The Liberian Health Equity Fund (LHEF): A narrative history

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Introduction

From July 2013 to July 2014 the USAID/RBHS project was tasked with supporting the Government of Liberia to design and implement a national health insurance system in Liberia. This narrative report provides an overview of the activities, processes, challenges, and way forward within the context of promoting Universal Health Coverage (UHC) in Liberia through the Liberian Health Equity Fund (LHEF).

In recent years, UHC has attracted increasing attention as a unifying goal for developing and developed countries alike. Translating the concept into reality has however proven to be a daunting task for policymakers and their technical colleagues. This narrative is intended to inform future work on health finance reform in Liberia and elsewhere. Many resources exist explaining what the outcome of reform is supposed to look like, but few document how that outcome was achieved. The truth is that these processes are rarely linear, carrried out as planned, or have a result that looks like the original design. A collection of documentation on the how of health finance reform from multiple countries would be a powerful educational tool. This document is offered up in that spirit.

RBHS would like to thank both USAID and the Government of Liberia for inviting us to work on this landmark reform and wish the country the best in future efforts that, hopefully, will build on what has come before. A special note of thanks goes to Deputy Ministers Zolia and Flomo of the Ministry of Health and Social Welfare for their commitment to this work.

Most importantly we all wish Liberia and its neighbors a speedy conclusion to the ebola outbreak which has proven so deadly and destabilizing over the course of the last six months.

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Background

Liberia's health sector is currently funded by a combination of domestically-generated resources, and external financing through an innovative pool fund as well as the usual means of off-budget, on-plan funding of international and local NGOs. There has been a USAID-funded results-based financing program in place, managed by the Ministry of Health and Social Welfare for several years and the World Bank is preparing a hospital-level, quality-only results-based financing program. Liberia's 15 counties are provided a block grant for health each year that is the subject of strict rules on allowable expenditures imposed by the Ministry of Finance. These grants are not subject to regular review to assess their appropriateness in light of changing population sizes, county needs or changes in external funding flows.

In light of concerns about diminishing external financing, beginning in 2010 a conversation about new mechanisms to attract additional funding from domestic sources took place. The Ministry of Health was interested to increase the level of funding into the health sector as well as to change the means by which the health sector was funded. Instituting some form of health insurance in Liberia was seen as a way of achieving these two goals. An initial discussion between the Liberian Ministry of Health and Social Welfare (MOHSW) and the World Bank led to a Bank-funded consultancy implemented by Oxford Policy Management (OPM). This consultancy published and disseminated three reports: one health financing assessment of Liberia and two separate feasibility reports focusing on Social Health Insurance (SHI) and Community-based Health Insurance (CBHI).

The OPM feasibility reports indicated that Liberia was not yet in a position to engage in either form of the proposed health insurance schemes; after this determination was made, the idea became dormant for several years.

The MOHSW communicated to the USAID/Liberia-funded RBHS (Rebuilding Basic Health Services) Project in early 2013 that they wanted to revive the health insurance conversation. At this point, Institute for Collaborative Development (ICD) was invited by the RBHS project for an introductory visit to advise the MOHSW on the way forward. It was clear that the overriding concern of the MOHSW by this point was to increase the resource envelope of the health sector. This stemmed from a widely held understanding that following the post-conflict reconstruction period in Liberia, international funding would stagnate or fall over time. The MOHSW has over the past few years improved its grasp on revenue generation, particularly through concessions for agricultural products.

The initial visit took place in July 2013 with a team of four health financing experts: Francis-Xavier Andoh-Adjei, senior official at the Ghanaian National Health Insurance Authority (NHIA); Eduardo Banzon, former head of the Filipino PhilHealth; Yogesh Rajkotia, a health financing expert with significant experience of the Ghanaian National Health Insurance Scheme and Erik Josephson, a health financing expert with experience working in Rwanda and Haiti. ICD's role during this trip was to present options to the Liberian government for structuring health insurance, ensuring that stakeholders shared a common understanding

of what insurance is, and how best to introduce a health insurance mechanism to the country.

