capitation, case based, fee-for-service or other basis (see also individual definitions).

Purchaser: This entity not only pays the premium, but also controls the premium amount before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Resource allocation: The process by which available resources are distributed between competing uses as a means of achieving a particular goal.

Social safety net: A system that would allow economically and socially deprived citizens to continue to receive social services through free services, subsidized care, social insurance and social assistance. The system should assure that citizens retire with dignity and income – pension benefits; citizens are insulated from the loss of income due to economic forces out of their control – unemployment benefits; citizens not bear the full risk and costs for illness and injury – health benefits; and citizens are provided social welfare support.

Special consumption taxes: Taxes used for effectively reducing the demand for harmful substances such as tobacco and alcohol by raising the price closer to its true social cost. These taxes may create a conflict of interest in a way that lowered demand and consumption can affect sources of revenue.

Universal Coverage: Access to key health promotion, preventive, curative and rehabilitative health interventions for all, at an affordable cost, thereby achieving equity in access. It incorporates two dimensions: depth-health care coverage as in adequate health care-and width-population coverage.

User charges: Payment for goods and services according to price list or fee schedule. User fee system is inequitable by its own nature. It makes the patients bear the cost of services and it makes the poor pay proportionally more than the rich.