Policy Brief

Enhancing Investments in Primary Health Care for the Achievement of Universal Health Coverage in Sierra Leone

Ministry of Health, Freetown, Sierra Leone

Key words: *Primary Health Care, Innovative financing, health expenditure*

Financing Alliance for Health

Executive Summary

According to the World Health Organization (WHO) & United Nations International Children Emergency Fund (UNICEF), Primary Health Care(PHC) is defined as, "a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment"[1].

The Government of Sierra Leone is committed to improve Primary Health Care (PHC) through global agendas such as the 2030 Sustainable Development Goals[2]. The National Health Sector Strategic Plan 2021-2025 and Health Care Financing Policy document focus on providing accessible and affordable quality health care services to the populace without suffering any financial hardship[3]. In recognizing this and in line with the 2018 Astana Declaration, the Government of Sierra Leone, through the Ministry of Health has renewed its commitment to revamp PHC system as part of improving health and well-being of its people.

A key takeaway from the 77th World Health Assembly in 2024 was the emphasis on reorienting health systems towards high-performing PHC services and interventions as the most effective pathway to achieving UHC. This approach aims to provide essential health services to all individuals without financial hardship[4]. Highly performing PHC system can achieve better health outcomes at reduced cost compared to systems that focus on disease-specific or hospital-based care.

The National Health Accounts reports of 2017 to 2021 indicate that household out-of-pocket expenditure is very high, it stood at 50.4% as a share of current health expenditure for the above period reviewed. This exposes the people of Sierra Leone to catastrophic health spending when they visit a health facility.

This policy brief therefore makes the following recommendations:

1. Increase Government allocation for Primary Health Care from 2% to 12%;
2. Implementation of a National Social Health Insurance scheme;
3. Innovative financing mechanisms to unlock domestic resources for Primary Health Care;
4. Re-introduction of Performance-Based Financing (PBF) and
5. Introduction of Direct Facility Financing (DFF).

Concerted efforts from government, donors, policy makers, political actors, health insurance managers, service providers, and the private sector are crucial for policy implementation.

Description of the Problem

In its effort to increase access to quality services to the people of Sierra Leone, the Ministry of Health has made significant strides in strengthening Primary Health Care (PHC) system.

Despite these advancements, existing challenges may hinder the attainment of Universal Health Coverage goals (UHC)[5]. These challenges are underscored:

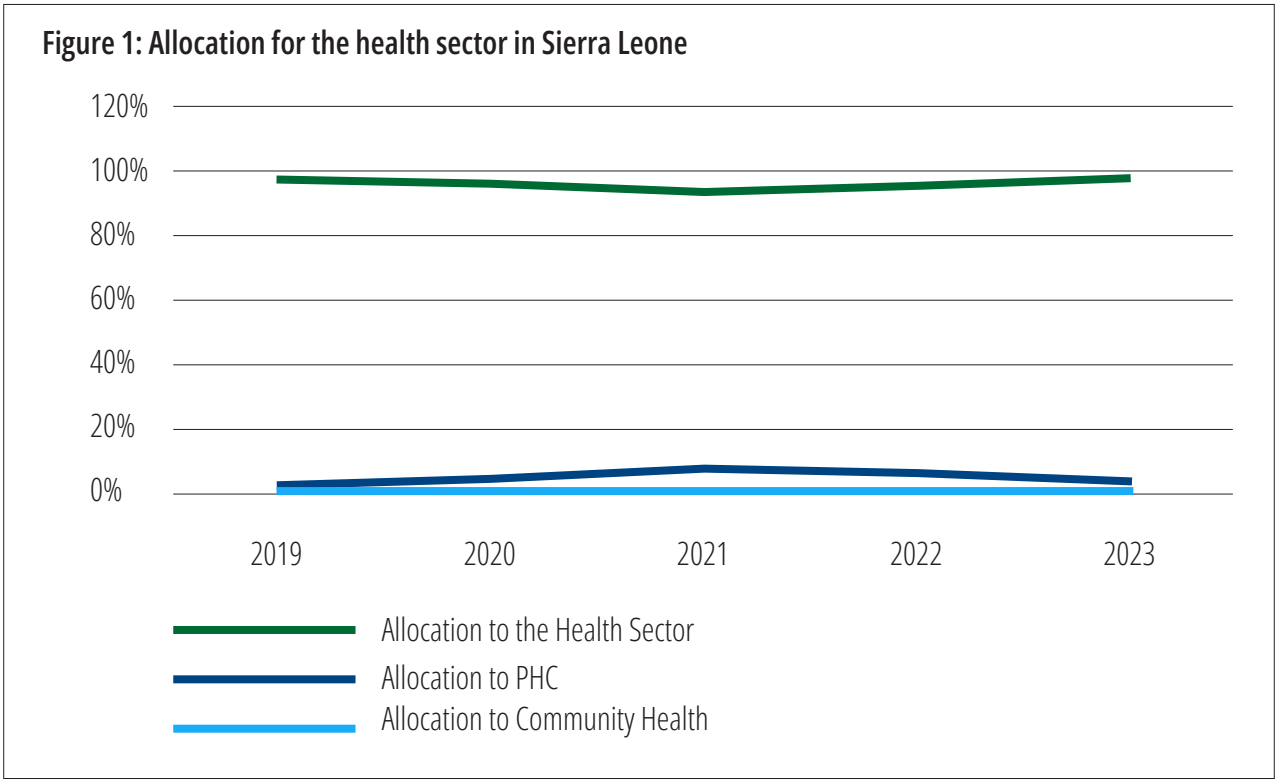
1. Limited funding

One of the most pressing issues facing the health care system in Sierra Leone is limited funding. This financial shortfall hampers the ability to provide essential services especially at the Primary Health Unit (PHU) level. The health sector's budget allocation is often insufficient to meet the growing demands of the population. The allocation made by the government to the health sector and PHC is as shown on figure 3 below. For primary health care in particular, the allocation is less than 5% of General Government Health Expenditure (GGHE)[6]. This limited funding results in shortage of medical supplies, old facilities, and limited availability of critical health services[7]. For instance, many health facilities lack basic diagnostic tools and essential medicines, which compromises the quality of care provided to patients.

