Liberia Health Equity Fund (LHEF)

Institutional Setting and Roadmap

October 2014

USAID
FROM THE AMERICAN PEOPLE

Contents

This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of JSI and do not necessarily reflect the views of USAID or the United States government.

1. Background

In recent years, **the Government of Liberia (GoL) has implemented a number of health policies that aim to increase access to basic health services.** These policies have resulted in significant improvements within the Liberia health delivery systems. For instance, the 2011-2021 National Health and Social Welfare Policy and Plan seeks to increase access and utilization of quality health and social welfare services for all citizens[1]. In 2007, the Liberia Basic Package of Health Services (BPHS) was introduced to ensure standardized health benefits across private and public health facilities. By 2011, 84% of health facilities in Liberia were implementing the BPHS[2].

Still, financial access to health services remains low with a high out-of-pocket (OOP) expenditure on health. OOP expenditure in Liberia accounted for 35 percent and over 21 percent of total health expenditure (THE) in 2008 and 2012 respectively[3]. It is with this backdrop that the government of Liberia is setting up a (mandatory) health insurance scheme that will secure access to basic healthcare services to all residents. The aim is to provide financial risk protection against catastrophic healthcare expenditure that has the potential to increase poverty incidence especially among low-income households.

The Legislature is in the process of passing a new law to provide the legal environment needed to implement this health insurance scheme, the Liberia Health Equity Fund (LHEF). The LHEF will be centered on the principles of risk pooling and cross-subsidization. This arrangement will promote equity in access and utilization of health services: where the well-off pays for the poor and the healthy help pay for the sick. The goal is to design and implement a customized demand-side financing mechanism based on the core functions of a health insurance system: revenue generation, pooling, purchasing, and health service delivery. This document outlines the institutional arrangement, functions, required personnel, and roadmap for the proposed LHEF and its purchasing agent (PA).

2. Approach to LHEF Implementation

Phased Approach for Setting Up the PA

The design and operationalization of a demand-side financing mechanism at a national scale could be complex and daunting. **A phased approach to implementation of the LHEF is recommended.** This process will ensure that the PA, National Health Equity Authority (NHEA), has enough time to grow into a robust organization; maximizes the use of its initial resources; adjusts to organizational and management challenges; and overcomes resistance to changes. Thus, the PA will be established in two stages:

1. **Incubation Stage:** The PA will be attached to the Ministry of Health and Social Welfare (MoHSW) for a period of two years as a secretariat headed by an Executive Secretary. During this period the

[1] MoHSW. 2011. National Health and Social Welfare Plan (2011-2021)
[2] Republic of Liberia. June 2011. Essential Package of Health Services(EPHS), Primary Care: the Community Health System. Ministry of Health & Social Walfare, Monrovia.
[3] WHO. 2013. Global Health Expenditure Database: Table of Key Indicators. http://apps.who.int/nha/database/ViewData/Indicators/en (assessed August 11, 2014).

NHEA will be a semi-autonomous entity that works with both MoHSW and Ministry of Finance (MoF) to establish the central pool fund to implement the LHEF.

2. **Maturity Stage:** The PA will move out of the MoHSW (potentially after a two year incubation period) as a fully functional autonomous entity. See Box 1 for examples of two countries in Sub-Saharan Africa (SSA) that utilized a phased approach to set up PAs in health insurance.

Box 1: Examples of Phased Approach to Setting Up a Purchasing Agent

Even though many countries in SSA have implemented health insurance programs, only Ghana (35% in 2012)[4] and Rwanda (91% in 2010)[5] have managed to achieve large population coverage. Both countries employed phased approaches to set up the PA.

Ghana: Prior to the enactment of the National Health Insurance (NHI) Law, Act 650 (2003), a PA secretariat was created within the Ministry of Health (MoH) to implement the NHI policy. During this inception phase, eight (8) technical committees were formed to design the various components of the scheme. After passage of the legislation, the PA moved out of the MoH. Over the years, the NHI Council (now NHI Authority) has expanded to meet the increasing demands driven by growth in membership, utilization, and provider claims. In 2012, a new NHI Act 852(2012) was passed to implement further organizational changes that streamline the functions of the NHIA.

Rwanda: In Rwanda, the purchasing agent, the Health Insurance Council, was housed by the MoH for over 10 years before becoming an independent autonomous agency.

Geographic Coverage

Consensus has been reached in the MoHSW that there will be a phased introduction of the LHEF. Three (3) counties (to be identified) will be covered during the first year of implementation. Six counties will be added in the second year after a thorough review of the program. It is expected that all 15 counties will be covered by the end of year three. The NHEA's institutional arrangement will be adjusted to meet anticipated organizational changes. For instance, additional staff will be hired to manage increased workload in membership registration and ID card demands generated by the addition of new counties.

Population Coverage

An overarching goal of the LHEF is to achieve Universal Health Coverage (UHC). Providing financial access to quality health services is an important step in reaching UHC in Liberia. Although the LHEF aims at eventually covering everyone, often poor households do not participate in health insurance schemes as expected. Reasons for the low insurance coverage for the poor include: (1) their inability to pay (re)enrolment fees and (2) difficulty in identifying them for exemptions. Under the LHEF, extreme poor households will be exempted from paying premium. The PA will leverage resources of the Social Welfare department to identify extreme poor households for exemptions, using a means testing process (to be developed).

