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# Sierra Leone FHCI fiscal space analysis

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## Background – Evaluation of FHCI

Introduced by the President of Sierra Leone in 2010, the FHCI abolished health user fees for pregnant women, lactating mothers and children under five years of age.

- Very high mortality and morbidity levels among mothers and children in Sierra Leone – some of the worst in the world;
- Reports that financial costs were a major barrier to health service uptake and use by these groups.

The FHCI is:

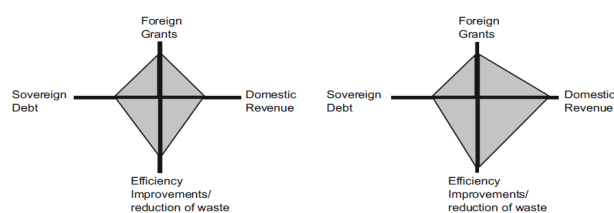
- **Drugs and equipment:** The continuous availability of equipment, drugs, and other essential commodities;
- **Health workforce:** Adequate number of qualified health workers;
- **Governance:** Strengthened and effective oversight and management arrangements;
- **Infrastructure:** Adequate infrastructure to deliver services;
- **Communication with the general public:** More and better information, education and communication to stimulate demand for free quality health services;
- **Monitoring and evaluation (M&E):** A comprehensive M&E system;
- **Financing:** Sufficient funds to fund the FHCI.

## How to finance this ?

Heller (2005, IMF):

“(...) the availability of budgetary room that allows a government to provide resources for a desired purpose, without any prejudice to the sustainability of a government’s financial position”

**Fiscal diamond** (% GDP)



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## Rationale: Why Fiscal Space Analysis?

Helps to put policy goals into context:

1. How much is **needed** to finance FHCI goals?
2. What is the level of financial resources that Sierra Leone can make **available** for FHCI?
3. How and over which time period will Sierra Leone be able to generate enough resources to **domestically sustain FHCI**?

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## Rationale: Why Fiscal Space Analysis?

Helps health and finance 'speak' to each other:

- Health present their financing needs within a macroeconomic context considering fiscal constraints
- Finance see multifaceted efforts of health sector including efficiency
- Use of mutually respected official data sources; e.g. NHA, IMF, Government budgets and development plans.

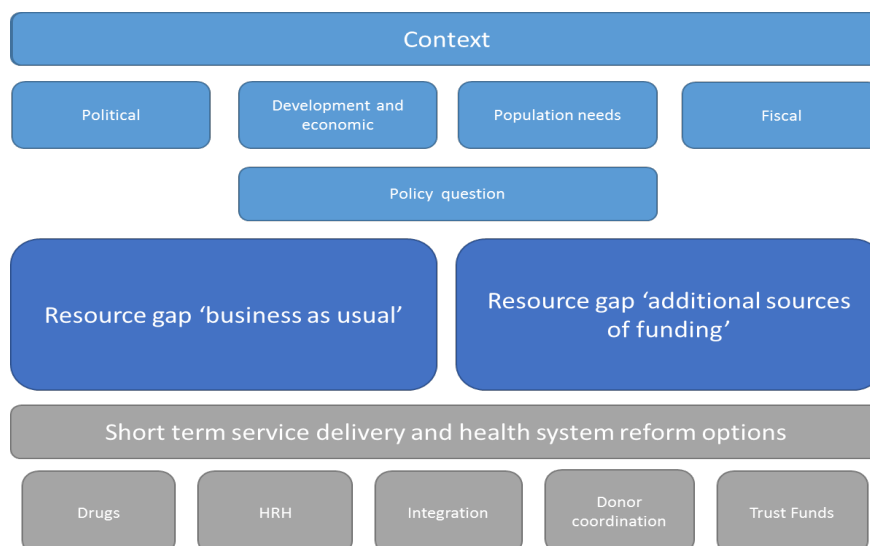
Can include information on research showing:

- Health is important to the economy as it contributes to GDP growth, it must be realised that investment in health can be a critical investment in the economy
- Budgeting decisions for the health sector must include discussion of labour productivity and time lost to disease to reflect the economic benefits to supporting the sector.

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## Methodology: How do we go about it?



