REPORT

Achieving Sustainable Health Financing in Liberia: Prospects and Advocacy Opportunities for Domestic Resource Mobilization

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April 2019

The Global Fund

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Contents

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Abbreviations and Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CHA	community health assistant
DFID	U.K. Department for International Development
FARA	fixed-amount reimbursement agreement
FY	fiscal year
GDP	gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOL	Government of Liberia
HIV	human immunodeficiency virus
LHEF	Liberia Health Equity Fund
MFDP	Ministry of Finance and Development Planning
MOH	Ministry of Health
NGO	nongovernmental organization
PBF	performance-based financing
RDF	revolving drug fund
TB	tuberculosis
US$	U.S. dollars
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

Liberia's Ministry of Health (MOH) is attempting to increase funding for the health sector in order to achieve the United Nation's Sustainable Development Goals for Liberia and to move the country toward universal health coverage. Despite high development assistance contributions, including a government-to-government reimbursement mechanism managed by the U.S. Agency for International Development (USAID) that directly funds service delivery in prioritized counties, Liberia faces significant resource gaps to finance its health sector strategic plan. Donor funding, which reached peak levels in 2014–2016 during the Ebola crisis, has begun to decline, highlighting the importance of improving domestic resource mobilization for health as a key policy priority in Liberia. The Government of Liberia's (GOL) allocation of 14.6% of the overall government budget to the health sector in fiscal year (FY) 2017/18 is commendable, as it nearly achieves the 15% target set by the Abuja Declaration.[1] However, it should be noted that the overall government budget is relatively small at only US$527 million in total.[2] Government revenue, excluding grants, is about 14% of gross domestic product (GDP) (IMF, 2018). After bottoming out during the Ebola crisis, the Liberian economy appears poised for a recovery, but due to declining aid flows and rising debt levels, the GOL is faced with difficult decisions on how it should prioritize spending its scarce resources.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) is one of the largest contributors supporting the health sector in Liberia. The GOL is now responsible for counterpart financing obligations equal to 5% of the Global Fund's contribution. HIV, tuberculosis (TB), and malaria all remain high-burden diseases in the country, with an adult HIV prevalence rate of 1.4% and 40,000 people living with HIV, a TB incidence rate of 308 per 100,000 people, and a malaria incidence rate of 193 cases per 1,000 people (UNAIDS, 2018; WHO, 2018a, 2018e). The TB and malaria rates are among the highest in the world. Consistent with overall aid inflows, there has been a declining trend in external funding for these disease areas despite need and the expectation is that this trend will continue. Given Liberia's limited fiscal space, establishing more reliable and predictable financing mechanisms for health through a national health insurance scheme and tax reforms, improving efficiency, and using limited resources as effectively as possible will all be key factors affecting the financial sustainability of the health sector.

This report, funded by the Global Fund, provides an overview of the health financing landscape in Liberia, serving as an evidence base for effective engagement and advocacy for increased domestic resource mobilization for health, specifically for HIV, TB, and malaria. The report explores how the health sector is financed, the status of various health financing mechanisms, the potential for increased resource mobilization, areas to increase efficiency, and the budget process as an entry point to advocacy. The assessment was conducted by Palladium and included a review of secondary data sources and key informant interviews.

1 Liberia's fiscal year is from July 1 to June 30.

2 All currency is provided in U.S. dollars.

Current Sources of Health Financing in Liberia

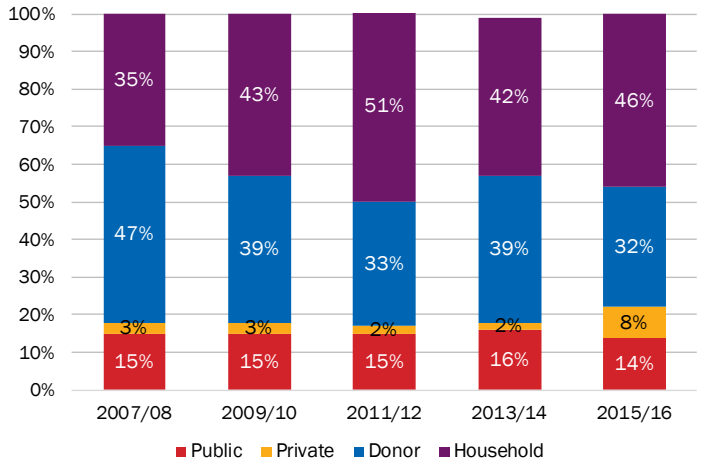
SOURCES OF HEALTH FINANCING

As of FY 2015/16, the most recent year for which National Health Accounts data is available (ROL, 2018), Liberia's health sector was primarily financed by households and development partners, with smaller contributions from the government and the private sector (Figure 1). Out-of-pocket expenditures are driven by non-prescribed medicines and medical supplies (58%) and total outpatient care (35%), which includes consultations, prescribed medicines, and exams, with women, urban dwellers, and the elderly most likely to incur spending out of pocket. Fifteen percent of households faced catastrophic health expenditure. The country substantially relies on external financing to support the health sector, with donor contributions representing 32% of total health expenditure in FY 2015/16. External financing comes from multilateral and bilateral donors that provide funding to the government through grants or to implementing partners, such as nongovernmental organizations (NGOs), civil society organizations, and providers. Until FY 2014/15, financing from the private sector was only 2–3% of total health expenditure; however, this increased substantially to 8% in the FY 2015/16 National Health Accounts.

The distribution of total health expenditure by financing agent (manager of the funds) in FY 2015/16 showed that 47% of health expenditures were managed by households, 25% by the GOL, 19% by NGOs, and 8% by private and public health insurance providers. Development partner and private not-for-profit financing includes mostly off-budget contributions and general government support through loans and grants. Support from the government includes general tax financing and general government support from other non-grant revenue. The GOL distribution of total health expenditure has remained fairly consistent over the most recent five years for which National Health Accounts data has been available—hovering at 14–16% of total health expenditure (Figure 1).

Figure 2 shows that government health expenditure per capita has remained relatively flat from FY 2011/12 to FY 2015/16 at around

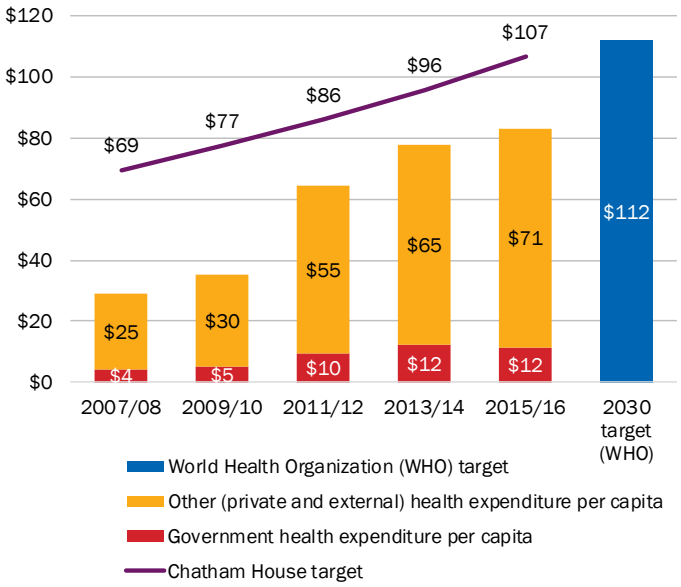
Figure 1. Total Health Expenditure, by Source



*2011/12 and 2013/14 do not sum to 100% due to rounding

Source: ROL, 2018; World Bank 2016

Figure 2. Per Capita Health Expenditure, Historical and Targets



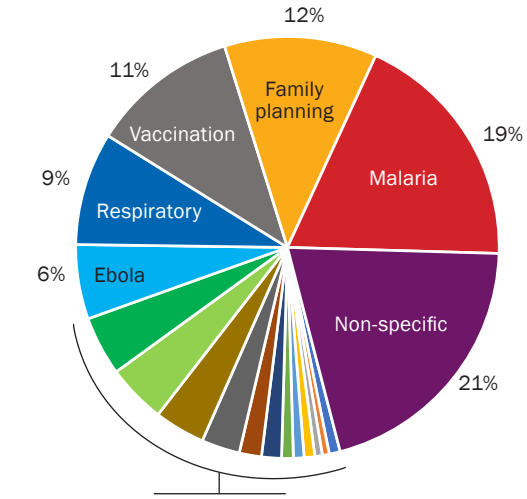
Source: ROL, 2018

$10–$12, well short of the Chatham House global target established in 2012 and the World Health Organization (WHO) target for achieving Sustainable Development Goals in low-income countries by 2030. From FY 2011/12 to FY 2015/16, the population of Liberia increased from about 4 to 4.5 million, growing at an average of 2.5% per year (World Bank, 2017b). Meanwhile, driven by increases in donor financing and private and out-of-pocket health expenditure, total health expenditure per capita reached $83 (ROL, 2018).

When examining health sector financing for specific disease or health areas, malaria has the highest share of total health expenditure at 19%, followed by family planning at 12% and vaccine preventable diseases at 11% (Figure 3). GOL health expenditure is broken down in the next section.