[4] National Health Insurance Authority. 2012 Annual Report. Accra, Ghana.
[5] Republic of Rwanda. Health Systems. http://www.gov.rw/Health-System (assessed August 10, 2014).

3. The Purchasing Agent (PA)

A critical step in the development and implementation of a health financing mechanism is the establishment of an effective governance structure. The LHEF legislation will create an autonomous PA, a National Health Equity Authority (NHEA), to administer the LHEF. The main purpose of the NHEA is to *implement the national health insurance policy that ensures access to basic healthcare services to all citizens* and residents. The functions of the NHEA are (but not limited) to the following:

1. Operate and manage the LHEF;
2. Determine in consultation with the MoHSW membership contributions;
3. Register and issue identity cards to members;
4. Identify and (re)enroll persons exempt from payment of contributions;
5. Grant credentials to healthcare providers that provide services to members of the LHEF;
6. Manage the financial pool of the LHEF;
7. Receive, process and pay claims for services rendered by healthcare providers;
8. Ensure the efficiency and quality of services under the LHEF;
9. Undertake public education on health insurance;
10. Inform the formulation of policies on health insurance;
11. Develop guidelines, processes and manuals for the effective implementation and management of the LHEF;
12. Train health providers on insurance policies, procedures, and regulations; and
13. Implement other functions approved by the oversight board.

Institutional Structure of the NHEA

The NHEA will be an autonomous entity with a governing board appointed by the President of the Republic of Liberia for a four-year term. Members may be re-appointed for an additional four-year term; but not to exceed two consecutive terms. Members of the Board will be representatives of key stakeholder organizations. The oversight Board of the NHEA will establish three (3) Committees to oversee the following:

i. Finance and investment of the pooled fund,
ii. Grievance and conflict resolution, and
iii. General NHEA operations.

Members of these committees will be appointed by the Board. The committees will comprise of **five (5)** current Board members and/or non-members and will meet **quarterly**. At least **half** of the members will have a minimum of (3 years) practical (public and private sector) experience in the assigned technical roles of the committee. The main functions of the committees are to:

- Perform oversight responsibilities in their specific assigned technical area,
- Deliberate on specific technical functions and advice the Board based on their findings,
- Provide the Board with written reports from their meetings, and
- Execute other functions assigned by the Board from time to time.

Other Technical Committees (besides the three mentioned above) will be established by the Board as needed. **The day-to-day administrative functions of the NHEA will be performed by a management team headed by the Executive Secretary** of the NHEA. Figure 1 illustrates proposed institutional arrangement of the NHEA.

