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National Health Insurance Design in Liberia: Key Considerations for Equitable, Efficient, and Sustainable Health Care Access

November 2014

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ACRONYMS

BPHS	Basic Package of Health Services
DRGs	Diagnosis Related Groupings
EPHS	Essential Package of Health Services
ETWG	Exclusions Technical Working Group
FFS	Fee For Service
FM	Financial Management
GDP	Gross Domestic Product
ICT	Information and Communication Technology
MoHSW	Ministry of Health and Social Welfare
NASSCORP	National Social Security and Welfare Corporation
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
OOP	Out of Pocket Payments
P4P	Pay-for-Performance
PBF	Performance Based Financing
SHI	Social Health Insurance

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PREAMBLE

IMPETUS FOR NATIONAL HEALTH INSURANCE DESIGN IN LIBERIA

In her 2010 address to the 63rd World Health Assembly, President Ellen Johnson Sirleaf stated that people should not have to die simply because they were poor[i]. With over 90% of Liberians living on less than US$2 a day, the President expressed her desire to find mechanisms that would allow the citizens to access the health care they need without having to pay up-front fees[ii]. She also recognized that free health care is not free and that someone must pay for it. In step with this lucid understanding, Liberia's National Health and Social Welfare Policy and Plan 2011-2021, promulgated shortly after President Sirleaf's momentous speech, sought to establish a reliable and sustainable domestic financing model to achieve universal health coverage for its population in an efficient and equitable manner[iii].

At the same World Health Assembly, World Bank president Jim Kim argued that the international community should make sure that no family, anywhere in the world, is forced into poverty because of health care expenses. He pointed out that even minimal out-of-pocket charges for the poor could drastically reduce their use of needed services. He then urged countries to replace point-of-service fees with evidence-backed sustainable financing options. Kim also emphasized the criticality of the elimination or sharp reduction in point-of-service payments to successfully achieving universal health coverage[iv]. An earnest realization of this monumental global challenge informs the proposed design of Liberia's national health insurance system.

Notably, in this marked shift in the rationale for designing a health insurance scheme, it is no longer viewed as merely a means for generating new resources. Instead, health insurance would be a stepping stone, creating the enabling environment for broader heath system reforms – building social solidarity and equitable health care access by ensuring largely prepaid revenues; pooling revenues into a single fund; and leveraging the large pooled health fund to improve health system efficiency – particularly by shifting from paying for inputs to purchasing outputs and performance. This demand-side financing approach transfers power from the provider to the patient as the money follows

the patient to her provider of choice. This would likely improve provider responsiveness to patient needs since they must delivery quality care in order to be paid.

In light of the above, the following guiding considerations form the bedrock of the proposed national health insurance scheme in Liberia:

- Sources of health financing including hypothecated taxes such as a VAT levy, mobile phone taxes, sin taxes and other options should seek to fund government subsidies for the poor through the health insurance fund. It is vital that a deliberate pro-poor slant be maintained in the design of the health insurance system. In Liberia, government subsidies to this point have been shown not to benefit all income groups equally[v]. Evidence from a 2010 study bears out that higher-income groups are more likely to use health services than lower-income groups and thus are more likely to benefit from government subsidies than lower-income groups. If "free care" policies are not accompanied by effective targeting strategies, they are more likely to be pro-rich rather than pro-poor.[vi]
- The systemic link of user fees to health insurance system should be duly recognized. In other words, since user fees will impact the magnitude of insurance payments that are made for health services, they should not merely be viewed as a tool to mobilize revenues for health but considered an integral part of the health insurance system. The government may decide to charge user fees for the non-poor yet uninsured sections of the population, rather than funding it through the public coffers. However, the poor must be protected from user fees by government subsidies for health insurance premiums. This combination of user fees and health insurance-financed health services is expected to improve the targeting of government subsidies to the poor.
- Health insurance provider payment mechanisms that purchase health services and outputs rather than inputs will help drive the expansion of budget-financed performance-based contracts. It may even result in the eventual shift of all input-based budgeting into purchasing for outputs and outcomes. This will drive overall health system efficiency.

In sum, the health insurance system for Liberia will be designed not only to mobilize more money for health in a sustainable, mostly pre-payment manner but also to improve equity and increase heath system efficiencies.

LIBERIA'S HEALTH SYSTEM: STATUS QUO AND THE NEED FOR NATIONAL HEALTH INSURANCE

In the past decade, Liberia has made significant strides in bolstering its health system and improving population health outcomes. This is largely attributable to its "Basic Package of Health Services (BPHS)", which was introduced in over 80% of health facilities. During the same period, the number of facilities providing comprehensive and emergency obstetric neonatal care also quadrupled. Broadly, any national health system's performance can be gauged from improvements in two key demographic health indicators i.e. infant and maternal mortality. While the BPHS and other health system improvements have contributed to a substantial decline of 46% in infant mortality rate (from 132 per 1000 live births in 2000 to 71 in the 2007), a persistently high maternal mortality ratio of 994 per 100,000 live births indicates that the Liberian health system still has a significant ground to cover[vii].

Despite increases in the government spending on health, per capita health expenditure remains very low at US$32 (NHA 2009/10). The Liberian health system also suffers from a continued over-reliance on external donor funding, with nearly half of the country's total health expenditure financed by donor monies. Out of pocket payments (OOP) accounted for 35% of total health expenditure, with 85% of OOP being paid to private health care providers. Even so, Liberia has rationalized the use of donor health funding by implementing performance based contracting and pooling of donor funds. A functioning financial management (FM) system is in place in the Ministry of Health and Social Welfare (MoHSW) with well-documented FM policies and procedures and updated financial statements. Furthermore, there is a robust accreditation system for public facilities with explicit standards and monitoring processes, a pool of accreditation surveyors, and a non-monetary recognition scheme.

There are grave equity concerns in the current structure of the Liberian health system. The non-poor income groups have largely captured public health spending, with subsidies at both public hospitals and health centres favouring the wealthier socio-economic segments, rather than the poorest demographic[viii]. In that sense, the distribution of limited public health care resources has been somewhat regressive in Liberia.

Further, there is widespread confusion as to what constitutes "free care". Even as Liberia began to expand its BPHS by designing and costing an essential package of health services (EPHS), it has yet to resolve ambiguities in which health services fall in the ambit of "free care". Beneficiaries have misconstrued all government-provided health services to be "free" at point of care. This has resulted in an eminently avoidable dilution of the concept of "free care" as poor patients still need to pay out of pocket for medicines and other essential care inputs resulting in sub-optimal utilization of health care services.

With the expansion of the BPHS to EPHS, the lack of clarity as to what is fully covered (e.g. consultations, diagnostics, medicines) has exacerbated, as the EPHS, with an augmented package of health care requires additional resource commitments. Consequently, this broader remit for the EPHS has triggered discussions for the introduction of user fees and health insurance as mechanisms to generate adequate funds to operationalize this tranche of health care services.

LIBERIA'S PUBLIC & PRIVATE HEALTH INSURANCE LANDSCAPE: COVERAGE AND SERVICE PROVISION

Traditionally, the first step in designing a health insurance scheme entails determining the size of the formal sector, and establishing whether there is any existing health insurance coverage for this population. In 2013, the formal sector comprised, at most, 15% of the population. Formal sector employees are covered by either the employment injury scheme, which is a part of the government-run social security scheme, or medical insurance coverage from private health insurers or employer-managed health facilities[ix].

The employment injury scheme is part of the government's social security benefits managed by the National Social Security and Welfare Corporation (NASSCORP) for both public and private formal sector employees. Contributions from both employers and employees pay for pensions and other social security benefits, including the employment injury scheme that pays for health care services to treat workplace-related injuries.

Formal sector populations can also obtain medical insurance from private health insurers. Many employers and/or employees' associations require their employees and/or

members to pay monthly deductible premiums from their salary, for life, accident and medical insurance coverage. The medical insurance usually covers the employee and dependents (one spouse and up to four children), and pays for outpatient and inpatient services (31 days maximum) and some surgical procedures delivered mostly by non-profit private health care providers.

Formal sector employees in the concessionaire sector, covering rubber, palm oil, and mining and forestry, in some cases, receive health care from employer-managed health facilities governed by the concessionaire's agreement with the government.