Although the GOL is responsible for counterpart financing obligations equal to 5% of the Global Fund's contribution to malaria, HIV, and TB, use of the GOL's co-financing commitment is for the entire health sector, not just the three disease areas. A snapshot of these disease areas is found in Table 1. Overall, the trend in donor funding for these disease areas has been declining, and the expectation is that this trend will continue. From FY 2013/14 to FY 2015/16, donor financing for these three diseases dropped in sum by 18% or $18.4 million, indicating that GOL must reorient its resources if it intends to account for this changing financing environment.

Figure 3. Total Health Expenditure by Disease or Health Area, FY 2015/16



Source: ROL, 2018

Table 1. Burden of Disease for HIV, TB, and Malaria Compared to Health Expenditure (FY 2015/16)

	HIV	TB	Malaria
Burden of disease	40,000 people living with HIV	308/100,000 incidence rate	193 malaria cases per 1,000 people (911,333 cases)
Prevalence rates	1.4% (adult)	2%	19%
Health expenditure for disease area	$14.9 million	$9.6 million	$61.5 million
Percentage of total health expenditure	5%	3%	19%
Percent of disease expenditure by donors/GOL/out-of-pocket	43%/16%/41%	46%/29%/26%	31%/20%/49%
Current annual resource need	$33 million	$7 million	$36 million

Sources: MFDP, 2017; UNAIDS, 2018; WHO, 2018a, 2018e

HIV

Liberia has a generalized HIV epidemic with an adult prevalence rate of 1.4% and a higher prevalence rate for key populations (19.8% for men who have sex with men; 3.9% for people who inject drugs) and women and girls aged 15 years and over (1.8%) (UNAIDS, 2017, 2018). In FY 2015/16, $15 million was spent on HIV, of which the GOL spent 16%, households 41%, and donors 43% (ROL, 2018). Antiretroviral therapy (ART) coverage of people living with HIV has fluctuated in the past six years, starting at 35% in 2013, dropping to 18% by 2016, and then rebounding to 29% in 2017 (Global Fund, 2016d; UNAIDS, 2018). The HIV National Strategic Plan aims to achieve a reduction in new HIV infections by 50% and have 74% of people living with HIV on ART by 2020. The plan also aims to maintain government funding at 15% of the national HIV response by 2020. Key activities to help achieve these goals include advocating for increased GOL funding for HIV to meet the increased resources needed to scale-up ART coverage and developing and operationalizing a national HIV resource mobilization strategy. It is estimated that $29–$35 million is needed in 2020 for HIV programming, including $6 million for treatment and $11 million for prevention activities. Even with donor financing, the estimated funding gap for 2019 and 2020 is forecasted to be about $14 million (Global Fund, 2016a). The Global Fund commitment in funding for HIV and TB from January 2018 to December 2020 is $24 million.

Tuberculosis

TB is a high public health burden in Liberia, as the country has one of the highest incidence rates in the world at 308 new cases per 100,000 people and a mortality rate of 60 deaths per 100,000 people (MOH, 2018). Consequently, TB is one of the health priorities in the MOH's national health plan and in its Essential Package of Health Services. As a result, 700 out of a total of 831 health facilities were providing TB treatment services as of 2016. The 2018–2022 TB strategic plan aims to provide universal access to TB services without clients having to incur catastrophic costs—out-of-pocket expenditure for health exceeding 10% of a household's total spending—regardless of geographic location, income, gender, age, or other affiliation. The expanded access is expected to increase case notification, treatment success, integrate TB and HIV to provide one-stop services for clients, provide rapid diagnosis and treatment for people with drug-resistant TB, and address the needs of key affected populations. In FY 2015/16, $9.6 million was spent on TB, of which the GOL spent 29%, households 26%, and donors 46% (ROL, 2018). To implement the plan and achieve the targets of reducing prevalence by 50% and mortality by 75% by 2025, it was estimated that the TB program required $6.7 million in 2018 (Global Fund, 2016c). However, data are not yet available to assess whether and to what extent there was a resource gap in 2018. One objective of the TB strategic plan is to increase domestic funding for TB to 50% by 2022. GOL expenditure for counterpart financing was estimated at $5.8 million in FY 2015/16 (Global Fund, 2016c). As previously mentioned, the Global Fund has committed $24 million for HIV and TB through the end of 2020.

Malaria

In 2017, the entire population of 4.7 million people in Liberia was considered at risk of malaria, with prevalence estimated at 19%, one of highest rates in the world (WHO, 2018e). Prevalence varies greatly by county, with the highest rates in the southeast reaching 49% (MOHSW, 2014). With the assistance of donors, the MOH has made great strides in reducing malaria prevalence significantly from the 66% rate reported in 2005 (MOHSW, 2014). Still, as the leading cause of outpatient department attendance (57%) and the highest cause of inpatient deaths (39%) in the country, malaria remains a major contributor to disease burden in the country. Of the $62 million spent on malaria in FY 2015/16, the GOL contributed 20%, households 49%, and donors 31% (ROL, 2018). The main goal and objectives of the current malaria national strategic plan is to reduce illness and death from malaria by 75% and sustain that reduction through 2020. The program also aims to increase access to prompt diagnosis and treatment to 90% of the population and ensure that 80% of the population is protected by malaria preventive measures by 2020 (MOHSW, 2014).

The total funding needs for the plan are estimated to be $33 million in 2019 and $39 million in 2020 (Global Fund, 2016b). The plan is primarily supported by two major donors, the Global Fund and the U.S. President's Malaria Initiative. GOL counterpart financing was estimated at $11.7 million in FY 2015/16 (Global Fund, 2016b). The Global Fund has committed $23 million for malaria from July 2018 to June 2021.

Role of Major Development Partners

As of FY 2015/16, 16 donors, including United Nations organizations (e.g., United Nations Development Programme, United Nations Population Fund, and United Nations Entity for Gender Equality and the Empowerment of Women) supported the health sector in Liberia (ROL, 2018). The World Bank was the largest contributor ($53 million), followed by USAID Liberia ($46 million), the Global Fund ($30 million), and WHO ($27 million). Other donors included the European Commission; Gavi, the Vaccine Alliance; the Government of Germany; Irish Aid; Islamic Development Bank; the Japan International Cooperation Agency; the U.K. Department for International Development (DFID); and USAID–Office of U.S. Foreign Disaster Assistance, among others (MOH, 2017a). On-budget funding from DFID and Irish Aid had previously been channeled through the Health Sector Pool Fund, but this mechanism ended recently. DFID, WHO, and the World Bank also contributed most of their funding directly to the GOL budget (MOH, 2017a). Other partners, such as UNICEF and the Swedish International Development Agency, provided funding through implementing partners. Much of the funding from the health sector's 10 largest donors was off-budget. About 25% of all donor funding was, and still is, applied at the central level. Montserrado County, which includes the capital of Monrovia, receives by far the largest amount of donor funding (25% of all donor health funding) at the county level (MOH, 2017a). The four largest donor investment areas focus on human resources for health, health infrastructure, epidemic preparedness and response, and improving quality of service delivery. In FY 2015/16, a third of all donor grants disbursed to the GOL were allocated to the health sector (IMF, 2018). No external loans were disbursed for the health sector in FY 2015/16.

The Chinese government began supporting Liberia as early as FY 2015/16 on infrastructure projects with the construction and renovation of roads, bridges, airports, and facilities (e.g., government ministry buildings). Typically, these projects are not funded through aid, but through non-concessionary loans to cover the cost of labor and materials. While China does also give aid, it does not report on aid activities, making it difficult to determine how much funding was allocated and how it was spent. Specific to health, China has made commitments to procure and donate drugs, but these contributions have been made through the Ministry of Foreign Affairs and have not been made public. According to USAID, China has recently made a large five-year commitment to purchase and donate malaria and laboratory commodities to Liberia.

DOMESTIC PUBLIC RESOURCES FOR HEALTH

The Government of Liberia's on-budget allocation for health is funded 65% by the government and 35% by external grants and subsidies. In FY 2017/18, the health sector was allocated $76.7 million in the Liberia national budget, of which $41.6 million was designated for compensation of 12,325 full-time equivalent employees and $8 million for goods and services, such as foreign travel, fuel, and telecommunications (MFDP, 2017). Of the GOL health allocation, 73% went directly to the MOH, 9% went to the National Public Health Institute, which is responsible for conducting surveillance and emergency response (e.g., Ebola), and 1% went to the National AIDS Commission (MFDP, 2017). The remaining 17% of the GOL health allocation was distributed directly to specific medical centers and hospitals, research institutions, health boards and councils, and regulatory authorities. Figure 4 provides an overview of the GOL's health sector allocation by spending agent, Figure 5 shows health allocations by functional area, and Figure 6 provides an overview of allocations to the MOH by policy area/department. In FY 2017/18, no allocations were made to the MOH for budget lines related to preventive services or social welfare.

