# The Gambia National Health Financing Strategic Plan 2019-2024

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## Acronyms

ANC Antenatal Care

BI Bamako Initiative

CBCs Community Birch Companions

CBR Crude Birth Rate

CDR Crude Death Rate

CDV Contract Development and Verification Agent

CHE Current Health Expenditure

CME Commission for Macro Economics

CMH Commission for Macroeconomics and Health

CNAs Community Nurse Attendants

CRF Consolidated Revenue Fund

DHS Director Health Services

DPI Director Planning and Information

DRG Drug Revolving Fund

FNS Food and Nutrition Security

FSA Fiscal Space Analysis

GAVI Global Alliance for Vaccine Initiative

GBoS Gambia Bureau of Statistics

GDP Gross Domestic Product

GFATM Global Fund for HIV/AIDS, Tuberculosis and Malaria

GHFP Gambia Health Financing Policy

GHFS Gambia Health Financing Strategy

GMD Gambia Dalasi

GNHFP Gambia National Health Financing Policy

GNHFS Gambia National Health Financing Strategy

GNHP Gambia National Health Policy

GNHSP Gambia National Health Strategy Plan

GNP Gambia National Health Policy

GNSP Gambia National Health Strategic Plan

GOTG Government of the Gambia

GPPA Gambia Public Procurement Authority

GRA Gambia Revenue Authority

HCRP Health Cost Recovery Programme

HDI Human Development Index

HFS Health Financing Strategy

HFS National Health Financing Strategy

HFTWG Health Financing Technical Working Group
HFU Health Financing Unit
IMR Infant Mortality Rate
IWC Infant Welfare Clinic
IYCF Infant and Young Child Feeding
LGA Local Government Authority
MCC Millennium Challenge Corporation
MCNHRP Maternal and Child Nutrition and Health Results Project
MMR Maternal Mortality Ratio
MOFEA Ministry of Finance and Economic Affairs
MOH Ministry of Health
MTR Mid-Term Review
NaNA National Nutrition Agency
NGO Non-Governmental Organization
NHA National Health Accounts
NHIS National Health Insurance Scheme
NSC National Steering Committee
OIC Officer In Charge
OOPE Out of Pocket Expenditure
OOPS Out of –pocket payments
OPD Outpatient
PBB Performance Based Budgeting
PCU Program Coordination Unit
PERs Public Expenditure Review
PMO Personnel Management Office
PS Permanent Secretary
RBF Results Based Financing
RBMER Results Based Monitoring, Evaluation and Reporting
RCH Reproductive and Child Health
RHDs Regional Health Directorates
RMP Resource Mobilization Plan
RSC Regional Steering Committee
SAM Severe Acute Malnutrition
SDG Sustainable Development Goal
SHI Social Health Insurance
SWAp Sector Wide Approach
TBA Traditional Birth Attendants

TGHE Total Government Health Expenditure

THE Total Health Expenditure

TMA Treasury Main Account

TPHE Total Private Health Expenditure

UHC Universal Health Coverage

UNDP United Nation Development Programme

VDC Village Development Committee

VHS Village Health Service

VHW Village Health Workers

VSG Village Support Group

WHO World Health Organization

## Foreword

The Ministry of Health (MoH) is pleased to present its first National Health Financing Strategy (NHFS, 2019-2024) which will pave the way for the successful implementation of the policy. We are optimistic that the strategy will provide a pathway for health care reform in the Gambia and further help establish the foundation for the development of a National Health Financing and Payment Mechanism with a view to ensuring security and protection for the rights of health care services for the population.

The development of this plan is based on a diagnosis of how the country's health system currently performs relative to stated goals and objectives, which are usually framed in terms of Universal Health Coverage (UHC). In addition, it takes a comprehensive view of all functions, policies, linkages and alignments across the health system as well as the National Development Plan (NDP, 2018-2021). The plan further identifies a set of detailed country-specific objectives, together with a prioritized set of actions which will address the problems identified within a specified time period.

Traditionally, the health care system in the Gambia has been based on a curative and hospital-oriented model. Such a system has lacked the capacity to deliver services that address the major health problems faced by the majority of the population in an equitable and sustainable manner. The current PHC structure is not based on cost-effective interventions that would ensure maximum health gains for available resources. Neither is it capable of responding effectively and efficiently to the complex and growing health needs of the population. It is therefore my fervent believe that the implementation of the NHFS will address these issues and ensure the timely delivery of cost-effective, integrated and standardized health services tailored to meet the priority health issues faced by the majority of the population. The NHFS will ensure equitable delivery of and access to quality health care services at all levels of our health care delivery system. Gradually, the implementation of this strategy will enable the Gambia to meet the benchmarks of National Health Policy (NHP, 2012-2020), National Health Sector Strategic Plan (NHSP, 2014-2020) and the Health Financing Policy (HFP, 2017-2030) as well as PHC strategies which advocates for making health care delivery services available to communities.

Therefore, I wish to extend my profound gratitude to the World Bank project (MCNRHP) which is jointly implemented by NaNA and MoH for the financial support and WHO Country Office for

providing technical support. I would also like to acknowledge the effort employed by all other Health Development Partners (HDPs), the Health Financing and Financial Management Technical Working Group and staff of the Directorate of Planning and Information for working extremely hard to produce this very important document which will in no doubt revolutionise the health financing system in the Gambia.

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**Dr. Ahmad Lamin Samateh**
**Hon. Minister of Health**

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**Mr. Dawda L Ceesay**
**PS Ministry of Health**

**Executive Summary**

The Gambia's first National Health Financing Strategy (HFS) outlines specific reform initiatives around financing arrangements in the health sector that are necessary for achieving goals and objectives that have been set for the health system. It is under-pinned by The Gambia National Health Policy (GNHP) 2012-2020[1] "Health is Wealth" that aims at accelerating provision of quality services and Universal Health Coverage (UHC) and The Gambia National Health Strategic Plan (GNHSP) 2014-2020. This Health Financing Strategy operationalizes The Gambia National Health Financing Policy 2017-2030 with the overarching goal of achieving Universal Health Coverage. The development of this strategy involved wide stakeholder consultations within the Government of The Gambia, National Assembly, Development Partners and The Gambia Revenue Authority.

Health financing in The Gambia is constrained by poor economic performance and high poverty levels and is mainly from donors and households. However, the Government of The Gambia has shown commitment to health care by progressively increasing funding for health care in the past decade. Government annual allocation to health over the past decade hovers around 7% to 10% of the National Budget. In the same vein, general government expenditure on health as percentage of total health expenditure increased from 28.11% in NHA 2013 to 32.78% in NHA 2015. However, situational analysis of health financing arrangements identified challenges around resource mobilization, pooling, purchasing and governance for health financing. The challenges with resource mobilization are:

- Low government budget allocation to the health sector
- Challenges with program planning, budgeting and budget disbursement
- Very low budget allocation to capital expenditure
- Unpredictability of level of external funding
- Inadequate levels of stewardship and coordination of external funding
- External funding not necessarily aligned to country's priorities in context of limited resources
- High out-of-pocket expenditures, which have resulted in catastrophic payments

[1] The Gambia National Health Policy 2012-2020

- Poor adherence to Public Financial Management practices
- Allocative Inefficiency-Budgeting process not sufficiently linked to health needs
- Inaccessibility of Drug Revolving Fund when required for use by facilities
- Un-quantified funding in the private sector

The challenges with pooling of funds are:

- High fragmentation of resource pools across the entire sector with a high likelihood of duplication and overlap in the use of resources
- Inadequate levels of coordination and complementarity between different resource pools
- Lack of mechanisms for income and risk cross subsidization across the contributory schemes
- Huge informal sector difficult to register for health insurance
- Inadequate human capacity for health financing

The challenges with purchasing of health services are:

- Provider payment arrangements not sufficiently linked to health provider performance
- Sustainability challenges for RBF program
- Inadequate capacity in MOH for strategic purchasing
- Essential benefit package not fully defined for all levels of care
- Referral system is not working effectively
- Inadequate coordination between levels of government and donors
- Separation of provider and purchaser roles not sufficiently demarcated within public sector
- Lack of transparency and accountability in utilization of the DRF
- Unreported payments for foreign medical services provided abroad

The challenges with governance for health financing are;

- No separation of functions for the Ministry of Health (MOH) is provider, purchaser and regulator of service provision
- Lack of transparency and accountability in virement of budget allocations
- Lack of transparency and accountability in the collection of user fees

Key areas of intervention in this strategy are informed by an analysis of The Gambian health system, wide stakeholder consultations and international best practice. These interventions are in the key functions of health financing namely revenue generation, pooling of funds and strategic purchasing. Strategic interventions are also made for governance for health financing.

**Raising Revenue**

| Area of Intervention | Priority Interventions | Timeframe | Responsible Entity |
|---|---|---|---|
| **1. Increase efficiency gains from existing resources** | 1.1 Build institutional capacity for sustainable health financing at all levels of the health system-program planning, budgeting and coordination | Short term | PS1 |
| | 1.2 Review of structures of the MOH to elicit greater efficiency | Short term | PS1& Principal Planner |
| | 1.3Place greater emphasis on investment in and implementation of interventions targeted at prevention-Revitalize PHC<br>1.4. Conduct a private sector assessment and examine potential for public-private-partnerships | Short term | DHS/Program manager PHC |
| **2. Increased reliance on public resources for the health sector** | 2.1. Conduct a Fiscal Space Analysis | Short term | Head, HF Unit |
| | 2.2. Advocacy for National Assembly and MOFEA to increase the funds | Short term | |

| | | | |
|---|---|---|---|
| | allocated to Ministry of Health and Social Welfare (fulfil Abuja targets) | | Director, DPI/Minister |
| **3. Innovative health financing mechanisms** | 3.1. Advocate 100% allocation of the Tobacco, alcohol tax and hazardous products (sin-tax) to the MOH.<br><br>3.2 Ring-fence taxes on airtime and internet data for health<br>3.3 Introduce mechanisms that allows communities to contribute to health system strengthening<br><br>3.4.Develop a framework for Public Private Partnerships<br><br>3.5Factor in costs of health care in environmental impact assessments for new businesses | Short term<br><br>Medium term<br><br>Medium term<br><br>Medium term | PS,/Minister<br><br>PS/Minister<br><br>PS/Minister<br><br>PS , Minister |
| **4.Program planning and Budgeting** | 4.1 Advocate for improved predictability and availability of public resources<br>4.2Strengthen capacity to monitor performance around PFM and enforce lines of accountability | Short term<br><br>Short term | PS, Minister<br><br>PS; MoH/MoFEA |
| **5.Improve the predictability and level of external resources** | 5.1Strengthen mandate and capacity of the PCU for donor coordination by implementing the COMPACT<br><br>5.2Set up virtual pool of funds for donors and make sure external assistance is reported on the budget | Short term<br><br>Short term | PS MoH<br><br>PS1 |

| | | | |
|---|---|---|---|
| **6.Improve efficiency of external assistance on health** | 6.1Use donor mapping to identify redundancies and underfunded programs<br><br>6.2Develop clear multiannual plans so that development partners can align on planned activities | Short term<br><br>Short term | Director DPI<br><br>Principal Planner |
| **7. Increase the contribution of prepayment schemes to the health sector** | 6.1Assessment of other prepayment schemes for raising revenue<br><br>6.2 Assessment of appropriateness of a mandatory National Health Insurance scheme<br><br>6.3 Advocate for the establishment of a mandatory National Health Insurance<br><br>6.4 develop a NHI ACT for the Gambia | Short term<br><br>Medium term<br><br>Medium<br><br>Medium | Director, DPI<br><br>PS1, HF Unit |