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## Macroeconomic context as a basis

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- **Assessment of resource availability** ⇔ macroeconomic context
- **Pragmatic approach**
  - Straightforward model, balance between credibility and feasibility
  - Link in with existing framework: IMF / Ministry of Finance – medium and long term national plans
  - Longer term projections use middle income averages for goals such as tax:GDP ratio.
- **Financial programming framework**
  - Ensure consistency between inter-related set of variables in different sectors of the economy
    - Real, fiscal, monetary and external sector + central government debt
    - Incorporating health using data from NHA and government sources – Ministry of Health Annual reports, etc.

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## 'Business as Usual' Baseline Scenario - Available Health Resources

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- **Two contributors:**
  - **Government** – Budget
  - **External Financing** – On and Off budget

⇒ **Total FHCI Expenditure** (*Household OOP and Private Sector excluded*)

⇒ Six categories: Salaries, Drugs and Medical Consumables, PBF, RMCH Interventions, Key Activities for Service Delivery, and Capital Expenditures.
- **'Business as Usual' assumes there are no major policy changes:**
  - **Government** – Baseline from Government budgets, MT as per budget projections and LT growth as per international norms along with GDP growth
  - **External Financing** – Baseline from Government budgets, MT from donor commitments and LT stable in real terms

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### Available resources Baseline Scenario: Business as Usual

- Official FHCI Spending rises from 97 million USD in 2015 to 136 million in 2025 – 40% of Official THE
- The sector is heavily donor dependent: 80% of financing from external sources in 2015. The methodology assumes a slowdown in donor funds and rise in ability of the GoSL to pay for these services which results in this dependency declining to 50% by 2025.
- Over the ten years the official FHCI expenditures account for 1.8% of GDP and 9.1% of GGE.



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### Resource needs estimates 2015 - 2025

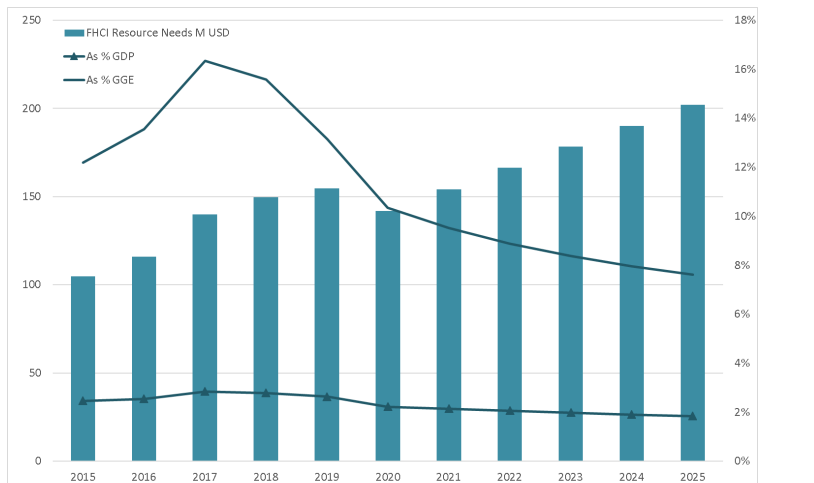
- **MT Basis = OneHealth Tool**
  - Population needs, coverage targets, unit costs
  - US\$70 per FHCI beneficiary
- **LT Basis for extrapolation 2020 - 2025**
  - Growth in FHCI population
  - Inflated this will reach US\$115 per beneficiary by 2025
- **Limitations**
  - LT projections over a decade
    - Expect changes in unit costs
    - Expect new technologies and service protocols

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### Resource Needs 2015 - 2025

- 154 million USD pa over the ten years, accounting for 2.3% of GDP and 11.2% of GGE
- This would provide 70 USD per FHCI beneficiary in 2015, rising to 115 USD in 2025

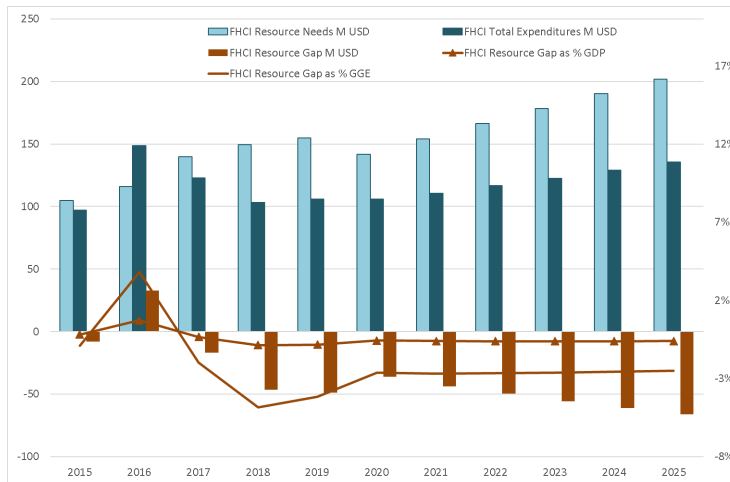


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### Business as Usual Financing Gap: Available Expenditures minus Resource Needs