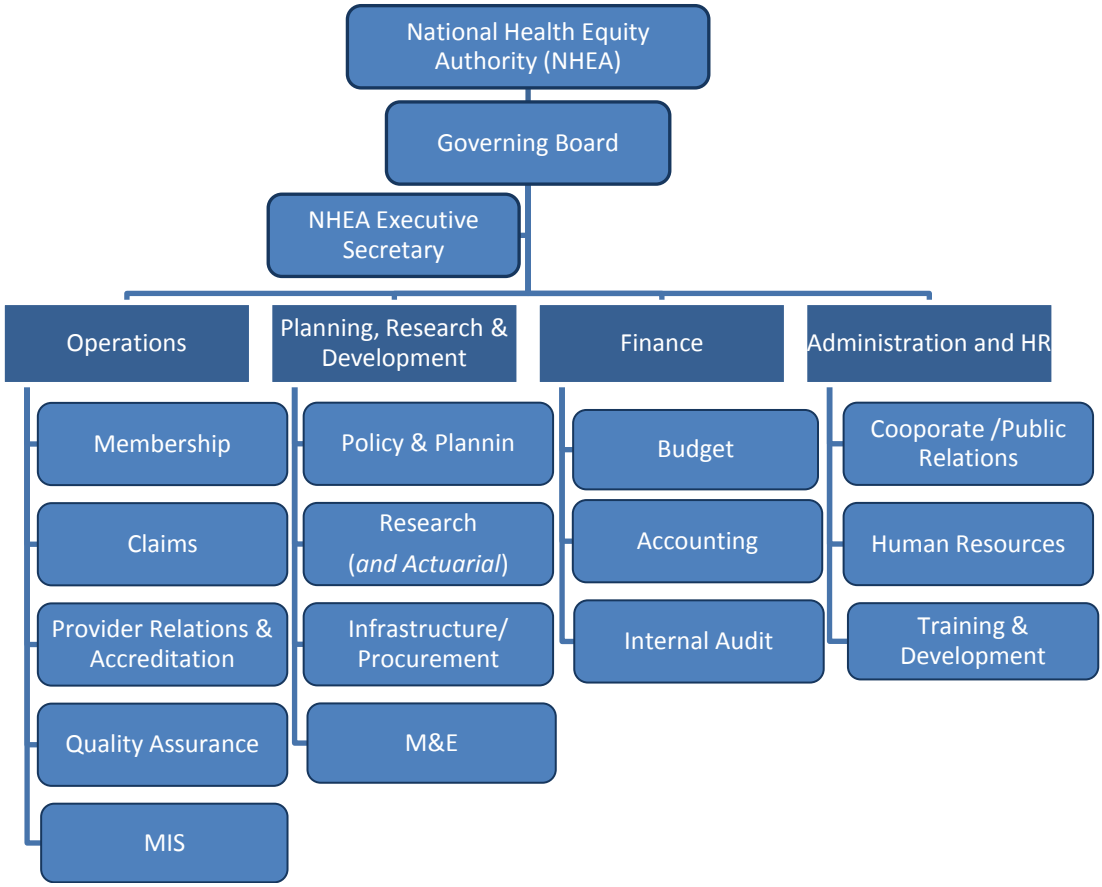

Figure 1: Proposed Institutional Structure of the LHEF Authority

Measures to Promote Good Governance, Accountability, and Transparency

The organizational structure of the LHEF is designed to promote good governance, accountability, and transparency. This will provide checks and balances between various actors in the performance of their functions. The following will be implemented to ensure public trust and transparency in the NHEA:

- **Publish audited financial and annual reports on NHEA website and the media.** This will allow individuals and institutions to have open access to data and information needed to make informed decision.
- **Disseminate NHEA efficiency ratios to measure performance semi-annually.** Efficiency ratios measure the effectiveness of resource utilization and cost reduction strategies. Knowledge of the scheme's operating expense ratio, operating cost divided by operating revenue, is necessary to understanding the cost incurred in operating physical properties and equipment. These ratios provide inputs for determining return on investments and ensure public accountability. Likewise,

the ratio of average days NHEA pays claims could highlight effectiveness of debt settlement. Delays in reimbursement of provider claims negatively impact service quality, deny members of their entitled health benefits, and reduce public trust in the NHEA.

- **The Legislature will approve NHEA's annual budgetary allocations.** The approval process that includes hearings and presentations by the NHEA and the sector Minister will ensure accountability in revenue generation and spending.
- **Address public and media enquiries and complaints promptly.** The ratio between enquiries received and NHEA's response time should be published quarterly.
- **Institute quarterly meet-the-press events** to answer questions from the media on NHEA operations. On these occasions, NHEA management will dialogue with the media to clarify issues that ensure accountability.
- **The NHEA should organize community events to interact directly with members of the scheme** and address their concerns.
- **Community Based Organizations (CBOs) and Non-Governmental Organizations (NGOs) can play an important role as watchdogs, whistle blowers,** and build the capacity of other institutions that ensures good governance within the NHEA.
- **Donors could promote transparency and accountability in governance by ensuring that donor funding to NHEA is contingent on NHEA sharing reports on good governance** with stakeholders. Health donor monitoring (M&E) of NHEA operations (and expenditure) is another approach to ensuring good governance.

Measures to Promote Local Ownership and Sustained Participation in LHEF

Local participation and ownership are critical elements needed for the scheme to thrive. In their absence, however, public confidence will diminish and the potential to increase membership will reduce. The following design features will promote community participation that sustains membership growth and possibly avert insurance risks such as adverse selection:

- **Select registration agents from communities.** People are more likely to trust and (re)enroll in prepayment schemes when they identify with those collecting the contributions.
- **Actively engage local leaders** such as chiefs, religious leaders, and union leaders in LHEF decision-making. This could be achieved by building their capacity and understanding of basic health insurance concepts through workshops. They can in turn sensitize their members and encourage them to (re)enroll in the LHEF.
- **Utilize community marketing and education strategies and tools that target specific populations.** Local radio presentations, community durbars, and outreach could be used to educate people on LHEF policies.
- **Partner with local institutions to identify the poor for exemptions.**
- **Implement household registration to reduce adverse selection.** Household registration will prevent families from enrolling only high risk family members in the LHEF. This method ensures that healthy individuals compensate for the high health risk imposed by the sick.

Generally, low annual (re)enrolment rates are significant bottlenecks of pre-paid health insurance mechanisms. The above stated conditions are essential for enhancing community participation and sustaining membership growth.

Key Personnel and Expertise Requirement

The NHEA will create a centralized administrative structure with decentralized management teams in each of the 15 counties. The goal is to promote participation and ownership at the community level, while implementing necessary central oversight to ensure cost containment. Table 1 shows detailed staffing and skill requirements for the proposed NHEA organization.