Setting the Initial Design

During the initial trip to Monrovia, the ICD team conducted stakeholder interviews with key MOHSW staff, representatives of the Ministries of Transport and Labor, representatives of health worker unions, and NGOs working in the health sector. These meetings provided an opportunity to validate the team's thinking on an appropriate design for a health insurance system for the Liberian context. Additionally, meeting with government representatives gave the team an opportunity to understand what the prevailing positions were concerning a potential health insurance system; this in turn helped the team get a sense of the political will needed to undertake a reform of this scope.

During this trip, ICD held a two-day design workshop at the Corina Hotel in Monrovia. During this workshop, participants were given a comprehensive overview of key health financing functions (revenue generation, pooling, purchasing), design options, and rationales for the various options. The participants included approximately 30 ministry officials, development partners, and media outlets. The workshop was mostly educative in nature and aimed to start a discussion on potential health insurance design options. It was structured along the classic health financing functions:

1. Revenue generation -- this looks at population coverage, sources of financing and collection mechanisms;
2. Pooling -- the ultimate goal is to ensure financial sustainability of the scheme. It also seeks to ensure that the risk of payment of healthcare cost is spread across wider socio-economic groups to reduce catastrophic spending by individuals;
3. Purchasing -- decisions on what health services to purchase (benefit package), how to pay for these health services (payment mechanisms), how much to pay for the health services (reimbursement rates), and from whom to purchase these health services (contracted health care providers).

The concepts covered were complex and new to many people. In retrospect, the ICD team believes that this workshop marked the very beginning of the education process to gain informed support for what would later become known as the Liberia Health Equity Fund (LHEF). The participants were engaged and interested, asking many questions, including some which sought to challenge whether this was the right approach for Liberia at the stage of development in which it found itself.

Following this trip the ICD team drafted a Design Options Paper (with a roadmap) which summarized the discussions which had taken place in Monrovia including sections on the context, the meetings held and the options presented according to each of the health financing functions. The paper articulates key concepts and components relevant to UHC, specifically: goals for health insurance in Liberia; revenue generation and collection; pooling; strategic purchasing; service provision; and institutional design. The roadmap is a tool that includes clear descriptions of key activities to promote UHC reforms, designated activity leads, and a detailed workplan. Activities addressed in the roadmap tool fall under the following categories: necessary legislation, coordination, implementation capacity, and public support. These activities are phased, and are described as occurring either before the

legislation, immediately after the legislation, and/or once the legislation has been fully implemented. The options paper and roadmap package provides clear guidance and structure to support the establishment of the LHEF. This paper was submitted to RBHS in mid August 2013, prior to being submitted to the MOHSW.

The MOHSW and partners reviewed the Design Options Paper and requested that ICD make a second trip to Liberia to carry the design and roll out discussion forward. At this point ICD became a sub-contractor to RBHS (henceforth all referenes in this document will be to RBHS). This trip took place in October 2013 with the primary goal of presenting the options for starting the LHEF to a senior group of policy makers. The meeting was branded as a "consensus building workshop" (building consensus around design options) and was chaired by the Ministery of Health, Dr Gwenigale. Senior line ministry officials attending included: the Minister of Transport; the Deputy Minister for Revenue from the Ministry of Finance; the Deputy Minister from Ministry of Commerce; the Chair of the Senate Health Committee; and the Vice Chair of the House Committee on Health. In addition, all four Deputy Ministers of Health attended the event.

During this workshop, facilitators reviewed the options under each of the three functions – with the objective of choosing one option. Ultimately, this workshop proved to be more of a political than a technical exercise, but nonetheless was an important beginning to open dialogue between Liberian officials. Designing a national health financing mechanism requires many small decisions to be taken in order to inform the larger approach. In addition a substantial amount of new information needs to be absorbed by policymakers and they must be allowed time to absorb the import of what they're learning.