Figure 4. Breakdown of FY 2017/18 GOL Health Allocation by Spending Agent

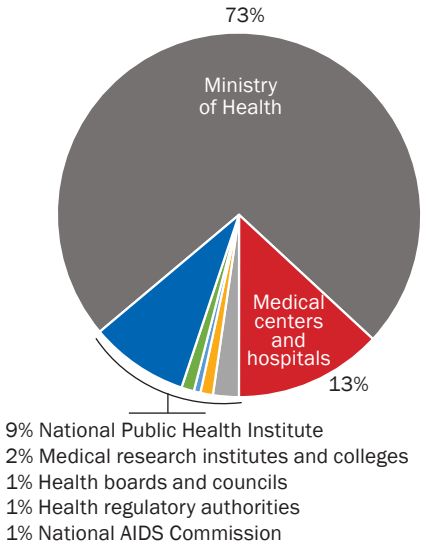


Figure 5. Breakdown of FY 2017/18 GOL Health Allocation by Function

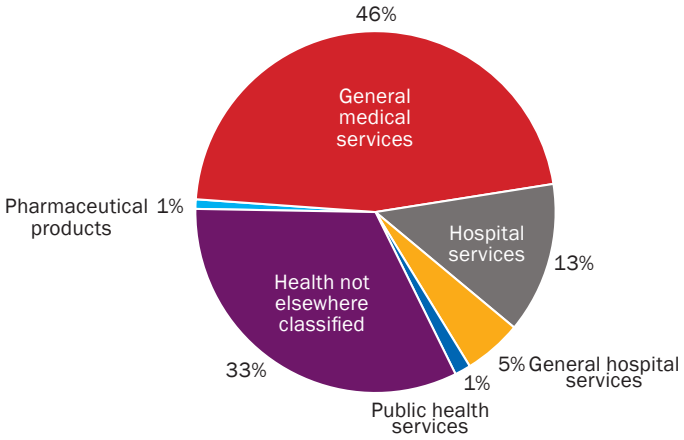
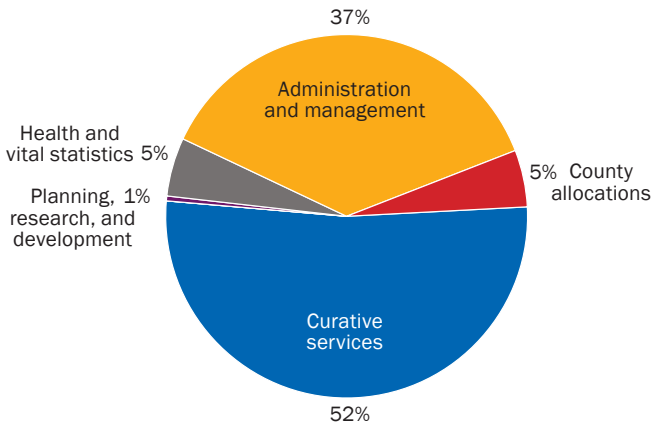


Figure 6. Breakdown of FY 2017/18 Allocations to the Ministry of Health by Department



Source (figures 4–6): MFDP, 2017

Insurance as a Mechanism for Domestic Resource Mobilization

In 2011, the MOH (at the time, named the Ministry of Health and Social Welfare) launched the *National Health and Social Welfare Financing Policy and Plan 2011–2021*, the first national plan to consider social health insurance as a mechanism for domestic resource mobilization (MOHSW, 2011). In 2013, the ministry began planning the Liberia Health Equity Fund (LHEF)—a risk-pooling insurance scheme meant to reduce catastrophic health expenditures, improve sustainability of revenue collection, and increase quality of healthcare. Today, discussions about the scheme's benefits package, population coverage, contribution rates, and provider payment mechanisms are still in the early stages. When the Ebola crisis began, efforts to design and operationalize the LHEF were put on hold. In 2015, the MOH was able to focus again on the LHEF as its primary health financing reform objective and developed a roadmap to implement the fund. Although the first draft of the LHEF bill targeting the formal sector was initially rejected in 2016, the fund currently has strong political support. In 2017, after several rounds of consultations with the Ministry of Finance and Development Planning (MFDP), insurance committees, and relevant technical working groups, a new LHEF concept note—which outlines 11 high-level priorities—was sent to the cabinet for consideration. A revised bill needs to be drafted and submitted to the Ministry of Justice to review the set-up of institutions proposed to govern the LHEF, after which, the bill must be presented to the cabinet. The MOH hopes that a resolution for the LHEF legislation will be signed within one year of presentation to the cabinet.

One of the main goals of the LHEF is to ensure that vulnerable and poor households have financial access to the Essential Package of Health Services. The MOH considers pregnant women, children under five years of age, and people living with HIV as vulnerable population groups. The MOH still needs to determine which populations will be eligible for coverage through subsidies. One option for the provision of subsides is a method similar to the Ministry of Labor's Social Cash Transfer Program, where eligibility for subsidies for the

BOX 1. SUSTAINABILITY OPPORTUNITY

Reducing Out-of-Pocket Health Expenditure

The creation of the Liberia Health Equity Fund offers an opportunity to increase the quality of care and financial protection for Liberians. Currently, only 3% of the country's population has health insurance coverage and 46% of all health expenditure is out-of-pocket. The LHEF has the possibility of reducing out-of-pocket costs while introducing performance-based financing mechanisms and facility accreditation requirements that could help increase the quality of care. An actuarial study is needed to determine the financial implications of scaling-up the fund, the cost of the benefits package, and the capacity of the government to implement such a scheme.

poor are determined based on a set of household characteristics. Given the small size of the formal sector in Liberia, initial thoughts are that the LHEF should be primarily tax based. The LHEF is planning on implementing a strategic purchasing mechanism (i.e., a performance-based model) for health service provision. HIV is not expected to be covered under the scheme initially. TB, however, is already included in the Essential Package of Health Services and would be included in the new benefits package.

The MOH has indicated it will consider concepts modeled from Ghana's national health insurance scheme to be applied to the LHEF. Some key features of the Ghana scheme are that it is primarily (74%) financed by tax revenue through a value-added tax and all residents are eligible for coverage, although not all enrollees are required to pay premiums (World Bank, 2017a). Only 3% of the scheme's revenue is from premium payments. Certain poor and vulnerable populations, such as indigent people, those aged under 18 or over 70 years, and beneficiaries of social protection programs, are not required to pay premiums. Ghana's national health insurance scheme's benefits package covers all outpatient, inpatient, and emergency care (subject to an exclusion list) and members pay no out-of-pocket costs for pharmaceuticals. Provider payments are a combination of fee-for-service and capitation. Although the lessons learned from Ghana are useful, results from the Ghanaian scheme have been mixed. For example, the scheme has run a deficit for much of its existence and has had difficulty enrolling informal sector workers and their families (World Bank, 2017a).

In 2013, an LHEF feasibility study recommended that the MOH carry out an actuarial study to inform the type of health services package that could be covered by the scheme and at what cost. An actuarial study is now needed to forecast the long-term feasibly of the scheme based on forecasted revenue and expenditures and provide an assessment of staffing and administrative requirements for running the scheme.

Health Insurance Currently Available in Liberia

Although the health insurance market in Liberia is small and fragmented, it is growing under three main contributory schemes. Civil servants are insured through the National Social Security and Welfare Corporation and the Group-Term Life, Accident, and Medical Scheme, the latter of which is operated by private insurance companies in Liberia. Police, army, and entry port staff are insured by Group-Term Life with the Medicare Insurance of Liberia (World Bank, 2017c). Meanwhile, about 30,000 employees and their dependents in the concessionaire sector—which includes rubber, palm oil, mining, and forestry—receive healthcare delivered in facilities owned and managed by their employers per the Concessionaire's Agreement with the GOL. The Ministry of Labor estimates that about 22,000 employees from various other private sector industries receive health insurance from their employers. In total, about 3% of Liberia's population currently has health insurance coverage (World Bank, 2017c).

A consumer preference market research study conducted in five Liberian counties found that most (82%) respondents favored some form of insurance and prepayment schemes that would improve financial access to health services (CSH, 2017). The study's conclusions, however, were

based on a small sample and may not necessarily be generalizable to the entire country. Additionally, other sub-Saharan African countries have experienced difficulty implementing and scaling-up voluntary health insurance.

Other Health Financing Mechanisms

Although the LHEF is the main health financing reform initiative in Liberia, the LHEF policy note also outlines other mechanisms for domestic resource mobilization and serves as a post-Ebola de facto health financing strategy document (World Bank, 2017c). These mechanisms are discussed next.

Revolving Drug Fund

According to the MOH, drug stock-outs have been one of the biggest challenges for the health sector over the last two years, and the situation appears to be getting worse. A revolving drug fund (RDF) mechanism had previously been implemented in Liberia from 1985 to 1989 and was financed by out-of-pocket user fees for drugs at the point of service. The objective of the RDF was to increase the availability of essential medicines and make pharmaceuticals more affordable. Fees collected for the RDF were managed by facilities and intended to serve as a financing buffer for the purchase of medicines at lower prices through bulk procurement.

The MOH believes that the RDF worked well 30 years ago, albeit under very different circumstances, when user fees were much more common under the Bamako Initiative. As a result, the MOH considers the RDF a best practice and rational stepping stone toward the establishment of the LHEF. Unlike the LHEF, which requires new legislation to be passed, the RDF only requires a presidential announcement for implementation to begin. Therefore, the MOH considers the RDF reform a quick and achievable way to raise financing for health. The aforementioned consumer preference study also showed that the RDF is something that people want (CSH, 2017). Lastly, the MOH likes the idea of giving health facilities more autonomy but recognizes that there are challenges to monitoring how additional financing is managed by facilities to ensure that funds are properly used to purchase drugs.