**Pooling of Funds**

| Pooling | Priority Interventions | Timeframe | Responsible Entity |
|---|---|---|---|
| **1. Pooling and Decentralizing Government Health Funds** | 1.1. Strengthen equalisation mechanism across local authorities.<br>1.2. Strengthen integration of monitoring and reporting of the DRF and MOH funds.<br>1.3. Ensure reporting of funds used for foreign medical trips on MOH funds<br>1.4.Establish a virtual basket of all public funds | Medium Term<br>Short Term<br>Short Term<br>Short Term | PS 1/DPI<br>Director of Planning/Head Int. Audit<br>Director of Planning/Head Int. Audit<br>PS/DPI |
| **2.Pool Donor and Non-governmental Organisations Health Funds** | 2.1Establish a virtual sector-wide coordination of all donor and non-governmental organisations health funds.<br>2.2Develop virtually integrated monitoring and reporting of the funds. | Medium Term<br>Medium Term | PS<br>PS |

| | | | |
|---|---|---|---|
| **3. Private Health Funds** | 3.1Quantify and map the potential of private funds<br><br>3.2.Develop regulatory framework for the medical schemes environment | Short Term | Principal Planner |
| **4.Pooling Government, Donor and Non-Governmental Health funds** | 4.1Establish a virtual basket of all public and donor health funds.<br>4.2Develop joint accounting, monitoring and reporting of the funds. | Long Term | PS/Minister |

**Purchasing of Services**

| Area of intervention | Priority interventions | Timing | Institution responsible |
|---|---|---|---|
| **1.Improve utilization of the Drug Revolving Fund** | 1.1 Strengthen capacity and improve governance of Central Medical Stores to procure, store and distribute medicines and pharmaceutical supplies to all health facilities in the country<br>1.2 Implement sector-wide approach to use of donor funds in procuring | Short Term<br><br>Short Term | PS/Dir NPS<br><br>Dir Planning |

| | | | |
|---|---|---|---|
| | medicines and pharmaceutical supplies | | |
| **2. Introduce strategic purchasing** | 2.1 Strengthen capacity for strategic purchasing within MOH and establishment of a dedicated purchasing unit | Short Term | PS/DHRH |
| **3. Strengthen Results Based Financing** | 3.1 Build Capacity for full institutionalisation of RBF across levels of care and services<br>3.2 Ensure sustainability of RBF through innovative financing mechanisms<br>3.3 Ensure Implementation of the RBF Sustainability Roadmap | Long Term<br>Medium Term<br>Short Term | PS/DHRH<br>PS<br>PS |
| **4. Equitable Resource Allocation** | 4.1Develop and implement needs-based resource allocation formula | Short Term | Principal Planner |
| **5.Ensure equitable and efficient delivery of Benefit Package** | 5.1Articulate the Benefit Package on a realistic resource envelope<br>5.2 Strengthen referral system by using financing incentives to improve quality | Short Term<br>Short Term | PS<br>Program Manager<br>QA |

The health financing strategy identifies changes in institutional and governance arrangements that are required for some of the proposed strategies to be successfully implemented. The main institutions directly involved in the implementation of the health financing strategy are:

- Ministry of Health (MOH),
- Ministry of Finance and Economic Affairs (MOFEA),
- Ministry of Women, Children and Social Welfare
- Ministry of Local Government

- Health Development Partners and Non-Governmental Organizations
- Private health sector providers and insurers

Progress in the implementation of the health financing strategy will be tracked with a Results Based Monitoring, Evaluation and reporting approach that ensures regular review of progress. This approach entails periodic measurement of performance indicators mapped to inputs and processes, outputs, outcomes and impacts

# Chapter 1: Background

## 1.1 Introduction

The Gambia is a small country in West Africa. It stretches 450 km along the Gambia River. Its 10, 689 sq. km area surrounded by Senegal, except for a 60 km Atlantic Ocean front. The country has a population of 1.9 million (GBoS, 2013). With 176 people per square kilometer, it is one of the most densely populated countries in Africa. Most of the population (57%) is concentrated around urban and peri-urban centers.

The Gambia has a small economy that relies primarily on tourism, rain-dependent agriculture, and remittances, and is vulnerable to external shocks. In recent years, the economy was hit by economic

shocks in agriculture caused by erratic rainfalls and in tourism caused by the spillover effects of the regional Ebola crisis and the political crisis during 2015-2016.

The economy recovered strongly in 2017, with growth estimated at 4.6% (below potential), up from 0.4% in 2016. Robust growth in the service sector (10.6%), mainly in commerce, drove this recovery. Tourist arrivals turned around in the second half of 2017. However, agriculture contracted by 8.1% due to uneven distribution of rainfall (World Bank Report, Nov. 2018).

Strengthened fiscal discipline and substantial donor support reduced the fiscal deficit from 6.5% of gross domestic product (GDP) in 2016 to 5.4% in 2017. These led to a sharp decline in net domestic borrowing from 8.4% of GDP in 2016 to –0.5% in 2017. Expenditure ceilings have helped, but tax collection declined from 11.1% of GDP in 2016 to 10.2% of GDP in 2017.

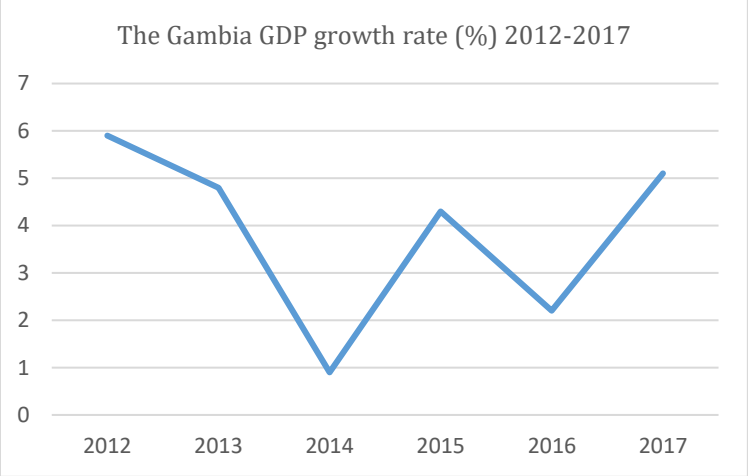
Public debt increased from 82.3% of GDP in 2016 to 88% in 2017 due to the low growth, the fiscal deficit, higher loan disbursement, recognition of external private debt, and debt reconciliation with creditors. As a result, The Gambia is currently in external debt distress and public debt is unsustainable. Interest payments consumes an inordinate share of available government revenues (42 in 2016 and 2017), leaving very little fiscal space to improve service delivery and undertake the public investments in physical and human capital needed to support the emergence of a thriving private sector. The external debt distress will also no doubt have an inflicting toll on public financing for health as a result of fiscal constrain.

The key long-term development challenges facing The Gambia are related to its undiversified economy, small internal market, limited access to resources, lack of skills necessary to build effective institutions, high population growth, lack of private sector job creation, and high rate of outmigration.

Economic growth is projected to accelerate to 5.4% in 2018 and 2019 and 5.2% in 2020 but will remain slightly below potential. This assumes a strong recovery in tourism and trade, a normal agricultural season, and improvements in electricity provision. Political stability, combined with improved macroeconomic conditions, would help strengthen investment activity. Economic activity would also be underpinned by key infrastructure developments, notably energy supply, as well as improved trade and re-export trade.

However, a legacy of fragility across various dimensions pose a risk for the medium-term outlook. The limited capacity of public institutions hinders public policy and its implementation. The Gambia's growing debt leaves little fiscal space to reinvigorate the economy and ensure inclusive growth. The share of immigrants has reached almost 10% of the population. While the loss of labor to migration has long slowed the country's economic development, remittance income is an increasingly crucial component of household consumption. A high propensity to erratic rainfalls exacerbates vulnerability to food insecurity and volatility of growth.

Figure 1. The Gambia GDP growth in percentage 2012-2017




Source: Gambia Bureau of Statistics

The Government of The Gambia debt to GDP ratio rose from 47.7% in 2013 to 65.6% in 2017[2]

The Gambia's first national Health Financing Strategy (HFS) outlines specific reform initiatives around financing arrangements in the health sector that are necessary for achieving goals and objectives that have been set for the health system. It is under-pinned by The Gambia National

[2] Central Bank of The Gambia

Health Policy (GNHP) 2012-2020[3] "Health is Wealth" that aims at accelerating provision of quality services and Universal Health Coverage (UHC) and The Gambia National Health Strategic Plan (GNHSP) 2014-2020[4]. The strategic objectives of the GNHSP are;

1. To provide high quality basic health care services that is affordable, available and accessible to all Gambian populace.

2. To reduce the burden of communicable and non-communicable diseases to a level that they cease to be a public health problem

3. To ensure the availability and retention of highly skilled and well-motivated Human Resources for Health for Gambian populace based on the health demands

4. To increase access to quality pharmaceutical, laboratory, radiology and blood transfusion services to all by 2020

5. To improve infrastructure and logistics requirements of the public health system for quality health care delivery

6. To establish an effective, efficient, equitable and sustainable health sector financing mechanism by 2024

7. To improve the effectiveness and efficiency of Health Information System for Planning and decision making to yield improved service delivery

8. To ensure effective and efficient health service provision through the development of effective regulatory framework and promoting effective coordination and partnership with all partners

This Health Financing Strategy derives directly from the recently developed Gambia Health Financing Policy (GHFP) 2017-2030. One of the guiding principles in The Gambia National Health Policy (GNHP) is that, in emergency health situations including severe pain, an injury, or sudden illness that makes a person believe that his/her health is in serious danger, he/she shall have the right to be screened and stabilized using emergency services. He/she should be able to use

[3] The Gambia National Health Policy 2012-2020
[4] The Gambia National Health Strategy 2014-2020

these services whenever and wherever needed without needing to wait for authorization and any financial payment[1].