The issue of political will was present at the beginning of UHC talks; a key question is exactly where political will for the UHC and more specifically, the LHEF, emanates from. Minister Gwenigale was the initial champion for UHC, who then advocated with President Sirleaf who took on the idea herself. The President announced the LHEF as a potential model for UHC in her Annual Message to the National Legislature in January 2014. When talking of health financing, firm backing from the senior ministerial level is a critical element in addition to full support from the head of state; without either, the process is much less likely to succeed. The locus of support for driving towards UHC remained with the Minister of Health throughout, and despite support from the President, it never became a genuinely Presidential initiative.

Translating Research into Policy

A key topical issue involves determining how to translate research into policy and communicate complex concepts to senior policy makers who have multiple competing interests. The politics surrounding health financing reform across line ministries has been a critical piece of the UHC puzzle.

Minister Gwenigale appointed Deputy Minister Zolia (responsible for Planning) to serve as the dedicated focal person for the LHEF. She oversees the Planning Bureau of the Department of Planning, Research, and Development. In this position, she manages two Assistant Ministers, three Directors and several focal persons; a substantial set of responsibilities. Deputy Minister Zolia in turn charged Acting Director of Health Financing Roland Kesselly with driving the process.

Technical Design Activities

A Coordination Team (CT) was formed with Director Kesselly in the lead. The team was composed of his team at the MoHSW, including an ODI Fellow, a representative from CHAI and Erik Josephson from RBHS. The CT started to assess specific issues – notably who would function as the purchasing agent, and under which structure this agent would be located. Additionally, the CT considered how legislation could best be crafted, and identified the processes needed to move this legislation forward. There were moves to establish a working relationship between the Ministries of Health and Finance; modelling potential revenue from each of the revenue streams identified during the consensus workshop in October; continuing work on costing the LHEF; and supporting the political aspects of the LHEF.

Identifying which funding streams would support the LHEF was a critical issue. To approach this, the CT wanted to foster a working relationship between the Ministries of Health and Finance. In November 2013, the CT conducted its first visit with the Ministry of Finance (MoF). The meeting was relatively informal and intended primarily to start a conversation on UHC. Time was spent on costing, specifically how much it would cost to offer health services through the LHEF. This meeting led to the realization that MoF and MOHSW need to have more regular discussions on health financing in order for the LHEF concept to move forward.

By December 2013, the politics surrounding UHC were becoming increasingly complex. During this critical period the CT focused on mobilizing a broad network of stakeholders -- this involved holding meetings with the National Drug Supply (NDS), the Tax Policy Unit at the MoF, the Ministry of Labor, the Civil Services Agency, and other relevant institutions. These meetings emphasized involving people in the process to educate, secure stakeholder buy-in, and understand the concerns surrounding UHC.

More Substantial Leadership for the LHEF

Despite the very positive contributions by the CT, it was clear that the profile of the LHEF was not sufficiently high within the MoHSW, and not at all visible within the MoF. Having started with a very high-profile consensus design workshop chaired by the Minister of Health with senior representation from the Legislature, the Ministry of Finance, the Ministry of Transport and other notables, the drive for the LHEF had disappeared into the bowels of the MoHSW. Reforming the way a health system is financed is a governmental project, not a health sector project. Not only will the reforms impact the sectors of several cabinet members but without the explicit approval of the Minister of Finance, the reforms are unlikely to pass. It was essential therefore that the LHEF reforms become a regular fixture on cabinet meeting agendas. As it was, these reforms were not even a regular fixture on MoHSW leadership meeting agendas.

As a means to at least getting on the agenda at MoHSW leadership meetings regularly, on the way to working up to the cabinet, the CT requested from Deputy Minister Zolia that a senior MoHSW figure become more intimately involved in the day to day work. The Special Assistant to the Minister, Dominic Rennie was recommended as the focal point to promote the LHEF. Mr. Rennie was proactive and understood how to ensure that work moved

forward and communication was clear and effective. He was however reticent to assume responsibilities which he felt were more appropriately taken on by a political appointee rather than a hand-picked executive assistant.

