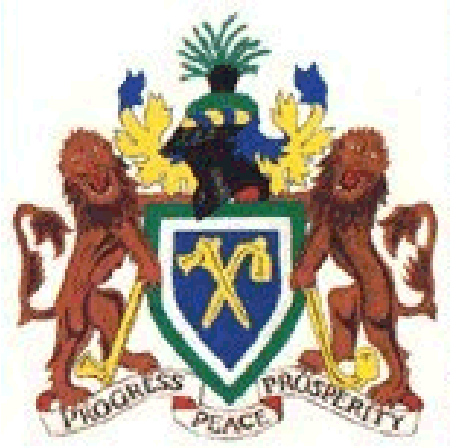
HEALTH FINANCING POLICY 2017 – 2030

Resourcing Pathway to Universal Health Coverage (UHC)



Equity and Quality in Health: No Health No Prosperity

Ministry of Health and Social Welfare
Republic of The Gambia

Foreword

I am pleased to introduce The Gambia Health Financing Policy. This Policy presents the policy directions the Government of The Gambia will adopt to move towards achieving Universal Health Coverage (UHC) as enshrined in the National Health Policy 2012-2020. This will ensure that all citizens have access to quality health services they need without suffering financial hardship.

Over the years the Gambia has implemented various health financing reforms such as 1988 cost recovery programme. However, the main sources of health financing are from government and development partners. Over 90% of health care is provided through public facilities. Recently, Results Based Financing (RBF) was introduced with assistance from the World Bank on Maternal and Child Nutrition and Health Results Projects (MCNHRP) which has addressed critical gaps in the maternal and child health area. Despite these initiatives significant challenges within health financing remain. Gambia is behind in meeting the Abuja Declaration of allocating 15% of the Government's budget towards health; the country has no social health insurance in place; and an out-of-pocket expenditure of about 21% (NHA, 2013) of all health expenditure leading to financial catastrophe and impoverishment for many Gambians.

This policy therefore seeks to respond to these challenges by providing the overarching framework to ensure that resources needed to achieve UHC are raised sustainably, allocated according to need and efficiently utilized. It will further present an opportunity to analyze the current situation and plan for strategies to ensure sufficient resources, assess financial and medical risks, and govern the purchasing function and health financing in general so as to meet the goal of UHC for the Gambia. I urge all stakeholders to be involved and to work together with MoH&SW to make UHC a reality for the Gambia.

Mrs. Saffie Lowe Ceesay

……..

Minister of Health & Social Welfare 2017

Acknowledgements

The Ministry of Health and Social Welfare wishes to acknowledge the immense support provided by the World Health Organization (Principal Financier), UNICEF and World Bank through MCNHRP. Beyond the financial support WHO provided technical support from the Regional Office in the drafting process in the person of Dr. Amos Petu. Also the Ministry wish to acknowledge the contribution of Dr. Nyasha for incorporating the RBF concept into the policy.

We wish to thank the various contributors to the developing process; Public, Private, NGO, Civil Society Organisations and Donor Community for their strong cooperation and support throughout the development process.

The Ministry of Health and Social Welfare acknowledges the strong coordination role of the Directorate of Planning and Information through the Health Financing Technical Team in the development of this document.

Abbreviations and Acronyms

BI	Bamako Initiative
BHCP	Basic Health Care Package
CBR	Crude Birth Rate
CDR	Crude Death Rate
CMH	Commission for Macro Economics and Health
DRG	Drug Revolving Fund
FNS	Food and Nutrition Security
GAVI	Global Alliance for Vaccine Initiative
GDHS	Gambia Demographic Health Survey
GBoS	Gambia Bureau of Statistics
GDP	Gross Domestic Product
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GMD	Gambian Dalasi
GPA	Gambia Ports Authority
HCRP	Health Cost Recovery Programme
HIV	Human Immune virus
HDI	Human Development Index
HMIS	Health Management System
LCDs	Least Developed Countries
LGA	Local Government Authority
MCNRP	Maternal Child and Nutrition Results Project
MMR	Maternal Mortality Rate
MoFEA	Ministry of Finance and Economic Affairs
MoH&SW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NaNA	National Nutrition Agency
NGO	Non-Governmental Organisation
NHA	National Health Accounts
HHFSP	National Health Financing Strategic Plan
NHIS	National Health Insurance Scheme
NHP	National Health Policy
OOPS	Out – Of - Pocket payments
PAGE	Programme for Accelerated Growth and Employment
PBB	Programme Based Budgeting
PER	Public Expenditure Review
PHC	Primary Health Care
RBF	Results Based Financing
SDGs	Sustainable Development Goals
SWAp	Sector Wide Approaches
THE	Total Health Expenditure
TPvtHE	Total Private Health Expenditure
UHC	Universal Health Coverage
UNDP	United Nation Development Programme
UNFPA	United Nations Funds for Population Activities
UNICEF	United Nations International Children Emergency Fund
WAHO	West African Health Organisation
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

Financing health care requires collaboration of Government, donors, other partners and the beneficiaries. In The Gambia available statistics indicate that over 46.7% (NHA, 2013) of the total health funding comes from donors (international health development partners) raising challenges of sustainability and predictability of funding to the health sector. In addition, cost of providing health care continues to rise due to increasing demand, changes in diagnostic and therapeutic technologies, inflation and currency fluctuations.

In 1988 a Cost Recovery Program was started as part of the National Health Development Program. This established the Drug Revolving Fund and the introduction of user fees as a form of health financing. Bamako Initiative (BI) was introduced in 1993 as a strategy to further develop the Cost Recovery Program. Other development partners (WHO, UNICEF, GAVI, GLOBAL FUND, UNFPA, etc) has been supporting the health sector through input financing. In 2014 the Government of The Gambia through the National Nutrition Agency (NaNA) and Ministry of Health and Social Welfare with support from the World Bank, introduced Results Based Financing with the overall objective of improving health and nutrition outcomes among women and children as well as increasing the utilization of community nutrition, maternal and child health services in selected regions. Results Based Financing was recognized as a financing mechanism that could scale-up the Primary Health Care (PHC) service delivery system, including the village health services and also fill the financing gap for high impact maternal and child health interventions as outlined in the Investment Case for Health 2013 to 2015. Results Based Financing is defined as a cash or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken unlike the traditional health financing mechanisms that provide input financing. Results Based Financing makes a clear distinction of institutional arrangements that separate the functions of fundholding, purchasing, service provision, regulation and verification and counter-verification of results outside and within MOHSW. This ensures transparency and accountability in utilization of health care resources.

Although some successes have been registered with these financing strategies, universal access and coverage still remains a major challenge.