Additionally, the limited financial resources restrict the government's ability to invest in health infrastructure, such as building new health facilities or upgrading existing ones. This inadequacy is particularly evident in rural areas where health facilities are often in poor condition and lack of essential amenities like clean water and electricity. In addition to this, it also affects the ability to maintain an adequate stock of medical supplies and equipment, leading to frequent shortages that can disrupt service delivery.

From the foregoing, it therefore becomes imperative that as a country, a focus be made towards strengthening the primary health care landscape, exploring innovative ways to reduce out of pocket expenditure and exploring strategic avenues to increase domestic financing and ensuring additional allocations to PHC.

Figure 1: Allocation for the health sector in Sierra Leone



2. High Household Out-of-Pocket Expenditures

High out-of-pocket (OOP) expenditures present a major obstacle to equitable health care access in Sierra Leone. Many patients face substantial costs when seeking medical care, which can deter them from utilizing health services. These expenses include costs for consultations, medications, diagnostic tests, and transportation to health facilities[5].

The National Health Account (NHA) reports from 2017 down to 2021 revealed that household out-of-pocket expenditure as a share of Current Health Expenditure (CHE) has been on the decline as seen on figure 2 below.
Nonetheless, the OOP of 50.4% in 2021 is still very high. This level of expenditure indicates that households in Sierra Leone are the principal contributors to health financing, which has severe implications for access to healthcare and financial protection.

Households in Sierra Leone face significant challenges in channeling out-of-pocket expenditures into prepayment schemes. The existing risk pooling mechanisms are limited to private insurance, which remains unaffordable for most of the informal sector. This high out-of-pocket spending poses a risk of impoverishment, especially considering that it contributed to 61% of the total health expenditure (THE) in the country in 2018, which is one of the highest rates in sub-Saharan Africa.

High OOP expenditures can deter individuals from seeking necessary medical care due to the financial burden it imposes. This is particularly problematic in a country like Sierra Leone, where the poverty rate is high, and many households live on subsistence incomes. The World Bank data indicates that over half of the population lives below the national poverty line. For these households, the cost of medical care can be catastrophic, forcing them to choose between healthcare and other essential needs such as food, education, and housing.

In practical terms, this financial barrier disproportionately affects vulnerable populations, including women, children, and the elderly, who are more likely to require frequent medical attention. For instance, a visit to a health facility for a common illness can cost a household an entire month's income, leading to financial distress and potentially driving them deeper into poverty.

The high OOP costs also lead to delays in seeking care, as individuals may wait until their condition becomes critical before seeking treatment. This delay not only worsens health outcomes but also increases the overall cost of treatment, as more advanced and expensive interventions may be required. The financial burden of health care expenses can also lead to increased indebtedness and exacerbate poverty, creating a cycle of poor health and economic hardship.