Continued Development of the Design

After a phase of somewhat joint, somewhat diffused leadership from Deputy Minister Zolia and Dominic Rennie, it became clear that the full magnitude of the task of health finance reform was not fully understood by MOHSW leadership, nor at the senior levels of government. The CT continued to work on the details of the design of the LHEF, including a plan to educate stakeholders, advocate for, and market the LHEF. The CT developed a tailored education, advocacy, and marketing plan rooted in the following principles:

- Transparency
- Common Understanding
- Rights of Patients
- Rights of Providers

The education component of the EAM plan focuses on ensuring that everyone understands exactly what is being proposed through the LHEF. This includes how the scheme works, what the benefits are, and enrollment, claims, and reimbursement processes. The advocacy component of the EAM plan is similar to the education component, but is more persuasive in intent. It aims to convince stakeholders of the value of designing and implementing the mechanism. The marketing component of the EAM plan is the most general of the three arms of the plan. Marketing for the LHEF essentially involves utilizing multiple communication channels to inform the general population of their rights under the LHEF system, how they can join the scheme, and what the benefits of membership are. The marketing campaign must be tailored to fit the unique Liberian context.

Ghana Study Tour

As part of the roadmap there were to be one or two study tours organized for Liberian stakeholders to learn from other countries that had gone down the path of a national insurer. There had already been much excitement about a potential visit to Rwanda, a country that had developed a “mutuelles” model of health insurance. RBHS felt however that this would not be an appropriate choice given the significant socio-cultural differences with Liberia. A matrix of four other options was presented by the CT to Deputy Minister Zolia and after some discussion Ghana was selected. Ghana is nearby to Liberia, had created a very similar model to what Liberia had in mind and usefully an original member of the RBHS team worked full time at the Ghanaian NHIA.

The study tour took place in mid-February 2014. The trip had a rigorous agenda, and produced a lot of energy. Daily presentations by Ghanaian NHIA staff ran through mid-afternoon, and were followed by late afternoon debriefs. The study tour team, led by Deputy Minister Zolia, was made up of 9 GoL officials, USAID staff, the RBHS Deputy Chief of Party, and a representative of CHAI. Participants were very receptive to the different levels of engagement.

When pursuing a reform with the scope of the LHEF, there is no substitute for seeing successful existing reference models in person. Further, there is great value in having people who have developed, implemented, and benefitted from this kind of reform carefully

explain the specific components and mechanisms. Over the course of the four-day trip, twenty-five different presenters addressed a wide range of topics; there was a qualitative difference by physically being in the NHIA offices in Accra. The study tour team went on field trips and witnessed firsthand how the various NHIA mechanisms work across health facilities at all levels. Seeing the claims management process in action was especially impressive.

Political Developments

In March 2014 the first high-level meeting between the MoHSW and the MoF since the consensus design workshop in October 2013 took place. Deputy Minister Zolia along with several Assistant Ministers met with Deputy Minister Muah (responsible for the Budget division of the MoF) and discussed plans for the LHEF. The opinions of the MoF representatives were extremely cautious in nature with valid concerns being aired regarding the governance context of Liberia and how the creation of a substantial financial fund would be handled.

Relationships between the health and finance sectors can be difficult to manage in any setting; dynamics between the Liberian MOHSW and MoF are particularly challenging. This disconnect between the two sectors is somewhat affected by the lack of experience of health sector actors in advocating with finance actors in terms which they understand. Establishing more regular and clear communication channels would be a positive step for the two Ministries to be effective in their work and achieve national goals, particularly advancing the LHEF; efforts are being taken to improve communication between the two sectors.

The political will surrounding the LHEF at least between the Minister of Health and the President was again apparent shortly after the Ghana Study Tour. At the West African Health Organization (WAHO) Meeting in April 2014, President Sirleaf presented the UHC concept to regional Health Ministers. Simultaneously in Washington DC, the World Bank-hosted the *Toward Universal Health Coverage by 2030* event brought UHC into the spotlight, with high level panels discussing key issues related to UHC.