A concern of policy-makers is to protect people from financial catastrophe and impoverishment as a result of use of health services. When people have to pay fees or co-payments for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household. Such high expenditure can mean that people have to cut down on necessities such as food and clothing, or are unable to pay for their children's education.

1.1 Justification: Global, Regional and National Health Policy Commitments

This policy has been developed with clear orientations from The Fifty-eighth World Health Assembly Resolution 58.33 on Sustainable Health Financing, Universal Health Coverage and Social Health Insurance. Also, the Health Financing Strategy for the African Region which emphasizes that the manner in which health system is financed affect both the performance of its functions and the achievement of its goals has been utilized in fashioning this document. This policy is designed for the transition to universal health coverage to contribute to meeting the needs of the population for health care and improving quality of health care, reducing poverty, attaining the health related Sustainable Development Goals (SDGs) and implementing the Paris Declaration on Aid Effectiveness. Furthermore, it is believed that the implementation of this policy will contribute towards the achievement of the Abuja Declaration of 2001 which request countries to progressively move towards allocating 15% of their national budget to health; and the recommendation of the Commission for Macroeconomic and Health (CMH) of $34 - $40 per capita expenditure on health for a package of basic health care services.

The Policy also draws insight from national policies such as the Poverty Reduction Strategy Paper (PRSP II) and most recently the Program for Accelerated Growth and Employment Two (PAGE II) now the National Development Plan which identifies adequate financing of health as means of social development through the introduction of Sector Wide Approaches (SWAp) and the operation of Mid-Term Expenditure

Framework (MTEF). The National Health Policy, advocates for the need to secure the required financial resources for the health sector and improving the management of available financial resources in the health sector.

Current funding for the health sector is less than optimal and the available resources are inadequate to provide the required quality of health care services for the population. In addition, donor inputs are not well coordinated while issues of efficiency and equity in the use of funds continue to be a challenge. It is against this background that this policy has been developed.

1.2 Purpose of the Health Financing Policy Document

The purpose of this health financing policy document is to provide all stakeholders in the health sector with the guiding philosophy that governs health financing in terms of governance, resource mobilization, distribution and use of funds in The Gambia. The policy recommends in detail the roles and responsibilities for stakeholders in funding health services and provide a framework for monitoring and evaluation.

1.3 Policy Development Process

This policy has been developed through a very elaborate and consultative process involving key stakeholders and government at the highest level. The process started with the establishment of a drafting team from government departments, International agencies, and the private sector. Thereafter, stakeholders' meetings were held at regional levels and included NGOs and CBOs. National consensus meeting and validation process was carried out through which the draft was revised and validated.

1.4 The Organisation of Remaining Chapters

The remaining part of this policy document is organized as follows:

- Chapter two focuses on the situational analysis, providing the economic, disease burden and epidemiological as well as the current health funding context for the development of the policy.
- Chapter three looks at health financing strategic policy direction while also providing the guiding principles and philosophy on which the policy is premised.

- Chapter four elaborates the policy strategic context, development of human resource for health financing, research and development and monitoring and evaluation.
- Chapter five deals with the implementation modalities of this policy.

CHAPTER 2: SITUATIONAL ANALYSIS

2.1 The Economy

The Gambia is amongst the Least Developed Countries (LDCs) with Gross Domestic Product (GDP) per capita of US$ 473.19 (WB Report 2016). Agriculture forms the backbone of the economy with nearly 70% of the working population involved in the agricultural sector. However, it is the service sector that is the biggest contributor to GDP, at 60%, with agriculture contributing about 30%. The economy grew by 7.2% in 2007 over the preceding fiscal year; national revenue has been increasing progressively; inflation reducing to low single digit levels and was 2.3% as at end May 2007 (PRSP II, 2007). According to MOFEA, the Gambia has been registering annual GDP growth rates of more than 5% (2008-2011) during the current global economic crisis, and has maintained a stable macroeconomic environment that is increasingly threatened by a mounting debt burden. The Gambia is ranked 173 out of 188 countries in the 2016 UN Human Development Report and the last poverty survey (IHS 2015-2016) revealed that 48.6% of the population lives below the poverty line of USD1.25 per day. The Gambia has limited natural resources, and the economy is dominated by the service and agriculture sectors. Despite the global economic crisis, The Gambian economy achieved robust growth of 5.3% between 1998 and 2001, and the GDP increased by 62.2% between 2004 and 2012, (MoFEA) However, growth rate has declined from 4.4% in 2015 to 2.1% in 2016 (UNDP African Economic Outlook 2017).

The national economy is based mainly on agriculture, with groundnut as the main export crop. The recent upturn in performance of the economy has however been driven mainly by the service sector including tourism, telecommunication, construction, etc. The economy suffered a contraction of GDP to 4.3% in 2011 due to drought resulting to a fall in crop production of around 45% in that year, despite several non-agricultural sectors of the economy, such as tourism, performing well during 2011. The figures for 2012 showed a rebound in GDP growth of 5.3% due to a recovery in crop production and strong growth in wholesale and retail trade, and construction. The services sector dropped by 1.8% from 16.3% in 2011 to 14.5% in 2012 (PAGE 2012).

2.2 Health System

The government is the major provider of health services in The Gambia. The public health care system has three tiers, based on the primary health care strategy. Presently, services are provided by seven (7) public hospitals at the tertiary level, 49 health centers at the secondary level and 634 health posts at the primary level. The system is complemented by 41 private and NGO clinics (HMIS 2016). In The Gambia the majority of health facilities and personnel are located in urban areas resulting in inequitable access to care. There are also disparities among regions, with the Western Region having most of the resources.

Private sector health services provision includes the private for-profit, private for non-profit and traditional healers. These are few and small in sizes each with bed capacity less than 50. However, the private sector health care practice is rapidly expanding. The large majority are located in the Greater Banjul Area, making choice in health services delivery point in the rural community non-existence. For most communities therefore, the first point of contact with health care services is the informal sector through traditional healers. However, in spite of the seemingly low capacity of the private sector, the Vision 2020 aims at attaining a fully-fledged private sector that is responsive to the development needs of the country and aims to use the private sector as an engine of growth.

The Ministry of Health and Social Welfare is responsible for the management of the health sector, which includes health services provision, regulation, resource mobilization including human resource development and health research. It is headed by a Minister assisted by a Permanent Secretary, who serves as the Chief Administrator of the Ministry. Other operations of the Ministry is organized around two departments (Department of Health Service and Department of Social Welfare). The Department of Health Services has the following directorates: Directorate of Health Services, Directorate of Planning and Information, Directorate of Pharmaceutical Services, Directorate of Health Promotion, Directorate of Health Research, Directorate of Human Resources for Health, Directorate of Public Health Laboratory, Directorate of Public and Environmental Health and the Directorate of Nursing and Midwifery.