Table 1: Human Resource and Skill Requirements

Key Staff	# of Personnel			Qualification/Experience
	Year 1	Year 2	*Full Operation*	
Centralized (National) Level Personnel				
Executive Secretary of the NHEA	1	1	1	Master's degree minimum: Must be a Liberian citizen with at least 5 years' experience in health financing and corporate management.
Directors	4	4	4	Master's degree: 5 years relevant experience with at least 3 years senior managerial role; outstanding leadership skills
Operations Directorate				
Deputy Director Operations	1	1	1	Master's degree: 4 years relevant experience(at least 2 years in management position); Business development; Health insurance systems management and financing, actuarial knowledge
Operations Manager, Membership	1	2	3	
Claims Manager	1	2	3	
Clinical Audit Manager	1	2	2	
Provider Relations Manager	1	2	2	
Client Relations Manager	1	1	1	
Accreditation Manager	1	1	1	
Quality Assurance Manager	1	1	1	
MIS Manager	1	1	1	
Planning, Research & Development Directorate				
Deputy Director Policy, Planning, Monitoring & Evaluation (PPME)	1	1	1	Master's degree: 4 years relevant experience (at least 2 years in management position); M&E; excellent analytical, writing, communication skills; research skills; knowledge of results frameworks.
Actuary	1	1	1	
Procurement Manager	1	1	1	
M&E Manager	1	1	1	
Finance & Budgeting Directorate				
Deputy Director, Finance & Budget	1	1	1	Master's degree in Public/Business Administration/Social Sciences: 4 years relevant experience(at least 2 years in senior management position); extensive knowledge of financial, procurement, budgeting, and auditing regulations
Budget Analyst	1	1	1	
Accountant	1	2	2	
Audit Manager, Internal	1	2	2	
Finance Manager	1	1	1	
Administration and HR				
Deputy Director, HR/Legal Counsel	1	1	1	Master's degree in HR Management/Public or Business Administration/Law: 4 years relevant experience(at least 2 years in senior management position); extensive knowledge HR management and concepts, labor law compliance,
Administrative Manager	1	1	1	

Key Staff	# of Personnel			Qualification/Experience
	Year 1	Year 2	*Full Operation*	
HR Manager, Recruitment & Training	1	2	2	
Public Relations Manager	1	1	1	
Total	**27**	**33**	**36**	
Decentralized (County) Level Personnel[6]				
Scheme manager	3	9	15	Master's degree: 5 years relevant experience; excellent management, administrative, and leadership skills; knowledge of social health insurance
MIS manager	3	9	15	Bachelor's degree/professional qualification in MIS: 4 years relevant experience.
Accountant	3	9	15	Diploma/Degree in Accounting/ Financial Management: 4 years relevant experience.
Publicity/marketing officer	6	18	30	Bachelor's degree in Social Sciences /HND in Marketing: 3 years relevant experience.
Data entry clerk	9	27	45	Post-Secondary/Secretariat Certificate: Formal computer training, proficient in MS Office, data entry, accurate keyboard skills (speed: xx wpm)
Field registration agent[7] *(temporal staff)*	267	801	1,335	Secondary/High school Diploma: data entry, revenue collection, excellent speaking and written communication, and community entry skills.
Total	**291**	**873**	**1,452**	

Centralized versus Decentralized Organizational Arrangement and Functions

There are tradeoffs between centralized and decentralized **management functions** in health insurance systems. A good balance is needed. Decentralization of public education, membership demand generation, and enrolment roles to local entities could ensure trust and increase participation by local communities. Also, a decentralized gatekeeper system should be enforced to control unnecessary utilization of services and healthcare cost. Under the gatekeeper arrangement members will be required to access higher-level (secondary and tertiary) services only after they have been appropriately referred from a primary care facility. During the initial stages of implementation, however, the LHEF's benefit package will include **only primary care services**. The benefit package will be expanded to cover secondary and tertiary-level services over time, after a comprehensive review.

Conversely, centralized provider contracting will be cost effective and ensure better outcomes. Health care institutions are experienced in provider service negotiations. The NHEA will need the right caliber of personnel to negotiate with providers for better prices and services. Utilizing a specialized team at the headquarters to negotiate provider contracts in all counties will maximize value for money for the NHEA.

Similarly, centralized claims management systems could ensure the efficient vetting of provider claims for prompt reimbursement and reduce financial leakages resulting from improper vetting of claims.[8]

[6] Use stepwise implementation approach to cover 3 Counties in year 1; 9 Counties in year 2; and all 15 Counties after year 3.
[7] Assuming it takes 10 to 12 minutes for an agent to register a client; that will be an average of 5 people per hour (30people/day). With an average county population of 267,000 people; 89 agents will be needed to register 30% (80,100 people) of county population in 30 days. [Number of agents per county per day = 80,100/30people * 1/30days = 89 agents]

However, capitation[9] is the likely provider payment mechanism for the LHEF. The capitation payment arrangement will eliminate the cost of claims preparation and vetting by the NHEA. Still, not all levels of care will be capitated from the onset. For example, specialized (tertiary) services will not be capitated from the beginning. Thus, the NHEA will still hire staff to manage claims submitted by facilities. Table 2 shows the various functions of the NHEA that could be centralized and/or decentralized.