Figure 2: Trend of Funding by source between 2017 to 2021

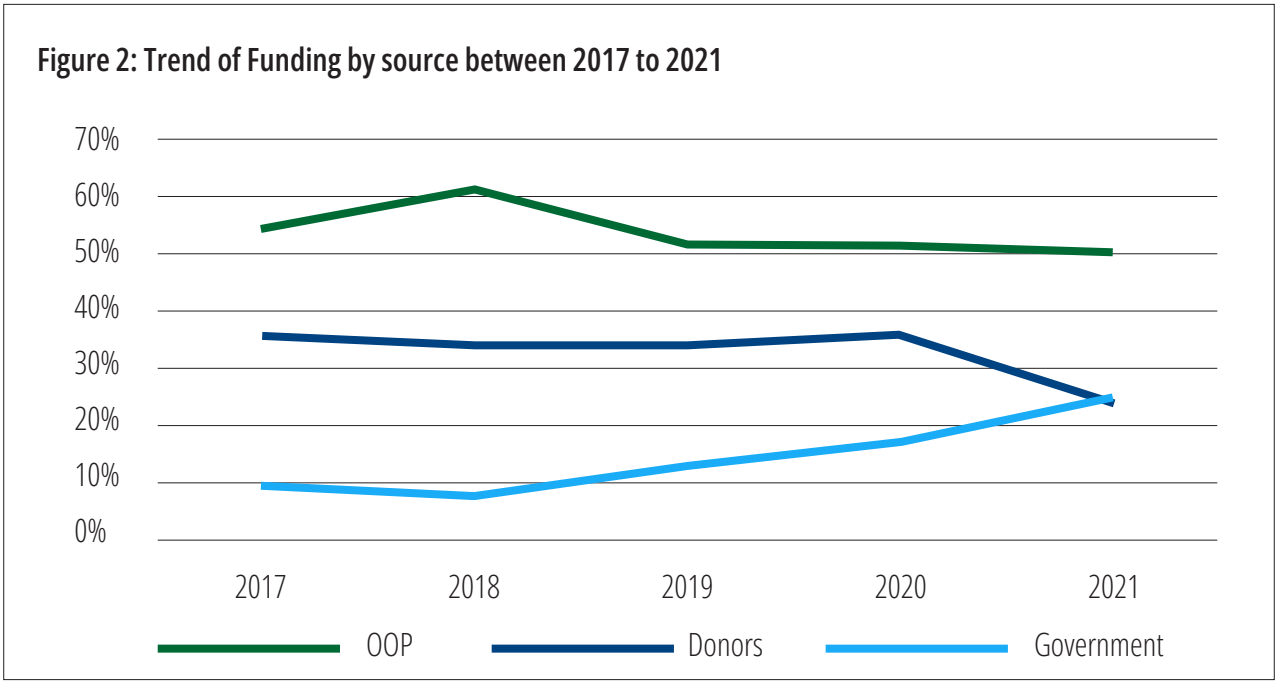


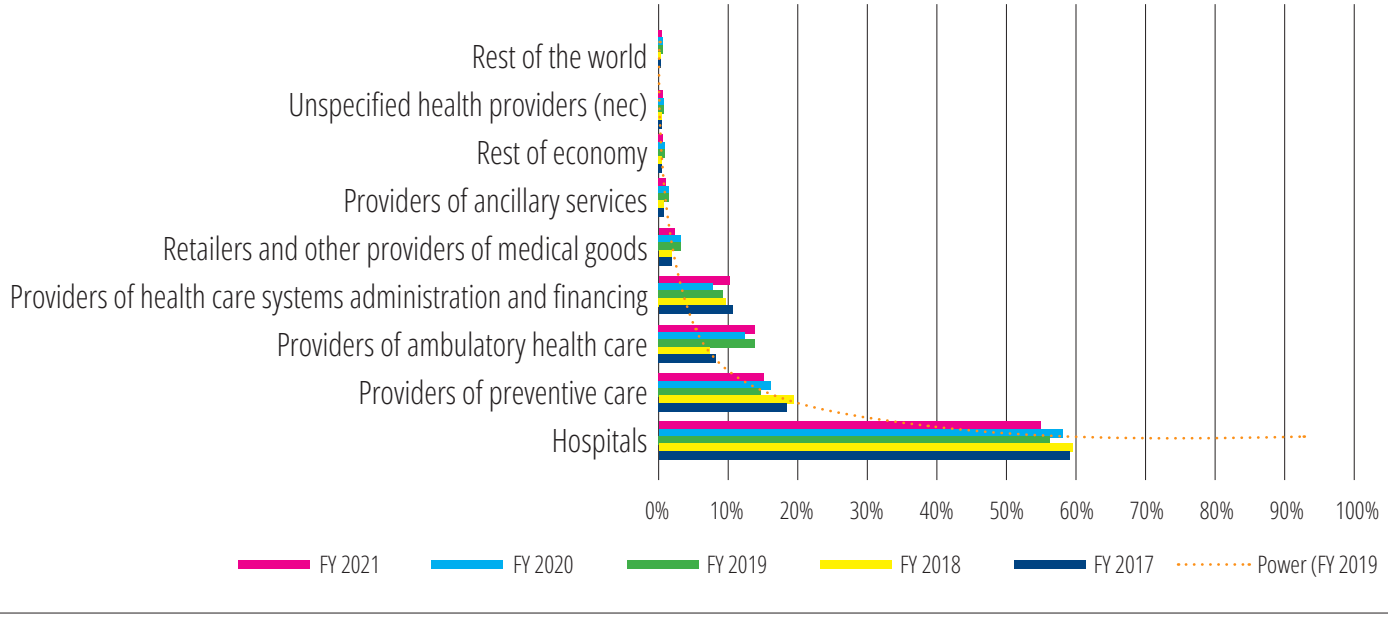
Figure 2 equally demonstrates that as donor funding dwindled, there was a steady increase in government expenditure. This is an indication that the government is moving towards the right direction to protect her citizens from catastrophic health expenditures and the need to put appropriate mechanisms/strategies in place to ensure individuals, especially vulnerable populations are protected from the financial burden of accessing health care as the country strives towards achieving Universal Health Coverage (UHC).

Despite this improvement in government expenditure, OOP expenditure remains very high.

Additionally, from 2017 to 2021, the government had spent hugely for hospitals and less for preventive care. Figure 3 below depicts that of the Total Health Expenditure (THE), more than 50% was spent on hospitals and less than 20% for preventive care.

In 2021 alone, of the THE, the government spent 55.0% on hospitals and only 15.5% on preventive care.
Worth mentioning that households in Sierra Leone remain the major contributors of the hospital and preventive health care spendings. In same 2021, households contributed 73.7%, government spent 15.7% and donors 10% on hospitals. This suggests that the country is still faced with very high levels of curative services spending compared to preventive ones.

Figure 3: Health Expenditure by health care provider 2017-2021



Given that preventive care offered at the PHC level is very important towards the attainment of universal health coverage, there is need for government to focus more on preventive services rather than curative services as preventive services are more cost effective and efficient[8].

Moreover in 2021, it was observed that external funding account for 60.6% on preventive healthcare expenditure whilst the government spent 39.3%; indicating that external funding is the main funding source of preventive care provision in the country. This dependency on donor support is unsustainable for the health system, as donor contributions are likely to diminish or be phased out over time, affecting the stability of healthcare programmes.