The lowest level for health service provision is the community health post. This provides the very basic minimum health package to the village. The service providers are the Village Health Workers (VHW) with very minimal training and Traditional Birth Companions (TBCs) with limited additional training. The village health provider provides treatment for uncomplicated malaria, diarrhoea, minor injuries, worm infestation and stomach pain. The village health services are complemented by Village OPD clinics and the Reproductive and Child Health (RCH) trekking visits from the health centres. The RCH package includes: antenatal care, family planning, birth registration, child immunization, weight monitoring and limited treatment for the sick.

2.3 Demographic and Health Profile of the Gambia

The population of The Gambia is 1.9 million, of which 40.9% are under 15 years, with an annual population growth rate of 3.1% (Census, 2013). The high fertility rate (5.6%) coupled with a high population density of 153 persons per square kilometer are recognized as key challenges to the country's development efforts. Illiteracy among adults is 62.2%. Urban inhabitants make up 57.3% of the population.

The Crude Birth Rate (CBR) is 40.5 per 1000 population (GBoS 2013) and the Crude Death Rate (CDR) is estimated at 9.24 per 1000 population (World Bank Report 2010). The Infant Mortality Rate (IMR) is 34 per 1000 and Under-5 Mortality Rate (<5 MR) is reported at 54 per 1000 live births (GDHS 2013), Maternal Mortality Ratio (MMR) is 433/100,000 live births (GDHS 2013).

The health sector, despite remarkable achievements registered in the past, is still under great pressure due to a number of factors: high population growth rate, increasing morbidity and mortality, insufficient financial and logistic support, deterioration of physical infrastructure, inadequacies of supplies and equipment, shortage of adequately and appropriately trained health personnel, high attrition rate as well as inadequate referral system. Poverty, traditional beliefs and low awareness have led to inappropriate health seeking behaviours thus contributing to ill health (NHP 2012-2020).

Maternal and Child health indicators have improved over the years, however more work needs to be done to strengthen the services. In addition, it is also crucial to address poverty, low literacy, communicable and non- communicable diseases such as Malaria,

Diarrhoea, Pneumonia, Tuberculosis, Accidents, Cardiovascular Diseases (e.g. Hypertension), Cancers, and Pregnancy related conditions, malnutrition and HIV and AIDS. Most of these diseases can easily be prevented if appropriate environmental and lifestyle measures are taken, with more attention paid to development of health promotion and prevention actions than merely focusing on curative care alone.

2.4 Health Expenditure Patterns and Trends

Government allocations to the health sector as a percentage of the total national budget continue to improve yearly. However, it is still below the Abuja Declaration of 15% budgetary allocation to the health sector.

In 2007, the first National Health Accounts (NHA) for The Gambia was conducted covering the fiscal years 2002 – 2004 and a subsequent one in 2013. The results revealed marginal increase in Total Health Expenditure (THE), moving from approximately D1, 185,223,103.00 in 2002; D1, 682,323,673 and 1.9 billion GMD in 2013. As a percentage of GDP, the total health expenditure (THE) has decreased from 16.1% in 2002, 14.9% in 2004 to 5.63% in 2013. Per capita health expenditure was D895 in 2002, D1203 in 2004 and 1013 in 2013. This ranges between US$33 and US$40, almost matching the WHO Commission for Macroeconomics and Health (CMH) recommendation of US$ 34 per capita expenditures for a package of essential health services. It is instructive that a significant amount of funding comes from donors. Over 37.7% of the total health funding came from international health development partners excluding NGOs of 8.9% (NHA 2013).

Government of The Gambia's contribution to Total Health Expenditure grew from 18% in 2002 to 24% in 2004, and a further increase to 28.18% in 2013. OOP declined from 2002 (12%) to 2004 (9%) but has worryingly increased to 21.21 % in the 2013 NHA. Total Out-of-pocket expenditure on health as 21.21 % and private expenditure on health is estimated to be consistently high at 70% for 2004, 2005 and 2006 signaling the heavy burden of funding health on households.

2.5 Basic Health Care Package (BHCP) Cost versus Government Allocation

The cost of the BHCP amount to 4,507,808,707.49 as shown in table 1 below. This is far more than government allocation to health as shown in table 2 for the years 2014 – 2017.

Table 1: Basic Health Care Packages Summary Cost (GMD)

NATIONAL LEVEL			
AREAS	**PREVENTION**	**CURATIVE**	**TOTAL COST**
Cost Centers	**Cost per Target Pop (GMD)**	**Cost per Target Pop (GMD)**	**(GMD)**
New Born	26,958,169.49	25,781.95	26,983,951.43
Infant	134,459,292.82	13,732,539.38	148,191,832.19
Child	425,457,437.48	19,793,787.28	445,251,224.76
Adolescent	533,762,609.19	10,304,726.80	544,067,335.99
Woman	1,790,938,698.11	58,478,232.67	1,849,416,930.77
Man	452,564,596.72	16,717,799.32	469,282,396.04
TOTAL COST NATIONAL	**4,388,755,840.11**	**119,052,867.38**	**4,507,808,707.49**

Table 2: Government Budgetary Allocations 2014-2017

Year	Allocation
2014	**741,839,293.00**
2015	**713,836,661.24**
2016	**1,154,824,838.39**
2017	**794, 867,000.00**
2018	**700,790,000.14**

Table 3 below also showed that the health sector is under funded by comparing the approved estimates with the total actual expenditures of the various departments.

Government Budget Allocation and Expenditure

Table 3: 2014 Budget (Actuals)

Programs	**Approved Estimates**	**Total Expenditure as at end Dec. 2014**
Development	148,949,321.00	33,814,196.15
Office of the Minister	155,594,425.00	151,754,413.78
Planning and Information	3,955,882.00	3,164,633.01
Basic Health Services	201,176,939.30	193,318,698.27
Social Welfare	9,007,347.00	8,756,373.41
Divisional Health Offices	7,909,159.00	7,699,469.70
Health Human Resource Production	5,294,820.00	4,449,923.27
Tertiary Health Care Services	207,151,399.70	206,267,670.61
Directorate of Food Hygiene & Food Safety	2,565,000.00	2,431,625.00
Directorate of Health Promotion and Education	235,000.00	208,684.00
Total	**741,839,293.00**	**611,865,687.20**

The table above shows that about 82% budgetary allocation was actually disbursed.