As the formal sector population is partially covered by private health insurers, as well as employer-owned and managed health facilities by concessionaries, the revenue pool is fragmented. Consequently, the national health insurance system design should aim to consolidate potential revenues, not only from within the formal sector population but also across the informal sector. The advantages of a single or large risk pool, the value of pre-payments and social solidarity, and efficiencies of a government-run health insurance system need to be highlighted to overcome the instinctive tendency of these covered formal sector populations to segregate their risk pools from the rest of the general population. The disinclination of the formal sector to merge into a common, national health insurance risk pool is compounded by scepticism about the government's capacity to deliver health insurance benefits particularly with respect to implementation activities, such as member management and claims processing.

The potential loss of business for private health insurance companies, the likely dual funding of health care facilities (from public and private health insurance), and contribution of employer share of the health insurance premiums would likely present opposition to a government-run health insurance system from private health insurance companies and concessionaires alike. While unsatisfactory customer experiences with private health insurance companies, ranging from their failure to properly inform members of benefits to the lack of preferential treatment for insured patients in government public health facilities have been reported, it is understood that at this point, the government may not have the capacity to deliver the "operational role" of a health insurer, including collection of premiums, member management, and claims reimbursement at scale.

As discussed earlier, the prevailing ambiguity in the understanding of "free care" makes it difficult to make the target population, especially potential beneficiaries in the informal sector, pay premiums for a health insurance system that will provide health services, which were previously assumed to be free at the point of care. Clearly, robust marketing and communication strategies will need to be devised and operationalized to counter this reluctance. However a re-imagination of the concept of "free care" is also required. As will be discussed later, some services will still be free to the patient at the point of care, but the way they are paid for will change.

The geographical distribution of Liberia's health care facilities is rather skewed – a majority (82%) of health facilities are located around the capital city of Monrovia (Liberia Private Sector Assessment 2011-12). Further, more than half of Liberian health facilities are privately owned. Additionally, the existence of private health insurance and concessionaire's schemes underscores the pre-eminence of the private sector in health care services provision in Liberia.

According to the National Strategic Plan 2011-2021[x], decentralization is a key plank of the Government of Liberia's strategy with respect to the health sector. The significance of a broad-based decentralization approach in government and public policy circles also emerged in several key informant interviews. The implications of decentralization for the conception of national health insurance in Liberia will be discussed later in the document, particularly in the sections on collection mechanisms and pooling.

Box 1: How does National Health Insurance benefit the health system?

A national health insurance system is a means of harmonizing funding into the health system, by having government funds, donor funds and premiums collected from the public all feed into a single, unified financial flow. It also changes the payment basis from inputs to outputs; thereby requiring providers to achieve previously agreed and contractually committed goals and targets before funds are disbursed. These two aspects, whilst seemingly simple and easily explained, are both extremely powerful and have fundamentally positive effects on the running and productivity of a health system.

In addition, equity and access to care can be improved under a health insurance system. A more equitable health system is one in which all members receive the same basic healthcare. Basic in this sense refers to essential primary and emergency care. Access to care can be improved under a health insurance system by reducing out of pocket payments (legal or otherwise), which deter the poor from seeking appropriate healthcare.

BEYOND MODELS – A FUNCTIONAL APPROACH TO NATIONAL HEALTH INSURANCE DESIGN IN LIBERIA

There is much deliberation on theoretical models in the health-financing domain. Two of the most prominent models with respect to health insurance, are social health insurance and community-based health insurance. While it is useful to mentally swirl these models in designing any national health insurance system, a customized solution for Liberia would likely encompass elements from all models to account for the particular context of Liberia. This document sequentially tackles all the functions of a health financing system (revenue generation, pooling, purchasing, and service delivery) to develop a customized and appropriate arrangement for Liberia. For each function, a range of practical options is examined and the most optimal and feasible solution is recommended. Any national insurance design cannot be proposed in a vacuum. Consequently, there are two key starting points for the proposed national health insurance design: 1) the current context of Liberian health system, and 2) goals of the Government of Liberia for health insurance.

I. REVENUE GENERATION: HOW DOES THE HEALTH INSURANCE SCHEME RAISE FUNDS?

The end goal of the revenue generation function is to mobilise sufficient funds in an equitable manner to sustain the health insurance scheme. In order to achieve this, one requires a broad membership base and a flexible payment schedule that enables everyone to contribute according to their paying capacity to ensure fairness in financing. Thus, revenue generation encompasses three distinct considerations: population coverage, sources of financing, and collection mechanisms.

POPULATION COVERAGE: WHO BENEFITS FROM HEALTH INSURANCE?

The population coverage question addresses which segment of the population should be enrolled into the health insurance scheme. While some countries start off with a particular segment of the population and progress incrementally to cover the rest of the population, others choose the "big-bang" approach to include the entire population right at the outset.

In Kenya, health insurance has been limited to formal sector employees who constitute only a small proportion of the population. Coverage of the population in Kenya stood at 19.9% after more than 21 years since its inception with the National Health Insurance Fund covering 16.9%, whereas private insurance companies and individual community-based schemes covered 1.8% and 1.2%, respectively. In Tanzania, health insurance was limited to the formal sector for nearly ten years before it began expanding to accommodate the informal sector and as of August 2013 covers about 10% of the population (NHIF's share is 5.3%). Nigeria's health insurance scheme (currently covering only about 4.6% of the population after nearly 8 years of operations) has remained confined to the formal sector until recently when studies were conducted to determine how to include the informal sector in order to accelerate progress towards universal coverage.

Rwanda on the other hand combined both the formal and informal sector population segments and covers over 80% of the population after nearly 10 years. In a similar fashion, Ghana opened up enrolment to both the formal sector and the informal sector population segments and has achieved active membership of 35% of its population in nearly 10 years of operations. In salient successful examples from East Asia, South Korea admits both the formal and informal sector population segments into the national health insurance scheme and has achieved 98% population coverage in less than 15 years. Likewise, Thailand, upon the inclusion of the informal sector has achieved nearly 100% population coverage.

Thus, global best practice demonstrates that countries that pool the formal and informal sector population segments together have progressed more quickly towards universal (100%) population coverage.

Coverage Options: There are two main options for consideration by the Government of Liberia.

Option 1: Adopt the **"big bang" approach** to cover all population segments ad-initio under a mixed-methods approach, while embarking on a path of progressive universal population coverage. This is the emerging paradigm in national health insurance design in developing countries. The advantage of this approach is that every resident in Liberia has the opportunity to belong to the scheme irrespective of his or her socio-economic status. It also seeks to strengthen the social support systems/solidarity that finds resonance in Liberian social norms. It strives to reduce the equity gap between the rich and the poor by enabling access to the same health benefits package; and creating collective ownership and buy-in of the scheme among all beneficiaries, which would be crucial to the long term sustainability of the scheme. This approach bolsters the case for an imposed tax to fund the scheme since all citizens have an opportunity to enrol in the scheme. In this case, Liberia is expected to make substantial progress towards universal population coverage in a relatively short timeframe, as evidenced by the examples of Rwanda, South Korea, and other countries that have taken a similar route to universal health coverage reform.

Option 2: Adopt the **incremental approach** by covering only the informal sector in an initial rollout of the scheme, and tacking on the formal sector at a later stage. This would be in line with the Ministry of Health and Social Welfare's intent (MoHSW) to adopt a pro-poor strategy in the health sector. This is also pertinent since the formal sector is already covered in large part by private insurance. This approach would likely result however in a less rapid advance towards universal coverage (in the vein of Kenya, Tanzania and Nigeria). Additionally, there would likely be implications for equity in this approach, as a two-tier health system would be inevitable: one for the wealthy and one for the rest.

Recommendation for Population Coverage

We recommend the "big bang" approach. We further advise that formal sector employees be required to make mandatory payroll contributions towards their premiums, while the informal sector population segments would make differently rated contributions under the same fund holder. The fund would likely be boosted by other contributions, such as various forms of taxes that government may deem appropriate to fully cover the poor and to subsidize the non-poor informal population segment in order to extend the membership base to the entire population.

SOURCES OF FINANCING: WHERE IS THE MONEY FOR HEALTH INSURANCE?

As noted, raising revenue is the primary objective of a health insurance system. In order to identify potential sources of revenue to finance the Liberian National Health Insurance Scheme, a number of consultations were held with key stakeholders and potential sources of revenue identified. Based on the responses of the various stakeholders, the team assessed the likelihood of capturing health revenues from these sources. The following table enumerates the potential financing sources that emerged from discussions and their potential to contribute substantially to the health revenue pool.