For reproductive health expenditure, it was observed that maternal conditions accounted for the highest share of reproductive expenditure (40%) in 2021 because of high intrapartum care (during birth) expenditure. Additionally, contraceptive management (family planning) and perinatal conditions accounted for 12.8% and 12.3% respectively. These gains should be sustained and continue increasing awareness and utilization of the different family planning methods and perinatal services.

Further analysis revealed that in 2021 alone, households' contribution towards reproductive health in Sierra Leone was the highest followed by government and donors respectively. This is a major concern because there is more burden on citizens in gaining access to reproductive care services in the country. Expenditure on unspecified reproductive healthcare conditions excluding maternal, perinatal and contraceptive management was 34.4% in the same year.

Examining the disease share of current health expenditure, from 2017 to 2021 reveals that spending on malaria accounted for more than 22% of the CHE. This is detailed in table 1 below.

Table 1: Current Health Expenditure by Disease/Conditions, 2017-2021

Diseases	2017	2018	2019	2020	2021
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	3.1%	3.0%	3.7%	5.2%	3.3%
Tuberculosis (TB)	0.5%	2.4%	1.5%	1.5%	1.4%
Malaria	25.5%	30.0%	23.0%	28.3%	22.9%
Respiratory Diseases	0.0%	0.0%	1.0%	1.8%	4.0%
Diarrheal diseases	10.1%	3.7%	7.1%	5.0%	3.2%
Neglected tropical diseases	1.0%	0.9%	0.8%	0.8%	1.1%
Vaccine preventable diseases	1.6%	1.0%	4.4%	3.1%	3.9%
Public Health Emergencies of International Concern (PHEIC)	0.0%	0.0%	0.0%	0.0%	3.3%
Other and unspecified infectious and parasitic diseases	2.3%	6.2%	9.8%	4.8%	11.1%
Reproductive health	14.0%	16.3%	16.3%	21.7%	17.3%
Nutritional deficiencies	12.0%	9.5%	9.8%	9.1%	8.5%
Non-Communicable diseases	16.4%	20.1%	18.1%	15.9%	17.0%
Injuries	1.1%	1.1%	2.5%	1.8%	2.6%
Non-disease specific	12.4%	5.8%	2.1%	1.0%	0.6%

3. Underutilization of PHC services

The underutilization of Primary Health Care (PHC) services in Sierra Leone at all levels of service delivery remains a significant concern and a major bottleneck to the attainment of UHC. The National Primary Health Care Operational Handbook outlines the guidelines for PHC services delivery in the country. However, the 2018 Sierra Leone Demographic and Health Survey identified cost as a significant barrier to the access and utilization of maternal and child healthcare services1. Unavailability of essential drugs and geographical barriers have also been identified as barriers to utilization. Despite the introduction of the Free Health Care Initiative (FHCI) in 2010 to enhance access and utilization of maternal and child health services by removal user-fess, the problem of underutilization persists[1].

The WHO emphasizes that over 90% of essential interventions for universal health coverage can be delivered using a Primary Health Care (PHC) approach2. Nevertheless, the utilization of PHC services in Sierra Leone is currently less than 50%. To enhance the utilization of PHC services in Sierra Leone, it is essential to focus on reducing financial and geographical barriers. This involves ensuring a steady supply of essential drugs and addressing additional challenges such as transportation and socio-cultural issues that hinder equitable access to healthcare. Overcoming these obstacles is vital for promoting PHC service usage and improving overall health outcomes in the country.

4. Overreliance of external funding

According to the 2021 National Health Accounts report, donors accounted for 60.6% of preventive healthcare expenditure, while the government contributed 39.3%. This heavy reliance on donor funding for preventive care is concerning for the long-term strengthening of the health system, as donor support is likely to decrease or phase out over time. Figure 2 shows that in 2017, donor contributions made up 36.9% of the Total Health Expenditure (THE), highlighting the Ministry of Health's dependence on external funding. For sustainable health system development, it is crucial to increase government allocations to health in line with the Abuja Declaration, which recommends that 15% of national budgets be allocated to the health sector.

5. Social Health Insurance:

The establishment of a Social Health Insurance (SHI) scheme in Sierra Leone is critical health systems gap yet to be addressed by the government. Currently, there is no scheme that contracts health facilities to provide healthcare services, which would help reduce out-of-pocket expenditures for citizens. Implementing SHI would offer substantial benefits, including risk pooling and strategic purchasing. Risk pooling spreads financial risks across all enrolled members, protecting individuals from medical costs, while strategic purchasing enables the SHI system to acquire health services more efficiently and effectively, thereby improving the quality and accessibility of care. It is imperative that the Ministry of Health expedites the implementation of the Sierra Leone Social Health Insurance scheme while ensuring that the population is adequately informed, sensitized, and enrolled. SHI will reduce financial barriers to healthcare and improving overall health outcomes through a structured and sustainable funding mechanism.

The issue of Health Insurance in Sierra Leone is a major supply-side issue, because this scheme has not been set-up by the government for health facilities to be contracted to provide health care services, which would help reduce households' out-of-pocket expenditure.

To avert this situation plans are in view for a scheme to kick off in November 2014, however, the Ministry of Health needs to fast track the process of launching and implementation of Sierra Leone Social Health Insurance scheme so that the population can receive adequate sensitization and enroll into the scheme.