The vision of The GHFP is to "achieve sustainable Universal Health Coverage (UHC) for every one living in the Gambia by 2030"[5]. The mission is "To establish integrated health financing mechanisms that promotes and protects the health of the population through equitable provision of quality health care and ensuring that no one suffers financial hardship in accessing healthcare". The goal of the GHFP is to ensure adequate and sustainable financing of health care services to protect the population from financial hardship particularly the poor and vulnerable.

Policy objectives of the GHFP are;

1. To increase access to quality health care service to the whole population by 2030
2. To establish a mechanism for revenue mobilization for the payment of health care services.
3. To ensure all financial resources available for health care delivery are pooled in a common basket by 2020 and allocated for both inputs and outputs financing.
4. To ensure choice and purchase of evidence based, high impact, cost-effective interventions, as well as give appropriate incentives to providers.
5. To ensure equity regarding distribution and access in the use of financial resources throughout the country.
6. To ensure health services financial risk protection for all.
7. To improve efficiency in administration of the health financing system.

While the GHFP set out the long term goals and principles for health financing in the country, the MOH Health Financing Technical Working Group (HFTWG) concluded at the validation meeting of the GHFP at Senegambia Hotel from 21-23 August 2017 that there was need to formulate this Health Financing Strategy (HFS)[6]. This HFS operationalizes and sets out clear priorities and activities to achieve progress towards UHC and ensure adequate financing to achieve the targets of the GNHSP 2014-2020. The GHFS aims to translate the GHFP into action-oriented

[1] The Gambia National Health Policy
[5] The Gambia National Health Financing Policy
[6] MOH Health Financing Technical Working validation meeting chaired by Permanent Secretary

interventions, building on analysis of documents available in the country and contributions from technical partners and stakeholders.

### 1.2 Rationale for Developing a Financing Strategy

The Gambia Health Financing Policy sets out the long terms goals and principles for health financing in the country. The HFS will operationalize and set out clear priorities and activities to achieve progress towards UHC and ensure adequate financing to achieve the targets of the GNHSP 2014-2020. This GHFS will translate the GHFP into action-oriented interventions that will result in reforms that improve health financing in The Gambia. The GHFS aims to address issues of inadequate funding for health care by improving resource mobilization for health care. The strategy will address inequities in funding for health care between the urban and rural populations, the rich and the poor and the sick and healthy. The strategy aims to improve solidarity between Gambians by reducing fragmentation of the health financing system and improving pooling of resources for health care. This strategy will improve efficiency in utilization of resources for health care by identifying strategic purchasing solutions to gain value for money and improve quality of health care services. The strategy will also address weaknesses in transparency and accountability in utilization of health care resources by putting in place a governance framework that will ensure accountability. The strategy has a monitoring and evaluation framework for tracking progress towards Universal Health Coverage.

### 1.3 Process of Developing the Health Financing Strategy

The process of formulating the HFS started with a stakeholders' consultation from 3-8 February 2018 by the international and local consultants. Consultations were done in MOH with the Minister, Permanent Secretary and Director of Health Services and the Health Financing Technical Working Group consisting of seven Directors from different departments in MOH. There were

consultative meetings with development partners namely WHO Representative, UNICEF Representative and UNFPA Representative. There was a consultative meeting with the seven member National Assembly Select Committee on Health Assessment and also with the Gambia Revenue Authority (GRA) Deputy Chief Commissioner, Chief Accountant and two other officers. A TWG workshop was held in Bwian from 30 October 2018 to 3 November 2018 for the formulation of the HFS under the chairmanship of the Director planning and Information. The workshop was attended by 40 representatives from MOH, NaNA, MOFEA, and the National Assembly, GRA and development partners. The workshop came up with a zero draft of the HFS. Another workshop that was officially opened and attended by the PS was held at Bwiam from 11-13 February 2019. Discussions were held for input into the strategies, governance for health financing, minimum health care package for health insurance and a monitoring and evaluation framework for the HFS.

### 1.4 Structure of the Health Financing Strategy

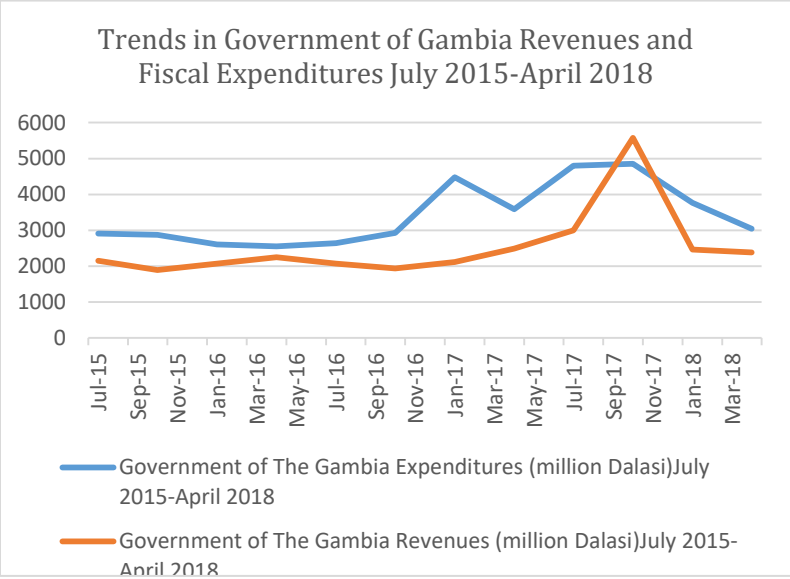
The HFS is organized into four chapters starting with this chapter on the background. *Chapter* 1 provides an overview of the macro-economic and fiscal context of the Gambia. In addition, the main features of the health system are summarized. A situational analysis of health financing in The Gambia, that provides a diagnostic assessment of health financing arrangements is also in this chapter. The analysis is done according to the three main financing functions: revenue collection, pooling and purchasing. In *Chapter 2*, strategic reforms for addressing these health financing challenges are outlined. *Chapter 3* describes governance and implementation arrangements necessary for the proposed strategies to be successfully implemented. In *Chapter 4*, a monitoring and evaluation plan for the proposed reform is described.

### 1.5. Government Revenue and Expenditure Trends

Government Revenues in The Gambia decreased to 2377.68 Dalasi Million in the first quarter of 2018 from 2456.69 Dalasi Million in the fourth quarter of 2017. Government Revenues in The

Gambia averaged 1479.04 Dalasi Million from 2004 until 2018, reaching an all time high of 5576.38 Dalasi Million in the third quarter of 2017 and a record low of 647.10 Dalasi Million in the third quarter of 2005. The Government of The Gambia gets its revenues from personal income tax charged at 30 percent , sales tax at 15 percent and corporate tax at 31 percent[7].

Figure 2. Trends in Government of The Gambia Revenues and Fiscal Expenditures July 2015 to April 2018




Source: The Gambia Bureau of Statistics

Fiscal Expenditure in The Gambia decreased to 3044.30 Dalasi Million in the first quarter of 2018 from 3740.45 million Dalasi in the fourth quarter of 2017. Fiscal Expenditure in The Gambia averaged 2183.64 Dalasi Million from 2008 until 2018, reaching an all time high of 4855.59 Dalasi Million in the third quarter of 2017 and a record low of 893.96 Dalasi Million in the first quarter of 2008.

The Gambia recorded a Government Budget deficit equal to 3.90 percent of the country's Gross Domestic Product in 2017. Government Budget in The Gambia averaged -4.91 percent of GDP from 2002 until 2017.

[7] The Gambia Revenue Authority

## 1.6. Overview of the Health Care Service Delivery 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 major health centers at the secondary level and 634 minor health posts at the primary level. The system is complemented by 41 private and NGO clinics[8]. 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[9].

Private sector health services provision includes the private for-profit, private-not-for-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 majority are located in the Greater Banjul Area, making choice in health services provider in the rural community limited. 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 MOH 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 two Permanent Secretaries, who serves as the Chief Administrator of the Ministry. Other operations of the Ministry are organized around one departments (Department of Health Service. 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.

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

[8] Health Management Information System 2016
[9] Ministry of Health Directorate of Planning and Information

(VHW) with very minimal training and community Birth Companions (CBCs) with limited additional training. The village health provider provides treatment for uncomplicated malaria, diarrhea, 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 (ANC), Family Planning, birth registration, child immunization, growth and development monitoring, vitamin A supplementation and deworming and limited treatment for the sick.

### 1.6.1. Structure of the Health System

Tertiary Health Care (Hospitals)

Currently there is one teaching and specialized hospital (Edward Francis Small Teaching Hospital) and five general public hospitals namely: Sheikh Zayed Regional Eye Care Centre in Kanifing, Bansang Hospital in Central River Region, Farafenni General Hospital in Farafenni, North Bank Region, Bwiam General Hospital in Bwiam, Serekunda General Hospital in Kanifing and Bundung Maternal and Child Health Hospital in Bundung. They have semi-autonomous status, with Hospital Management Boards, and are not generally supplied or supervised by the Regional Health Directorates (RHDs). They do, however, have some important responsibilities to the RHDs, including reporting diseases incidences, maternal deaths, and providing feedback on patients referred to them by the VHS and basic health facilities. The administration at the hospitals generally consists of the Chief Executive Officer and several administrative staff.[10]

**Basic Health Services**

Basic Health Service is at the secondary level of the national health systems and it comprises of major and minor health facilities. The major health centre serves as the referral point for minor health centres for services such as: Family planning (prescribe contraceptives and follow-up users; perform surgical contraception for men and women), Maternal and Child Health (provide basic gynaecological services; manage normal and complicated deliveries (including C-section);

[10] Ministry of Health Directorate of Planning and Information

counsel mothers on infant and child nutrition; management of Severe Acute Malnutrition (SAM), audit maternal deaths; provide antenatal, postnatal care (in facility and through treks) Disease Management: (Diagnose and treat cases of diarrhoea/dehydration, ARI, malaria, HIV/AIDS, STIs, leprosy and TB; manage simple mental health cases ), Minor Surgery, Radiology Services, and Laboratory Services and Referral (refer and transport serious illnesses and injuries, or cases needing specialist care, to the nearest public hospital). The standard bed capacity for the 49 major health centers ranges from 110-150 beds per 150,000 - 200,000 population.