Table 1: Resource Generation Options for the National Health Insurance Fund

Potential Revenue Source Description	Revenue Capture Probability
Social Security: NASSCORP has significant surpluses in its national pension fund. Insurance was perceived as a significant value-add to pensioners. Further, pension contributions to the insurance fund were deemed politically feasible.	Medium to High
NGO Tax: NGOs working in Liberia are taxed at a rate of 10% by the Liberian Government to support development. There is a possibility to work with the Ministry of Finance to divert the taxes collected from NGOs in the health sector to finance the health insurance scheme. However, this option is not likely to produce significant revenue.	Medium
County Development Fund: Extractive industry has created county development funds to support social sector development in Liberia. While these funds represent another avenue to raise revenues for health insurance, it might be politically intractable to divert these funds to the health insurance fund.	Low to Medium
Sin Taxes & Airline Levies: Taxes on alcohol, tobacco, and airline tickets emerged as potential options for funding the health sector. Apparently, such taxes were backed by the Liberian parliament. CHAI has done significant work in this area, analysing the potential revenue from these sources and building political support for implementation. We believe that this option should be explored further to see if the requisite support exists with the President's office as well as the Ministry of Finance to determine viability.	Medium to High
Payroll Taxes: Levying a payroll tax on the formally employed also emerged as a desirable and feasible means to raise revenue. Further investigation of this through engagement with Ministry of Finance and Ministry of Labour will be important.	High
Other Corporate Social Responsibility by Expatriate Corporations: Other than the funding to the County Development Fund, there may be potential to source funds from foreign corporations operating in Liberia, e.g. fees on particular activities.	Low to Medium
Individual Premiums: The notion of charging premiums to the non-formal sector was met with mixed support. Some felt that it was too burdensome and inefficient to charge the non-formal sector, especially since most live on $1 per day. Others felt that everyone should pay. This will need to be carefully examined.	High
Vehicle-related Fees: The Ministry of Transport is seeking to put in place a vehicle registration fee. A proportion of this could be channelled to the insurance fund, as well as a proportion of vehicle insurance premiums, since in some measure these will be health-related.	Medium to High

Recommendations for Financing Sources

The following recommendations on sources of financing take into account both the likelihood of capturing revenues, which varies by source type, as well as the amount of revenue it would be feasible to capture. Those that were not expected to generate enough funds in absolute terms were rejected outright.

- The regular government budgetary allocation to the health sector, donor pooled funds and those from the US Government (through the Fixed Amount Reimbursement Agreement) should continue to be provided. Government budgetary allocation, as a percentage of GDP, should increase as the economy improves.
- Mandatory payroll contributions, amounting to 6% of each employee's basic salary to be equally shared between the employee and the employer (3% each) should be deducted at source and channeled into the health insurance fund to provide health insurance coverage for all formal sector employees.
- Government should negotiate with NASSCORP for a proportion of the pension fund to be transferred into the health insurance fund to provide coverage for all pensioners who have contributed at to the Social Security Fund.
- Innovative ways should be explored to enable the non-poor informal sector to secure membership of the scheme by contributing according to their paying capacity. Revenue mobilization among the non-poor informal population segment may be organized around identifiable groups in Liberia such as the drivers' union, petty traders' associations, the motorbike drivers' association, beauticians' association and cash crop farmers' associations. Non-banking financial institutions such as the "susu" unions (community social funds) could be used as bonded collection agents to maximize revenue mobilization.
- Earmarked taxes (tobacco, alcohol, airline levy, value-added tax) should be levied and channeled exclusively into the health insurance fund to provide re-insurance and cross-subsidy across all population segments in the scheme.
- Government should negotiate with the National Insurance Commission to transfer an agreed proportion of vehicle insurance premiums (currently being proposed by the Minister of Transport as a mandatory scheme) into the health insurance fund since vehicles pose health hazards to the population.
- Government should negotiate with the Driver and Vehicle Licensing Authority to transfer an agreed proportion of vehicle registration fees as well as vehicle licensing renewal fees into the health insurance fund to provide cross-subsidization across all population segments.

Recommendations for Collection Mechanism

With the exception of funds mobilization among the informal sector population at the community level, each of the proposed funding sources already has, or could make use of, an existing mechanism for revenue mobilization and therefore, there will be no need to re-invent the wheel. Thus, existing structures for revenue collection (e.g. the Ministry of Finance, or in future the proposed Liberia Revenue Authority) should be used to reduce the administrative cost of collection. A dedicated fund may be created and all funds mobilized in the name of health insurance transferred into it.

- Mandatory payroll contributions: Mandatory payroll contributions may be deducted at source by the employer and transferred into the health insurance fund. Transfer advice would then be issued to the national health insurance fund holder, which will use an agreed reconciliation mechanism to verify transfers periodically.
- Pension fund: Transfers from the pension fund may be made directly into the health insurance fund by NASSCORP and payment advice submitted to the national health insurance fund holder.
- Earmarked taxes for health insurance: Earmarked taxes such as the VAT may be collected by the existing revenue collection agencies and transferred to the national health insurance fund.
- Differently rated community collections: Differently rated premiums from the informal sector population segment may be collected by bonded commissioned community agents, also known as "susu" collection agents. Another approach might be to encourage various communities to form voluntary "community health insurance committees" who may be empowered with the relevant information to conduct community mobilization and sensitization within their respective catchment areas. Committee members may be elected by members of the community based on the trust that the community may have in them. In addition to their sensitization duties, they may be bonded and entrusted with assisting with premium collection and enrolment of members within their catchment areas into the scheme.

II. POOLING RISK: HOW TO ENSURE FINANCIALLY VIABILITY OF THE HEALTH FUND?

Pooling ensures financial sustainability of the health insurance scheme through risk diversification across wider socio-economic, demographic, and health risk groups. This, in turn, serves to reduce catastrophic spending by individuals. Achieving financial sustainability depends on the composition of risk pools, the extent of fragmentation and how the risk pools are managed. Studies have shown that a financing system that targets specific social groups with different risk pools does not allow for risk-equalization across different population segments (Carrin and James, 2004[xi]). In such a case, pools with high-risk enrolees suffer sustainability challenges if risk-equalization mechanisms are not instituted to provide adequate protection for all. Multiple risk pools may be required to inject some competition into the health insurance market but a mechanism will also be needed to ensure fairness and to control abuse, and to guarantee the best interests of beneficiaries to the schemes.

In the context of the broad strategic theme of decentralization in Liberia, it needs to be assessed if the pool structure of national health insurance should mirror the local county-

centric governance structure. Insurance pooling principally requires acquiring a sufficiently wide client base, cutting across geographies and social groups, so that the health risks are widely distributed. In Liberia, with a population of merely four million, having fifteen distinct risk pools along county lines may not result in excessive fragmentation. Further, given the large differences in population sizes across the fifteen counties, the hedging of health risks may be unbalanced – better for counties with a larger population base than those with smaller populations. Moreover, the administrative costs and efficiency losses could be considerable, especially in view of the limited capacity for insurance management in Liberia.

A centralized pool, or a small number of regional pools, does not prevent decentralization in the focal areas of service provision and administration, which will materially benefit from that process. Service provision and management of health services are selected for decentralization because of the benefits that come from being closer to the facility level. Pooling and payment are specialized functions, which will be rendered inefficient if decentralized.

POOL STRUCTURE: WHAT DOES THE RISK POOL LOOK LIKE?

Based on whether the funding source is fragmented or integrated, health insurance systems may be classified into single payer and multiple payer systems. Pools can be split along geographical lines, targeted to the type of client (e.g. specific social groups) or both. Thailand is a typical example where the health insurance system is a multiple payer system with three main financing arrangements, separate payment channels and separate management structures. On the other hand, Ghana's National Health Insurance Scheme is a single payer system although it has different funding sources. All the funds are pooled into a single National Health Insurance Fund (NHIF), which is managed by one National Health Insurance Authority, the fund holder. In Rwanda, a percentage of the funds collected at a health centre are transferred up to a district risk pool (to cover secondary care). Another proportion of the collected funds is transferred up to a national risk pool (to cover tertiary care). These transfers also allow re-insurance within the system. Donor funds are also invested in the pools apart from the premiums collected from the population.