Proposed Policy options

1. Increasing government budget allocations to primary health care (PHC)

One of the specific aims of the National Health Sector Strategic Plan 2021-2025 is to increase government budget allocations for primary health care in Sierra Leone to twelve percent (12%) by 2025. Insights can be drawn from Nigeria's Basic Health Care Provision Fund (BHCPF), a pivotal step towards achieving Universal Health Coverage. Established by an Act of Parliament in 2014, the BHCPF supports the effective delivery of primary and secondary health care services by providing a Basic Minimum Package of Healthcare Services (BMPHS) and Emergency Medical Treatment (EMT)[9]. The 2014 National Health Act mandates that one percent (1%) of the Consolidated Federal Revenue (CFR) be allocated to the Basic Health Care Provision Fund (BHCPF), which supports both supply and demand-side investments in primary health care (PHC). The BHCPF also receives funding from international donors and various other sources, including the private sector.

a.) Pros of increase budget allocation to PHC

Improved Health Outcomes: Investment in primary health care is the best approach to achieving universal health coverage as stipulated by the WHO. Adequate investment in PHC can lead to better health outcomes. By focusing on preventive and early intervention services, PHC can reduce the need for unnecessary hospital admissions, prevent avoidable readmissions, and limit inappropriate use of emergency departments[12].

Reduced Mortality: Model estimates suggest that increasing PHC expenditure from an average of 5.6% of GDP to 6.6% of GDP in 67 low-income and middle-income countries could avert up to 64 million deaths[12]. This highlights the potential impact of increased funding on mortality reduction.

Equity and Accessibility: Allocating resources to PHC ensures that essential health services are accessible and affordable to all, regardless of socioeconomic status[13]. A resource allocation formula based on need or per capita distribution can promote equity in allocation.

Visibility and Accountability: Making PHC allocations more visible in health budgets helps emphasize the importance of essential public health functions. It also incentivizes accountability for sector performance14.

Cost-effectiveness: Making more allocations and increasing investment to PHC has been proven to be more cost effective and efficient[14].

In summary, investing in PHC can yield significant benefits for population health, equity, and overall health system performance. Research indicates that every dollar invested in PHC in Sub-Saharan Africa can yield a return of up to $10 in economic and social benefits due to reduced healthcare costs, increased productivity, and enhanced quality of life . Governments should prioritize adequate funding for PHC to achieve these positive outcomes and ensure sustainable health improvements.

b.) Cons of Increase allocations to PHC

Increasing government budget allocation for primary health care (PHC) is not devoid of challenges.

Resource allocation challenge: Inadequate political commitment and diffuse political interest may lead to interference in decision-making and budget allocation processes. This can affect resource allocation and priorities. There should be political will to prioritize Primary Health Care.

Resource Utilization Challenges: While increased funding is essential, it doesn't guarantee that resources will effectively reach frontline services. Ensuring that PHC allocations reach frontline providers requires strategic purchasing, transparency and accountability mechanisms[15].

Inefficiencies: Without proper management and oversight, increased budgets may lead to inefficiencies and misallocation of funds. It's crucial to monitor spending and ensure that resources are used effectively.

While increasing PHC budgets is essential, it's equally important to address these challenges to maximize the impact of PHC funding on health outcomes. Continual monitoring, evaluation, and strategic planning are key to successful implementation of primary health care activities.

2. Improving the risk pooling mechanisms for health care services

a.) National Social Health Insurance

There are good examples of countries in the African continent with robust health insurance schemes (Rwanda and Ghana) that can be illustrated here. Since its inception in 2003, the Ghanaian government has made significant strides toward achieving universal health care. By 2014, the NHIS enrolled 10.5 million people, representing 40 percent of the nation's population. ***Notably, Ghana is the only country globally to primarily fund its health insurance scheme through value-added tax (VAT) revenue.*** This approach ensures that NHIS revenue consistently aligns with economic growth, as highlighted by the stable share of NHIS revenue in total government spending. Utilizing VAT for health care funding also creates an implicit subsidy for essential care and facilitates risk and cost pooling at the national level, thus avoiding the scheme fragmentation seen in many other countries. However, a major drawback of this mechanism is that revenue does not increase in proportion to expanding coverage.16 The National Health Insurance Scheme (NHIS) is chiefly funded by tax revenue, with claims constituting most of its expenses. The NHI levy contributes 74 percent of NHIS income, while deductions from the Social Security and National Insurance Trust (SSNIT) make up another 20 percent. Premium payments account for only 3 percent. On the expenditure side, claims payments represent 77 percent of NHIS spending.[16]

Research has shown that, on average, women enrolled in the insurance scheme are more inclined to seek formal medical care when ill, have a higher number of prescriptions, are more likely to have visited a clinic or hospital in the year preceding the interview, and are significantly more likely to have had an overnight stay at a hospital in the past year[17]. Results from another investigation indicated that the NHIS had a noticeable effect in alleviating the financial strain of healthcare costs, aligning with findings from similar studies in other low- and middle-income countries (LMICs). More precisely, insurance has been linked with a reduction of 1 to 6% in out-of-pocket expenditures (OOPEs) in Indonesia (2%), Vietnam (6%), India (2%), Kenya (2%), Mali (3%), and Nigeria.[18]