Some partners, such as the World Bank, are advising against reintroduction of the RDF due to limited and mixed evidence that the mechanism actually increases access to drugs and to the belief that the RDF user fees may foster unequal access to health services. Research has shown that user fees impose barriers to health services, especially for the poor (World Bank, 2017c). However, given the potential political support for the RDF, the World Bank suggests that a prepayment version of the RDF, serving as a voluntary risk pool for essential medicines financed by out-of-pocket expenditure, might be a better design choice. A risk pool could allow for vulnerable groups to be exempt from user fees through cross-subsidization, and a prepayment version of the RDF could help prepare the health system for the LHEF by informing future design elements.

Tax Reforms Including Earmarks for Health

Two tax reform options are currently being discussed in Liberia. One is an excise tax for tobacco and alcohol, which appears likely to get implemented and is forecasted to raise $16–$17 million per year, according to USAID key informant interviews. A portion of the revenue generated could be earmarked for social sectors such as health and/or education. The MOH prefers that any earmark for health be sent directly to the LHEF to be used for strategic purchasing of health service provision. Although "sin" taxes may contribute to combating the negative effects of alcohol and tobacco use, if the tax rates are high enough to impact consumption, it is a regressive tax, meaning it will more likely impact people with lower incomes. Meanwhile, the other tax reform option, a value-added tax, is being considered for implementation in FY 2019/20. A goods and services tax like a value-added tax is more progressive and strikes a better balance between increasing revenue and protecting vulnerable groups. However, the MOH does not believe that earmarks will be set aside for specific sectors like health under the value-added tax, especially if an earmark for health has already been established under the "sin" tax. A political and financial feasibility study of earmarked taxes is needed to determine the potential of this revenue generation mechanism.

Remittances

Remittances, defined as private transfers from migrant workers to recipients in their country of origin, account for 17% of GDP (IMF, 2018), with some estimates as high as 33% (World Bank, 2017c). According to a 2018 USAID study on remittances in Liberia, in 2016, Liberia was the fifth largest recipient of remittances ($549 million) in the world in absolute terms, the majority of which were used by households to meet basic subsistence needs. Most inflows to Liberia come from the United States, with 2.4% ($13.2 million) of remittances used for health, 61.9% for consumption, and 21.7% for education. Although wealthier households tend to receive larger remittance amounts than poor households, overall, the extra income does contribute to poverty reduction. Consequently, the MOH is exploring how remittances can be leveraged to increase financing for health and how such a mechanism would work. According to the MOH, ideas being considered include directing remittances to a prepayment mechanism such as the LHEF or developing a diaspora bond to fund investments in health. USAID recommends focusing on improving sending/receiving channels to make them more affordable and avoid taxing remittances, as the additional transaction cost would diminish the amounts received through formal channels. As of 2018, charges ranged widely, with Western Union and MoneyGram charging 7.5%, Ria charging 2.5%, bank account transfers or credit/debit cards charging 2%, and bank branches charging 6%. USAID is recommending using more innovative and cheaper cash transfer platforms, such as Send Money Africa, Boxpay, Remittance Prices Worldwide, or Monito.

Domestic Financing for the National Community Health Assistant Program

Community health assistants (CHAs) are essential to increasing access to services, especially health and hygiene promotion, social mobilization, and community case management of diarrhea, pneumonia, and malaria, as CHAs serve about 30% of the country's population. In 2017, the MOH health workforce plan estimated a funding gap of $111 million for the CHA program over the next two years (World Bank, 2017c). According to staff interviewed at Last Mile Health, an NGO working with CHAs in Liberia, approximately 30% ($32 million) of the annual costs for the CHA program is funded by the three main donors—The Global Fund, USAID, and the World Bank—while the GOL contributes around $12.5 million. According to Last Mile Health, for the CHA program to be sustainable, total costs must be reduced to $95 million per year, donors must continue their funding levels while the GOL simultaneously increases its budget allocation by $3 million per year for the next six years, an additional $3 million each year must be raised through innovative financing, and new philanthropic/donor funding must increase by $2–$3 million each year. Last Mile Health is supporting accelerated efforts to advocate and raise financing for the CHA program, with the aim of getting a CHA funding line on the GOL budget books and/or including select community health professionals on the GOL payroll.

BOX 2 . DOMESTIC RESOURCE MOBILIZATION OPPORTUNITY

Remittances as a Mechanism for Health Financing

Conceptualizing and implementing an innovative mechanism to fund investments in health, leveraging financing from remittances (17% of GDP), has the potential to provide a funding base for health.

PRIVATE SECTOR CONTRIBUTION TO HEALTH

As previously mentioned, the private sector's contribution as a percentage of total health expenditure has historically been small (2–3%) but grew to 8%, as reported in the last available National Health Accounts in FY 2015/16. It is not clear from the National Health Accounts why the private sector contribution increased between FY 2013/14 and FY 2015/16. One possible explanation is that the increase is a result of corporations expanding coverage of health insurance for employees, as mentioned previously.

Increasing the private sector's contribution to health is a relatively unexplored topic in Liberia. At the moment, there is no formal dialogue on establishing public–private partnerships and no concrete plans have been developed to try to raise domestic resources for health through corporate social responsibility. A coordinated private sector strategy is needed. Foreign direct investment in Liberia has been primarily directed to mining and infrastructure, while health is an underexplored area.

Private Providers

Of the 831 total health facilities in Liberia, 374 (45%) are private, which is an almost twofold increase in private facilities over the last two years (WHO, 2018d). Of the private facilities, about 3% are hospitals, 8% health centers, and 89% clinics, which are the first and most basic level of health facility in Liberia (WHO, 2018d). In FY 2013/14, 36% of total health expenditure was spent at private facilities (ROL, 2018). People in the richest quintile made up 40% of the households that sought care at private clinics and 85% of households that went to private clinics reported paying for the visit with their own money (ROL, 2018).

Although 93% of private facilities reported offering malaria diagnosis and treatment services, only 7% offered TB services (WHO, 2018d). About 60% of private facilities provided some form of HIV care and support services, but only 9% offered antiretroviral drug prescriptions and 19% offered prevention of mother-to-child transmission of HIV services (WHO, 2018d). Based on these findings, it appears the availability of and access to HIV and TB services at private facilities needs to be increased.

KEY TAKEAWAYS: CURRENT SOURCES OF HEALTH FINANCING

- Health is mainly financed by out-of-pocket expenditure (46%) and external financing (32%).
- Government of Liberia per capita health spending falls considerably short of globally established targets.
- At 19%, malaria accounts for the largest percentage of total health expenditure.
- HIV, TB, and malaria contribute substantially to disease burden in Liberia and are heavily reliant on donor funding.
- Most government spending is on curative care and may be too heavily favored toward hospital-based care.
- The LHEF is the most prominent health financing reform initiative in Liberia, but is still in the early stages of implementation.
- Private sector financing for the health sector is small but growing (now 8% of total health expenditure). More thinking is needed to leverage financing from the private sector.

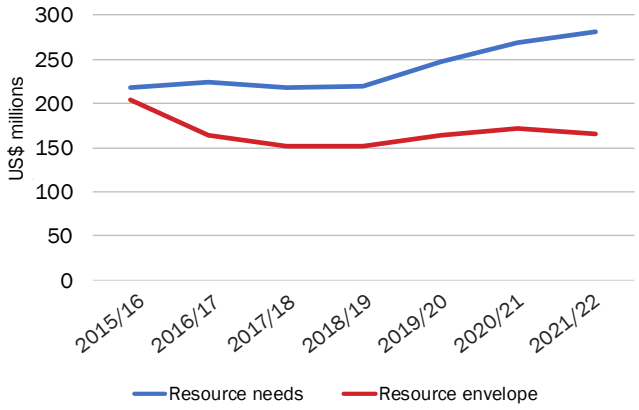
Finding the Money: Creating Additional Fiscal Space for Health

Liberia faces significant financing challenges to meet its health sector goals. The MOH, in coordination with the MFDP and other ministries and agencies at the national, county, and local levels, must continue to emphasize the need for greater efficiency and increased budget allocations and prioritization for health at all administrative levels of government.

CURRENT TARGETS FOR DOMESTIC HEALTH SPENDING

In 2015, the MOH, in collaboration with the World Bank and other partners, developed an investment plan for building a resilient health system in Liberia between 2015 and 2021. The plan costed out the resource requirements needed to address the country's top health priorities, including building a productive health force that can equitably and effectively deliver quality services, reengineering the health infrastructure to conform to the population's needs, and strengthening epidemic and emergency preparedness surveillance and response. The projected resource needs and resource envelope from the investment plan (including grants and contributions from the private sector) under a scenario considering ideal interventions are shown in Figure 7. These projections include assumptions for increased fiscal space for health from growing government budget contributions, implementation of tax reforms to generate additional domestic resources for health, and improved technical and allocative efficiency. The total cost to implement the investment plan was projected to be $1.73 billion over seven years from 2015/16 to 2021/22. Given the projected resource envelope, that leaves an estimated financing gap of $757 million over that period (World Bank, 2016).[3]

Figure 7. Projected Health Sector Resource Needs versus Resource Envelope



Source: World Bank, 2016

FISCAL AND MACROECONOMIC CONTEXT

A new government took office in 2017, with a mandate to achieve ambitious pro-poor development objectives, including improving basic public services. Based on an International Monetary Fund 2018 country report, although Liberia's GDP growth bottomed out in 2016 (Table 2), the economy appears poised for a recovery, assuming sound policies, with GDP growth forecasted at around 5% for the next five years. GDP growth is expected to be driven by the recovery and expansion of the mining sector, particularly gold and iron, with mining representing 70% of the country's exports. However, half of the country's population lives in poverty, making the prospects for improving living conditions fragile. A sizeable portion of Liberians rely on diaspora remittance inflows, which represents 17% of GDP, for income (IMF, 2018).