The minor health facilities provide the following services: RCH services, FP services, Nutrition services, control of common endemic diseases, Health promotion and protection and provision of essential drugs and vaccines. A minor health facility has between 20–40 beds per 15000 population and should provide 70% of the basic health care package.

These BHS facilities provide the core outpatient (OPD) clinics and the Reproductive and Child Health (RCH) services. OPD clinics usually are held daily and treat children age five and above and all non-pregnant adults, as well as children less than five years and pregnant women. RCH clinics provide most of the health care to children under the age of five (Infant Welfare Clinic, IWC) and antenatal care for pregnant women. RCH base clinics are held at the facility at least once per week. Trekking team visits a set schedule of outreach clinics in each health facility's catchments area. These trekking stations are visited at least once a month, depending on the catchment area population. The RCH team usually consists of a nurse midwife, health facility-based CHNs or CHN/midwives (with the addition of the VHS/CHN at some of the clinics), Community Nurse Attendant(s) (CNAs), an APHO for EPI activities and a Drug Revolving Fund (DRF) collector. The number of staff will vary with the size of the facility and the catchment area[12]

Village Health Services (VHS)

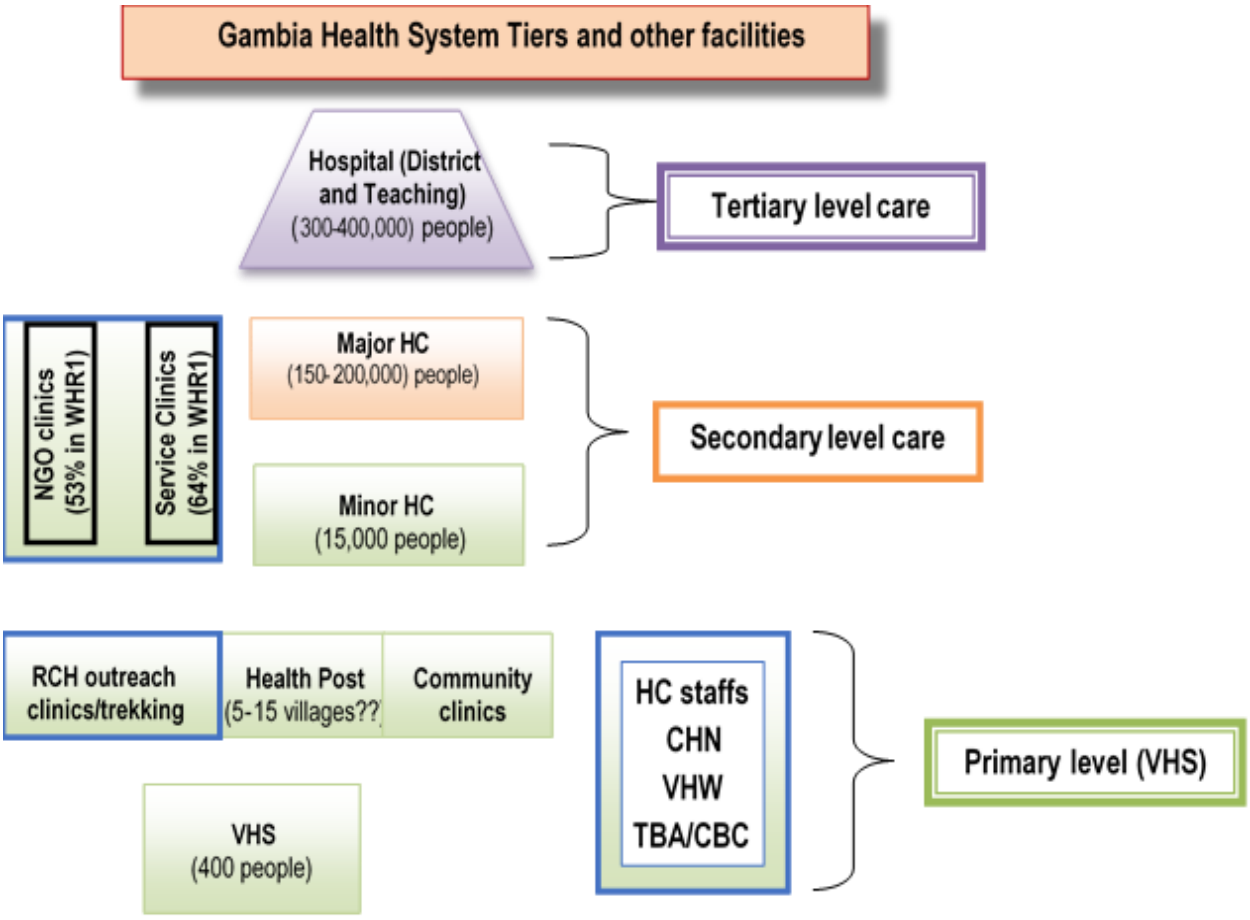
Primary health care villages have been selected from those with a population of 400 and above or from those located in relatively isolated areas. Village Health Workers (VHWs) and Community Birth Companions (CBC) are selected by the Village Development Committee (VDC). CBCs are trained for 6 weeks and VHW are trained for to 8 weeks using a standardized curriculum at a

[12] Ministry of Health Directorate of Planning and Information

designated place by the MOH&SW and partners. These workers are issued a minimal start-up supply of medication and equipment by the Government. A fee of GMD 25 ($0.50)[11] is charged for each patient seen. This money is paid to the VDC treasurer to be used for the purchase of additional drugs and supplies as needed. The VDC provides support to VHWs through in-kind contributions or voluntary labor in their farms. The VHW functions as a primary health care provider for minor illnesses and injuries, serving males and females of all ages. In addition, the VHW functions as a community based health educator and adviser. The CBC formerly known as Traditional Birth Attendants (TBA), as their name formerly implied, were part of the culture long before the formal health care system was introduced. They function as trained CBCs, as antenatal and postnatal advisers, family planning distributors and health educators. Both CBCs and VHW are expected to refer serious cases to the local health facility.The VHWs and CBCss are supervised and given continuing education by VHS/Community Health Nurses (VHS/CHN) who oversees circuits of 4 to 10 PHC villages. These VHS/CHNs in turn report through their nearest BHS facility and is supervised by the Officer in Charge (OIC) of that facility and by the Regional Health Team. There are 891 PHC villages organized into 69 circuits (update). The CHNs were provided with motorcycles for supervisory VHS trekking. The VHS/CHNs are essential for the successful functioning of primary health care in The Gambia[12]. Effective and efficient referral services from one level of health care to another are important in-patient management and disease outcome.

[11] Drug Revolving Fund Act ??

[12] Primary Health Care Roadmap




### 1.6.2 Burden of Disease

The population of The Gambia is 1.9 million, of which 40.9 percent 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). 25% of children under age 5 years in The Gambia are stunted (short for their age), 12 % are wasted (thin for their height), and 16 % are underweight (thin for their age).

Only 3% of children are overweight (heavy for their height). Almost all (99%) last-born children under age 2 were breastfed at some point in their life. 47% of children under six months are exclusively breastfed, and 54% of children age 6-8 months are breastfeeding and consuming complementary foods. Only 8 % of children age 6-23 months are fed in accordance with the three core infant and young child feeding (IYCF) practices.

69% of children age 6-59 months had received vitamin A supplements in the past six months, 17 % received iron supplements in the past seven days, 34 % received deworming medication in the past six months, and 76% lived in households with iodized salt at the time of The GDHS 2013.[13]

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 behaviors 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), Diabetes, 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.

### 1.7. Summary of Situation Analysis of Health Financing for The Gambia

In providing good access to health care, there are three main interrelated financing functions of a health system that are critical. These are revenue collection, pooling of resources and purchasing

[13] The Gambia Demographic and Health Survey 2013

of interventions[14]. The situation analysis of health financing arrangements in The Gambia conducted in this section is presented along these lines. This provides a guide for proper diagnosis of financing challenges and a framework for identification of the appropriate interventions necessary for improving health system financing.

*Revenue collection* is the process by which health systems receive money from government, households, organizations, companies and donors. Ideally, this process should ensure that revenue for the health sector is collected through fair mechanisms that are pro-poor, sustainable and do not cause catastrophe or impoverishment

*Resource pooling* is concerned with accumulating prepaid revenues for health on behalf of some or all of the population and whether these are combined in one or more fund pools. This is aimed at ensuring that there is equity in allocation, and income and risk cross-subsidization.

*Purchasing* is concerned with the allocation of prepaid resources from the pool to the providers for service benefits, including decisions on benefit package design and rationing. Good purchasing arrangements ensure that allocated resources are based on health priorities needs and create incentives for health providers to deliver quality health services efficiently in exchange for payment received.

### 1.7.1.Revenue Sources for Health

Total Health Expenditure decreased by 6.9 percent from D1, 907 billion($50,314million) or 5.6% of GDP[15] in 2013 to D1, 783 billion($44,710million) or 4.7% of GDP[16] in 2015 (NHA 2015). Total Health Expenditure (THE) as a percentage of GDP was 4.7% and slightly below the globally recommended 5% of GDP. Globally it has been noted that Universal Health Coverage is difficult to achieve if public health financing is less than 5% of GDP. There was a decrease in health expenditure per capita from $28.08PPP in 2013 to $22.67PPP in 2015. The THE per capita for both financial years (2013 and 2015) is much lower than the minimum $34-40 PPP or $84PPP per

[14] WHO (2000) World Health Report
[15] The Gambia National Health Accounts 2013
[16] The Gambia National Health Accounts 2015

capita recommended by the Commission for Macroeconomics and Health (CMH)[17] and Chatham House[18] respectively.

Most of the finances for health in The Gambia are sourced from the rest of the world (donors and NGOs). According to the 2015 NHA, external financing accounted for 36.5% of total health expenditure.

The public sector and private sector constituted 32.8 % and 30.8% of total health expenditure respectively. The private sector expenditure has three components namely Out of Pocket (OOPs), private health insurance and expenditure by private employers. Out of Pocket expenditure constituted 24.4%, private health insurance, 3.2% and private employers 3.2%.