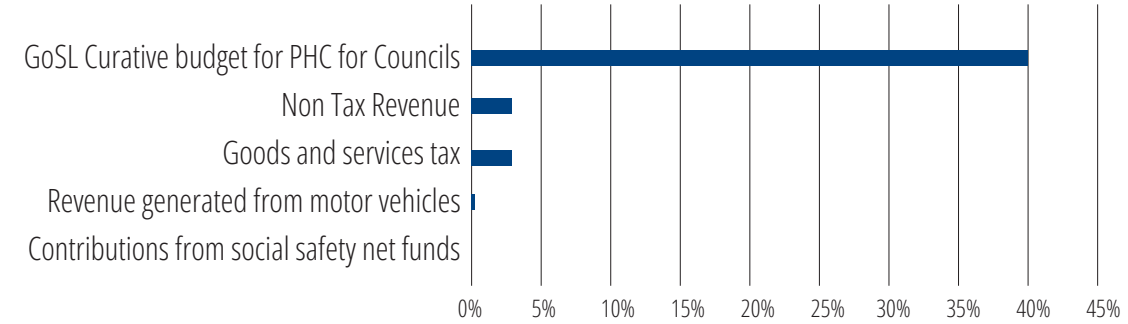
The Ghana NHIS has made significant contributions to improve health services utilization and outcomes since its introduction in 2003[19]. While the scheme faces challenges, some strategies that led to success are: innovative registration methods, addressing health care provider claims delays, evidence-based solutions, primary health care focus and purchasing.

Sierra Leone Social Health Insurance benefit package should be re-designed to reduce OOP payments for the population[20]. This scheme should factor the provision of quality PHC services for free. The advantage of the scheme is that it will reduce out-of-pocket expenditure by protecting household from financial risk associated with health care expenses and reduce the burden on families. This cost will therefore be borne by the Government.

Contributions to support SLeSHI in the first phase will be raised from formal sector employees (6% of salaries payable through payroll on a monthly basis) and informal sector employees (SLL20,237.16 (US$3.6) per adult, in the range of SLL14,000 (US$2.5) to about SLL35,000 (US$6.2), SLL15,000 voluntary contribution per month[21]. About US$54.4 million and US$79.99 million will be generated annually by both official and informal membership donations, respectively[22].

In order to sustain SLeSHI, an estimated US$240 million in annual costs will need to be covered[21]. This additional financing will come from other tax collections and budgetary allocations. If the government follows through on its intention to exempt roughly 62.2% of the population from paying insurance premiums, the projected budget deficit for SLeSHI will increase. Additional financing of $27.8 million per annum is also expected to come from various sources as indicated on the figure 4 below. The Sierra Leone Social Insurance Scheme should learn lessons from the strategies that led to success of health insurance in Rwanda and Ghana for a well-informed, structured and sustainable scheme.

Figure 4: Additional Funding for SLeSHI



b.) Community-Based Health Insurance

A successful case study is the Rwandan Community-Based Health Insurance (CBHI). The Government of Rwanda started to implement the Community-Based Health Insurance program, locally referred to as Mutuelle de santé, in 2004. The most recent data available indicate that the Coverage rate for CBHI as of 2023 Financial Year stood at 91%. By 2008, the program had expanded to cover about 86 percent of the population.[23] The CBHI operates as a national program but is significantly decentralized and organized around each of the 30 districts. The central oversight of the CBHI is managed by the Ministry of Finance through the Rwanda Social Security Board (RSSB)[24], which is responsible for the program's guidance and overall policy formulation. Beneficiaries are entitled to the packages of services defined by the MOH and provided at public health facilities: health centers, district and tertiary hospitals. Payment is due at the beginning of the Rwandan fiscal year spanning July-June and covers membership during the entire year.[25] ***The scheme's revenue depends heavily on premiums.*** The government contributed 14%, covering costs for indigent members, referral hospital bills, and other CBHI operational expenses. The Global Fund provided 10% of the funding, while patient copayments made up 6% of the total revenue. Since 2008, other insurance companies have been required to contribute 5% of their income to CBHI, although this only represents 1% of the overall CBHI revenue. A household survey carried out in 2013 revealed that CBHI meets most health needs for most of its members (78 percent), including the provision of access to medications[26]. As of now, CBHI members had an annual per capita health care utilization rate of 1.56 visit. Overall, this marked a significant increase from the 0.25 visits per capita recorded in 1999 and surpassed the WHO recommended average of 1.0 visit per capita[25]. Additional financing sources (classified as" innovative") for CBHI have been identified and published through a Prime Minister Order published in 2020 in order to cater for the increasing expenditures of the scheme.

The success of Rwanda's CBHI can be attributed to several key strategies such as political will, community engagement, gradual expansion, equity in financing, strategic purchasing, use of technologies and focus on universal health coverage.

Pros of Social Health Insurance

Implementation of social health insurance would have several positive outcomes as follows:

Improved health outcomes: When people have access to health insurance interventions, they are more likely to seek preventive care, manage chronic conditions and receive timely treatment.

Increased access to Health Services: Having health insurance is associated with better access to health services

Financial risk protection: Social Health insurance provides financial protection by reducing out-of-pocket expenses for medical care. When people are covered by health insurance, they are less likely to face catastrophic health costs that could lead to financial hardship.

Cons of Social Health Insurance

CBHI face challenges such as the following:

Incomplete Access to Care: While health insurance provides coverage, it doesn't guarantee complete access to care. Some treatments or services may not be covered, leaving individuals with out-of-pocket expenses.

Network Limitations: Most plans require using in-network providers, which might mean not being able to see your preferred doctor. Academic medical centers offering advanced treatments may not be in-network.

These cons can vary based on the specific social health insurance system and country.