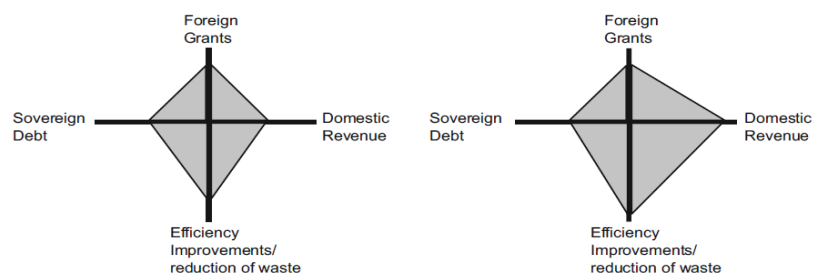
- Widening from 8 million USD in 2015 to 66 million in 2025
- Per annum 0.5% of GDP; 2.2% of GGE
- Per FHCI beneficiary this means an average of 22 additional USD is required each year.



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## How to finance this ?



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## Domestic Sources of Funding

### What are the policy options available to close the health financing gap?

- FHCI needs are not likely to be met under current financing policies
- Second Scenario 'Maximising Fiscal Space':
  - Projections assume the GoSL adopts policies to prioritise FHC to meet resource needs over the next ten years
  - Four policy options are discussed:
    1. Increased government allocations to FHCI,
    2. Implementation of an earmarked levy for FHCI,
    3. Efficiency savings, and
    4. Borrowing.

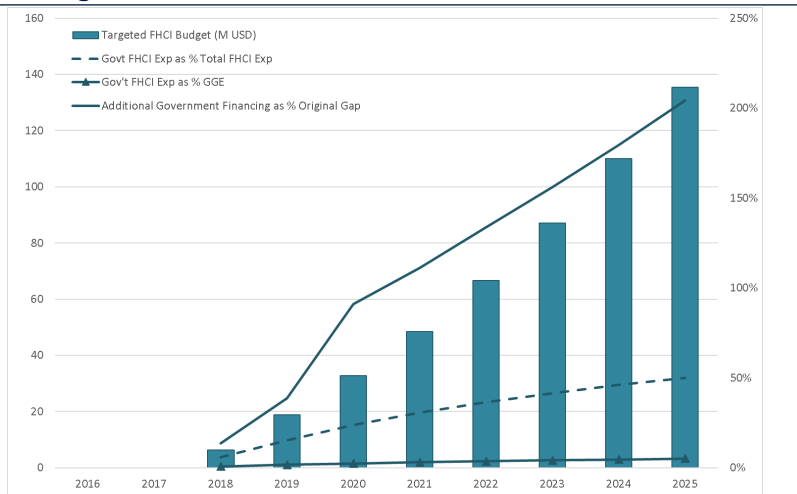
⇒ Potential impact of these policies will be aggregated into one combined resource gap for FHCI

Note: Again OOP and Private sector funds are not included

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## Increasing Government Contribution



- As 2016 to 2017 budget are already set out the model begins the move towards Abuja in 2018, and is achieved by 2025. The increased share to FHCI would average an additional 63 million USD a year (from this rise in health allocation of 15% of GGE). **This policy change alone would close the financing gap for FHCI in Sierra Leone by 2021.**

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## Implementing Earmarked Taxes

### Five types considered for Sierra Leone

- Top scoring levies: **Airline** and **Sin Taxes** (Dormant funds are not relevant in Sierra Leone).
- Remittances** and **Airtime** do not score well they have been discussed in country, so will be put forward for consideration.
- New levy not included in table: funds from **withholding taxes**, currently being discussed in parliament in Sierra Leone.

### Each has been measured on a five-point scale:

- sustainability of resource flows over time;
- stability of funding;
- progressiveness (i.e. impact on equality);
- administrative efficiency (how costly it would be to set up and maintain the levy);
- any potential side effects.