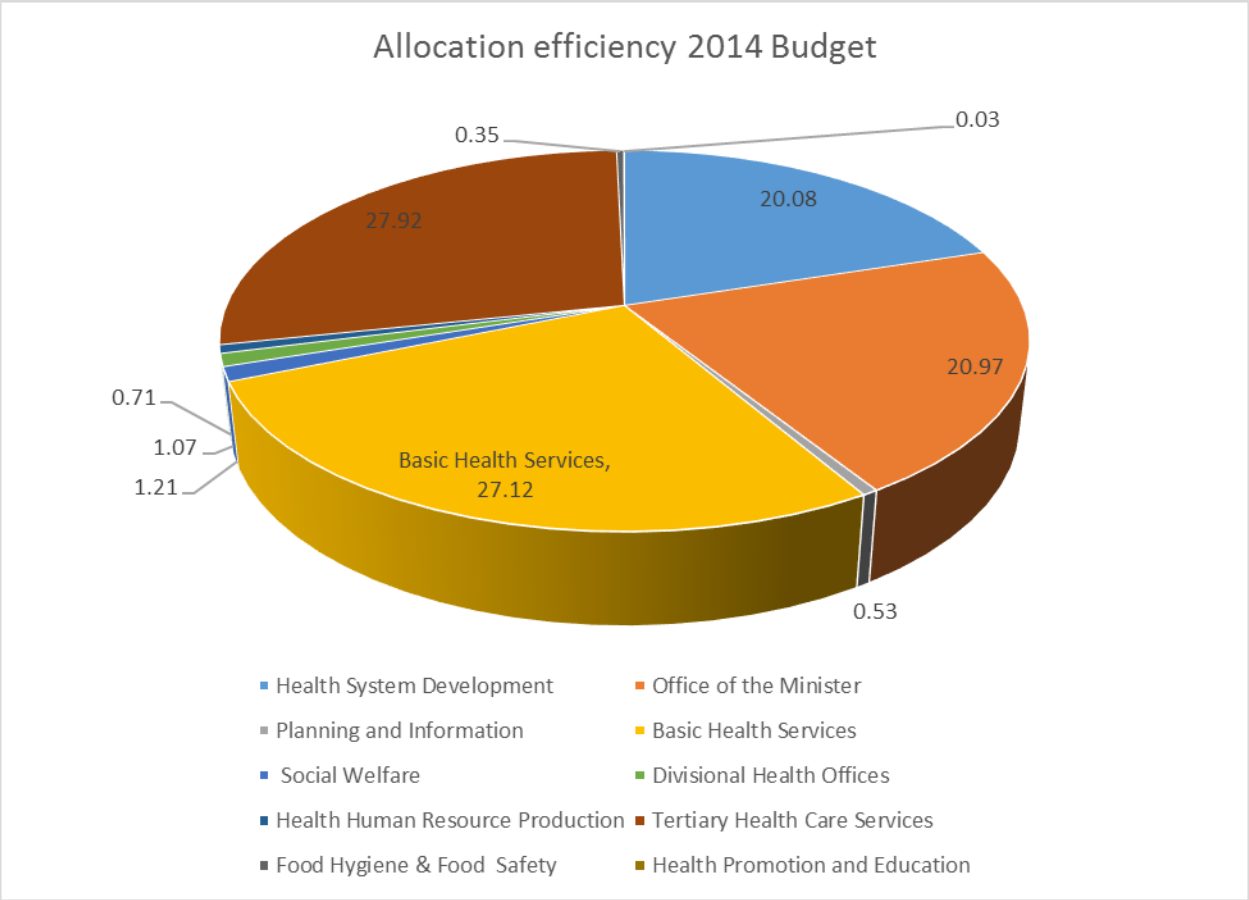
For the programme areas, the table 4 below shows that whilst 97.5% of the Office of the Minister's budgetary allocation was met only 22.7% of health system development budgetary allocation was met.

Table 4: Allocation Efficiency

Budget Programs	Approved Estimates	Actual Expenditure	Percentage
Total Budget	741,839,293.00	611,865,687.20	82.47955
Office of the minister	155,594,425.00	151,754,413.78	97.53204
Health System Development	148,949,321.00	33,814,196.15	22.70181
Basic Health Services	201,176,939.30	193,318,698.27	96.09387
Tertiary Health Services	207,151,399.70	206,267,670.61	99.57339
Health Human Resource Production	5,294,820.00	4,449,923.27	84.04296

The pie chart below also shows that the office of the Minister was allocated 20.97%, Basic Health Services 27.1%, Social Welfare 1.21%, Health Human Resource production 0.71%, Tertiary Health Services 27.92%, Health promotion and Education 0.03%.

Figure 1: A Chart showing Allocation efficiency in 2014 Budget



Health Public Expenditure Review 2001

The table 5 below compares well with the 2014 budgetary allocations indicating good efficiency in budgetary allocation in health. However, the problem is the government budgetary allocation to the sector.

Table 5: Programme Budget Allocation

Program	Contents	Proportion of 2002 Budget
Management of the Health Sector	Administration of central departments, general responsibilities such as contributions to international organizations	17%
Planning, Monitoring and Evaluation	Directorate of Planning and information	1%
Support Services	Technical and other support services	3%
Improving access to basic Health Services	RHTs, primary and secondary care, vertical programs, some training, and drugs and operations for basic services	51%
Tertiary level health services delivery	Hospitals and some training	27%
Social Welfare	Directorate of Social Welfare	1%

Presently the funding from international donors (e.g. bilateral and multi-lateral agencies, World Bank, WHO, UNICEF, UNFPA, UNDP, Global Fund for AIDS, Tuberculosis and Malaria, WAHO and GAVI) is channeled directly to the intervention programmes through the Ministry of Health and Social Welfare. The Government of The Gambia in 2014 secured a grant amounting to Eight Million, Six Hundred and Eighty Thousand US Dollars (US$8,680,000.00) from the World Bank to implement a Maternal and Child Nutrition and Health Results Project (MCNHRP) using Results Based Financing (RBF) for Health approach. To further compliment the efforts of the project, and to address the Food and Nutrition Security (FNS) situation and likely Ebola crisis in the country, an additional funding of Five million US Dollars (US$5.0) million was approved to scale up the Community Nutrition and Primary Health Care services, and strengthen the Ebola Response. To mitigate social impact at household level of the fiscal crisis, another US$7.5 million was approved in January 2017.

2.6 Health Financing in The Gambia

Health Financing System in The Gambia is organized through Government tax revenue, allocated by the Ministry of Finance and Economic Affairs to various financing agents, e.g. Ministry of Health and Social Welfare, Education, Defense, Interior and Foreign Affairs. The contribution from direct out-of-pocket payments (OOPs) for health goods and services do not go through any resource pooling and risk-sharing mechanism. Current trends have shown that some private sector operators (Banks and NGOs) do provide medical cover for their employees, either through self-operated health clinics (e.g. Gambia Ports Authority (GPA) Clinic) or by paying premiums into private health insurance schemes. However, there is no social health insurance in the Gambia. Another innovation has been for the private sector to adopt hospital wards in health facilities for funding.