3 See the full World Bank report for a complete list of assumptions and methods.

Although foreign aid inflows are still substantial, they have dropped from the elevated levels during the Ebola crisis (2014–2016). The decrease in foreign aid from 19.3% of GDP in 2016 to 16.7% in 2017 (Table 2) and the withdrawal of the United Nations Mission in Liberia has resulted in a $160 million reduction in available resources (IMF, 2018). This declining trend has put pressure on fiscal resources and, as a result, Liberia is forecasted to run a fiscal deficit of close to 5% of GDP over the next several years (Table 2). This income deficit highlights a critical need to mobilize resources through, for example, enhanced information technology systems for the Liberia Revenue Authority, and to improve compliance and efficiency of tax collection. Domestic tax revenue generation in Liberia is relatively low by regional standards (IMF, 2018; Table 2).

While the medium-term economic outlook for GDP growth appears favorable, macroeconomic stability is essential for advancing the demanding government agenda. Relatively high inflation, which reached 14% by the end of 2017, combined with the decline in aid inflows, put a strain on the exchange rate, which depreciated year-on-year by 22.5% in 2017 (IMF, 2018). The International Monetary Fund has recommended that Liberia prioritize recapitalizing the central bank in order to safeguard the international reserves necessary to maintain price stability. Additionally, debt levels have been rising steadily in recent years (Table 2), and Liberia is now at moderate risk of debt distress, owing $736 million to international creditors (IMF, 2018). To ensure debt sustainability, new debt should only be taken on with concessional terms.

In summary, although prospects for GDP growth look promising in the medium term, the GOL's fiscal space remains restricted due to its budget deficit, escalating debt levels, and declining grant inflows. These factors limit the new administration's ability to realize its development agenda. Any new spending must be considered with pragmatism and caution and limited to only essential policy initiatives. The International Monetary Fund has recommended that the GOL prioritize the spending of scarce resources on rebuilding infrastructure and recapitalizing the central bank (IMF, 2018).

Table 2. GDP Growth, Revenue, Expenditure, Debt, and Inflation

	2016	2017	2018*	2019*	2020*	2021*	2022*	2023*
Real GDP growth (annual % change)	(1.6)	2.5	3.2	4.7	4.8	5.3	5.2	5.3
Tax, investment, and other revenue (% of GDP)	14.0	14.3	13.0	13.6	14.2	14.5	14.7	14.9
Grant revenue (% of GDP)	19.3	16.7	15.2	14.7	13.4	11.9	10.9	9.7
Total revenue (% of GDP)	33.3	31.0	28.2	28.3	27.6	26.4	25.6	24.6
Total expenditure (% of GDP)	36.0	35.8	33.3	33.4	32.3	31.3	30.5	29.0
Fiscal balance (% of GDP)	(2.7)	(4.8)	(5.2)	(5.1)	(4.7)	(4.8)	(4.9)	(4.4)
Public debt (% of GDP)	18.3	24.6	28.6	30.8	33.0	35.0	36.7	37.8
Inflation (annual average %)	8.8	12.4	11.7	10.5	9.5	8.5	7.5	6.3

*Estimated

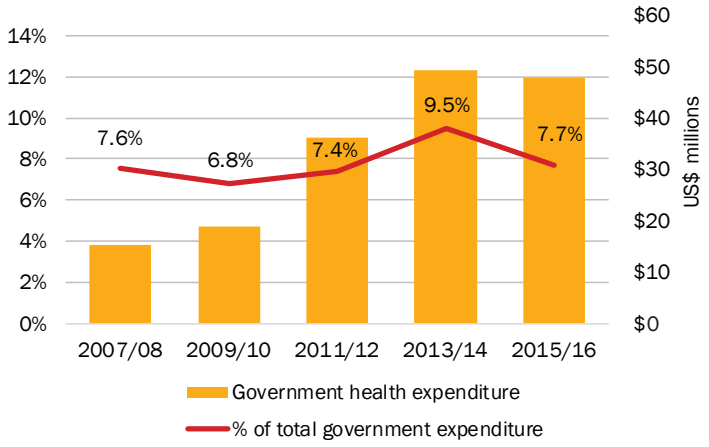
Source: IMF, 2018

PRIORITIZATION OF THE HEALTH SECTOR

Government health expenditure in Liberia has generally increased nominally since FY 2007/08, though it dipped slightly to $47.7 million in FY 2015/16, a decrease of $1.7 million from the previous year (Figure 8). As a percentage of total government expenditure, government health expenditure has been fairly flat, hovering between 6.8% and 7.7% between FY 2007/08 and FY 2015/16, with the exception of 2013/14, when it peaked at 9.5% (ROL, 2018).

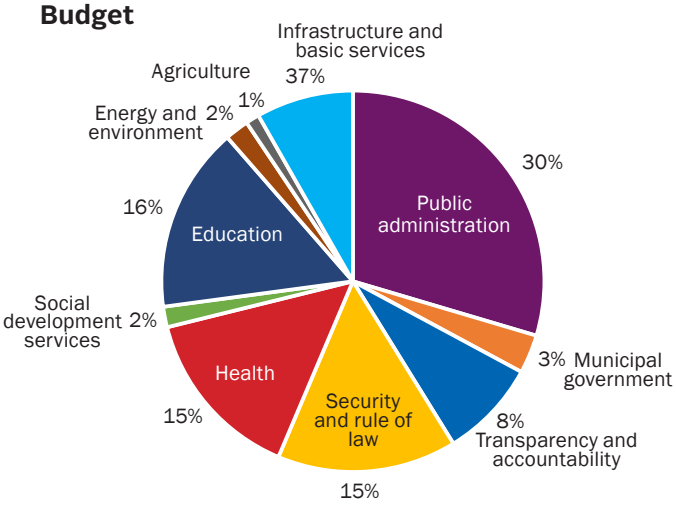
In the FY 2017/18 budget books, the health sector received an allocation of 14.6% of the total government budget, which includes on-budget contributions from donors (Figure 9), an increase from 11% in FY 2015/16 and 13% in FY 2016/17 (MFDP, 2017). This allocation to health is commendable, as it nearly achieves the 15% target set by the Abuja Declaration. However, it must be acknowledged that the entire government budget is relatively small at $526.5 million (inclusive of on-budget support from donors). In terms of percentage of the total government budget, the health sector ranked fourth, just behind the education sector and security, which received allocations of 16% and 15%, respectively. Public administration claimed the largest share at 30%.

Figure 8. Government Actual Health Expenditure Nominally and as a Share of Total Government Expenditure



Source: ROL, 2018

Figure 9. FY 2017/18 Government Allocation by Sector as a Percentage of the Total Government Budget



Source: MFDP, 2017

KEY TAKEAWAYS: FISCAL SPACE FOR HEALTH

- GDP growth is poised for recovery post-Ebola, but Liberia's persistent fiscal deficit (5% of GDP), declining grant in-flows, and rising debt levels restrict an increase in the fiscal space for health.
- The health sector is heavily dependent on donors even though there has been a decline in aid support.
- The health sector resource gap is estimated to reach US$757 million over the period of 2015/16 to 2021/22.
- The International Monetary Fund recommends that the GOL prioritize rebuilding infrastructure and recapitalizing the central bank to protect against high inflation and currency depreciation.
- Although over 14% of the overall GOL budget is allocated to health, indicating high prioritization, the resource envelop is limited given the small size of the overall GOL budget.

Getting More for the Money: Efficiency in Health Spending

Given the low prospects for increased government spending for health and prospective declines in donor funding, it is important to improve efficiency in health spending. The data in Table 3 summarizes key indicators related to budget efficiency, allocative efficiency, and technical efficiency for health spending.