Operating a multiple payer system means running parallel administrative systems with its attendant costs. It also requires an effort to harmonise systems such as data systems. Rwanda and Vietnam are noted to have managed to make some progress in coordinating their fragmented schemes under a single and robust national health insurance strategy. Notwithstanding these positive examples, it has been noted that one major challenge in progress towards universal health coverage is inadequate coordination among fragmented health protection schemes. For instance, in China, with three national health plans that cover almost the entire population, ad hoc systems coupled with inadequate data management capacity make actual enrolment and service utilization difficult to ascertain. Most countries also fail to coordinate effectively the benefits across their fragmented schemes thereby leaving many social groups with inadequate protection against health-related impoverishment.

In Liberia, nearly 15% of the population are in formal sector employment. It is also estimated that about 76% of the population lives on less than US$1 a day, leaving only 9% in the non-poor informal sector. Creating a risk pool for only the 15% of the population, employed in the formal sector will imply leaving 85% of the population uninsured.

Creating a separate risk pool for the estimated 9% non-poor informal sector population segment alone will not be cost effective, considering the administrative cost in managing such a small fund. Besides, the risk pool may not generate adequate funds to cover the cost of services that members may consume. It will therefore be prudent to pool all population segments together to create a broad-based risk pool in order to derive the benefits of cross-subsidisation across all population segments. In light of the above, the following options were evaluated:

***Option 1*: A single pooled fund for all population segments** into which, (i) mandatory payroll contributions from formal sector employees, (ii) direct contributions from the non-poor in the informal sector, and (iii) government subsidies from the general budgetary allocation and combination of taxes, would be channelled. A single pooled fund obviates fragmentation, which undermines the long-term sustainability of an insurance scheme. It enables the fund holder to invest initial surpluses to serve as short-term re-insurance in times of sustainability challenges. It is relatively simple to manage and lends itself to greater accountability.

Option 2: **Two separate funds**, one fund for the formal sector employees financed by mandatory payroll deductions, and a second joint fund for poor and non-poor informal sector population segments funded by contributions from the non-poor, government subsidies and supplemented by 5%-10% of the formal sector population fund revenues. Whilst potentially easier to sell to the formal sector, this option fragments the risk pool, and is not conducive to the sustainability of the scheme. It also denies the scheme of the advantage of investing initial surpluses to earn maximum returns, which provide another source of income for the scheme. Learning from Ghana's experience, returns on investment, until recently, constituted an average of 12%-15% of the total income of the scheme, essentially because all the funds were funnelled into a single risk pool fund.

Option 3: **Three separate funds,** one for the formal sector population segment, a second for the non-poor informal population segment and a third for the poor informal population segment. In this case, both segments in the informal sector pay premiums to be supported partly by government subsidies and supplemented by 5%-10% of the formal sector population fund. This option has the same pros and cons as option 2, apart from the fact that the poor are also expected to share costs, by paying a part of their premiums. This is at odds with the primary construct of a pro-poor health insurance scheme and therefore, in some ways, a more regressive option compared to options 1 and 2 above.

Recommendation for Pool Structure

Our recommendation with regard to pooling is **Option 1, i.e. the single pooled fund**. The advantages of this structure are significant for health equity. This option is far more likely to support a single unified health system with the same service offering for the whole population. Further for a population of roughly four million, there is little need to create multiple pools. A single pool is far more straightforward to manage than multiple pools, and has lower administrative costs; this would help shore up the operational efficiency of the scheme.

FUNDHOLDING ARRANGEMENT: HOW ARE HEALTH INSURANCE MONIES ADMINISTERED?

The allocation of pooled funds is carried out by a fund holder, which may be a non-competing monopsony of state administration as in the case of Ghana and South Korea or competing health plans. For a non-competing monopsony, the administrative structure may be an independent agency, supervised by the ministry responsible for health as in the case of Ghana and South Korea or potentially a dedicated department or directorate within the mainstream ministry responsible for health. At the initial stages, the health insurance administrative structure in Ghana was subsumed under the directorate for policy planning, monitoring and evaluation until such time that the necessary legislative environment was created and systems and structures put in place before the National Health Insurance Authority was established to take up the fundholding responsibilities.

In Liberia, the pre-feasibility study report on social health insurance[xii] points to a consensus that "an independent agency free from government control" would be the preferred choice of stakeholders. NASSCORP which is the only existing government organization identified in the study to be "managing a fund that bears some similarities to the SHI agency", was not perceived to have the capacity to take on the additional responsibility of managing a health insurance fund. From the foregoing, Liberia has three options to consider under the fundholding arrangements.

Option 1: **Using existing MOHSW structures**: Liberia may want to consider using existing MoHSW structures to manage the health insurance scheme/fund. The challenge, with this approach, however, is that the policy direction of the Ministry is to decouple the operational responsibilities from the stewardship functions and taking on the management of the health insurance scheme may be in conflict with this policy direction.

Option 2: **Non-competing monopsony of state administration**: A second option is to create an independent, centralised third party administration, with directional oversight from the MoHSW to ensure that the government's policy priorities are not compromised. This will have to be legislated to give it the requisite legal backing. As an interim measure, the directorate of Planning, Research and Development may be tasked with the initial responsibilities to kick-start operational activities prior to passage of the required legislation.

Option 3: **Decentralised (regionally-based) third party fund management arrangement**: This option is consonant with the decentralization policy being pursued by government and the Ministry.

Recommendation for fundholding arrangement

We recommend **option 2, i.e. an independent, yet centralized third party administration as the fund-holder.** With a total population of less than four million, it would not be cost effective to manage claims in a decentralised manner. Mobilization offices may be created at the regional level or even county levels to mobilize membership and premiums from the communities, undertake ID card issuance and renewals, as well as monitor health care providers and beneficiaries to ensure efficient use of scarce resources at peripheral levels.

III. STRATEGIC PURCHASING FOR NATIONAL HEALTH INSURANCE

Strategic purchasing in a national health insurance system is a complex optimization problem. It presents an elaborate matrix of choices that involves making informed decisions on which health services to buy (benefits package), how to pay for these health services (payment mechanisms, how much to pay for health services (reimbursement rates), and from whom to purchase these health services (contracted health care providers).

BENEFITS PACKAGE: WHICH HEALTH SERVICES SHOULD BE COVERED BY HEALTH INSURANCE?

Recommendation for Reinsurance

The government should institute **a tax regime to mobilize additional funds** for the scheme. This will serve as an equity fund to pay premiums on behalf of the poor who may be unable to afford to pay themselves. This fund can also cross subsidize across population segments. In addition, it will also help secure funds for investment that may be redeemed to re-insure the scheme in times of sustainability challenges. Finally, the government must commit to guaranteeing the solvency of the fund by acting as a reinsurer to help tide over financial crises.

The formulation of a health care benefits package to be purchased by the health insurer should integral to the overall health purchasing decisions of the government. Liberia has had experience with two health benefits packages, the older BPHS, and the newly instituted EPHS, which has now replaced it. These packages include the priority health services that government wants to purchase and provide for its citizens. These are purchased as inputs (i.e. salaries, capital, operating budget, etc.), and expected to be provided free of cost, at point of care for patients. However, the BPHS experience shows that the available funds were inadequate to purchase the requisite inputs to ensure optimal utilization of the BPHS. This budgetary shortfall meant that the BPHS enrolees were unable to get all the necessary consultations, diagnostics, medicines, and other health care services. The new EPHS benefits package should clearly describe which of the EPHS services would be “free care” funded by the general budget and which of the EPHS services will be funded by health insurance, and not available as “free care” if one is not insured. This will help to avoid the free care confusion fiasco that failed BPHS.