To a lesser extent the Local Government Authorities also contribute to health financing in the area of environmental sanitation and the employment of auxiliary health workers. User charges for services are being made as part of cost recovery programme introduced in 1988 to supplement the high Government expenditure in health. This was part of the Economic Recovery Programme / Structural Adjustment Programme of the eighties.

Formal community health insurance schemes do not exist in The Gambia. However, as part of community contribution to the health sector, some communities do construct health facilities or donate ambulances. This shows the vast opportunities available at that level to be harnessed to fund the health sector.

2.7 Challenges in Health Financing

2.7.1 Revenue Generation and Resource Mobilization

- The current GDP per capita of $473.19 is way below the per capita GDP of $1900 needed to achieve UHC according to international standards and calls for a diversification in economic productivity of The Gambia.

- The current Per capita Expenditure on Health as average exchange rate (US$) 28 as at (NHA, 2013) is still below the Commission on Macroeconomics and Health (CMH 2001) recommendation between $34 - $40 per capita per annum to give a basic package of health services. This represents a serious challenge in the face of rising health needs that have to be met if the country is to reach the Sustainable Development Goals (SDG) targets.

- Health as a share of government budget allocation is at 10.56% of the total National Budget (2016 Estimates of Revenue and Expenditure) have remained below the Abuja Declaration commitment for domestic spending.

- The rise in the share of total external funding of 46% increases donor dependency risk.

- An increase in OOP over the years from 9% in 2004 to 21% in 2013 highlights the lack of financial protection and equity of access to healthcare services.

- Earmarking of non-government funds to specific diseases/programs tend to result to unfunded programs in the basket (orphan programs).

2.7.2 Pooling of Risk and Financial Protection

- The Gambia has a national pool of resources as it provides a set of publicly funded services to all Gambians. However, current purchasing arrangements, limited resource availability and underutilization of the Drug Revolving Fund reduce the ability of the pool to impact financial protection and equity on a

national scale. Currently the Gambia has no National Health Insurance Scheme (NHIS).

- The proportion of the population that is covered by private health insurance schemes is very small hence the rest of the population is not able to benefit from the risk pooling function of health insurance. Therefore, voluntary nature of medical insurance in The Gambia, and the current pooling mechanisms that are fragmented result in inadequate risk pooling and does not allow for cross-subsidization across various income and population groups (healthy/sick and working/non-working).

2.7.3 Equity in Health Financing and Universal Health Coverage (UHC)

To achieve universal health coverage, there is need to address equity in the collection, allocation and provision of health resources and services. Inequality remains a determining feature of socio-economic wellbeing and addressing equity is key to achieving health goals under the SDGs for The Gambia. Addressing equity in health financing implies mobilizing revenue according to ability to pay through progressive financing; allocating resources according to health need; pooling funding for income and risk cross subsidies; analyzing key determinants of health equity across various socio-economic and demographic factors that pose barriers to access and effective coverage of health care; and ensuring financial protection. Equity challenges for health financing for universal health coverage that need to be addressed in the policy include:

Financial protection when accessing health services remains low, especially for the low-income groups. Access to health services remains primarily dependent upon highly regressive OOP payments. According to the GDHS 2013, 43 percent of women age 15-49 reported that they have at least one problem in accessing health care. 33 percent of women reported getting money for treatment as a problem, and 28 percent noted that distance to a health facility is a concern. Furthermore, 10 percent of women cited not wanting to go alone for treatment as a problem in accessing health care, and 5 percent reported that getting permission for treatment is a hindrance.

2.8 Priorities for the Health Financing Policy

Based on the above situational analysis, the following are considered the priorities of the Health Financing Policy:

1. Increasing the Per capita Expenditure on Health to $40 as recommended by the Commission on Macroeconomics and Health (CMH 2001)

2. Increasing health share of government budget allocation to 15% of the National Budget as recommended by the Abuja Declaration commitment for domestic spending.

3. Reducing OOP on health to increase financial risk protection and equity in access to healthcare services.

4. Applying the principles of SWap (enhancing partners' participation in the development of health programs).

CHAPTER 3: HEALTH FINANCING STRATEGIC POLICY DIRECTIONS

3.1 General Health Financing Policy Guidelines

3.1.1 Vision

Achieve sustainable Universal Health Coverage (UHC) for every one living in the Gambia by 2030

3.1.2 Mission

To establish integrated health financing mechanisms that promote and protect the health of the population through equitable provision of quality health care and ensuring that no one suffers financial hardship in accessing healthcare.

3.1.3 Goal

To ensure adequate and sustainable financing of health care services to protect the population from financial hardship particularly the poor and vulnerable

3.1.4 Core Values or Guiding Principles

The core values and guiding principles for this policy are aligned with the core values and guiding principles espoused in other national documents like the National Health Policy and National Development Plan.

In particular:

3.1.4.1 This policy is premised on country ownership driven by the patriotic principles of government's responsibility to the welfare of the citizenry

3.1.4.2 This policy framework shall give due cognizance to fostering equity in access among all population groups; with special attention to vulnerable groups (e.g. the poor, elderly, persons with disabilities, women and children).

3.1.4.3 This policy shall ensure equity in financing; making sure that contributions to the funding of the health system are made according to ability to pay and long before health care is needed in order to protect families from impoverishment.

3.1.4.4 Within this policy, efficiency shall be given due consideration; ensuring that maximum health benefits are derived from available resources, with particular attention to both immediate operating expenditures and the long-term recurrent cost implications of major human resources and capital investments

3.1.4.5 In line with Government Policy a high degree of transparency and accountability shall be demanded in all financial procedures and mechanisms.

3.1.4.6 This policy shall amplify risk sharing mechanisms in the spirit of solidarity and cross subsidization, expanding the proportion of the health budget that is pooled and reduce the proportion that comes as out-of-pocket payments.

3.1.4.7 Implementing this policy shall be on evidence-based decision-making, practiced on a day-to-day basis, harmonized with health financing reforms, relying on best practices, and be economically viable.

3.1.4.8 Implementation of this policy shall require a multi-sectoral partnership involving all health- related sectors, various levels of government, the private sector, NGO community, international development organizations, communities and civil society organization. There shall be improved coordination of funding leading to SWAp

3.1.4.9 Accessibility to twenty-four-hour quality essential services for the population

3.1.4.10 Help patients feel more confident in the health care system by enforcing the Patient Bill of Rights.

CHAPTER 4: POLICY STRATEGIC CONTEXT

The policy components are developed with the aim of strengthening: the stewardship of health financing; the three functions of health financing (revenue collection; risk pooling and purchasing); the development of human resources for health financing; research and development; and monitoring and evaluation.