[17] Commission for Macroeconomics and Health
[18] Chatham House

**Table 3: Trends of Health Expenditure by Financing Source**

| Financing Source | NHA 2013 (GMD) | % | NHA 2015 (GMD) | % |
|---|---|---|---|---|
| Donor | 890,793,512.00($23,498million) | 46.7 | 650,309,916.80($16,298Million) | 36.5 |
| Employer | 33,792,441.68($891,385) | 1.8 | 56,774,097.60 ($1,423million) | 3.2 |
| Insurance | 42,126,838.28($1,111million) | 2.2 | 56,402,579.90 ($1,414million) | 3.2 |
| Household (Out-of pocket) | 404,608,500.00($10,673million) | 21.2 | 435,672,343.30($10,919milllion) | 24.4 |
| Government | 536,073,625.74($14,141million) | 28.1 | 584,809,446.50 ($14,657million) | 32.8 |
| **Total** | 1,907,394,917.77($50,314) | 100 | 1,783,968,384.10($44,710 million) | 100 |

Source: The Gambia National Health Accounts 2013 and 2015

Key issues for the three main sources of health financing (public, private and external funding) are explored in turn.

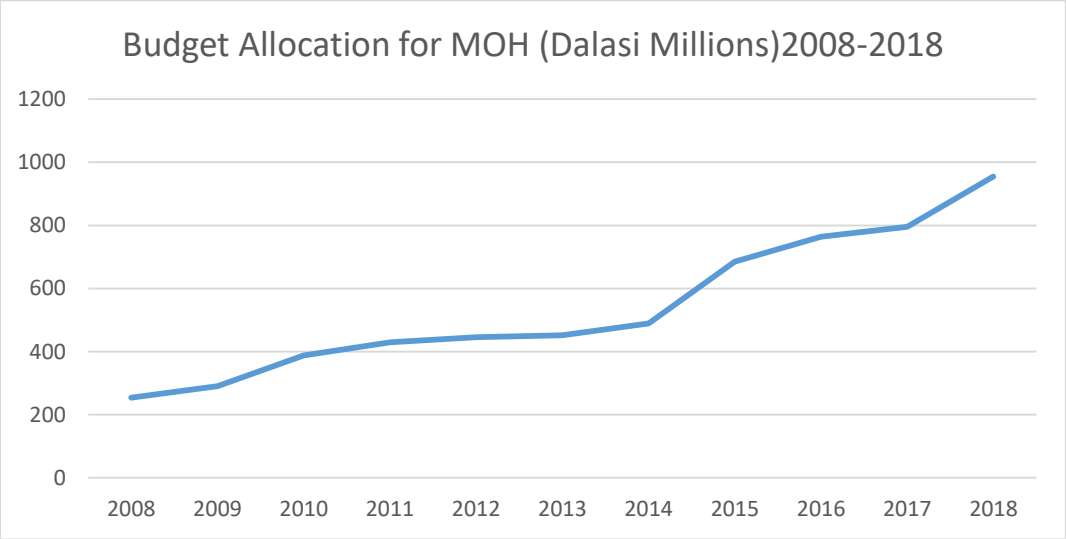
Financing from Government

Health Financing from GOTG is from tax-based funds from the National Treasury that flow through the Ministry of Finance and Economic Affairs (MOFEA) to the MOH and other government agencies that operate health services to their employees and their dependents like uniformed forces and prison health services. An estimated 33% of Total Health Expenditures

(THE) were sourced from tax-based fund according to the 2015 NHA. Salaries and emoluments for civil service health workers do not flow through the MOH; they are managed by the Personnel Management Office within MoFEA and are paid directly by the National Treasury Department. 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 but do not have health budgets. The Local Government Act of 2002 enacted decentralization and allows regional governments to raise their own resources[19]. However, lacking a substantial tax base and their taxing authority having eroded since enactment, their revenue generating potential is low and few local resources are allocated to health.[20] User fees for services are paid as part of a 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 that led to the Bamako Initiative in 1993[21].

The Government of The Gambia has shown political will by increasing funding for health care by through its annual allocation to the sector which covers around 7% to 10% from 2008 to 2018. The allocations, however remain below the Abuja Declaration of 15% of the national budget for health.

**Figure 4: Government Budgetary Allocations in Dalasi Millions 2014-2017**




[19] The Local Government Act 2002

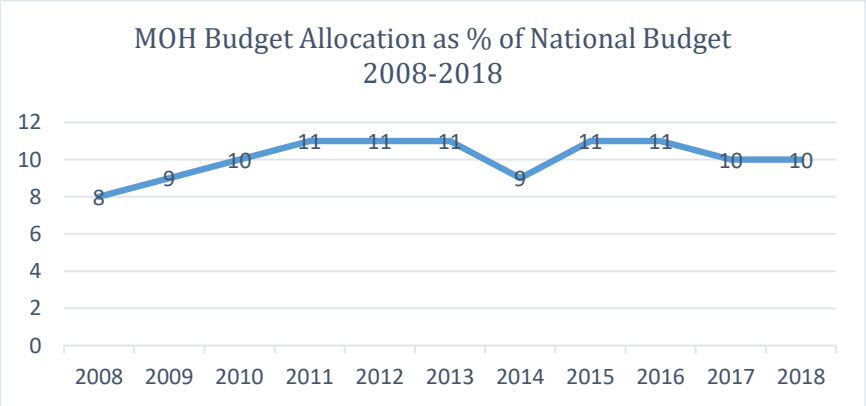
[20] Assessment of the Health System of The Gambia 2018

[21] Bamako Initiative 1993

Source; Directorate of Information and Planning

The MOH budget allocations have ranged between 8-11 % of the national budget from 2008 and 2018. It is of major concern that the proportion of the national budget allocated has declined to 10% for 2017 and 2018 compared with 11% in 2015 and 2016

**Figure 5: Ministry of Health budget allocations as a proportion of the national budget**




Source: Directorate of Planning and Information

**Key Challenges**

There is political commitment towards health care financing in the Gambia as highlighted above by the progressive increase in budget allocations to the MOH. However the following challenges exist which need concerted efforts to address:

- The current GDP per capita of $534.50 is way below the per capita GDP of $1900 PPP needed to achieve UHC according to international standards.
- Health as a share of government budget allocation of 10% and actual spending of D 955,172,000 in 2018 has remained below the Abuja Declaration Commitment for domestic spending, reflecting to some extent fiscal pressures and downward adjustments given declining external funding
- The current per capita level of government funding at $7.43 (NHA, 2015) is well below the Chatham House estimated $86 needed to provide an essential benefit package in low and middle-income countries. This presents 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.
- Although the share of total external funding has decreased from 46% of THE (NHA 2013) to 36.5% of THE (NHA 2015), external funding remains the highest contributor to THE creating a serious risk of donor dependency
- An increase in OOP over the years from 9% in 2004, 21% in 2013 and 24.4% in 2015 highlights the lack of financial protection and equity of access to healthcare services.
- Earmarking of non-government funds to specific diseases also reduces universality and equity. Vertical funding arrangements are able to raise funds for certain priority programmes but undermine equity and service provision for other disease areas.

In MOH Consultations that were done with the Minister of Health, the Permanent Secretary and the Director of Health Services, they all expressed high commitment to health sector reform for UHC including structural & system changes as informed by the HFS in order to re-establish the Primary Health Care system of The Gambia. They expressed high commitment to defragmenting the health system eliminating overlaps, duplications and misalignments to achieve greater efficiency and effectiveness. There was also a high commitment to streamlining and harmonizing health sector issues such as food safety, environmental health and Primary Health Care. Development partners indicated that this HFS should aim to revitalize PHC & strengthen effectiveness of referral system, should focus on UHC and address HF in a comprehensive manner

and should capture pertinent issues to be addressed in next budget cycle. They said The Government of the Gambia through MOH should own, drive and endorse financing mechanisms and approaches. They advised that the MOH should focus on innovations and learn from the region and global experiences on various taxes that are being used to increase financing for health care. There was however concern that the steering committees enunciated in the HFP had not been activated. MOH was advised to piggy bank on success of advocacy for increased funding for health care as evidenced by eminence of HF in discussions by MOFEA and the Legislature in The Gambia. They expressed the need to consider gaps in important funding e.g. GFTAM only funding old HIV patients & other conditions such as Viral Hepatitis. The partners expressed the need to address transparency, accountability and system failures in flow of funds and establish why some funds are being utilized effectively within MOH and why others cause system blockages and address the gaps through the HFS. The development partners reiterated the need by MOH to demonstrate capacity to absorb funds and focus on Government of The Gambia targets for SDGs and not "Project Targets" and make sure that all plans are aligned to the GOG vision. The partners advised that there should be clarity between Health Financing for Health Care and Financing for Social Welfare. A new Ministry of Women, Children and Social Welfare has since been formed therefore separating the financing for the two ministries[22]. MOH were advised to seek technical assistance to build capacity for GOG procurement, HRH management and Accounting before full decentralization of these functions and this is addressed in this HFS. As part of improving efficiency partners advised of the need to compare the amount of funding that is coming into the MOH in The Gambia with other countries and how effective it has been and efficiency mechanisms in other settings in the formulation of this HFS.

The National Assembly Select Committee on Health Assessment expressed the need to keep the committee in the loop always to strengthen their insight and capacity for debate that is favorable for Health Financing in parliament. They expressed high commitment to drive debate on enacting new laws to implement Health Sector Reform and that there was need to focus on health interventions that limit population growth. They expressed concern and the need to address through the HFS issues of migration and utilization of services by neighboring countries e.g.

[22] Government of The Gambia 2019 Budget

MNCH services. Their committee would also advocate for more scrutiny on how GRA revenue is utilized because they felt that citizens are already over taxed in The Gambia. The committee said the HFS should lead to improvement in health financing and that will reduce financial burden on households and create savings for other felt needs. The committee emphasized the need to prioritize improving health care services for poor and vulnerable and PHC in short to medium term and then contributory National Health Insurance in the long term. The committee expressed the need for full decentralization of health financing through the HFS and having regions and facilities accessing the Drug Revolving Fund.

The Gambia Revenue Authority was very grateful for being involved in the HFS formulation process from the onset. They advised on the need to use Public Expenditure Review reports as part of literature review for formulating the HFS. They promised that they would use the experience with tobacco tax and green tea tax in looking at other innovative financing mechanisms for health care. The GRA seconded officers to the HFTWG to be part of the process.[23]

**Private Funds**

According to The Gambia NHA 2015, Out of Pocket Expenditure (OOPE) on health by households was D435, 672,343.30($10,919million) and this constituted 24.4% of THE. Private insurance expenditure was D56, 402,579.90($1,414million) constituting 3.2% of THE. Private Insurance companies in The Gambia underwrite different plans such as medical insurance policies. Under the medical insurance policy, insurance companies will offer different plans to their potential clients/customers like silver, platinum, diamond etc. plans. The policy holders could be individual or group who pay an annual premium and the company pay claims to the beneficiaries depending on the type of plan the policy holder subscribes. The benefit package of the various plans ranges from local to overseas treatments. Contribution by private employers was D56, 774,097.60($1423million) constituting 3.2% of THE. These figures indicate an increase of 68% in health expenditure by employers, an increase of 33.9% in health expenditure by private insurance and an increase of 7.7% in out-of-pocket health expenditure by households in comparison with the 2013 NHA. The population that is covered by private health insurance is estimated at 4%. Although laws are available for regulating the private sectors, they are outdated

[23] Stakeholders Consultative Process 3-8 February 2018

and not being enforced, resulting in the private sector being reluctant to provide data on the number of people that they provide services to and the amounts of revenue generated from service provision. There is need to revise the Health Services Act and make reporting a mandatory statutory requirement.