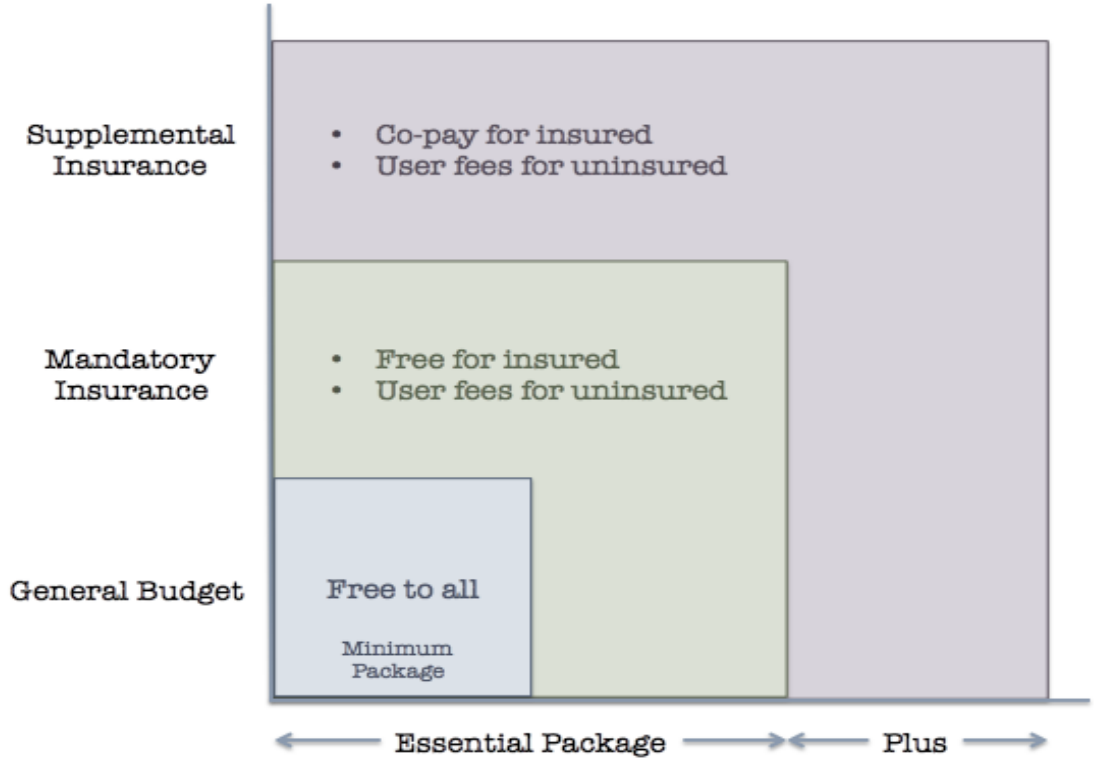
Recommendation for Benefits Package

It is imperative that the benefits package should be explicit as to what health insurance pays for. It should also be clear on who pays for the health services that would not be covered or paid for by the health insurance system. It is assumed that the EPHS benefits that are not covered by health insurance would be fully funded by the budget. Health services that fall outside the purview of EPHS may still be covered by basic health insurance or may have to be paid for by a supplemental health insurance scheme.

The following framework helps think through a potential split of health care services included in benefits packages to be covered by different funding sources. The X-axis maps

the progressively improved benefits package, while the Y-axis presents the funding sources that might be leveraged to finance varying levels of benefits packages.

Fig. 1: Who pays for what? – Tailoring funding sources to the benefits package



Source: ICD Analysis

EPHS was reviewed to determine the health services that could be appropriately funded by budget financing. The selection of EPHS services identified to be appropriately financed through health insurance would constitute the primary benefit package of the health insurance system. Depending on the final premium calculations and the ability of the employers/employees to contribute, the non-poor informal sector to self-pay, and the extent of government subsidies for the poor informal sector, non-EPHS health services may be added to the benefits package (see Annex A for a detailed proposal for the split of services to be funded from different sources).

The minimum, “free to all” package should include maternal, child, and reproductive health services, control of communicable diseases, and soon-to-be finalized list of essential hospital services. Since the EPHS did not plan for outpatient treatment of non-communicable diseases, this element may not be a part of the benefits package.

The benefits package can eventually be reconfigured to reflect the traditional classification of benefits packages, viz. inpatient care, day surgery and procedures, outpatient consultations and diagnostics, and outpatient drugs.

Coverage of expensive tertiary care interventions that may be provided in an outpatient setting, including renal replacement therapy (e.g. dialysis), treatment of cancer (e.g. chemotherapy and radiotherapy) and similar interventions (e.g. bone marrow treatment, etc.), needs to be studied in the context of provider capacity and impact on required

premium contributions. Similarly, coverage of complex, high cost hospital treatments, including transplant surgeries and other interventions of the same complexity and cost shall also be studied to determine suitability for inclusion in the benefits package.

It is neither necessary nor desirable that the national health insurance scheme should cover all costs from an inputs perspective (salaries, pharmaceuticals, consumables, other operational needs). However, it is recommended that the salaries continue to be covered through the government budget. Clearly, many pharmaceuticals and consumables currently directly funded by donors will also continue to be so into the future. The following table is indicative of how three broad categories of inputs would be financed after the introduction of a national health insurance system.

Table 2: Sources of Funding by Input Types for Primary, Secondary and Tertiary Care

Funding Sources	Input Categories		
	Salaries	**Drugs, diagnostics, medical supplies**	**Other operational expenses**
Government Budget	✓	☐	☐
Performance Based Financing	✓	☐	✓*
Insurance Premiums	☐	✓	✓
Donor Funds	☐	✓	✓
User Fees	☐	☐	☐

Source: ICD Analysis

*Note: *PBF is not a recommended mode of financing for other operational expenses at tertiary level of care.*

EXCLUSIONS: WHICH HEALTH SERVICES ARE NOT COVERED BY INSURANCE PREPAYMENTS?

There are two types of exclusions in the design of the benefits package for national health insurance – "permanent exclusions" that would never be covered by the health insurance system and, "temporary exclusions" that are not covered for the moment due to funding constraints but would be included when the premium rates are increased to adequately cover and pay for these health services.

In Liberian context, permanent exclusions would be the minimal (free to all) package, under the EPHS benefits package that will necessarily be funded by the government budget. Permanent exclusion shall also include health services deemed to be cost-ineffective and inappropriate; and health services that may be more appropriately paid by out of pocket payments (e.g. over the counter drugs such as paracetamol). An 'Exclusions Technical Working Group' (ETWG) will be established to review and update the list of permanent exclusions.

Temporary Exclusions are health services that have not been included in the current benefits package due to financing constraints. As the premiums or subsidy rates are

gradually increased, they would be re-evaluated and included in the benefits package, subject to advice and approval of the ETWG.

It is vital that exclusions are explicitly stated and widely communicated to the members and the general population to stave off confusion and ambiguity regarding covered benefits.

PAYMENT MECHANISMS: HOW SHOULD THE HEALTH CARE PROVIDERS BE PAID?

The provider payment system is the mechanism by which health care claims are determined and service providers reimbursed for services they provide to enrolees. Witter et al[xiii] identify four main methods for reimbursing providers of health care services, be they individuals or institutions, namely, time-based payment, service-based payment, population-based payment (i.e. capitation), and mixed payment. Provider payment systems should be tailored to the institutional realities encompassing both demand and supply side. Additionally, the effects of any alternative provider payment method on cost, access, and quality must be tracked, occasioning the need for a robust monitoring and evaluation system. The Government of Liberia may consider the following provider payment options for its national health insurance system.

Option 1: Time-based payment

Time-based payment method seeks to reimburse providers on salary basis and according to the number of employees hired to provide services with some adjustments for related items. This method has been observed to create perverse incentives since the providers are paid fixed salaries regardless of performance, in terms of quality as well as quantity. Consequently, they are likely to have little incentive to utilize their time efficiently or to provide high quality care.

In most African countries, the Ministry of Health and for that matter, the government pays the salaries of public sector health workers irrespective of their work output. Additionally, there is a dedicated budget for administration and services (excluding staff salaries) and a dedicated budget for investment. This trend is changing gradually, especially in countries like Ghana where health insurance funds are used to reimburse service providers for services rendered to insured clients. Whilst salaries of health workers continue to be paid from a fixed envelope central budget, payment for administration and partially for services in the public facilities has gradually shifted to the health insurance funds.

Efforts are also being made to introduce performance-based financing (PBF) also known as pay-for-performance (P4P), as in Rwanda, to transfer some of the financial risk associated with service provision to managers of the service. Some of the basic principles underpinning P4P include increased efficiency in the provision of health care services, expansion of services, enhanced patients' choice, and increased patients' satisfaction. It is also intended to encourage providers to be responsive to patients and consumer preferences, keep costs under control, channel funding where it is most needed, introduce fairness and transparency in paying providers, encourage the development of new, cost effective treatment pathways and make service provision more responsive to beneficiaries by improving quality.