BUDGET EFFICIENCY

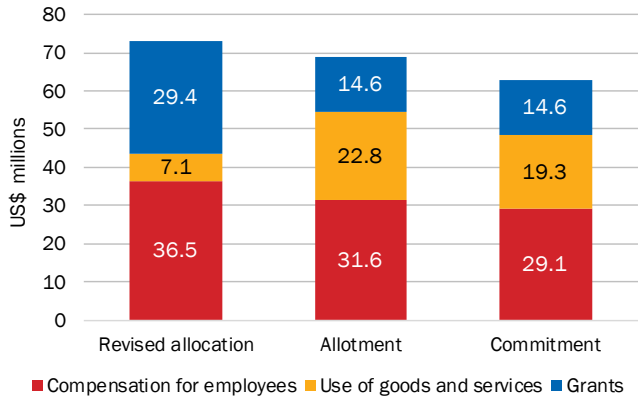
Budget efficiency indicates the extent to which funds are allocated, released, and spent, on time and as planned. During any given fiscal year, the GOL may realize that revenue collection to finance the total planned government budget may not be adequate and, therefore, decide to shift domestic resources from one area to other more highly prioritized areas. The FY 2017/18 fiscal outrun annual report showed that during the course of the fiscal year, the original on-budget allocation to the health sector of $76.7 million was revised to $73.0 million, a 5% decrease (MFDP, 2018a). The reduction in the health allocation may have been the result of more off-budget funding being disbursed for health from external financing than expected. A total of $88.8 million was projected for FY 2017/18 from off-budget grants and loans for the health sector, but $119.5 million was actually disbursed, 35% more than what was planned (MFDP, 2018a). Figure 10 shows budget disbursement (allotment) and budget execution (commitment) performance for on-budget allocations to health in FY 2017/18. Out of the revised allocation to health, 95% was disbursed, of which 91% was expended, although there was some variation between sub-budget lines (MFDP, 2018a). A 95% budget disbursement rate is commendable, and the 91% budget execution rate shows fairly good absorption capacity for money that is released to health (MFDP, 2018a). This is an improvement over budget execution rates in FY 2015/16 (89%) and FY 2016/17 (71%) (MFDP, 2017). It is unclear what caused the low disbursement rate of 50% for on-budget grant funding. It is also unclear why disbursement for the budget line "use of goods and services" was significantly higher than what had been allocated, but funding appeared to have been shifted from the equivalent budget line of other sectors, particularly public administration and security.

Table 3. Efficiency Indicators, FY 2017/18

Indicator	Value
Budget Efficiency	
GOL health budget disbursement rate (GOL; external financing)	95% (125%; 50%)
GOL health sector budget execution rate (GOL; external financing)	91% (89%; 100%)
MOH budget execution rate	81%
National Public Health Institute of Liberia budget execution rate	96%
National AIDS Commission budget execution rate	96%
Allocative Efficiency	
Is burden of disease considered in MOH transfer formulas?	Yes
Is an epidemiological modeling tool used to make resource allocation decisions?	No
Health worker-to-population ratio	1.15/1,000 people
Percentage of health facilities that have essential medicines in stock for treatment of illnesses	44%
Technical Efficiency	
Absenteeism rate	5%
Malaria test positivity rate with rapid diagnostic test	62%
TB treatment success rate for new cases	77%
TB case detection rate	42%
ART retention rate (at 12 months)	70%

Sources: Global Fund, 2016d; MFDP, 2018a, 2018b; MOH, 2018; MOHSW, 2010; NAC, 2014; WHO, 2018a, 2018d, 2018e

Figure 10. Summary of MOH Allocation and Expenditure in FY 2017/18



Sources: MFDP, 2018a

ALLOCATIVE EFFICIENCY

Beyond if and how the budget is spent, allocative efficiency examines if funds are allocated appropriately based on priorities and needs. Liberia's MOH has prioritized updating its resource allocation formula to better reflect the country's needs, utilization of health services, and populations within its catchment areas. In 2013, the World Bank completed an analysis on the resource allocation formula used, but its recommendations were never implemented due to the political climate, as the timing was close to Liberian Senate elections. The World Bank is currently providing technical assistance to the MOH again on this topic, as a follow on to the 2013 work, with the hope that its new recommendations will be implemented. Under the new work, the World Bank aims to better understand the process of how the GOL channels funding to the county level and how funds are further divided among individual facilities. The World Bank is also trying to determine the major categories under which grant funding is spent at the county level.

According to key informant interviews with the World Bank, the final output from this work will be recommendations on how the resource allocation formula can be improved to increase efficiency and equity. The World Bank believes that one key issue is that a disproportionate amount of money is being allocated to the secondary level of the health system while primary healthcare is underfunded. Another issue is that the population weighting formula is outdated and needs to be updated once a new census is completed. This exercise is expected to begin in November 2019. To improve equity, a county's distance to Monrovia and the road infrastructure covering that distance must be factored into the allocation formula to account for supply chain and transport costs. In addition to geography, other variables to be considered in the formula, based on best practices globally, are demography, morbidity (service needs), poverty status, and supply of services (World Bank, 2013). Lastly, variations in the amount of donor financing going to specific counties must also be considered. The World Bank will assist the MOH in developing a concept note to be used to advocate for implementation of its recommendations by the Legislature. The MOH believes that there is currently political backing for this initiative.

A lack of human resources for health, especially at the county level in Liberia, also contributes to inefficiency. The MOH has set a target of employing 15,000 personnel by 2021, which would require hiring an additional 3,000 health workers. The health worker-to-population ratio is 1.15 skilled workers per 1,000 people compared to 4.45 skilled health workers per 1,000 people, the WHO estimate for the density needed to reach the median universal health coverage achievement of 80% (WHO, 2016b; World Bank, 2017c). The number of registered midwives and physicians in Liberia are also well below WHO recommended workforce levels (World Bank, 2017c). Although investments in mid-level cadres, particularly nurses and midwives, have been steadily increasing since 2000, investment in the number of physicians remains low (World Bank, 2017c). The MOH is attempting to develop a human resources for health strategy to optimize the health workforce, harmonize salary scales, and establish performance management systems (World Bank, 2017c). These objectives all have implications for financing the health sector, particularly impacting training budgets and percentage of the budget spent on salaries, which must all be considered in the resource allocation methodology.

TECHNICAL EFFICIENCY

Once resources are appropriately allocated, it is important that the resources are used effectively to avoid duplication or wastage and to maximize impact. The MOH has recently begun a decentralization policy and strategy meant to restructure the MOH to make it more effective and efficient. Part of this strategy is to shift task functions, authority, and resources to the local level (MOHSW, 2012). According to a key-informant interview with Last Mile Health, its recent analyses of District Health Information System 2 data showed favorable cost comparisons for CHAs responsible for a similar number of malaria cases at the community-based level compared to treatment at the health facility level. To improve internal coordination of donor fund management and to cut down on the excessive transaction costs resulting from the current fragmented arrangement, the MOH is setting up a Joint Project Coordination Unit to strengthen alignment of all resources with the health sector (MOH, 2017b).

Efficiency in Service Delivery of HIV, Tuberculosis, and Malaria

Although the national strategic plans for HIV, TB, and malaria all have goals to improve efficiency, they do not specify how this objective can be achieved. Findings and lessons learned from research conducted on interventions aimed at achieving cost savings through technical efficiencies in other sub-Saharan African countries will help inform the design and implementation of Liberia's efficiency practices.

For HIV, the use of differentiated care—a client-centered approach that simplifies and adapts HIV services to reflect the preferences of various groups of people living with HIV while reducing unnecessary burdens on the health system—is meant to address this issue (IAS, n.d.). The 2016 WHO consolidated antiretroviral drug treatment and prevention guidelines recommends differentiating care to four groups: (1) people living with HIV presenting for care at earlier stages of the disease, (2) people living with HIV presenting with advanced disease, (3) patients stable on ART, and (4) patients who are unstable (WHO, 2016a). In addition to the WHO guidelines, several countries have developed country-specific guidelines that adopt aspects of differentiated care to help ensure that more patients can be seen by existing health workers and facilities. Differentiated care guidelines have not yet been put in practice in Liberia.

Losses along the HIV clinical cascade—from identification to treatment and retention—are another major source of inefficiency and prevent reductions in incidence and mortality. For example, only 29% of people living with HIV in Liberia are on ART (70% on treatment are retained), interventions targeting high prevalence key population groups are limited, and testing and counseling rates remain low (UNAIDS, 2018; Global Fund, 2016d). Current service delivery models in place in Liberia (e.g., traditional testing modes and standardized treatment protocols) may not be cost-efficient. Analyzing cascade failure points and quantifying efficiency gains of new interventions and service delivery models being scaled up (e.g., virtual outreach, index and self-testing, and differentiated HIV support services) can help the MOH understand the impact and cost of interventions to improve the HIV cascade. Findings can inform stakeholders how to differentiate approaches by subpopulation group to better target resources.

One approach that can reduce costs and improve patient care and treatment, is the integration of HIV and TB interventions. By integrating HIV and TB services, implementers are able to take advantage of synergies between program activities. In 2016, only 22% of health facilities in Liberia provided integrated TB and HIV services, and only 73% of TB patients were tested for HIV (Global Fund, 2016d). People living with HIV are 20 times more likely to fall ill with TB, which accounts for a third of AIDS deaths worldwide (WHO, 2018b). TB and HIV prevention and care interventions are mutually reinforcing. For example, intensifying TB case finding in areas of high HIV prevalence and increasing staff capacity to provide comprehensive care can help achieve cost efficiencies (WHO, 2018c).

Lastly, to improve the efficiency, cost-effectiveness, and sustainability of malaria programs, WHO recommends that countries implement the principles of integrated vector management. Integrated vector management is a rational decision-making process for the optimal use of resources for vector control (WHO, 2015).

Drug Procurement

The 2018 Service Availability and Readiness Assessment reported that only 44% of health facilities had essential medicines in stock for treatment of illnesses, which indicates that access to essential medicine by patients is a critical challenge (WHO, 2018d). The overall trend is that stock-out rates increased over the last two years, especially for vaccines (WHO, 2018d). It is possible that wastage and leakage may be contributing to high stock-out rates. Other supply chain factors, such as the volume of drugs coming into the system, which is driven by budget allocation for procurement and spending efficiency, add complexity to the issue.