**Development Assistance for Health**

International partners are the source for a substantial proportion of THE, most of which flow through the MOH through a special account within the MOH and managed separately from the account through which National Treasury funds are channeled.

Over the past few years, external funding for health has decreased by 28% from $10.12 per capita (2013 NHA) to $7.29 per capita (2015 NHA). Currently, major development partners are Global Fund, UNDP, GAVI, WHO and The World Bank, and a few other philanthropic organizations. A key challenge with donor funding is the unpredictability of funding from donors. In addition, most external funding is earmarked towards a few disease areas.

According to the Gambia NHA 2015, health expenditure by NGOs was D76, 639,859.00($1,921million) constituting 4.3% of THE. External donor funding contributed D573, 670,057.80($14,378million) to health expenditure in 2015 constituting 32.2% of THE. Expenditure incurred by rest of the world (donors and NGO combined) was D650, 309,916.80($16,298million) constituting 36.5% of the total health expenditure. Donor funds are mostly directed towards infectious and parasitic disease in The Gambia and very little to any other health conditions as indicated in the table below.

Thirty percent of Current Health Expenditure (CHE) was towards infectious and parasitic conditions with very little expenditure on reproductive health, NCDs and nutrition and with no expenditure at all for injuries. It is however commendable that 4.3% of expenditure was towards non-disease specific and that is favorable for health system strengthening.

### 1.7.2 Pooling of Resources

Pooling is accomplished primarily through budget allocations to the MOH and other government agencies that provide health services like uniformed forces to defined populations. The GNHSP 2014-2020 calls for pooling of international partner resources through a Sector Wide Approach (SWAp). International partners have not however endorsed a SWAp arrangement. Instead, some international partners - mostly multilateral agencies, including the Global Fund for AIDS, TB and Malaria (GFATM), GAVI, UNICEF, UNFPA and WHO - channel funds through a separate MOH budget account that is disbursed under co-management terms by the MOH and contributing international partners. Bilateral international partners contribute a small percentage of resources for the health sector and most do not participate in this pooling arrangement. Most user fees collected at public health facilities are centralized to the national Drug Revolving Fund (DRF) managed at the National Treasury. Some user fees, for instance those collected at public health facilities designated as "Bamako Initiative health centers" and those participating in a Results Based Financing MCNHRP initiative, are pooled but not used at the health facility except D1000 that is kept by VDCS to replenish medicines and commodities at village level. There is lack of transparency and accountability in collection and utilization of the DRF at village level and at national level where health facilities deposit the money to treasury. There are no accessible records of the amounts of money collected and there is no system for tracking the expenditure of the DRF.

**Government Pools**

The Gambia has a national pool of resources as it provides a set of publicly funded services to all Gambians. There is a Consolidated Revenue Fund (CRF) and the Treasury Main Account (TMA) which serves as government pool. Gambia Revenue Authority (GRA) revenue collection is deposited on a special revenue account that is periodically transferred to the CRF and TMA (once a week). Funds are transferred from CRF to TMA on a cash basis, following approval by the Budget Director. The sub-treasuries have both an operation and a revenue account with the commercial banks all collected revenues are lodged into these accounts and are remitted to the CRF at the Central Bank. During budget execution, MoFEA through Accountant General Department allocate resources to different sectors including health from the CRF account.

However, current purchasing arrangements, limited resource availability and under-utilization 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).

**Multiple Pools of Development Assistance for Health**

There are multiple pools of donor funds finance vertical disease programs. 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 programs through the MOH. There is paucity of data on the actual amounts of operational funding that the MOH receives from donors such as Global Fund, UNFPA, UNDP, UNICEF and WHO except data for capital expenditure in the 2015 NHA. 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.[24] 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. Data from the 2015 NHA indicates that 63.5% of total capital expenditure was from the rest of the world and particularly Global Fund, UNDP, World Bank and UNICEF and WHO.

Contributory Schemes

There is private health insurance where employers contribute for their employees but the population covered is estimated at 4%. However the contribution of employers to total health

[24] NaNA Project Implementation Committee Reports

expenditure has increased remarkably by 77.8% from D 33,792,441.68 in the 2013 NHA to D 56,774,097.60 in the 2015 NHA indicating a growing contribution by employers.

In 2015, private health insurance expenditure was D56, 402,579.90 an increase of 34% from D42,126,838.28 in 2013 indicating a growing private health insurance industry. . Formal Community Based 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.

**Summary**

Overall, The Gambia's health sector is fragmented with numerous health resource pools and with limited to interaction between these pools. This does not support income and risk cross-subsidisation. Considering the decision to achieve UHC, it is imperative that barriers to risk and income cross subsidisation be removed. The level of fragmentation of health pools has to be reduced to the minimum possible. In addition, high fragmentation of pools is also associated with waste of resources due to duplication of efforts and administrative costs of managing relatively small but numerous pools. Under the current economic dispensation, improving efficiency is imperative.

### 1.7.3.Purchasing

This section focuses on the different purchasing arrangements used in The Gambia by government, development partners and the prepayment schemes. Most health services are "purchased" through allocations fragmented across central government agency budget line items and programs that in sum fund services provided at health facilities level. Civil service health worker services are likewise purchased through the Ministry of Finance and Economic Affairs' (MOFEA) and Personnel Management Office (PMO) through salary and emoluments payments. Funds for

medical products and supplies are allocated to Gambia Public Procurement Authority (GPPA) for purchasing. Facilities construction and maintenance budgets are allocated and managed separately. The MOH does purchase some services through outsourcing contracts such as for distribution of drugs and supplies and for central MOH transportation needs. Development partners (WHO,GAVI, UNFPA, UNDP, Global Fund) purchase services from MOH for their target areas of funding. Under a results-based financing (RBF) scheme, the MOH signed contracts with health facilities at the local level to provide coverage. The health facilities are paid by the National Nutrition Agency (NaNA) for achieved and verified results. As part of the RBF program the MOH also contracts with the Village Development Committee (VDC) and the Village Support Group (VSG) to provide health information and education services. In the limited, private health insurance market, schemes largely purchase services on a fee-for-service reimbursement basis.

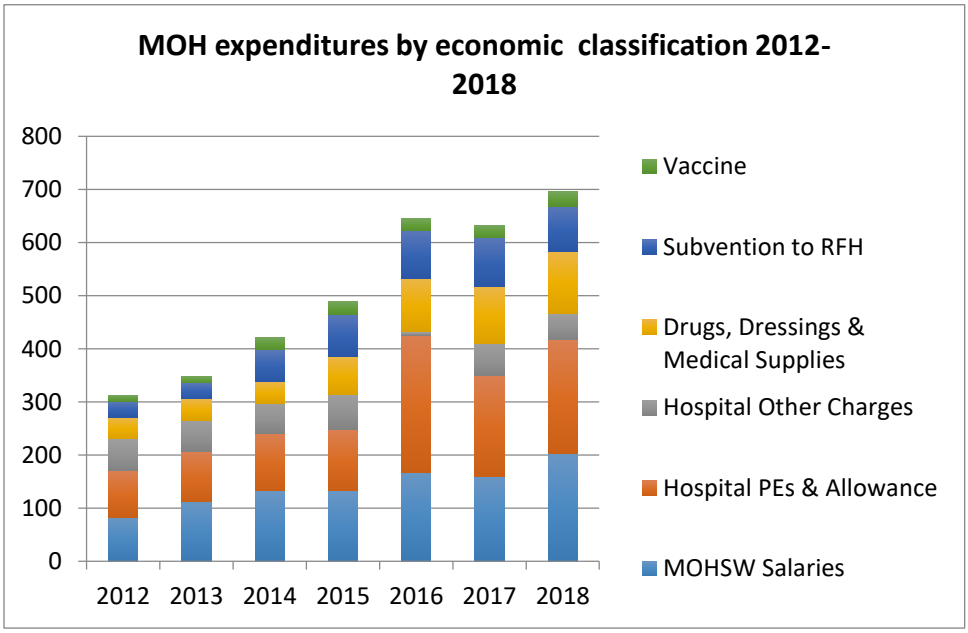
**Public Sector**

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 reduces the ability of the pool to impact financial protection and equity on a national scale. The government provides primary, secondary and tertiary care to the population through primary care, minor, major, and tertiary MOH health facilities. The main payment mechanism employed by the central government is an integrated approach. This involves program-based budgets and salaries for health personnel. The potential advantage of this approach is that it offers strong administrative control by government, and salaries by nature are incentive-neutral for either under-providing or over-providing services. However, the main disadvantage is that it does not offer the government good information to track and understand the right combination of interventions to use, or to promote efficiency and quality. In addition, it does not provide any direct incentive to the provider to provide the most cost-effective health interventions or to decrease costs. Patients pay user fees at point of care and the funds are channeled to the centralized Drug Revolving Fund that is not easily accessible to the facilities when they need the funds. VDCs keep 1000Dalasis (USD20) per month and the rest of the collections are deposited to the Regional Treasurer who also deposit the money to the national treasury. Health Institutions deposit the user fees into the DRF to National Treasury and are

supposed to access drugs from the National Pharmaceutical Stores using this facility. However all informants said there was lack of transparency in knowing how much money each VDC and Health Institution were entitled to in the DRF and no audit reports were available to show how the money is being utilized.

Mechanisms for a more strategic approach to purchasing have recently been introduced in MOH. Results Based Financing is being used in purchasing primary, secondary and tertiary care services from MOH by NaNA. The recently introduced Program Based Budgeting is also expected to strengthen the link between inputs and outputs towards more efficient purchasing from the government resources. Programme Based Budgeting distributes money by programmes or functional areas and therefore aligns spending with programme objectives.

**Figure 6: MOH expenditures by economic classification 2012-2018**




Source: Ministry of Health Directorate of Planning and Information

The MOH budget allocation has increased over time. However the greater proportion of the budget (31%) was used to pay for Hospital Personnel Emoluments and Allowances followed by MOH

salaries (29%) in 2018. Purchasing of drugs, dressings and medical supplies has risen steadily from 9% of the budget in 2014 to 15% in 2018 but remains unacceptably low compared with the 60% spent on salaries and allowances[25]. Although the health sector is a human resource intense sector, there is need to ensure availability of the tools to ascertain effective quality coverage of health services. There is a budget used to pay for foreign medical trips and treatment abroad.