Option 2: Service-based payment

Service-based remuneration manifests itself in a number of ways, including fee-for-service, fee for each bed-day, and fee for each patient.

Fee for service (FFS): Under the fee-for-service system, reimbursement is made according to the number of services that are provided to the patient. Also known as "itemized billing" providers bill for each service item that they provide to the service user and fees differ among service provider levels. Health care service providers find this payment system attractive because they believe they are able to fully recover their cost.

The FFS payment mechanism has a number of disadvantages including supplier-induced demand for services, provision of services that are not necessarily superior but more expensive and irrational prescribing. Thus, the challenge with fee for service is that it reduces efficiency in service provision because it provides an incentive for over-servicing of enrolees by providers since the more you provide the higher the claim you submit. Moreover, it presents an inordinate degree of moral hazard to the providers, who may be inclined to list services they have not provided or inputs they have not used. The result in either case is artificially inflated bills, which may threaten the sustainability of the scheme.

Fee for each bed day: As the name suggests, under this payment system, the providers receive payment according to the number of days a patient stays admitted in the facility regardless of the services provided. The payment for each bed day provides incentive to reduce services but prolong a patient's hospital stay.

Payment for each patient seen: This payment mechanism provides incentives for providers to see too many patients at a time without adequately considering their genuine health needs. Another issue with this mechanism is that providers have a perverse incentive to cream-skim their patients by selecting simpler cases as opposed to complex ones because payment is made regardless of the time spent on the case and the amount of consumables used for managing the case.

Diagnosis related groupings (DRGs): This is the most popular case mix payment methodology. The general principle of DRG is that diagnoses that require similar inputs to manage are grouped together and given a uniform price or tariff. The tariff is a weighted average of the costs of treating the individual conditions in the group. Thus, the DRG attempts to pay providers an average fee for cases whose management requires same or similar amount of time and resources.

On the flip side, however, DRGs can have the unintended consequence of some providers attempting to "game" the system by "re-categorizing simple cases into more complex and lucrative categories"[xiv]. The DRG system is also beset by some of the pitfalls of fee-for-service in that a service that is not provided may be billed for. Efficiency is however improved because unjustified use of inputs is curtailed, as there is no extra payment for extra inputs used.

In Ghana, for instance, the national health insurance scheme utilized a fee-for-service payment mechanism at initial rollout, but subsequently introduced the DRG system in an attempt to control costs. However, the introduction of DRG backfired enormously, as Ghana found itself paying about three times for claims compared to when it had fee-for-service, due to DRG-related "upcoding". This transpired partly due to lack of a robust monitoring and evaluation system.

Option 3: Capitation payment mechanism

Capitation pays the provider a fixed annual amount per enrolee. It improves utilisation efficiency since enrolees are not able to go provider shopping. Capitated payments also incentivize the service providers to educate their clients on health promotion and disease prevention because the less frequently the enrolees feel ill, the more money the provider saves. Capitation also improves health system efficiency and reduces over-servicing. The intention is not only to share the risk of service provision among the health insurance scheme, its accredited providers and subscribers but also, and more importantly, to secure continuity of care for enrolees.

Notwithstanding the advantages, there is a very real risk of under-servicing of beneficiaries by service providers in a bid to save money under capitation. For this reason, capitation is generally believed to inherently reduce the quality of care. However, there are counter-mechanisms that can be threaded in to capitation, to improve service provision quality. These include giving the option to enrolees to select their own providers in the first instance, and allowing them to change their service provider at agreed intervals if they are not satisfied with their chosen service provider.

Option 4: Mixed payment system

Most modern and emerging national health insurance systems deploy a mixed payment mechanism to leverage the strengths of different methods and temper the weaknesses emanating from each. Quite intuitively, a mixed payment method involves the use of a combination of two or more provider payment systems. Typically, a scheme may decide to combine capitation, DRG and fee-for-service.

Recommendations for Provider Payment Mechanism

Upon weighing the options enumerated above, the proposed national health insurance system should adopt a **mixed provider payment system**.

Inpatient admissions including day surgeries, normal deliveries in non-hospital health facilities, and ambulatory procedures should be paid by case payment. A simple case-based payment scheme of about 30 case payment rates would be deployed initially, while data and information on costing and severity is collected and analysed. After three years, the case payment scheme is expected to graduate to a case mix payment scheme through the introduction of modifiers, wherein the case rates will be increased based on the modifiers for each admission. Going forward, the case mix payment scheme shall continue to be the mainstay payment mechanism for the health insurance system.

The use of simple case payment and eventually a case mix system would be new for Liberia as private health insurers currently pay for health services using fee-for-service (FFS) with caps for each designated cost centre (i.e. room, medicines, doctor's fees, etc.) This payment method often results in overprovision, superfluous care and fraud driven by the FFS aspect and inadequate financial protection due to the artificially imposed caps for the designated cost centres. The introduction of case payments combined with the expansion of performance contracts is for budget-financed EPHS is expected to create the right incentives for health care providers and drive greater efficiency in delivering health care services.

Outpatient services should be paid by a combination of capitation and fee-for-service payments for health services that are determined to be "under-utilized".

REIMBURSEMENT RATE: HOW MUCH SHOULD BE PAID TO THE HEALTH CARE PROVIDERS?

The reimbursement rates will initially be calculated for partial payment of health services (i.e. excluding staff salaries) but should steadily be ramped up to pay full cost reimbursement. The eventual reimbursement rate and the pace of increasing it will be dependent on the ability of the government to convince the population to pay the required premium rates and enrol enough young and healthy citizens to subsidize the higher-risk populations, who are more prone to illness. It would also depend on the capacity of the government to subsidize the poor at this higher premium or subsidy rate.

CLAIMS MANAGEMENT: HOW SHOULD PROVIDER CLAIMS BE ADMINISTERED?

The claims management system should utilize a combination of intensive audit of selected claims, post-audit of hospital records, outlier analysis, differential treatment of health care providers, and the use of other analytics. The claims management process should not rely on itemized audit and adjudication of services and their corresponding charges for *all* submitted claims documents. This approach is not only time-consuming for insurance staff, but also is data-intensive, and does not produce any tangible benefits.

Selective audit will be adequate to make health care providers refrain from regularly and persistently attempting to submit less than truthful claims documents. Post-audit will allow referencing the claims submissions with the onsite hospital records. This will allow review of the source documents of the claims submissions and thus deter fraudulent or incorrectly prepared claims submissions. Outlier analysis informs a differential claims processing treatment of health care providers, based on their favourable claims submission history. Claims from identified “good” health care providers will be quickly processed with minimal audit and reviews while claims from potentially “bad” health care providers as determined by outlier and other analytics will be audited and reviewed much more rigorously. The resultant quick turnaround and payment for the “good” hospitals and the expected longer turnaround and payment for the “bad” hospitals will likely present appropriate incentives and sanctions for submitting legitimate, well-documented claims.

The extent to which the claims processing should be centralized or decentralized will likely depend on the extent to which the claims documents are prepared in an electronic format. In case of electronic claims, a central claims processing unit can handle and process claims from all over the country. However, if most claims continue to be paper-based (as are those currently submitted to the private health insurers), decentralizing claims processing to at least five subnational units will allow timely processing of paper claims submissions.

The use of case-based payment for inpatient admissions and capitation for outpatient care further simplifies claims processing as the data required for these payment methods is not as extensive as that required for claims paid by FFS.

COST SHARING: HOW TO PROMOTE VERTICAL EQUITY AND PREVENT MORAL HAZARD?

Vertical equity is a key tenet of progressive health financing. It posits that individuals who are unequal in society should be treated differently. In a health insurance context, it

means that premium contribution expectations for enrolees should be aligned with their socio-economic status and paying capacity. An optimal balance must be struck, as inadequate cost sharing can create moral hazard and indiscriminate use of health care services by the beneficiaries, whereas too much cost sharing can impose an undue financial burden, especially on poor people, resulting in decreased utilization; this would defeat the very purpose of a health insurance scheme.

Consequently, cost sharing should neither be implicit nor left to the discretion of health care providers. Instead, it would be formally incorporated into the health insurance system through two approaches.

The first is the promotion of supplemental health insurance coverage to pay for health services not covered by budget or the national health insurance system. The second is the use of co-payments for selected health services that are prone to abuse, especially elective surgeries and outpatient drugs for chronic diseases.