4.1 Stewardship for Health Financing

Government through relevant Ministries, departments and agencies will pursue the following strategies and legislations to strengthen health financing:

4.1.1 The development of a holistic health financing mechanism legislation which secures statutory protection for health financing including but not limited to an allocation of at least 15% of the national budget to the health sector and; increase financing of health related interventions such as access to safe water, improved sanitation and household nutrition.

4.1.2 The development of a costed National Health Financing Strategic Plan (NHFSP) with a clear roadmap for achieving the Sustainable Development Goals (SDGs) and eventually UHC and indicators for monitoring progress of achievement of the health financing policy objectives.

4.1.3 Ensure that the NHFSP is incorporated into National Development frameworks such as NDP and MTEF/PBB.

4.1.4 The strengthening of the health sector stewardship, oversight, transparency and accountability through separation of functions of fund holding, strategic purchasing of services, provision of services, regulation and verification and counter-verification of results within and outside MoH&SW and through the enforcement of existing rules and regulations to enhance resource optimization

4.1.5 The maximization of inter-sectoral collaboration and actively pursuing all relevant forms of technical cooperation with other countries and international

organizations (e.g. WHO, World Bank, UNICEF, GFATM, GTZ, ILO) in the implementation of the National Health Financing Policy (NHFP).

4.2 Broad Objectives

- Government of the Gambia financing at least 50% of the Basic Health Care Packages
- Per capita health expenditure increased to minimum $40 as recommended by CMH 2001
- Eliminated out-of-pocket (OOP) health expenditure in registered and accredited health facilities country wide

4.3 Health Financing Policy

Based on the priorities above, the following will constitute the core Strategic Policy Directions:

1. Sustainable Resource Mobilization and Revenue Collection
2. Risk pooling and cross subsidization
3. Purchasing/provider payment mechanisms
4. Governance

4.3.1 Sustainable Resource Mobilsation and Revenue and collection

Policy Objective:

The overall objective is to mobilize adequate resources for sustainable funding of the health sector and to coordinate the use of these resources for improved targeting of budget allocations. Specifically it seeks to:

1. Ensure adequate funding for administrative, preventive, curative and research for health care services
2. Ensure the government finances the Basic Health Care packages
3. Introduce progressive mandatory pre-payment financing

Policy Directions:

4.3.1.1 Developing a mandatory mix of prepayment mechanisms including social health insurance, tax- based and non-tax based financing of health care to achieve UHC goal.

4.3.1.2 Government will seek to strengthen domestic health financing and abide by the Abuja Declaration on health where not less than 15% of the national revenue shall be allocated to health.

4.3.1.3 Establishment of a Primary Health Care Fund, through the share of 25% of the levy on tobacco and alcohol, sale of hazardous products, and vehicles fuel tax

4.3.1.4 Private health will continue to be available as a voluntary pre-payment mechanism for services not covered in the minimum benefit package

4.3.1.5 Special revenue generation provisions will be requested for diseases of high national public health concerns/significance as and when they emerge

4.3.1.6 All external aid for health will be harmonized, coordinated, monitored and evaluated in line health priorities and plans of the government of the Gambia.

4.3.1.7 Government will explore, ensuring consistency with its key policy principles and goals, innovative partnership mechanisms with the private sector to increase resources to health such as joint ventures and outsourcing guided by a strong regulatory framework

4.3.2 Risk Pooling and Cross Subsidization

Policy Directions

To enhance the adequacy of health financing and financial protection of households and ensure that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector

4.3.2.1 Government will strengthen prepayment systems, where funds collected through taxes, levies, special funds and insurance contributions are used to protect citizens from financial catastrophe by reducing out-of-pocket spending.

4.3.2.2 Government will strengthen the national health financing system, including financing structures, processes and management systems as well as building (or strengthening) prepayment systems (include health insurance) with community participation.

4.3.2.3 Government will use a combination of mechanisms (exemptions, subsidies, compulsory insurance for specific groups, voluntary insurance, domestic philanthropies and charities) to effectively manage financial risk and provide social safety nets to protect the poor

4.3.3 Purchasing/Provider Payments Mechanisms

Policy Objective

To ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services.

Policy Directions:

4.3.3.1 Government will ensure financial resource allocation in the health sector guided by needs assessment and priority setting supported by policy objectives.

4.3.3.2 There will be use of a mix of provider payment mechanisms that promote optimal provider performance while containing costs, such as providing inputs, capitation, fee for

service and Results Based Financing and any other mechanisms that may prove to be effective.

4.3.3.3 Government will ensure that there is transparency and accountability in resource utilization through the establishment of a body that will guarantee quality improvement for the services purchase and periodic reporting on health expenditures.

4.3.3.4 Services will be purchased from all registered and accredited providers (private including NGOs, public, and traditional practitioners).

4.3.3.5 A frame work for regular evaluation of benefit and cost intervention and technologies will be put in place to ensure optimal choices.

4.3.3.6 There will be quality assurance for services purchased irrespective of funding mechanisms and level of care.

4.3.4 Governance

Policy Objective:

To strengthen institutional framework and administrative arrangements to ensure effective and efficient links between revenue generation and collection, pooling and purchasing of health services

Policy Directions:

4.3.4.1 Establishment of a Health Financing Coordinating body within the Ministry of Health and Social Welfare to coordinate the various pillars of this policy (funds collection, pooling and purchasing functions)

4.3.4.2 The role of the Performance Based Financing will be clearly defined to strengthen the purchasers functions

4.3.4.3 Planning, budgeting and resource allocation, will be harmonized along the results based management principles in consultation with all stakeholders

4.3.4.4 The government will establish new structures and systems for coordination and harmonization of funding at all levels of healthcare financing

4.4. Health Sector Regulatory Framework

All health and health related laws will be reviewed and updated as necessary for positive health outcomes and this include the Health Financing legislation. The purpose being to ensure commonness of policy directions and implementation guidelines that protect the population and increase access to quality care.

4.5 Development of Human Resource for Health Financing

The human resources for health is far from having the required number and the health financing personnel represent one of the most under staff cadre in the sector. The human resource policy and strategy plan laid emphasis on staff training, motivation and retention. Having the required number of personnel to implement the health financing policy is critical in overcoming the other challenges facing the health sector. Therefore Government through the various departments and agencies shall under take the following measure:

4.5.1 Allocation of funds for both domestic and external training of health economists, health planners, and accountants,

4.5.2 Allocate funds to strengthen the capacity of local training institutions for training of health economists, health planners, and accountants,

4.5.3 Organize regular in service short term training in new developments in health financing, negotiation and resource mobilization for staff of the Ministry of Health &Social Welfare and Ministry of Finance and Economic Affairs with the main goal of developing adequate capacity for the National Health Financing Agency.