In early May 2014, the CT sought to secure support for the LHEF from provider groups, including the Liberian Medical and Dental Association (LMDA) and the Liberian Nurses Association (LNA). Erik Josephson represented the CT in the LMDA meeting in Bomi County. The meeting was attended by the Minister of Health in his capacity as a doctor. The CT presentation laid out the goals of the LHEF, basic details of its design and the work achieved so far on the LHEF. Following this presentation, Minister Gwenigale spoke eloquently for several minutes in support of the LHEF highlighting his clear ongoing support for the LHEF. This was an important development, as the Minister had not been present at any of the LHEF meetings since October 2013.

In spite of the President's mention of UHC in her annual Message to the National Legislature as well as at the WAHO meeting, the LHEF was not gaining traction on the development of an Advisory Council, which had been a recommendation since the start of the design process. The Advisory Council was to include the Minister of Health, the Minister of Finance, the Minister of Transport, the Chair of the Senate Health Committee, the Chair of the House Health Committee and others. The goal of this body would be to convene regularly (e.g.

every two months) to track progress and to provide high-level impetus to the design and implementation.

The limited progress by mid May 2014 became cause for concern, and was seen as evidence of a difficult political environment for the LHEF. While it had been clear at the LMDA meeting that Minister Gwenigale fully supported the LHEF, it was becoming apparent that buy-in was not forthcoming from other quarters within government. The lack of an Advisory Council was clearly a result of a lack of consensus at cabinet level. Lack of a clear communication from the Minister of Health's office to his Deputy Ministers resulted in significant procedural delays.

The fact of political will emanating strongly from only one of the three primary actors was dampening momentum. The President along with the Minister of Health and Finance must fully and proactively support the reform[1]. From May onwards a twin track strategy was adopted in response to the meeting with the MoF in March. On one track the MoHSW would continue to focus on the design of the LHEF while on the other it would look at developing a more evidence-based equitable resource allocation for the public budget provided to counties.

It was felt that there was much work to be done to reform the way existing public budget allocations were made to the counties. The rules had for some time been rigid, not allowing for changes from year to year, and the allocations were far from being equitable between counties. A World Bank report on revising the resource allocation formula was much reviewed and discussed during this time and a further engagement with the Finance staff of the Ministry of Health created. A proposal for a revised allocation formula was close to fruition by the end of the contract.

Education, Quality and Costing

Tunis Health Financing Workshop

In June 2014 a course on Health Financing for UHC was facilitated by WHO Geneva and held in Tunis. The original intent was to have Deputy Ministers Dahn and Flomo attend. At the last minute there was the realization that the Global Fund were due to visit Liberia and requested that the Deputy Ministers both be present. Some negotiation followed which resulted in Deputy Minister Dahn staying in Monrovia and Deputy Minister Flomo traveling to Tunis accompanied by Acting Director of Health Financing Roland Kesselly. Erik Josephson, ICD Liberia Lead, also attended. The week was extremely useful, with Deputy Minister Flomo participating enthusiastically. From a political point of view this was very important as up to this point Deputy Minister Zolia had shouldered much of the burden of the driving the LHEF. It was unfortunate however that Deputy Minister Dahn was unable to attend.

During the conference, participants discussed in depth what health financing reform looks like. The conference offered participants, primarily officials from various African Ministries

[1] The newly created Liberian Revenue Agency (LRA) will need to support the LHEF in addition to the MoF, the MoHSW, and the President. The LRA is a semi-autonomous agency of the GoL in charge of tax administration, i.e. administering and enforcing the Revenue Code of Liberia.

of Health, a forum to further educate and engage colleagues primarily from other Ministries of Health. A key lesson learned from this experience was figuring out how to take complex, controversial topics and impart them to the MOHSW and partners. Effectively communicating these topics is essential, particularly given their time sensitivity. While it is not necessary that senior officials know all the details, the Tunis Conference successfully educated and exposed participants to fundamental information on health financing.

On the other track of continuing to develop the LHEF a costing conducted under RBHS in 2009 (using CORE Plus) was used to create a model of estimated need to cover the Basic Package of Health Services under the LHEF over a ten year time frame. A narrative document was drawn up to accompany the model and explain all the methodologies and assumptions contained therein. It was felt that the costing from 2009 needed updating given the age of the data included in it, as well as the fact that Liberia's HMIS was in its infancy at the time that costing was produced. A terms of reference were drawn up and consultants identified to work on the costing, including a person who had done much of the work on the 2009 costing. However the planned country visits were due to happen just as the ebola outbreak increased significantly in intensity and the consultancy was abandoned.