Table 2: Centralized versus Decentralized Functions of the LHEF

Core Function	Operational Level		Key Actor/Remarks
	Local	National	
Revenue generation			
Premiums collection from informal sector	X		By locally trained and bonded registration agents.
Payroll contributions by formal sector, sin tax, donor fund, etc.		X	Ministry of Finance collects and transfers funds to the NHEF.
Determination of premium rates		X	NHEA
Community sensitization/Outreach	X		NHEA county offices
Pooling			
Management of central pooled fund		X	All revenues deposited into a central fund managed by the NHEA.
Management of reserve fund		X	
Reinsurance		X	
Purchasing			
Determination of provider payment rates		X	NHEA contracts public and private healthcare providers.
Contracting health service providers		X	
Management of Claims		X	Reduced/eliminated under capitation.
Clinical Audit		X	
Design/review of payment mechanism		X	
Service delivery			
Provider accreditation		X	MoHSW accredits healthcare providers.
Adherence to benefit package	X	X	
Quality assurance	X	X	NHEA implements QA.
Other Supporting Functions			
Membership (re)enrolment	X		ID card production and distribution could be done simultaneously with biometric registration.
Production of ID card		X	
Distribution of ID card	X		
Identification of the poor & exemption	X		NHEA and Social Welfare Department
Marketing and branding	X	X	Both headquarters and county offices
Strategic Advocacy		X	NHEA
Monitoring and Evaluation (M&E)	X	X	Implement at all levels of operations.

[8] National Health Insurance Authority. 2012 Annual Report. Accra, Ghana.
[9] Capitation is a payment mechanism by which service providers are paid a fixed amount in advance for a given period of time (yearly, monthly, etc.) for each health insurance enrollee in their network.

Centralized (National) Management Team

The NHEA will be responsible for the overall oversight of the LHEF. Each of the four directorates of the NHEA: (1) Operations; (2) Planning, Research, and Development; (3) Finance; and (4) Administration and Human Resources will be headed by a Director who reports to the Executive Secretary. See Figure 1. The Director is responsible for the successful execution of activities within core functional areas managed by the Deputy Directors reporting to them.

However, **NHEA functions that require expertise that could impose unnecessarily weighty administrative, training, and financial burden on the Authority could be outsourced** to independent private or public sector organizations. Strategic outsourcing of technical functions will allow the NHEA to concentrate on its core businesses of: revenue mobilization, management of the pooled fund, and purchasing of quality health services for scheme members. Outsourcing technical functions such as the determination of benefit package, premium rates, drug list, exclusions list, policy development, marketing and branding during the inception phase of the project will ensure a cost-efficient use of NHEA's limited resources. In the long term, specialized core tasks including research, training, actuarial studies, and program evaluation could be contracted out.

Decentralized (County) Management Team

The NHIA will progressively establish satellite offices in each of the 15 Counties (according to the phased plan) with management responsibilities including:

- (Re)enrolment of members of the LHEF,
- Hiring and managing bonded[10] field registration agents,
- Collection of contributions from paying informal sector enrollees,
- Issuing of ID cards prepared at the NHEA headquarters,
- Engaging in community sensitization and education on NHEA policies, and
- Providing support for the identification of the poor for premium exemptions.

The core staff complement at the County NHEA office will include:

1. Scheme manager,
2. MIS manager,
3. Accountant,
4. Publicity/marketing manager,
5. Data entry clerk, and
6. Field registration agents.

The scheme manager, MIS manager, publicity manager, and the accountant will be salaried employees of the NHEA. Other auxiliary staff and temporal employees will be paid allowances. For instance, temporal employees could be hired during major outreach and registration events.

Field agents will receive a (10 percent) commission on the total revenue collected. The field agents will be bonded to reduce the risk of fraud and misappropriation of funds. Field agents will be trained in data

[10] Third party agent (individual or company) authorized to collect premiums and register clients on behalf of the NHEA. Agents will be required to register with the NHEA and provide a collateral guarantee equivalent to anticipated 3 months premium collection per agent.

entry, communication skills, financial management, and community entry to improve performance. In addition, strict auditing procedures should be implemented to ensure proper financial management.

Cashless premium collection methods can eliminate the risk of collecting and handling funds in cash by agents, increase efficiency, and reduce the cost of collecting premiums. The steady growth in mobile phone coverage in Liberia offers an enormous potential for cashless collection of contributions. In 2012, cell phone market penetration had reached 68.4% with over 2.3 million subscribers.[11]

The application of mobile payment technology will serve multiple purposes including: (1) premium collection, (2) membership renewals, (3) marketing and dissemination of insurance information, and (4) checking membership status before health services are offered. It is important to explore innovative ICT solutions that integrate into existing platforms such as mHealth (mobile health) and mobile money. Building on existing systems is a cost efficient way to implement mobile payment systems in Liberia, a country with limited ICT resources. Preparatory work for the design and use of mobile payment system will include:

- Registering all cell phones to enable individuals to transfer airtime credit for premium payment,[12]
- Hiring a consultant (firm) to assess ICT needs of NHEA, design, and maintain the mobile payment platform, and
- Leveraging resources of Telecom companies to launch the mobile platform.

The Registration Process

Undoubtedly, mobile payment will speed up the enrolment process. Still, field agents will be hired to complete registration forms, take pictures for membership ID card printing, and distribute ID cards. Figure 2 outlines generic steps to enroll in the LHEF.