4.5.4 The Ministry of Health and Social Welfare and Ministry of Higher Education Research Science and Technology (Directorate of Planning, Budgeting and Policy

Analysis) and the University of the Gambia will actively participate in the review of curricular for the schools of economics, medicine, public health and nursing to incorporate modules on health financing and health economics.

4.5.5 To promote health economists and health planners association as an umbrella organization for sharing of information, experiences and promotion of networking with other regional and global associations

4.6 Research and development

As part of generation of evidence to support implementation, Government will reinforce capacities for health financing (including cost) evidence generation, dissemination and utilization in decision-making.

4.6.1 The Ministry of Health and Social Welfare in collaboration with MOHERST and other relevant government and non-government institution, private and civil society will institutionalize national, sub-national and intervention specific health accounts.

4.6.2 The Ministry of Health and Social Welfare in collaboration with other relevant government institutions will fund and institutionalize monitoring of economic efficiency of the national health system.

4.6.3 The Ministry of Health and Social Welfare will evaluate different practices in health financing, including collection of revenue, pooling and purchasing (or provision) of services as well as evaluate cost-effective health interventions and services the country moves towards universal coverage.

4.6.4 Ministry of Health and Social Welfare, in collaboration with other relevant government institutions, will institutionalize monitoring of equity in health finance and equity in the use of health services and distribution of health systems resources.

4.6.5 The Ministry of Health and Social Welfare will identify and support other priority areas of health financing research that will foster the implementation of the NHFP.

4.6.6 The Ministry of Health and Social Welfare will mobilize support for participation of national health economists and health planners at national, sub-regional, regional and international health economics associations for continuing education and sharing of experiences.

4.7 Monitoring, Evaluation and Research

4.7.1 The Ministry of Health and Social Welfare will ensure that systems for timely and timely routine and periodic monitoring of resource accountability are in place such as resource mapping and National Health Account

4.7.2 There will be use of current evidence based research for development of innovative approaches in health financing

4.7.3 In addition too overall monitoring of the HFP implementation, there will be monitoring and evaluation at all levels of health care to ensure that health financing reforms and policies are adopted effectively

4.7.4 Both qualitative and quantitative indicators will be used to assess the impact of the HFP towards achieve universal health coverage

CHAPTER 5: IMPLEMENTATION OF THE HEALTH FINANCING POLICY

5.1 Implementation of this HFP will be based on successive Health Financing Strategic Plan and annual rolling plans that will define key heath financing activities at each level of care over a period of five years.

5.2 The Ministry of Health and Social Welfare will be responsible for implementation of HFP along with other relevant government ministries such as MoFEA and Ministry of Trade Regional Integration Industry and Employment

5.3 CONCLUSION

The ultimate vision of this policy is to ensure that the whole population of the Gambia has access to the highest possible level of health and quality of life regardless of income levels, social status, or residency. To fulfill this vision will require the utmost solidarity from all stakeholders and the political will to implement the necessary reforms as laid out in the policy**.**

6 REFERENCES

1. Health financing a strategy for the African region; WHO Regional office for Africa, 2007
2. Zimbabwe National Health Financing Policy
3. A guide for developing National Health Financing Policy: Draft WHO Regional office for Africa
4. National Financing Policy 2006, Federal Republic of Nigeria (zero draft)
5. National Health Policy: 'Health is Wealth' 2007, Republic of The Gambia.
6. Health Master Plan 'Wealth through Health' 2007 – 2020 Republic of The Gambia
7. MDG Assessment Report 2006
8. PRSP II 2006 NHA 2007 Republic of The Gambia Demography and Household Survey 2013
9. Multiple Indicator Cluster Survey 2005-2006
10. UN Development Report 2007
11. National Budget Speech 2008, Ministry of Finance and Economic Affairs
12. Integrated Household Survey 2003
13. National Health Account Survey 2013
14. www.rbfhealth.org

7 GLOSSARY OF TECHNICAL TERMS

Adverse Selection: The tendency of purchasing health insurance benefit packages by individuals with high health risk affecting health expenditure increases more than people with low health risk.

Benefit Package: A minimum set of services that are offered to an insured person within a level of contributions.

Capital Cost, Capital Expenditure: Cost of inputs whose useful life is usually longer than one year. In terms of health investments, refers to expenditure on physical assets such as hospitals, beds, health centres, medical and diagnostic plant and equipment, etc.

Catastrophic health expenditure: A situation where a household spends on health more than 40% of its income after paying for subsistence needs, e.g. food. It can be caused by catastrophic illness, either high cost but low frequency event or by low cost and high frequency events.

Contracting: The process in which a legal agreement between a payer and a subscribing group or individual such as purchasers, insurers, takes place which specifies rates, performance covenants, and the relationship among the parties, schedule of benefits and other pertinent conditions.

Co-payment: A fixed amount of payment, which must be paid by a beneficiary for each service at time of service use.

Cost: Resources in monetary terms expended in carrying out activities.

Recurrent cost: Costs of inputs whose useful life is less than one year.

Cost-effectiveness analysis: A form of economic evaluation where costs are expressed in money terms but consequences are expressed in physical units. It is used to compare different ways of achieving the same objective.

Costing: The techniques and processes of ascertaining the expenditures the amount of expenditure incurred on particular products and services.

Debt stock: Total value of borrowings of an entity such as a sovereign country or a firm, which constitutes a liability of the entity, measured at a given point in time.

Decentralization: Transfer of administrative power from a central to a local authority, also referred as “devolution of power”.

Demand: The level of consumption preferred by consumers at different prices.

Deferral and Exemption: Deferral and Exemption scheme aims at guaranteeing access to quality health care to the mass population of the poor in the society. It tends to encourage those who temporarily lack the capacity to pay cash immediately for the treatment or other health service to have the service and later come back at a specified period for payment (deferral). Those who permanently lack the money to pay for the service can also access the service without personally paying for it (exemption). These are the unemployed and others unable to pay for economic and social reasons

Earmarked Tax: Contribution dedicated to health or particular function. Earmarked taxes sometimes reduce flexibility over time in allocating public funds to the best possible use. It may also reduce accountability of agencies to which funds are allocated when those revenues are determined by factors independent of the number or quality of services provided.

Effectiveness: The effect of the activity and the end results, outcomes or benefits for the population achieved in relation to the stated objectives. It is an expression of desired effect of programme, service intervention in reducing a health problem or improving an unsatisfactory health situation.

Efficiency: The effect or end results achieved in relation to the effort expended in terms of money, resources and time.

Technical Efficiency: The production of the greatest amount or quality of outcome for any specified level of resources.