**Development Partners**

Most development partners use the traditional input financing to purchase services mostly through vertical disease control programs funded through a co-monitored account at MOH that is separate from the MOH budget account. The WHO, UNICEF, UNDP, Global Fund and GAVI purchase services according to specific disease control programs through an account that is managed by the Program Coordination Unit (PCU) in MOH. The table below shows services purchased by partners according to the 2015 NHA

**Table 5. Proportions of Current Health Expenditure from Government of Gambia and Rest of the world**

| Financing Source | Infectious & Parasitic diseases | Reproductive Health | Non-Communicable Diseases | Injuries | Non-Disease Specific | Other | Nutrition Deficit |
|---|---|---|---|---|---|---|---|
| % of CHE by Government of Gambia | 16.5 | 5 | 11.6 | 0 | 2.3 | 0.3 | 0 |

[25] Ministry of Health Directorate of Planning and Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| % of Rest of the world | 30.6 | 1 | 0.1 | 0 | 4.3 | 0 | 0.3 |

Source: The Gambia National Health Accounts 2015

The Maternal and Child Nutrition and Health Results Project (MCNHR Project), supported by the World Bank, is the first RBF initiative implemented in The Gambia. This ongoing project is implemented by the NaNA and the MOH is the first effort to expand purchasing arrangements for public sector services beyond Program Based Budgeting. As indicated by the project title, this arrangement pertains only to maternal and child (under age 5) health services. Other services provided by participating health facilities are not covered by this initiative. Incentive payments are made to both participating health facilities and to Village Support Groups based on verified performance against pre-determined service delivery targets and for various health promotion community activities. 60% of facility-based performance payments must be spent to improve facility conditions and to maintain adequate stocks of essential medicines and supplies. 40% of the funds can be spent on staff incentive payments[26]. At the time of the health system assessment, the RBF initiative was being implemented in nearly one-quarter of all health facilities in the project's five implementation regions (nearly 20% of all health facilities nationwide). Project plans include further roll-out to reach a total of 600 facilities (one-third of all facilities nationwide). It is worth noting that the project design includes graduating health facilities (and communities) after 2 years of participation and presumed achievement of facility and service quality improvement goals. Thereafter, purchasing of maternal and child health services at graduated facilities reverts to the MOH program-based budgeting approach.

The RBF initiative has shown promising results towards increasing access to and use of health facilities by the target population groups and improving health outcomes. There is consensus that RBF has improved the quality of care and readiness of health facilities, particularly health centers, and has restored trust among communities in the services rendered at those facilities[27]. The MOH has adopted RBF as a funding mechanism to increase the proportion of spending devoted to PHC,

[26] Results Based Financing Project Operational Manual 2017

[27] Assessment of the Health System of The Gambia 2018

a major goal of the MOH, and to contribute to the goal of shifting demand for primary health care services away from hospitals and back to the primary care level.

**Private Sector**

Private, commercial health insurance schemes in The Gambia purchase services on a fee-for-service basis. There are numerous challenges to insurance-mediated purchasing arrangements, including control of benefits use by non-enrolled persons (usually extended family members not included on the scheme's "immediate family" enrollees list), over provision and over billing of services by providers[2829], and lack of effective claims verification. Some insurance schemes attempt to control costs by placing limits on the maximum value of benefits that can be claimed for an enrolled beneficiary and her/his family unit. The MOH DPI staffs have little knowledge of the benefits packages offered through these private insurance schemes.[30]

A substantial proportion of OOP spending by consumers is through direct purchase of health goods and services. As noted earlier, it is estimated that less than 10 % of all health care services provided in The Gambia are from private providers. However given extensive medical products stock-outs at public sector health facilities, consumers directly purchase a large quantity of pharmaceutical supplies and medical products from private pharmacies.[31] Private employers either contribute to their employee's private health insurance or pay for the services provided to their employee by a private health provider.

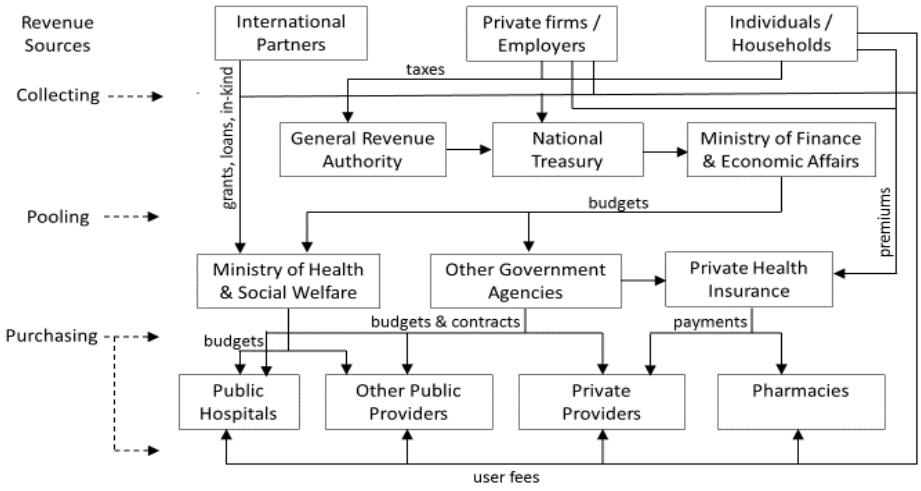
**Figure 7: Health Financing Flowchart for the Gambia**

[28] Langenbrunner, J.C. and Liu, X. 2005. How to pay? Understanding and using payment incentives. In: Spending Wisely: Buying health services for the poor. Eds Preker, A.S. and Langenbrunner, J.C. The World Bank, Washington D.C.

[29] Jegers, M., Kesteloot, K.,De Graeve, D., Gilles, W. 2002. A typology for provider payment systems in health care. Health Policy 60 255-273

[30] Assessment of the Health System of The Gambia Report 2018

[31] Assessment of the Health System of The Gambia 2018




Source: Assessment of the Health System of The Gambia 2018

**Summary of the Diagnosis of The Gambia's Health Financing System**

A SWOT analysis of the key challenges identified in the section above that need to be addressed if the country is to move towards UHC is provided below.

**Revenue Generation**

- Low government budget allocation to the health sector
- Challenges with program planning, budgeting and budget disbursement
- Very low budget allocation to capital expenditure
- Unpredictability in level of external funding
- Inadequate levels of stewardship and coordination of external funding
- External funding not necessarily aligned to country's priorities in context of limited resources

- High out-of-pocket expenditures, which have resulted in catastrophic payments
- Poor adherence to Public Financial Management practices
- Budgeting process not sufficiently linked to health needs
- Inaccessibility of Drug Revolving Fund when required for use by facilities
- Un-quantified funding in the private sector

**Pooling**

- High fragmentation of resource pools across the entire sector with likelihood of duplication and overlap in the use of resources
- Inadequate levels of coordination and complementarity between different resource pools
- Inadequacy of mechanisms for income and risk cross subsidization across the contributory schemes
- Huge informal sector difficult to register for health insurance
- Inadequate human capacity for health financing

**Strategic Purchasing**

- Provider payment arrangements not sufficiently linked to health provider performance
- Sustainability challenges for RBF program
- Inadequate capacity in MOH for strategic purchasing
- Resource allocation does not sufficiently consider health needs
- Essential benefit package not fully defined for all levels of care
- Referral system is not working effectively
- Inadequate coordination between levels of government and donors
- Separation of provider and purchaser roles not sufficiently demarcated within public sector

- Lack of transparency and accountability in utilization of the DRF
- Huge payments for foreign medical services provided abroad

Chapter 2 : Strategies for Reform of Health Financing Arrangements

## 2.1. Strategic Agenda

The strategies outlined in this section are developed according to the three main Health Financing functions. Based on the main issues raised in the previous chapter, 'key areas of intervention' have been identified. Under each of these areas for intervention, a set of strategies are outlined for bringing about the necessary change in financing arrangements. Detailed implementation guidelines and operational activities necessary for each of the strategies will be developed in an implementation matrix including a monitoring and evaluation framework.. The strategies outlined provide broad guidance around what needs to be done. For most of these strategies, details around how they are to be operationally achieved will still need to be determined by the MOH. For each strategy, one or more institutions are identified as responsible (or critical) for its successful implementation. The Technical Working Group of the Health Financing Strategy under the guidance of the MOH will identify the specific units, departments or individuals within these institutions who will be responsible for implementing the strategies.

For each financing function, high priority strategies are identified. These are strategies of higher importance and must be implemented at the minimum. Factors considered in identifying these priority strategies are cost of implementation, impact on priority health programmes, and sequencing of strategies. Given the current financial dispensation, strategies that require minimal cost and have the potential to significantly improve efficiency and fiscal space are prioritised. In

addition, the level of success and impact of some strategies will depend on changes from other strategies. Some of the proposed reform initiatives to be implemented will require institutional and regulatory changes in order for them to be successfully implemented. These required arrangements are discussed in Chapter 5.

The timelines proposed for strategies are in three categories

- Strategies listed under short-term are those that are to be initiated and carried out within the first 2 years of the reform period (2019-2020);
- Medium term strategies are those that are to be implemented around 2 to 5 years from the initiation of the Health Financing Strategy (2021-2024);

**Vision**

Sustainable Universal Health Coverage (UHC) for everyone living in The Gambia by 2030

**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.

**Goal**

To ensure adequate and sustainable resource mobilization for health care services and to ensure universal membership of the population whilst improving allocative efficiency and technical efficiency in utilization of resources.

Strategic Objectives

1. To mobilize more resources for health from the current $ 29 PPP per capita from the Government of The Gambia to $60PPP per capita by 2024

2. To reduce the pools of funding for health care from the current ten pools to six virtual pools by 2024

3. To ensure strategic purchasing of quality health services from accredited health facilities and institutions by 2024

Guiding Principles and Values

Underpinning the MOH's mission are the following values that will guide the Health Financing Strategy at all levels:

- Social solidarity
- Equity in health and health care
- Gender equality
- Healthcare as a right and shared responsibility
- Essential quality services integrating comprehensive primary health care
- Cost benefit and value for money
- Efficiency
- Appropriateness
- Affordability
- Public participation and user and provider satisfaction
- Transparency and accountability
- Ownership and
- Partnership in health.