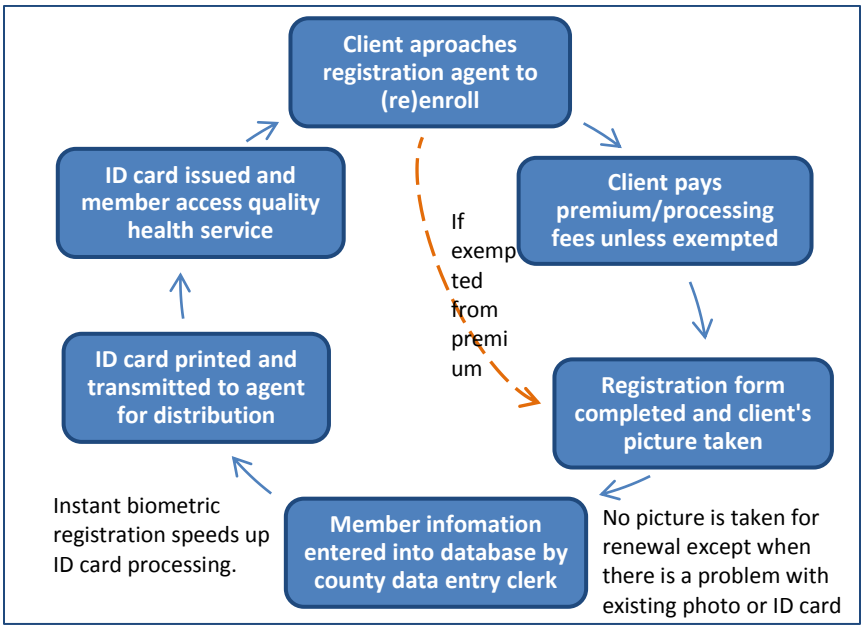

Figure 2: The Registration Process

[11] Liberia Telecommunication Authority, 2012 Annual Report.
[12] An individual purchases airtime credit (or scratch card) and transfers it via a cell phone to a central NHEA account to pay for premium; a receipt and code are received as proof of payment that allows the person to register with the scheme.

Extreme poor households will be identified for exemptions. The NHEA will partner with the Social Welfare department to develop processes and procedures for identifying poor households. The list of people identifies will be used by county management of the LHEF for premium exemptions. There are varieties of methods for identifying the poor that the NHEA can consider: (1) proxy-means testing, (2) community-based targeting, and (3) other hybrid techniques for identifying the poor. Any mechanism selected should be trusted by the people and be accurate in identifying the poor; most of whom are in the informal sector with no verifiable income data. Granted, identification of the poor is difficult and there is no perfect system for the process. Local management boards could be established at the county-level to approve the list of identified poor households in communities. However, creating NHEA structures at the county-level have cost implications.

Should the NHEA Establish Management Boards at the County-Level?

Generally, decentralized management arrangements promote community ownership and improve sustainability of health insurance systems. The Board of Directors (BoD) at the local scheme level play an active role in decentralized decision-making, oversight of the scheme, approve spending, and appoint local staff. Notwithstanding, the establishment of BoD at the county-level in Liberia will add to the cost and bureaucracy of the NHEA. Therefore, the **NHEA should not establish local Boards at the county-level.** See Box 2 for comments on the decentralized BoD under the Ghana National Health Insurance Scheme (NHIS) in Ghana.

Box 2: Board of Directors Under the Ghana NHIS

During the first 10 years of implementation of the NHIS in Ghana, the semi-autonomous District Mutual Health Insurance Schemes were governed by local BoD. Members of the Board were selected by a General Assembly comprising of representatives from community health insurance committees. E.g. in June 2007, the Nkoranza District Mutual Health Insurance Scheme had a 15-member Board.

These Boards were expensive to operate and possessed overwhelming decision-making powers; yet they had low technical expertise to oversee the management of the schemes. Hence, they were discontinued in 2012 with the passage of the new NHI Act 852(2012).[13]

4. Roadmap and Deliverables

Existing government institutions have enormous potential to support the establishment of the proposed LHEF. The GoL has demonstrated the support and political will necessary for initiating the program. What is needed is a roadmap that ensures that all key actors play their respective roles to get the implementation of NHEA off to a good start. This section of the document outlines the timelines and deliverables for a phased implementation of the LHEF.

[13] Field observation. (include a reference???)

Project Phases and Important Benchmarks

Much preparatory work has been undertaken to set the stage for takeoff. Critical steps to help design and start implementation of the LHEF include (but not limited to) the following:

- Enactment of legislation,
- Strategic advocacy,
- Creation of the oversight board,
- Selection of Purchasing Agent and hiring the Executive Secretary,
- Establishment of county-level management team,
- Recruitment and training of registration agents to start membership enrolments,
- Provider registration and accreditation,
- Engaging health service providers to sign contracts, and
- Sensitization/training of healthcare providers on provider contracting, payment mechanism, payment tariff rate. See Figure 3 for implementation phases and summary of outputs.