At present, responsibility for the procurement of essential medicines is divided: development partners buy program drugs and the GOL buys all non-program essential medicines. The Global Fund purchases HIV, TB, and malaria commodities, as well as diagnostic equipment and supplies; USAID buys malaria and family planning commodities; Gavi, the Vaccine Alliance covers vaccinations; the United Nations Population Fund buys family planning commodities; and UNICEF buys integrated community case management of childhood illness products. The GOL currently does not procure any of these commodities. In the future, should the GOL begin procuring these commodities, it should determine a way to contribute funds to the procurement orders managed by partners or other international procurement agents in order to take advantage of cost savings from pooled procurement. It would be inefficient for the GOL to procure commodities such as antiretroviral drugs and laboratory reagents on its own.

Absenteeism of Healthcare Workers

In 2009, the African Health Observatory recognized that ghost workers were a problem for the Liberia health system (AHO and WHO AFRO, 2009). However, the MOH acknowledged there was not much data available on the absenteeism rate of the health workforce. The last two national census reports of health workers in Liberia revealed that 5% of health workers were absent in 2010 (MOHSW, 2010) and 2% in 2016 (MOH, 2016), however, these reports indicated that it was not possible to calculate a true absenteeism rate and even the structural absenteeism rate would likely be much higher than this. To address the issue of improving health workforce productivity, USAID has supported the creation of county management dashboards to track absenteeism, staff complaints, number of unfilled positions, number of staff not receiving monthly salaries, and number of staff needing training (USAID, 2015).

Performance-Based Financing

From 2011 to 2015, USAID's health sector fixed amount reimbursement agreement (FARA) supported the GOL with $42 million in performance-based financing (PBF) for the delivery of the Essential Package of Health Services at the primary healthcare level in three counties (USAID, 2017). The FARA awarded performance-based contracts to NGOs to provide service delivery for family planning, immunizations, malaria, maternal and child health, and water, sanitation, and hygiene programs. Results were mixed, as FARA counties performed no better or worse than non-FARA counties, although FARA facilities did perform better than non-FARA facilities nationally for almost all indicators tracked (USAID, 2017). Among specific indicators, FARA facilities showed the most improvement in the areas of malaria and maternal and child health, but performance for family planning remained poor. The FARA PBF incentive scheme did appear to have a highly positive effect on staff motivation, performance, and attendance (USAID, 2017), which may account for the better performance from FARA facilities than non-FARA facilities.

USAID believes that there is enough evidence to recommend introducing the FARA mechanism to other partners and widening the range of clinical indicators covered under the mechanism (USAID, 2017). The mechanism is currently being expanded to five additional counties. Further investigation is needed to understand root causes of past performance, inform recommendations to address problematic areas and unintended consequences, and adjust performance indicators, targets, and institutional arrangements as needed. Such an analysis of past PBF performance can inform future roll-out of the program.

With support from the World Bank Global Financing Facility, the MOH is designing another PBF contracting-in approach in which the GOL will directly contract counties with the lowest performance on basic health and service indicators to provide reproductive, maternal, newborn, child, and adolescent health services. Additionally, the MOH is working with the World Bank to implement PBF in six secondary and tertiary hospitals to improve the quality of care (World Bank, 2017b). The World Bank mechanisms, with support from USAID, are intended to build upon, learn from, and harmonize with the FARA mechanism. The MOH hopes to learn from these PBF initiatives so they can move away from the way health services are currently purchased, which does not take into account health outcomes or the quality of health services being provided. A medium-term objective is for the MOH to design a strategic purchasing strategy built upon performance-based provider payment mechanisms within the LHEF.

BOX 3. EFFICIENCY OPPORTUNITY

Harmonizing Performance-Based Financing Initiatives

If the FARA and World Bank PBF mechanisms are successful in improving performance and quality for reproductive, maternal, newborn, child, and adolescent health services, there is an opportunity to apply a similar approach to improve service delivery for HIV, TB, and malaria, which can work alongside the mechanisms already in place.

KEY TAKEAWAYS: EFFICIENCY IN HEALTH SPENDING

- The 91% budget execution rate showed fairly good absorption capacity for money that is released to health.
- Cost savings could be achieved through more efficient service delivery models for HIV and TB, such as differentiated care; once identified, these models should be included in national guidelines for implementation.
- USAID and the World Bank are implementing PBF to improve quality of care for maternal and child health, family planning, malaria, and other services. These PBF systems could guide development of an LHEF strategic purchasing strategy.

Effective Advocacy for Health

Increasing domestic allocations to health will require sustained, effective, and targeted advocacy. A comprehensive understanding of the budget process is critical to identify key entry points and the appropriate audience and timing of advocacy efforts. The following section illustrates the budget process and identifies key opportunities for advocacy.

UNDERSTANDING THE HEALTH BUDGET PROCESS

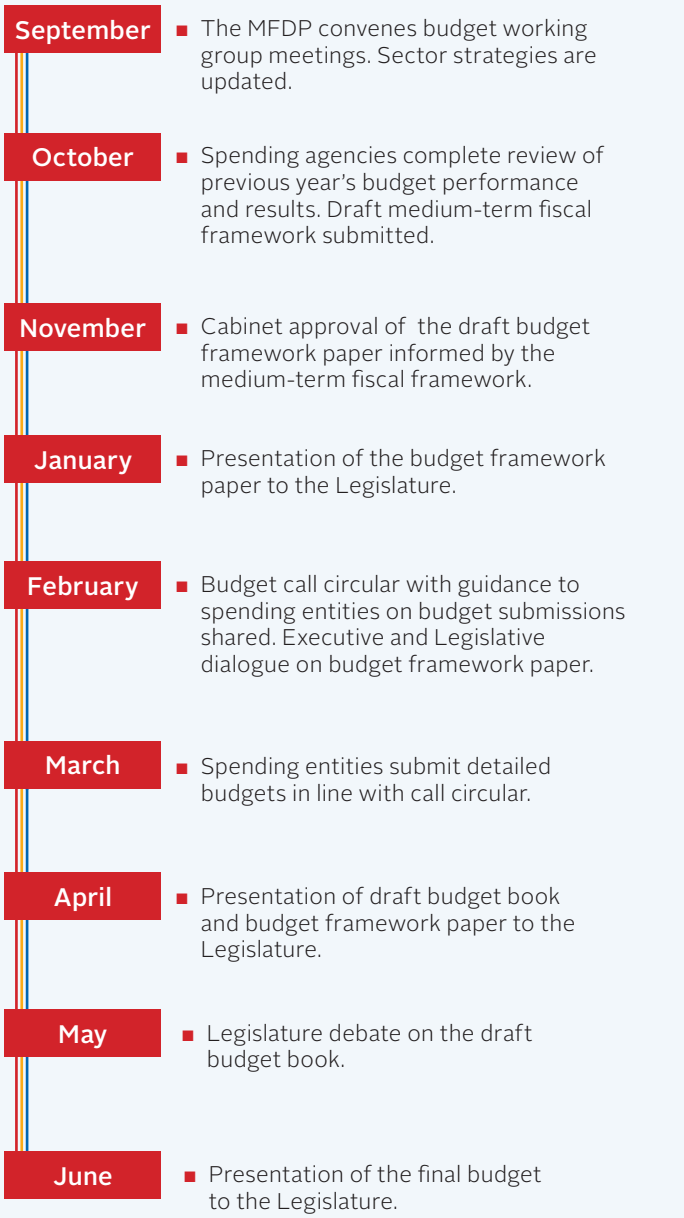
The Liberia budget development cycle is a consultative process that invites inputs from various stakeholder groups throughout the country, including civil society organizations. This process is regulated by the Public Finance Management Act of 2009 (GOL, 2009). The budget process is carried out by the MFDP, the president, the cabinet, spending agencies, and the Legislature. Nearly three-quarters of the health sector's allocations are made at the central level under the MOH budget line, although input to budget development is provided by subnational entities. The budget process starts in September and ends in June (Figure 11), with the fiscal year starting on July 1.

Budget Preparation

The MFDP leads the budget preparation process, which consists of two main phases: the first phase is the preparation of a budget framework paper and a budget call circular and the second phase is the preparation of a detailed annual budget that addresses the policies and priorities set out in the budget framework paper.

The first phase of the budget cycle begins by determining the resource envelope available for the year via the medium-term macroeconomic and fiscal framework. Next, a medium-term expenditure framework is prepared that considers revenue and spending figures from the past

Figure 11. Budget Preparation and Approval Process



Source: Adapted from MFDP, 2018c

year and estimated outruns of the current year. Indicative spending ceilings are established for the budget year, which considers national policy priorities and sector-specific strategies that are established through a consultative process. This initial phase is expected to be completed with the approval of the consolidated budget framework paper by the president and cabinet no later than five months before the start of the fiscal year (by the end of January).

The second phase of the budget cycle begins with issuance of budget guidelines and a budget call circular by the MFDP. Spending agencies must submit their budget requests within the parameters outlined in the budget call circular. The MFDP oversees the consolidation of budget submissions and, in consultation with the president, finalizes the budget after a series of budget hearings with spending agencies. A draft annual national budget is submitted to the National Legislature by the end of April each year.