Allocative Efficiency: An allocation of the mix of resources for maximal benefit, i.e. such that no change in spending priorities could improve the overall welfare.

Equity: The absence of systematic disparities in health between social groups who have different levels of underlying social advantage or disadvantage - that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged such as by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group at further disadvantage with respect to their health.

Fair Financing: A way health care is financed is perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status and their use of health services.

Fee for Service: Payments to a provider for each item or services provided.

Foreign Direct investment (FDI): Investment by firm based in one country in actual productive capacity or other real assets in another country, normally through creation of a subsidiary by a multinational corporation. Used as a measure of globalization of capital. Effects on growth and inequality in developing countries disputed.

Formal Sector: Enterprises, which are registered and licensed to conduct business and whose employees earn regular salaries and wages.

Functions of Health Care Financing: The core functions of health financing are: collecting revenue, pooling of resources and purchasing:

Collecting Revenue: is the process by which health systems receive money from households, companies and institutions as well as from donors. Various ways of collecting revenues are general taxation, social health insurance, private health insurance, out-of pocket payments and grant and charitable donations and multilateral borrowing.

Pooling of Resources: the process of accumulation and management of revenues to ensure that the risk of having to pay for health care is borne by all the members of the pool and not by each contributor individually. Various forms of tax and social health insurance schemes aiming at sharing the financial risk and funds among the contributing members are the main focus of this function.

Purchasing of Health Services: is the process by which the most needed and effective health interventions are chosen and provided in an efficient and equitable manner, and the providers are paid appropriately from the pooled financial resources for delivering defined sets of services and interventions. Purchasing has three interwoven elements; "allocating financial resources", establishing "provider payment options" and "contracting" with providers. Funders Organizations contributing to the coverage of health care expenditures or providing the funding for health care through budgets, contracts, grants or donations to a health care provider.

Gross domestic product (GDP): The total value of goods and services produced within a country each year.

Health Insurance: Financial protection against medical care costs arising from disease or injury. The reduction or elimination of the uncertain risks of loss for the individual or household, by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member.

Community Based Health Insurance (CBHI): A micro-insurance scheme managed independently by community members, a community-based organization whereby the term community may be defined as members of a professional group, residents of a particular location, a faith-based organization etc.

Social Health Insurance: Compulsory health insurance, regarded as part of a social security system, funded from contributions – often community rated- and managed by an autonomous yet legal entity.

Private Health Insurance: A health insurance scheme often characterized with the following features: voluntary, managed outside the social security system where premiums are risk- rated rather than community-rated, managed by an independent legal entity (an incorporation, organization, association or foundation) not by a state/quasi state body, operating for profit or non-profit.

Voluntary Health Insurance: Health insurance that offers benefit to its members entitled on a voluntary basis, which can be managed by a private, public or quasi-public body. Health Maintenance Organization (HMO): An organization that accepts responsibility for organizing and providing a defined set of services for its enrolled population, in exchange for a predetermined, fixed, periodic payment for each person or family unit enrolled (see also Managed Care).

Health Spending: As one of the Health for All global strategy, WHO advised the Member States to spend minimum 5% of GDP on health? In many countries only one disease, such as diabetes could consume the entire amount. High level of spending may not necessarily lead to high health outcomes. At any given level of income and spending health outcome varies. Therefore, efficient use of available funds becomes critical. It is

also important to correct imbalances, low spending in some areas and high spending in others.

Informal Sector: Enterprises, which are not registered and licensed to conduct business but do so in an entrepreneurial, independent manner, and whose earnings are not reported or declared as part of a payroll process. Compared with wage-earning workers in the formal sector, the informal sector has more labor-intensive mode of production. Informal production units typically operate at a low level of organization, with little or no division between labour and capital on small-scale labour operations. Their existence is based on casual employment, kinship or personal and social relations rather than contractual arrangements with formal agreement.

Moral Hazard: Abuse of insurance benefit by insured people which yields to an increase in health expenditure.

National Health Accounts (NHA): A framework and methodology for measurement and presentation of information on total national health expenditure including public and private sources of funds. NHA tracks financial resources from sources, to providers and functions. It is important because, health systems are complex and policy makers need tools to analyses HCF, how and how much resources used in a health system, what resource allocation patterns, use and options exist.

Out-of-pocket payments: Payment out of private purse as opposed to public made directly by a patient to a health service provider without reimbursement.

Payer: The public or private organization that is responsible for payment for health care expenses. Payers may be insurance companies or self-insured employers or persons.

Pay roll taxes: Contributions levied against labour income. They are inexpensive to administer but easier to avoid than other forms of taxes.

Per Capita Income: A measure of human progress, using overall well-being to judge the level of a country's development.

Policy: An agreement or consensus among relevant partners on the issues to be addressed and on the approaches or strategies to deal with them.

Poverty gap ratio: is the mean distance separating the population from the poverty line (with the non-poor being given a distance of zero), expressed as a percentage of the poverty line.

Prepayment Scheme: A method of paying for the cost of health care services in advance of their use. This is a method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions, including those contributions that are made to a health fund by employers on behalf of their employees.

Prepayment Ratio: Ratio between the benefit paid by health insurance and total benefit provided to a patient.

Premium: Amount paid to a carrier for providing insurance coverage under a contract. Money paid out in advance for insurance coverage. Contributions are often defined as percentage of salary for formal sector employees or monthly level of payments for informal sector employees to health insurance fund on regular basis.

Provider Payment Methods: Ways or means of paying health care providers such as on a capitation, case based, fee-for-service or other basis (see also individual definitions).

Purchaser: This entity not only pays the premium, but also controls the premium amount before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Resource Allocation: The process by which available resources are distributed between competing uses as a means of achieving a particular goal.

Social Safety Net: A system that would allow economically and socially deprived citizens to continue to receive social services through free services, subsidized care, social insurance and social assistance. The system should assure that citizens retire with dignity and income – pension benefits; citizens are insulated from the loss of income due to economic forces out of their control – unemployment benefits; citizens not bear the full

risk and costs for illness and injury – health benefits; and citizens are provided social welfare support.

Special Consumption Taxes: Taxes used for effectively reducing the demand for harmful substances such as tobacco and alcohol by raising the price closer to its true social cost. These taxes may create a conflict of interest in a way that lowered demand and consumption can affect sources of revenue.

Universal Coverage: Access to key health promotion, preventive, curative and rehabilitative health interventions for all, at an affordable cost, thereby achieving equity in access. It incorporates two dimensions: depth-health care coverage as in adequate health care-and width-population coverage.

User Charges: Payment for goods and services according to price list or fee schedule. User fee system is inequitable by its own nature. It makes the patients bear the cost of services and it makes the poor pay proportionally more than the rich.