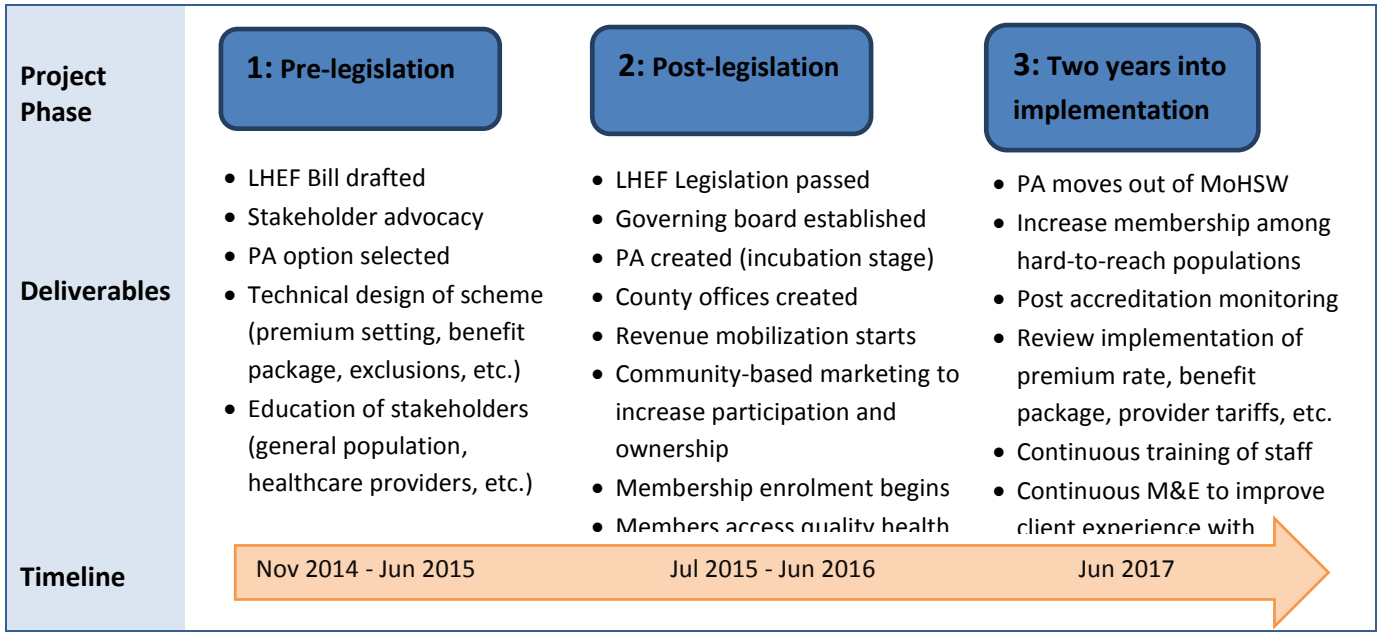

Figure 3: Implementation Phases and Output

In all, the enactment of the LHEF Act that will provide the legal framework for implementation of the LHEF is the most critical step. The execution of most activities depends on this step, yet it could take considerable amount of time. The consensus building process on the draft Bill by key stakeholders including the Legislature (the Senate and House of Representatives) can be lengthy. However, advocating with high-level stakeholders could deepen their understanding of the LHEF and speed up the passage of the LHEF Act.

Strategic advocacy at early stages of the scheme's design could ensure proper engagement of key actors. The initiator(s) of the LHEF should coordinate efforts of the MoHSW, MoF, and other stakeholders towards the common mission, establishment of the LHEF. Members of the committees on health care, social welfare, and finance in the Legislature should be particularly educated on the LHEF.

This high-level engagement is critical in ensuring commitment, political buy-in, and passage of the legislation.

Timelines

The LHEF program will be implemented in stages. The project roadmap is organized into 3 phases: (i) pre-legislation, (ii) post-legislation, and (iii) full operations. **Annex 1** illustrates key activities and timelines for the design and implementation of the LHEF.

5. Potential Risk to Program Implementation

There is great excitement and enthusiasm within the Government of Liberia to improve financial access to health services and reduce poverty. This political will and support is needed for setting up the LHEF. The MoHSW and other stakeholders should seize this window of opportunity to implement this new demand-side-financing mechanism, the LHEF. Still, the following factors could negatively impact plans for the establishment of the LHEF:

- **Political will and collaboration** among the different LHEF actors are critical for the timely passage of LHEF legislation. The enactment of the LHEF Act is a fundamental step for creating the legal entity needed to implement the LHEF. Policy engagement with policy makers and political leaders could speed up the legislative process.
- **Unanticipated national public health events** such as the recent ebola disease outbreak could slow down progress of the LHEF. Resources are justifiably being diverted to support containment. It is difficult to predict at this stage when ebola will be brought under control.
- **Perception of (mis)trust by community members** based on previous experiences with other prepayment arrangements could affect client confidence in the LHEF. Generally, people do not trust health insurance programs run by governments. The general public perceives insurance companies to be untrustworthy and feel that: (1) benefits may not be provided as promised, (2) payment of claims may be unnecessarily delayed, or (3) registration agents may embezzle their contributions.[14] For instance, some registration agents of the NHIS in Ghana have been accused of collecting unofficial fees to register members of the scheme.[15] This unscrupulous behavior by agents can potentially increase distrust and reduce membership enrolment rates. Misconceptions in health insurance could be addressed with targeted sensitization of members and by selecting revenue collectors from communities.
- **Regular funding for technical assistance to the LHEF is critical** for successful implementation of the program. Inadequate donor funding could potentially disrupt progress in implementation of the LHEF. It is crucial that the initiators of the LHEF secure additional funding for TA support to the scheme.