Budget Approval

Upon receipt of budget estimates, the minister of finance conducts budget hearings with ministries and spending agencies to review strategic plans and estimates in order to ensure that they are in accordance with the government's macroeconomic policy and fiscal framework. When necessary, the minister of finance may require ministries and agencies to adjust their submissions in March/April. The proposed budget is then presented by the president to the Legislature, which then approves the national budget.

Budget Execution and Disbursement

Once the Legislature approves the national budget estimates and after a general warrant is issued by the president, spending agencies are authorized to spend their allocated budget. Total aggregate allotments for a particular appropriation line in a given fiscal year may not exceed the amount appropriated. The heads of ministries, government agencies, or spending units have budgetary control over their activities and expenditures. Indicative cash flow requirements, broken down by month and by quarter to show how budgets are intended to be spent in order to plan for release of funds, are submitted to the minister of budget. Debt service payments are among the first call on expenditures.

Subject to the rules and regulations of the 2009 Public Finance Management Act, the deputy minister of budget may approve reallocation of appropriations to promote efficiency in the government, support changes in programs enacted by the Legislature taking effect during the year, or provide resources deemed necessary for an agency to render essential basic services. At the end of each financial year, unexpended money is redeposited into the consolidated fund, unless permission has been granted by the minister of budget to rollover funds to be used in the next fiscal year.

Budget Monitoring and Evaluation

The Internal Audit Governance Board was established to provide budget oversight and to monitor whether ministries and agencies are complying with the Public Finance Management Act of 2009. Each government agency or organization has its own internal audit unit. Additionally, the General Auditing Commission serves as a watchdog to monitor and audit government use of public funds and program performance. The commission is empowered to serve as a pillar of accountability, transparency, and fiscal probity within the public sector. Responsibilities include conducting post-transaction audits, financial investigations, reconciliations and analyses, and routine audits. The commission's Public Expenditure Tracking Unit conducts expenditure surveys to inform recommendations to improve accountability, transparency, and efficiency of the transfer of resources. Each agency prepares an internal action plan to implement these recommendations.

KEY TAKEAWAYS: OPPORTUNITIES FOR ADVOCACY

The budgetary and legislative cycles provide several key windows of opportunity for the MOH, civil society organizations, and partners to advocate for increased or more targeted resource allocations and to move forward the health financing reform agenda. The following describe advocacy actions and windows of opportunity.

1. **Engage legislative committees:** The legislative debate on the draft budget book in May/June is a key advocacy opportunity. Direct engagement with influential committees, such as the Ways, Means, and Finance Committee and Budget Committee, provides an opportunity to reinforce advocacy "asks" and provide input into budget speeches by health financing champions in front of the full Legislature. In low-income settings, ministries of finance have often cited poor absorption as justification for not allocating more money to health. However, in Liberia, in FY 2017/18, the MOH's 91% budget execution rate showed fairly good absorption capacity for money that is released to health, an important point to make during the advocacy process.
2. **Participate in inter-ministerial budget consultations with the MFDP:** According to the MFDP deputy minister for planning, the MOH has an opportunity for increased domestic resource mobilization if it can show that financing can be tied to improved health sector outcomes. Advocacy for health has been unsuccessful in the past because requests were not sufficiently supported by evidence. The MFDP also cited a need to improve coordination and alignment of external financing to ensure that key health areas that suffer from major resource gaps can be prioritized by donors.
3. **Support the MOH in engaging the Legislature on health financing reforms:** According to a member of the House of Representatives, the advocacy process must start early in January/February for a bill to have a better chance of being passed before the House goes into recess at the end of August. Universal healthcare is already an accepted concept in Liberia, making the timing opportunistic for LHEF reform. Advocates may support the drafting of the bill itself; once the bill is called for a public hearing, they also have the opportunity to form a coalition with civil society organizations, partners, and House and Senate champions to support the bill. Another window for engagement to advocate for the bill's merits and necessity is at the open session of the plenary where public participation is welcomed.

Given that the fiscal space for health is tight, despite GDP growth, the most promising prospects to increase domestic resource mobilization for health are the various reform initiatives currently under consideration in Liberia to establish more sustainable financing mechanisms for health.

Conclusion

Given the projected resource envelope for health, which includes substantial but declining donor aid, there is an estimated financing gap of $757 million needed over seven years to implement the MOH's investment plan. Although the GOL's per capita health expenditure has remained relatively flat over time at around $10–$12, health ranked fourth in terms of sectors prioritized and received a 14.6% allocation of the total government budget. While this indicates that health is a high priority in public budgeting, the small overall GOL resource base contributes to the observed very low per capita government spending on health. As a result, out-of-pocket expenditure and donor dependence for financing health remains high. Liberia's economy looked poised for strong GDP growth after recovering from the Ebola crisis, however, the fiscal space to mobilize significant additional resources for health is limited due to the government's recurring budget deficit, declining grant inflows, and escalating debt levels. In this context, achieving increased budget allocations for health through advocacy during the budget formulation process will likely be a substantial challenge. Still, advocacy is important to prevent erosion of budget allocations to health.

Recent resource gaps and trends for malaria, HIV, and TB programming indicate a decline in donor financing for these disease areas. This suggests that the GOL must reorient its resources to account for this changing financing environment. The GOL is now responsible for counterpart financing equal to 5% of Global Fund's contribution to malaria, HIV, and TB, although that contribution need not be allocated to these three disease program areas. The MOH will have a better chance of increasing domestic resource mobilization if it can show that financing can be tied to improved health sector outcomes and if advocacy efforts for health aimed at the MFDP are sufficiently supported by evidence.

To improve efficiency and quality of care, the World Bank is currently providing technical assistance to improve the resource allocation formula. Current government spending may be too heavily favored toward hospital-based care, with not enough going to primary healthcare. The MOH also has an opportunity to learn from PBF initiatives being implemented by USAID and the World Bank, which can inform the design of a strategic purchasing strategy that is built upon performance-based provider payment mechanisms within the LHEF. The MOH can also adapt or learn from interventions adopted in other sub-Saharan countries that use more efficient models of service delivery, such as differentiated care for HIV, to help ensure that more patients can be seen by existing health workers and facilities within the current scope of financial resources. Further analyses are needed to inform where efficiency gains can be found. Examples of activities to address information gaps include the following:

- Analyze past performance from FARA program counties to inform future rollout and scale-up of a program that will improve quality of health services. This includes further investigation to understand root causes of poor performance; technical assistance to adjust performance indicators, targets, and institutional arrangements, as necessary; and a deeper dive into comparing FARA counties to non-FARA counties, controlling for differences in demographics, health burden, and funding levels.
- Quantify savings that could be achieved through more efficient service delivery models for HIV and TB, such as differentiated care, and then develop national guidelines to implement these models.
- Conduct a comprehensive costing of Liberia's HIV clinical cascade to identify promising and cost-effective practices to improve how people living with HIV are identified, linked to care, initiated on treatment, and retained on treatment to achieve viral suppression.

- To address the issue of improving health workforce productivity, better tracking mechanisms for absenteeism and staffing is needed. USAID is supporting this effort.

The most promising prospects to increase domestic resource mobilization and establish more sustainable financing mechanisms for health are the various reform initiatives currently under consideration in Liberia. Although efforts to operationalize the LHEF were put on hold during the Ebola crisis, it has reemerged as the primary health financing reform objective for the MOH and appears to have the political backing needed for an LHEF bill to be passed. The following activities are needed to inform and galvanize domestic resource mobilization efforts.

- Increase advocacy and sensitization on the merits of the LHEF, including increased financial protection for the poor and vulnerable, to the full House of Representatives, which may help move the legislative process to successful conclusion.
- An actuarial study should be conducted to determine the financial implications of LHEF scale-up, the cost of the benefits package, and the capacity of the GOL to implement such a scheme. This study can forecast the long-term feasibly of the scheme based on forecasted revenue and expenditures and provide an assessment of staffing and administrative requirements for running the scheme. This is a key gap in the data needed to support the LHEF.
- Establish a Liberia Chapter of the Africa Healthcare Federation to act as an advocacy institution and provide a venue for the private health sector to engage with the GOL to raise domestic resources for health through public–private partnerships and corporate social responsibility. The private sector's financing contribution to the health sector is small, but is growing, presenting an opportunity to leverage more financing from the private sector.
- Explore possibilities to leverage grant funding from China for health, given China's growing interest in partnering with the GOL.
- The leveraging of remittances to increase financing for health is an innovative mechanism that should be conceptualized and implemented. Remittances represent large cash inflows into the country and could potentially be a substantial and reliable revenue stream if it can be pooled into a mechanism like the LHEF.
- Weigh the pros and cons of tax reforms, such as earmarked sin taxes, with its regressive nature, and the potential for increased revenue from a more progressive value-added tax. An analysis to understand feasibility and revenue prospects of such reforms is needed, given that proposals for tax reforms have gained traction.
- The MOH should explore additional innovative mechanisms with potential for increasing financing for health. For example, a blended financing intervention that finances co-pays for insurance subsidies may be a way to decrease out-of-pocket health expenditure for the poor.

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