Mechanism	General Findings					Total
	Sustainability	Stability	Progressivity	Administrative Efficiency	Side Effects	
Airline levy	4	4	5	4	4	21
Dormant funds	4	4	5	3	4	20
Tourism levy	4	4	5	3	3	19
Sin taxes – Alcohol & Tobacco	4	4	2	4	3	17
Remittances levy	4	3	2	4	3	16
Private sector contributions	3	3	3	3	4	16
Airtime levy	4	4	2	4	1	15
Health bonds	1	5	3	1	4	14
Health lottery	2	2	1	2	4	11
						<b>Total</b>

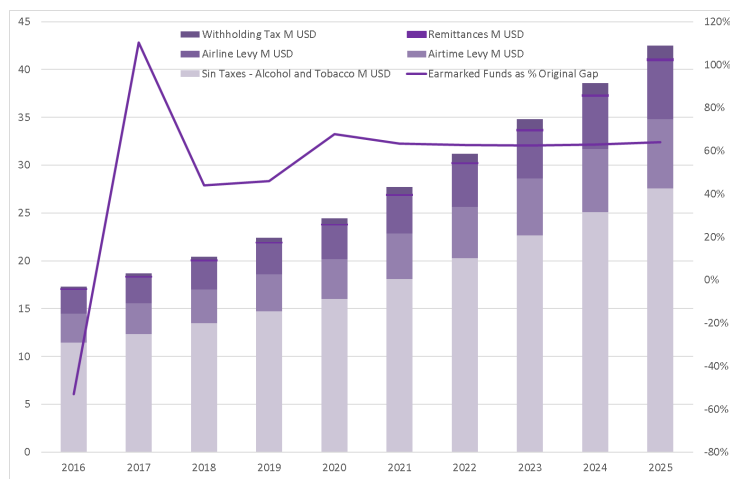
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## Implementing Earmarked Taxes

- Findings from other countries suggest that Sierra Leone could gain \$28 million pa
- Equivalent to 0.5 percentage points of tax:GDP



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## Efficiency

- **Efficiency gains are another way to create fiscal space**
  - Inefficiency refers to a failure to fully exploit available resources.
  - Efficiency gains can be thought of as achieving one of two things:
    - Better health outcomes for the same level of investment; or
    - The same health outcomes at a reduced level of investment.
- **How much could we gain from improved efficiency?**
  - World Health Report 2010: 20% to 40% of all health resources globally are wasted
  - Sierra Leone is relatively inefficient: 80% less efficient compared with those countries producing at the production frontier
  - If Sierra Leone was to continue on an efficiency improvement path it is projected to be only 67% less efficient by 2025
  - And so require less resources to achieve the same health outcomes but much more needs to be done to improve efficiency

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## Efficiency savings – more health for the money

### Medicines:

- underuse of generics, higher than necessary prices
- inappropriate or ineffective use
- use of sub-standard and counterfeit medicines

### Services:

- medical errors, poor quality
- inappropriate hospital size (low use of infrastructure)
- inappropriate hospital admissions and length of stay

### Products and services:

- oversupply and overuse of equipment, investigations, procedures

### Health workers:

- inappropriate or costly staff mix, unmotivated workers

### Interventions:

- inefficient mix or inappropriate level of strategies

### Leakages:

- waste, corruption, fraud

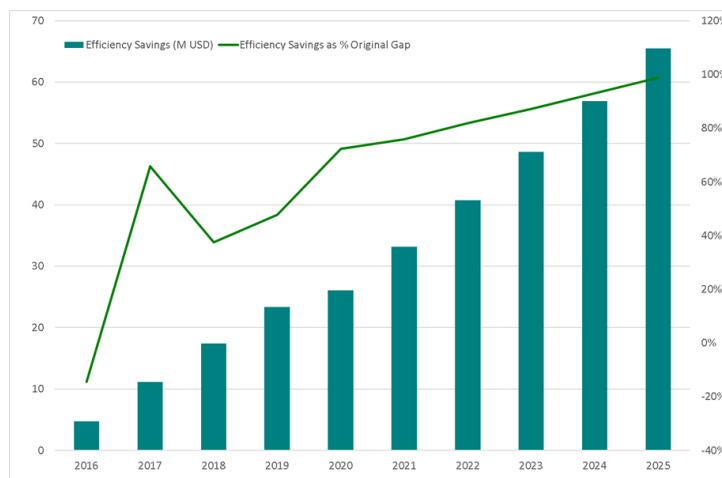
Source: World Health Report (2010), Chapter 4