3. Innovative Financing Mechanisms

Innovative health financing mechanisms refer to creative approaches designed to supplement traditional funding for global health. These mechanisms aim to mobilize, pool, allocate, and disburse additional funding more effectively for health interventions[27].

Innovative financing approaches help create fiscal space for health and address underfunding challenges. They play a crucial role in improving health systems and promoting well-being across the continent.

Generally, these mechanisms aim to enhance existing health financing, improve health systems and health outcomes, and ensure sustainable funding for health programs. Their effectiveness is measured and evaluated in terms of relevance, coherence, efficiency and sustainability.

In a study conducted by World Health Organization (WHO) in the WHO African Region in 2020, ten (10) innovative financing mechanisms were identified namely: excise tax on tobacco; excise tax on alcoholic beverages and spirits; airline levy; sugar-based levy; tax on oil gas and minerals; HIV/AIDs Trust Fund; social impact bond; financial transaction tax; mobile phone tax and equity funds[28]. These innovative financing mechanisms were equally highlighted in a Thinkwell report published in 2020 which indicated that health taxes standout as an important financing opportunity and suggested that if countries could increase excise taxes on tobacco, alcohol and sugary beverages by 50 percent more than 50 million premature deaths could be averted worldwide in the next 50 years, raising an additional and over $20 trillion[29].

Sin taxes

These are taxes which are generally levied on goods and products which are perceived by governments to have potentials to adversely affect the health of the population. Many countries in the WHO Africa Region have been able to impose this form of taxes on good and products which are detrimental to health of the population.

Excise Tax on Tobacco

Table 2: Tobacco tax allocated to health and health-related activities in Africa

Country	Tobacco tax system in %	Earmarked for Health
Algeria	34.2	Used for emergency health services
Botswana	49.9	Earmarked for health
Cape Verde	11.2	Used for sports and health care
Chad	34.1	An additional 2% tax is used for antiretroviral medication
Comoros	37.3	a portion of the 5% extra tax on tobacco is directed to the Ministry of Sports and another portion to hospital emergency services
Congo	38.7	50% allocated to health insurance and the other half for sports
Cote d'voire	33.3	2% of producers prices are used for HIV/AIDS care
Madagascar	80.4	Allocated to tobacco control, sport and culture
Mauritania	9.6	Extra 7% on import costs earmarked for cancer research
Mauritius	83.5	Portion of the tax allocated to the treatment of tobacco-related conditions

In the same study, excise tax on tobacco products prevailed in 43 out of the 47 countries in the WHO African Region.

Over the past decade, Rwanda has been able to use innovative financing to increase Public Resources for Health. The country made progress by increasing both domestic and donor resources for health. The role out of health insurance in the country and a decentralized, performance-based financing approach for health facilities have been key factors. This country has used Results-Based Financing approach, catalytic funding, impact investing and socially responsible investing to enhance health financing.

These efforts demonstrate Rwanda's commitment to improving access to health services and moving towards Universal Health Coverage.

With the implementation of these innovative health financing initiatives, Rwanda out-of-pocket expenditure as a share of current health expenditures dropped from 28.46% in 2002 to 11.67% in 2019. Its maternal mortality rate dropped from 818 per 100,000 live births in 2014 to 203 in 2020.

For Sierra Leone, we need to consider innovative financing mechanisms such as SIN Taxes (Tobacco, alcohol and sugar beverages), taxes from the mining sector, transaction taxes (mobile phone and remittances) and vehicle license tax. For each of these taxes, appropriate allocations should be made to primary health care.

a.) Pros of Innovative Financing

Implementing innovative health financing mechanisms can have several potential outcomes in the context of health systems as follows:

Increased Funding: Innovative financing mechanisms can create additional fiscal space for health by generating new resources of funding. These mechanisms may include taxes on tobacco products, alcoholic beverages, and other items, as well as levies on airline tickets and oil, gas and mineral extraction.

Cost-Effective Services: By incentivizing providers to offer cost-effective health services, this mechanism can improve the quality of care. Strengthening health systems and tracking services become more feasible, leading to better outcomes for the population.

Community Support: Successful implementation of innovative financing often involves multi-stakeholder participation. Engaging local communities and gaining their support is crucial for sustainability of health financing.

Implementing innovative health financing mechanism contribute to financial risk protection, efficient spending, and improved health outcomes. It's essential to carefully design and monitor these mechanisms to ensure their effectiveness and equity.

b.) Cons of Innovative Financing

Risk: There might be fluctuations income due to changes in market prices, change in behaviour. While innovative financing encourages taking risks, it also poses risks itself. There's a need for health leaders to generate and deploy innovative financing mechanisms, including private sector involvement, to meet Sustainable Development Goal 3 (SDG 3) targets[30].

Diversion: Risk of diversion of PHC funds to other programs and sectors. There is need for proper monitoring of earmarked funds to ensure that it is not diverted.

Addressing these challenges requires careful planning, collaboration, and continuous evaluation to ensure that innovative financing mechanisms contribute effectively to global health goals.

4. Performance-Based Financing

PBF has been used in primary healthcare, maternal and child health, malaria, HIV, TB, and family planning services in low- and middle-income countries[31]. PBF programs offer a chance to reward better access and quality of health care services. PBF programs can particularly reward facility- or community-based providers for achieving performance goals and service delivery targets. Rwanda's RBF program, initiated in 2005, included family planning services and has led to increased use of family planning services and improved quality of care[32]. With support from the world bank, Benin adopted RBF in its health facilities. The system uses bonuses to motivate hospitals and health centre to improve service efficiency.