IV. SERVICE PROVISION: WHAT IS THE OPTIMAL MIX OF HEALTH CARE PROVIDERS?

Mixed provision, wherein health care is provided by a combination of public, private self-financing and not-for-profit providers, is the emerging paradigm in the provision of health care services and contracting arrangements under health insurance. While the fund holder engages these providers through different arrangements, the participating providers are required to accept every patient without discrimination in accordance with the fund holder's contractual provisions.

All health care providers, including public providers are expected to comply with contracting requirements. Both formal and informal sector populations are expected to have access to similar types of contracted health care providers to ensure a unified single-tier health system.

PROVIDER ELIGIBILITY

Health insurance systems can contract with both public and private providers. The distribution of funds between public and private health care providers will depend on which input apportionments to public providers are made through the public budget (e.g. salaries) and which through health insurance. If all funding to public providers were made through health insurance, then the payments through health insurance to public and private health care providers would be the same.

Recommendation for Provider Eligibility

Both public and private providers should be funded through the health insurance system. Private providers can fill the gaps known to exist in the public health provision network of the Government of Liberia. However, robust regulation of private providers is necessary. In a well-regulated health care market, private providers can allow a certain measure of competition in the health system, which can augur well for making the health system work for the poor.

ACCREDITATION

Accreditation is a key element of health insurance. A strong accreditation system allows the payer to establish a quality threshold for service provision. Providers who do not meet accreditation requirements will not be contracted through a health insurance system.

In Liberia, a nationwide accreditation system, instituted by the MoHSW has been in place for several years. It provides an excellent platform to understand current benchmarks, and shape the accreditation system for a national health insurance system.

V. INSTITUTIONAL DESIGN: THE BACKBONE OF NATIONAL HEALTH INSURANCE

REGULATORY AND IMPLEMENTING BODIES

The most appropriate implementing body for the national health insurance system is an autonomous authority attached to the Ministry of Health and Social Welfare to be governed by a board chaired by the Health Minister. This authority will manage a dedicated fund, which will be separate from the MoHSW's general fund. It will act as the primary "implementer" of the purchasing function with overall purchasing oversight, but may delegate specific purchasing functions to units within the MoHSW, other government agencies, non-profit organizations, community groups, or even private corporations.

The contracting of health care providers can be delegated to the MoHSW unit working on the accreditation of health care providers while collection from self-paying non-poor informal sector may be coordinated with community groups, cooperatives, and micro-finance organizations. The collection of compulsory payroll contributions from the formal sector can be done by NASSCOR on behalf of the authority while claims processing can be outsourced to private health insurers. An alternative approach is to develop the authority to assume the capacity of a complete insurance purchaser, without the need to delegate or outsource any of the purchasing functions.

GOVERNING BOARD

Even prior to the formal adoption of the health insurance system by the parliament, an advisory board for health insurance can be created to helped champion health insurance and advise on its final design. The advisory board is envisaged as the forerunner of the governing board, to be set up later to guide the implementation of the national health insurance system. It would also act as the principal policy-making body of the national health insurance agency or authority. The advisory board shall be led by the Minister of Health and Social Welfare and would also include the Minister of Transport, Minister of Labour and Minister of Finance. Representation from the civil society, employers, workers, health care providers, and NGOs would be helpful in advancing the health insurance agenda. Donors who are currently members of the health care financing task group may sit as observers on the advisory board.

After the national health insurance system is enacted into law by the Liberian parliament, all the tasks of the advisory board will be taken over by the governing board. Its final composition and functions will be dependent on the law and its provisions that would be approved by the parliament and the President. It is highly recommended that it be chaired by the Health and Social Welfare Minister and co-chaired by the Finance Minister. Possible members would include the Minister of Transport, the Minister of Labour, and the Deputy Minister for Health Services. Other potential members would be representatives from

business (employers); civil society (NGOs); formal sector employees and informal sector workers; and health care providers (doctors/hospitals). The “soon to be established” National Health Insurance Authority shall act as the secretariat for the governing board. Representatives of donor partners may sit as observers on the board.

The board shall spearhead the implementation of the Health Insurance Fund with a single national risk pool composed of a non-contributory government subsidized scheme for the poor, mandatory contributory scheme for formal sector workers, and self-paying contributory scheme for the non-poor informal sector. It shall formulate the final policies on premium and subsidy levels, collection processes, membership eligibility, benefit coverage, provider payment mechanisms, and contracting of health care providers. It shall also decide on implementation of the operational aspects of health insurance, such as member management and claims processing, including considering outsourcing these functions to non-profit or for-profit private partners.

MANAGEMENT TEAM

The authority shall be headed by an executive director and include staff with prior work experience in demand side financing; health information technology (IT) and systems; drug procurement and distribution; and quality of care programs in the health sector. It shall have technical capacity on member management (particularly the use of IT-enabled member identification cards), fund management, provider contracting, and purchasing health services. The authority is to be supported on issues of technical import through engagement with outsourced providers of health financing and insurance research. Examples of technical work that might be outsourced include studies on benefits package and exclusions; fund management processes; member management rules and policies; contracting public and private providers; provider payment policies; and other health financing policies and guidelines.

M&E FRAMEWORK FOR ASSURING PERFORMANCE

In order to ensure that the health insurance authority and the MoHSW are performing the purchaser functions properly, a non-governmental research organization should be contracted to conduct an independent third party monitoring and evaluation of the implementation of the national health insurance system.

A Health Insurance Stakeholder Alliance shall be organized, supported by a private firm that would be contracted to draft and support the implementation of the health insurance marketing and communications plan. This national alliance would also support and monitor the implementation of the national health insurance system.

VI. CRITICAL SUCCESS FACTORS

The success of a health insurance scheme leans heavily on strong political will and leadership, national consensus, risk management and cost containment strategies, information, education, communication and behaviour change strategies, availability of the required information and communication technology (ICT),

training and capacity building, and an institutionalised monitoring and evaluation system. These are critical success factors of a public health insurance scheme.

POLITICAL WILL AND LEADERSHIP

Discussions with the leadership of Liberia's Ministry of Health and Social Welfare and other ministries, government departments and agencies revealed a strong political will and commitment to make quality health care and social services accessible to all citizens of the country as articulated in the National Health Strategic Plan as well as the National Health Financing Strategic Plan. This is the vital first step, because it takes political commitment at the highest level to initiate and sustain the implementation of a colossal multi-sectoral project such as national health insurance. It is particularly vital that the Head of State and the Minister of Finance be intimately bought into the process. To sustain and augment the political buy-in, it is recommended that existing political structures be utilised for sensitisation, communication, and information sharing. There is a need for constant engagement between the technocrats and politicians across the political divide. In addition, health insurance champions within the country should be recruited for partnership in public education and consensus building.

NATIONAL CONSENSUS

It is important to secure the commitment of the citizenry towards the introduction of a health insurance scheme, especially one that is universal in coverage and depends vitally on mandatory membership for success. It was evident during the pre-feasibility study that 'many stakeholders see the desirability of SHI but due to their limited knowledge of SHI, it cannot be said that there is clear consensus". If the citizens do not have a clear understanding of, or do not appreciate the usefulness of a health insurance scheme, patronage and responsible membership could prove challenging. It is therefore recommended that a massive public sensitisation programme be embarked upon prior to the launch of the scheme and certainly prior to the introduction of legislation in the parliament. The media and civil society should be engaged early in the process. A mass communication campaign targeted at the population to evangelize the advantages and *modus operandi* of the health insurance scheme would be vital to locking in social commitment and building trust in the system. Such sensitisation should be sustained throughout the implementation period.

RISK MANAGEMENT AND COST CONTAINMENT STRATEGIES

Management of Liberia's national health insurance scheme will need to identify risks associated with all its operational and financial activities with a view to addressing them in a systematic fashion. If the recommended funding sources are explored, it is expected that the scheme will have some initial funds for investment. However, as membership of the scheme increases, utilisation is likely to rise and claims will progressively increase. It will therefore be necessary to study the potential sources of financial leakages and factor them into the operational plan of the scheme. A cyclical continuous improvement approach, involving a plan-do-check-act loop will enable the risk managers to stay on top of emergent potential crises and devise strategies to address them in a timely manner.