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## Efficiency

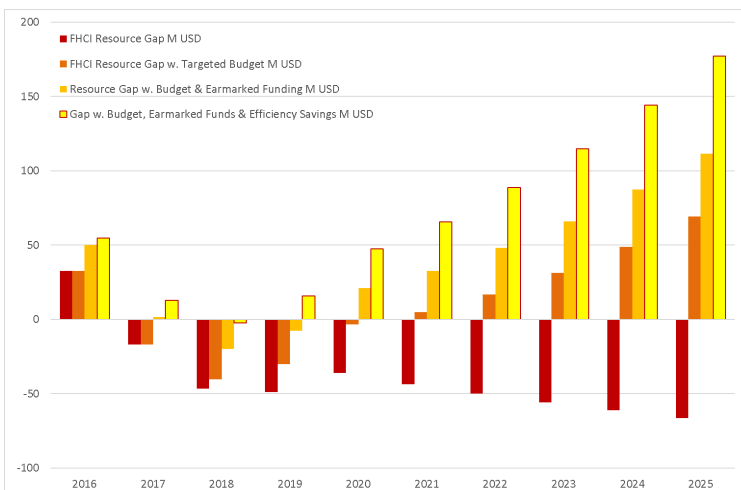
- Efficiency savings could be in the region of \$33 million pa
- This could close the resource gap by 65%



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## Maximising Fiscal Space – Revised Financing Gap



- **Raising Government Contributions, imposing earmarked taxes and making efficiency savings could remove the financing the gap over the next ten years**

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## Conclusions

- If Sierra Leone is to continue along its current policy path AND external financing does decline projections show a large financing gap for FHCI.
  - The speed of this will vary depending on reality versus assumptions.
- With a reprioritised focus on FHCI financing policy the resource gap can be closed.
  - Medium term earmarked taxes and efficiency savings should be further researched, planned and implemented for their introduction in the near term before economic growth can support greater budgetary allocation to FHCI for long term sustainable domestic financing.

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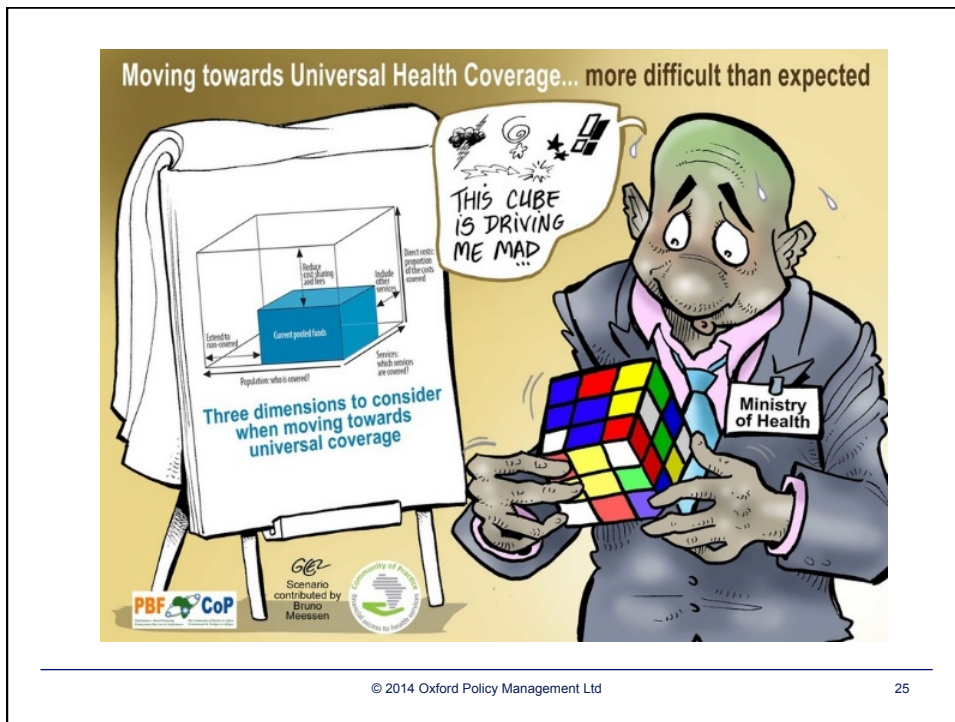
## Conclusion

- Removal of user fee can be step in right direction towards UHC
- Fiscal space can be found for FHCI and eventually UHC
- Requires strong political commitment and will continue to require donor support

## References and resources

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Thank you