On average public financing of 10-15 USD per capita is required for RBF implementation[20]. This would pay for the all-inclusive primary and hospital level health plans that include a number of free health care services thereby greatly reducing out of pocket payments. Generally, at the primary level in Low- and Middle-Income Countries (LMIC), it costs at least USD 7–10 per person year, and at the hospital level, it costs at least USD 20 per person annually to provide quality healthcare[33].

For their 2020–2022 budget, Cameroun suggested spending USD 4-5; in Rwanda and Burundi, PBF support is approximately USD 2 per person annually.

As a policy recommendation, Sierra should embark on implementation of Performance-Based Financing which will rapidly strengthen all the WHO buildings blocks.

a.) Pros of Performance-Based Financing

Performance-Based Financing (PBF) in the health sector has been a topic of interest in low-income and middle-income countries and its implementation would lead to the following positive outcomes:

Improved service use and quality: PBF can enhance the utilization and quality of health services. By linking financial incentives to performance indicators, it encourages health facilities and providers to deliver better care.

Cost reduction: PBF programs aim to use limited resources effectively. By incentivizing efficient service delivery, they can stabilize or even reduce the costs of health services.

Staff motivation and retention: PBF provides financial rewards based on performance, which can boost staff motivation and morale. This incentive structure may contribute to staff retention and improved service delivery.
Increased productivity: Facilities implementing PBF have shown higher technical efficiency scores, allowing for potential reductions in inputs without affecting outputs.

It is important to note that it is essential to recognize that the actual impact of PBF depends on the context, implementation, and other factors.

b.) Cons of PBF

Verification Costs: PBF involves significant costs to verify achievement of performance indicators. Ensuring accurate measurement and validation can be resource-intensive[34].
External Funding Dependency: Most PBF schemes have been externally funded. Integrating PBF into domestic financing for long-term sustainability remains a challenge[34].
Focusing on Specific Indicators: These include focusing on targeted services at the expense of others, false reporting, cherry-picking patients, and dilution of intrinsic motivation[35].

In summary, while PBF aims to improve outcomes, careful consideration of its design, costs, potential unintended consequences and context is essential.

5. Direct Facility Financing in Health

Direct Facility Financing (DFF) is a funding approach where financial resources are allocated directly to local health facilities, such as health centers, rather than being channeled through central authorities or intermediaries. This method promotes autonomy and efficiency at the grassroots level, allowing for better resource management and service delivery tailored to local needs. Successful examples of DFF implementation can be seen in Kenya, Uganda, and Rwanda.

a.) Pros of Direct Facility Financing (DFF)

Predictable Funding: DFF provides a predictable financing mechanism for health facilities, allowing them to plan and allocate resources effectively.
Local Empowerment: DFF empowers local actors in decision making and oversight based on health facility operations.
Autonomy: DFF empowers health facility managers by giving them control over financial resources and decision-making based on context specific needs.

Direct Facility Financing can enhance equity by tailoring services to local needs and addressing specific health challenges within communities.

b.) Cons of Direct Facility Financing

Administrative Burden: A larger budget often means more administrative work, including financial management, reporting, and oversight. If not handled efficiently, this administrative burden can divert attention from actual service delivery.
Managerial and Spending Autonomy: Contrary to expectations, DFF does not necessarily enhance the managerial or spending autonomy of service providers. Mechanisms should be put in place to ensure that autonomy is effective.

In summary, while DFF aims to improve health care delivery, it can have unintended consequences. Thus, understanding these disadvantages is crucial for effective policy implementation.

Policy Recommendations

The five policy recommendations highlighted in this policy brief are as follows:

1) Increase Government allocation for Primary Health Care from 2% to 5%;
2) Implementation of a National Social Health Insurance scheme;
3) Innovative financing mechanisms to unlock domestic resources for primary health care;
4) Re-introduction of Performance-Based Financing (PBF) and
5) Introduce Direct Facility Financing (DFF).

Concerted efforts from government, donors, policy makers, political actors, health insurance managers, service providers, and the private sector is crucial in the policy implementation.

Government: Governments play a central role in designing, implementing, and regulating health financing systems. The government will allocate funds, set policies, and oversee all health financing mechanisms.
Donors: International organizations, bilateral agencies, and philanthropic foundations provide financial support and technical assistance. They will contribute to health financing reforms and capacity-building efforts.
Policy Makers: Policymakers shape health financing policies, including decisions on allocations to health, benefit packages, premium rates, and coverage criteria. They balance equity, efficiency, and sustainability.
Health Insurance Managers: These professionals manage health insurance schemes. They handle enrollment, claims processing, risk pooling, and provider payment mechanisms.
Service Providers: Hospitals, Primary Health Units, and healthcare professionals participate in the provision of health care services. They deliver services to insured individuals and negotiate payment terms.
Private Sector: Private sector players (for-profit and not-for-profit) contribute to health financing. They manage private hospitals and private clinics providing services to the population.

Conclusion

Optimal allocation and efficient use of funds are critical in the drive towards Universal Health Coverage. Leveraging and effectively implementing the recommended policy options, informed by lessons learned from other countries, will be a major step towards reducing out-of-pocket payments and enhancing health outcomes for the people of Sierra Leone. Increasing funding for primary health care through innovative financing mechanisms, implementation of SLeSHI and Performance-Based Financing is a sure way of improving the quality of health care services and health outcomes for the people of Sierra Leone.

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