INFORMATION, COMMUNICATION, EDUCATION AND BEHAVIOUR CHANGE STRATEGIES

The target population and beneficiaries are the primary reason for the existence of the scheme. Their interest, expectations, and satisfaction should, therefore, be of utmost importance for scheme operators. Documented strategies should be put in place to

ensure that the enrolees and the target population are always informed, sensitized, and communicated to on all matters concerning the scheme, with a view to fostering partnership, mutual respect, and understanding. The citizenry deserves to know why things are done the way they are and must be kept abreast of any changes in scheme policies and procedures. There is also need for continual engagement with service providers and other stakeholders. It is recommended that community workers and health workers be empowered to play a key role in the mass sensitisation phase.

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT)

For efficient and effective running of a health insurance system, particularly on a universal scale, ICT is indispensable. It is required for enrolee management, financing, payment, monitoring and evaluation, and communications management. ICT can be leveraged for the execution of most of the scheme's functions. For example, in membership management, some of the questions that need to be answered in relation to ICT requirements include membership data storage and retrieval, ID card printing, portability management, membership authentication at the provider site, claims management, and electronic payment of providers.

Further, in case of ID cards, the key decisions would concern which type of card to use and whether to issue instant ID cards. For instance, issuing instant ID cards circumvents difficulties with ID card distribution as is being experienced in Ghana. Issuing biometric cards will also help prevent duplicate registration and enhance membership authentication at the provider site. With respect to data capture on the members, the availability of a comprehensive database of the target population needs to be ascertained. It also needs to be seen if the available data can be interfaced with the scheme's ICT system. For example, in Thailand the existing schemes ride on the back of national identification data.

TRAINING AND CAPACITY BUILDING

Regular training needs assessment must be done and training gaps addressed quickly by providing appropriate training to the staff responsible for operating the scheme.

MONITORING AND EVALUATION

The scheme would need to set up a comprehensive monitoring and evaluation system for all aspects of its operations. The funds have to be monitored; membership must be tracked; aspects of service provision including quality, efficiency, utilisation and client satisfaction also need to be assessed periodically, as do the issues related to claims. Indicators and checklists will need to be developed for monitoring and evaluation of these and other systems.

ANNEX A

PROPOSED BREAKDOWN OF SERVICES AND FUNDING SOURCES

The following is an example of a possible split of services between budget-financed and insurance-financed.

Budget Financed EPHS	Health Insurance Benefit Package (Insurance Financed EPHS + non-EPHS)

Maternal and newborn health services
– Maternal and Newborn Nutrition
  ○ Iron and Vitamin A supplements
– Family Planning (FP) Services
  ○ FP commodities
	Maternal and newborn health services
	– Antenatal Care
	  ○ At least four ante-natal consultations
	– Labour and Delivery Care - with partograph
	– Emergency Obstetric and Newborn Care
	– Postpartum Care

Child health services
– Expanded Program on Immunization
– Child Nutrition
  ○ Infant and young child feeding
  ○ Micronutrient Supplementation
  ▪ Vitamin A supplements and de-worming medications every six months
  ○ Rapid nutrition assessments
  ○ Growth monitoring
– Infant and Young Child Feeding
– Management of Acute Malnutrition (MAM)
  ○ Therapeutic and supplementary feeding programs
	Child health services
	– Integrated Management of Neonatal and Childhood Illnesses

Reproductive health
– Adolescent Sexual Reproductive Health
– IEC/BCC programs on SRH, HIV/STI and SGBV
– Research on Reproductive Cancer
  ○ Baseline prevalence for breast, cervical and prostate cancers
  ○ Appropriate strategies designed
	Reproductive health
	– Sexual and Gender-Based Violence
	  ○ Counselling, post-exposure prophylaxis for HIV and STIs and treatment
	– Management of Obstetric Fistula

Communicable disease prevention and control
– Prevention and Control of Malaria
  ○ Prevention strategies
  ▪ Insecticide-treated mosquito nets (ITNs)
  ▪ Indoor residual spraying in selected communities
– Prevention and Control of other Diseases with Epidemic Potential.
  ○ Disease Surveillance System
	Communicable disease prevention and control
	– Prevention and Control of STI/HIV/AIDS
	  ○ ART, PMTCT and HCT services
	– Prevention and Control of Tuberculosis.
	  ○ Diagnosis and high-quality DOTS
	  ○ TB/HIV services integrated
	– Prevention and Control of Malaria.
	  ○ Treatment upon positive rapid diagnostic test (RDT) or microscopy

Budget Financed EPHS	Health Insurance Benefit Package (Insurance Financed EPHS + non-EPHS)
strengthened.	
Mental health – Inpatient capacity through the establishment of wellness units at all county hospitals – Training of selected professionals in identifying, managing and referring mental health cases	Essential Package of Hospital Services – Package of hospital services available through the upper levels of the system. – Standardized package of services at each level of hospital – *EPHS surgeries and procedures which can be done in ambulatory surgical centres or health facilities will be paid if provide in these facilities*
Emergency health – All health workers trained on basic stabilization of emergency cases	Non-EPHS health services (may be covered in the basic package or by a supplemental health insurance benefit package) – Outpatient consultation and treatment of communicable and non-communicable diseases (NCDs) including drugs for non-communicable diseases – Hospital services that are not part of the Essential package of hospital services
Non-communicable diseases (NCDs) – Awareness and behaviour change communication (BCC) campaigns – Prevalence of diabetes, hypertension, obesity and other NCDs determined – NCDs unit will be established at the MOHSW	
Neglected tropical diseases – Countrywide surveys to establish the baseline prevalence of diseases such as leprosy – Trained on early detection, timely treatment and referral of complicated cases.	
Environmental and occupational health – Water and food safety and environmental sanitation – Waste disposal, water supply, health education and water testing	
School health services – Micronutrient supplementation (vitamin A and iron–folic acid) – De-worming – Screening for eye, ear, dental and skin problems	

Budget Financed EPHS	Health Insurance Benefit Package (Insurance Financed EPHS + non-EPHS)
– Family planning counselling – Life skills and health promotion	
Eye care – Community ophthalmic nurses (CONs), teachers and CHVs trained on the early recognition of eye problems and how to teach about hygiene, nutrition and safety to prevent blindness within the com- munity. – Clinic and health centre staff recognize, treat and/or refer visual acuity, simple eye conditions and eye injuries	
Prison health services – Package of health services to be provided to all prison inmates has been developed and will be implemented by County Health and Social Welfare Teams (CHSWTs).	

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ANNEX C

LIST OF PERSONS CONTACTED

During the two weeks spent in Monrovia, interviews were conducted with key stakeholders (see table below). Towards the end of the consultancy, a stakeholder workshop was held with representatives of the MoHSW, RBHS, WHO, CHAI, USAID and two media outlets. Following this workshop, this options paper was developed.

Name	Organization	Title
Vivek Kulkarni	CHAI	Financial Analyst
William Martin	MoHSW	Pool Fund Manager
Louise Mapleh	MoHSW	PBF, FARA Coordinator
Dominic Togba	MoHSW	PBF, FARA
Toagoe Karzon	MoHSW	Controller, OFM
Vivian Cherue	MoHSW	Deputy Minister, Social Welfare
Benedict Harris	MoHSW	Assistant Minister, Planning
Teta M Lincoln	MoHSW	Country Health Services Coordinator
Samson Varpilah	Min of Transport	Minister Proper
Cecelia Morris	Liberia Board of Nurses and Midwives	Chairperson
Richard Ngafuan	Min of Labour	Assistant Minister, Research & Statistics
Ivan Korvah	Central Bank of Liberia	Actuary, Insurance Supervision Unit
Bernice Dahn	MoHSW	Deputy Minister, Health Services
Saye Bawo	MoHSW	Assistant Minister, Health Services
Daniel Naatehn	Secure Risk Insurance Co.	Managing Director
Noah Kai	Secure Risk Insurance Co.	Administrative Manager
Robert Johnson	Secure Risk Insurance Co.	Claims Manager
Philip Cooper	Secure Risk Insurance Co.	Marketing Manager
Victor Geekor	Secure Risk Insurance Co.	Underwriting Manager
Walter Gwenigale	MoHSW	Minister Proper
Yah Zolia	MoHSW	Deputy Minister, Policy & Planning
Moses Massaquoi	CHAI	Country Director
	Liberia Medical and Dental Association	President

ANNEX E

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