[14] Preker Alexander, Richard MS, and Mark CB. 2007. *Private Voluntary Health Insurance in Development: Friend or Foe?* The World Bank. Washington, DC.

[15] Dalinjong and Laar. The National Health Insurance Scheme: Perceptions and Experiences of Health Care Providers and Clients in Two Districts of Ghana. *Health Economic Review* 2012, 2:13.

6. Conclusion

The LHEF has the potential to secure financial risk protection against catastrophic health expenditure and expand access to health services for all residents. It is imperative that the Liberia Legislature passes the LHEF Act that will create the legal entity and purchasing agent to implement this health equity fund. Through policy engagements and strategic advocacy, stakeholder interest could be aligned for the design and implementation of the scheme. A phased approach to implementation is recommended. Using this method, successful lessons learned from earlier stages could help improve structure, functions, and operations of the LHEF organization. These achievements in demand-side health financing will help the GoL to attain an important long-term goal, Universal Health Coverage.

ANNEXES

Annex 1: Proposed Timelines and Deliverables for the LHEF

Benchmark/Deliverable	Lead	Phase 1 (Pre-Legislation)								Phase 2 (Post-Legislation)										
		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19
DESIGN PHASE COORDINATION																				
Advisory Council monthly meetings																				
Coordination Team bi-weekly meetings																				
POLICY & LEGISLATION																				
Policy briefings for the President (monthly / bi-monthly)																				
Support (and provide inputs) for legislative review of the LHEF Bill																				
ADVOCACY, MARKETING AND BRANDING																				
Strategic advocacy with the Legislature (House Committees on health care, and finance) and heads of key sector ministries for political buy in																				
Organize national stakeholder workshops on LHEF																				
Hire specialized marketing firm to finalize marketing plan																				
Finalize and implement LHEF marketing plan																				
Advocate with the media																				
Advocate with healthcare providers																				
Advocate with pressure groups (formal sector employee unions)																				
Educate general population on LHEF legislation (Bill and Act) and entitlements																				
INSTITUTIONAL SETTING & STRUCTURE																				
Central/National Level																				
Select a purchasing agent (PA)																				
Establish oversight board																				
Establish 3 technical committees (finance, operations, grievance)																				
Establish governance structure of the PA																				
Establish pooled fund management and reserve investment rules																				
Operationalization of PA																				
Hire Executive Secretary																				
Hire staff for departments/units																				

Benchmark/Deliverable	Lead	Phase 1 (Pre-Legislation)								Phase 2 (Post-Legislation)										
		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19
Select/acquire a building and office equipment and logistics																				
Develop LHEF operations manual and procedures																				
Create internal audit system																				
Create provider contracts																				
Decentralized County-Level Offices																				
Establish satellite/County LHEF offices																				
Hire key staff complement (scheme manager, MIS, publicity, and accountant)																				
Hire and train field registration agents																				
Establish process of engagement and disengagement of personnel																				
FINANCING (REVENUE GENERATION & MANAGEMENT)																				
Determine potential sources of revenue to the LHEF pool fund																				
Set informal sector premium rates																				
Set formal sector contribution rates (payroll deduction)																				
Establish premium collection mechanisms																				
Map private sector employers																				
Establish the central pool fund																				
Establish disbursement formula and procedure for the pool fund																				
RISK POOLING																				
Establish procedure for identification of the poor																				
Establish premium exemption policies																				
Establish enrolment process and procedure																				
Establish membership ID system																				
PURCHASING & SERVICE DELIVERY																				
Establish accreditation process																				
Create provider accreditation standards and tools																				
Publish list of accredited health facilities (public and private)																				
Establish capitation formula																				
MoHSW / PA to establish capitation formula based on int'l best practice																				
Train providers on capitation formula																				

Benchmark/Deliverable	Lead	Phase 1 (Pre-Legislation)								Phase 2 (Post-Legislation)										
		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19
Integrate RBF mechanism for active purchasing into PA																				
Develop provider contracts																				
Create forms for: member and provider registration, ID card																				
Establish a benefit package[16] and exclusions at the 3 levels of care																				
Map preferred service providers by clients for capitation																				
Develop essential drug list and Set provider tariffs for pharmaceuticals																				
Establish provider quality standards																				
RESEARCH, MONITORING AND EVALUATION																				
Establish LHEF monitoring systems for service utilization, governance, etc.																				
Establish post accreditation monitoring system																				
Develop member rights and complaint (and redress) system																				
Provide technical assistance for LHEF implementation																				
Conduct feasibility/scoping study on the role of mobile payments (ICT) in LHEF																				
Engage an ICT consultant to design applications for premium collection, (re)enrolment, M&E, etc.																				

[16] Based on the Basic Package of Health Services (BPHS) introduced in 2007.