The RBHS team commissioned a consultancy in June and July 2014 on incentivizing quality of care while promoting UHC reforms. Quality of care is defined by the Institute of Medicine as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[2] Quality health care requires the right combination of effective, motivated health workers and administrative staff; best clinical practices; functioning logistics and information systems; commodities, supplies, and equipment; and infrastructure. These inputs are all necessary conditions to allow skilled health providers to effectively implement national clinical guidelines and respond to patient needs. With a results-based, sector-wide approach, there has been major investment across all health system building blocks in Liberia, including clinical service delivery and quality.

Quality Improvement Collaboratives (ICs) were introduced in 2013 by the USAID-funded Rebuilding Basic Health Services (RBHS) project in three hospitals in Liberia. An Improvement Collaborative is a quality improvement approach that organizes teams or health facilities to work together to rapidly achieve significant improvements in processes, quality, and efficiency of a specific area of care, with the intention of spreading these methods to other sites.[3] ICs in Liberia have had three rounds of learning with measurable improvements across indicators, including: the rollout of inpatient clinical standards, partograph use for the management of labor, and family planning.

[2] Institute of Medicine, Quality definition. Available from: http://www.iom.edu/Global/News%20Announcements/Crossing-the-Quality-chasm-The-IOM-Health-Care Quality Initiative.aspx (Accessed 30 September, 2014).

[3] USAID Healthcare Improvement Project. 2008. The Improvement Collaborative: An Approach to Rapidly Improve Health Care and Scale Up Quality Services. Health Care Improvement Project, Bethesda, MD: University Research Co., LLC (URC).

Conclusion

Efforts to achieve Universal Health Coverage will require significant focus on the political landscape. It is strongly recommended that the MOHSW designate a senior staff person to focus on health finance reform full time. This person must be at least at Deputy Minister level and preferably would be a political appointee. In addition the establishment of the Advisory Council is essential.

The legislation, which already exists in draft form, needs to be finalized and submitted to the Legislature for review and passage. However limited buy-in from the MoF has been a key roadblock to achieving this goal. To address this issue and move forward, there is a need to reconvene with MoF leadership, review the LHEF and its objectives, and discuss any remaining concerns held by the MoF.

It is essential that the LHEF emphasize quality as one of the key outcomes of reform, and that it is fully able to leverage opportunities from design to operationalization in order to improve the quality of care across the health system. Health financing reforms and mechanisms will only have a positive impact on quality if the design incorporates evidence on what works and what does not in promoting quality care through health financing measures.

ICD has made the following key recommendations for the design and implementation of the LHEF, as a strategic purchaser, to continue to improve quality of care:

1. Require facilities to meet a baseline standard quality of care in order to receive payments.
2. Pay providers for outputs (both quality and quantity);
3. Design cost-effective benefit packages with quality standards that maximally benefit the health of the population; and
4. Measure, review, and report to the population about provider performance.

Improving financial access to care is one of the many steps towards achieving universal health coverage. Unless quality is improved at the service delivery level, the public will stay away from service delivery points, and for those who do use services, the chances of improved health will remain low. Therefore, it is critical that the LHEF emphasize quality as one of the key outcomes of reform, leveraging opportunities from design to operationalization to thereby improve quality across the system. While enormous challenges remain, systems for incentivizing quality services, both financially and through monitoring, have been established in Liberia over the past 10 years. Liberia has made impressive progress since 2004, particularly in how it has comprehensively strengthened its health system to improve quality of care. The LHEF can further support and utilize these systems to improve quality.

The current Ebola outbreak, which began in March 2014 and has surged in recent months, is having a significant negative impact on gains previously made in rebuilding the post-conflict health system. Analysts will have to assess the ultimate scope of the long-term impact on the Liberian health system.