## 2.2 Strategic intervention Area One: Mobilize More Resources for Health

The Gambian health system relies significantly on external assistance and direct out of pocket payments from households. Consequently, strategies to raise revenues should aim to increase efficiency and equity in healthcare financing. In the context of The Gambia, the end goal of raising revenue for health is twofold: increasing the share of public spending on health (equity lens) and moving towards more predictable and sustainable level of public funding (efficiency lens). Based on international experience, in raising revenues for health, two guiding principles should prevail:

- Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation Increase predictability in the level of public (and external) funding over a period of years
- Improve coordination in program planning and budgeting of public and external funds during any given year for allocation efficiency

As noted in chapter 3, the most critical challenge around financing of health care is the limited financial resources for health. Creating fiscal space can be done through:

(i) Improving overall macroeconomic and fiscal conditions;
(ii) Prioritizing health sector within the government budget through reallocation from other sectors;
(iii) Increasing the pool of tax payers;
(iv) Increase external funding of health by loans and/or grants from development assistance for health; and
(v) Improving efficiency in the use of available resources for health.

Feasible options recommended include firstly, improving efficiency in the use of financial resources for health, secondly, instituting earmarked taxes for the health sector and exploring opportunities for public private partnerships in revenue generation. The GOTG will continue to explore options for raising revenue in a more equitable and efficient manner. Following consultations among stakeholders, the option for allocating more public sector resources to the health sector has been considered as an additional approach to raising revenue for health.

The strategies identified for improving revenue raising are presented in the table below.
The table includes key intervention areas and priority interventions within each of these areas. Guidance on sequencing of the interventions and responsible institution are listed in the third and fourth columns respectively.

Table 4.1: **Strategic interventions for Mobilizing More Resources for Health**

| Area of Intervention | Priority Interventions | Timeframe | Responsible Entity |
|---|---|---|---|
| **1. Increase efficiency gains from existing resources** | 1.1 Build institutional capacity for sustainable health financing at all levels of the health system-program planning, budgeting and coordination | Short term | PS1 |
| | 1.2 Review of structures of the MOH to elicit greater efficiency | Short term | PS1& Principal Planner |
| | 1.3Place greater emphasis on investment in and implementation of interventions targeted at prevention-Revitalize PHC | Short term | DHS/Program manager PHC |
| | 1.4. Conduct a private sector assessment and examine potential for public-private-partnerships | | |

| | | | |
|---|---|---|---|
| **2. Increased reliance on public resources for the health sector** | 2.1. Conduct a Fiscal Space Analysis<br><br>2.2. Organize an advocacy meeting for National Assembly and MOFEA to increase the funds allocated to MOH and Social Welfare (fulfil Abuja targets) | Short term<br><br>Short term | Head, HF Unit<br><br>Director, DPI/Minister |
| **3. Innovative health financing mechanisms** | 3.1. Advocate 100% allocation of the Tobacco, alcohol tax and hazardous products (sin-tax) to the MOH.<br><br>3.2 Ring-fence taxes on airtime and internet data for health<br>3.3 Introduce mechanisms that allows communities to contribute to health system strengthening<br><br>3.4.Develop a framework for Public Private Partnerships<br><br>3.5Factor in costs of health care in environmental impact assessments for new businesses | Short term<br><br>Medium term<br><br>Medium term<br><br>Medium term | PS,/Minister<br><br>PS/Minister<br><br>PS/Minister<br><br>PS , Minister |
| **4.Program planning and Budgeting** | 4.1 Advocate for improved predictability and availability of public resources<br>4.2Strengthen capacity to monitor performance around PFM and enforce lines of accountability | Short term<br><br>Short term | PS, Minister<br><br>PS; MoH/MoFEA |

| | | | |
|---|---|---|---|
| **5.Improve the predictability and level of external resources** | 5.1 Strengthen mandate and capacity of the PCU for donor coordination by implementing the COMPACT<br><br>5.2 Include all donor funds in the medium term expenditure framwork<br><br>5.3 Set up virtual pool of funds for donors and make sure external assistance is reported on the budget | Short term<br><br>Short term | PS MoH/DPI<br><br>PS1/DPI |
| **6.Improve efficiency of external assistance on health** | 6.1Use donor mapping to identify redundancies and underfunded programs<br><br>6.2Develop clear multiannual plans so that development partners can align on planned activities | Short term<br><br>Short term | Director DPI<br><br>Principal Planner |
| **7. Increase the contribution of prepayment to the health sector** | 6.1Assessment of other prepayment schemes to raise revenue<br><br>6.2 Assessment of appropriateness of a mandatory National Health Insurance scheme | Short term<br><br>Short term | Director, DPI<br><br>PS1, HF Unit |

### 2.2.1 Increase efficiency gains from existing resources

Getting more value for the available health resources through efficiency gains is critical given the limited scope for increased allocations to health. Numerous informants during the Health System

assessment[32] stated that current MOH structure presents considerable challenges to cross-program planning, coordination and collaboration. Most agree that ten health directorates and the large "proliferating and fragmented" number of programs under each directorate, coupled with non-technical leadership at the top of the structure does not promote strong governance and leads to considerable inefficiency in resource use. The MOH will review its existing structures, processes, positions, committees and programmes within the Ministry to eliminate duplication, redundancy and wastage. This includes ensuring that processes for planning, programming and budgeting are coordinated by the DPI and are inclusive of all health sector players and stakeholders. Activities such as an audit of the health system to identify bottlenecks and areas for intervention in the broader health system will be carried out. Other initiatives to improve efficiency will include the following:

- Reducing the transaction costs associated with the multiplicity of actors in supply chain of pharmaceutical products. This would entail improving the level of coordination among different entities involved in the purchase of pharmaceutical products, and instituting government-led price negotiation for essential medicines to the public sector. In addition, the government will invest in the capacity of Central Medical Stores (in purchasing, storage, skills and systems, and distribution) to procure, store and distribute pharmaceutical supplies for the public health system.
- Reducing the burden of ill-health through disease prevention is an efficient way of addressing health challenges and will be given greater emphasis in health expenditure going forward. The MOH will expedite the implementation of the Primary Health Care Roadmap.
- The MOH will reduce administrative costs such as foreign travel and workshops and seminars away from the workplace
- MOH will reduce overseas travel for medical treatment and channel resources to strengthening The Gambia Health System
- MOH will drive a review of the activities of the private medical insurance and develop a regulatory framework that ensures value for money for private medical insurance members

[32] Assessment of Health System in The Gambia-overview, Medical Products, Health Financing and Leadership and Governance components 2018

- The MOH will also ensure that additional resource generated for the health sector increases the proportion of total health expenditure that is accounted for by non-wage expenditure. Although the health sector is a human-resource intensive sector, without the necessary medical supplies, productivity of paid health workers (both quality and quantity) remains sub-optimal.

### 2.2.2 Increasing reliance on public resources for the health sector

The MOH will work with relevant ministries and levels of government to ensure that allocations to the health sector appropriately represents the level of priority placed on the health sector, relative to other sectors. The National Assembly Select Committee on Health Assessment[33] expressed the need to keep the committee in the loop always to strengthen their insight and capacity for debate that is favorable for Health Financing in parliament. They expressed high commitment to drive debate on enacting new laws to implement Health Sector Reform given that health sector legislation in The Gambia is outdated[17]. Most legislation dates from the 1980s and provides broad powers to the MOH and the regulatory councils. The MOH plans to update legislation to better address emerging priorities, including the commitment to achieve UHC, regulating the health professions, and address financial and operational sustainability issues[34]. This will include the use of both international and domestic empirical evidence on health needs and expenditure. In addition, the MOH will ensure that pattern of public funding of health programmes are reflective of their levels of priority even where external funding to the sector declines.

### 2.2.3 Improve the predictability and level of external resources

[33] Key Informant Interviews with the seven members of The National Assembly Select Committee on Health Assessment

[34] Assessment of the Health System of The Gambia Report 2018

As the main point of operational engagement with development partners, the capacity of the Directorate of Planning and Information will be strengthened to include skills and resources necessary to effectively engage with development partners. This will include an assessment of skills gap, and subsequent hiring of the required staff. In addition, to prevent inefficiencies associated with parallel engagements between development partners and government, this Unit will be empowered to engage with all development partners on behalf of the MOH. The specific aspects and levels of the engagements with development partners that will fall under the jurisdiction of the Unit will be determined by the MOH given that there currently is the Central Project Coordinating Unit (CPCU) at MOFEA and PCU at MOH that development partners are channelling funding through. The Health System Assessment report recommends that the existing SWAp mechanisms for aligning projects to polices and strategies could be extended to coordinate project inputs, as a precursor to developing truly integrated oversight and management of health programming within the MOH.

A more capacitated Planning and Information Unit is also better equipped to outline the needs of the government to development partners, and secure assistance in a manner that is more predictable and in line with the unique health needs of The Gambia. The MOH also intends to explore options for leveraging resources from the private sector. In addition to engaging with donors, the DPI will identify areas of possible collaboration with the private sector and support the development of a policy framework for public-private-partnership. The use of a virtual pool will afford better coordination of donor funding.

### 2.2.4 Improve efficiency of external assistance on health

Mapping of donor funds points out who the donors are, how much they are contributing and where these contributions are being made. Donor mapping will therefore help with the identification of areas where there are redundancies and duplication of donor effort. In addition, it will be useful in identifying areas that donor support can have a greater impact on the health system. These are crucial in informing a shift in the distribution of donor funds for greater efficiency and equity. Short, medium and long-term health plans provide development partners with a better sense of current and future health priorities and are therefore useful to ensure that activities of donors are

in alignment with The Gambia's priorities. The MOH and Development Partners will ensure that annual Resource Mapping reports are produced and annual National Health Accounts are institutionalized to provide evidence for decision making in resource allocation.

### 2.2.5 Increase the contribution of prepayment to the health sector

The long-term plan of the MOH is to implement a mandatory health insurance scheme. The specific nature and structure of the scheme is still being debated in the policy arena. Options such as a National Health Insurance Scheme are under consideration. In the short-medium term, the MOH will work towards using prepayment contributions to increase available resources for health. The most feasible opportunity in the short term is to implement a mandatory pre-payment scheme for all civil servants and other formal sector employees that are not insured. The MOH will do assessments of the feasibility of other types of prepayment schemes to finance the health sector.

### 2.2.6 Innovative health financing mechanisms

The Government of The Gambia will explore options for improving existing resource generation mechanisms for health and introducing new innovative approaches for generating resources but should take cognisance of the fact that the National Assembly Select Committee for Health advocates for more scrutiny for how Gambia Revenue Authority revenue is utilized because they felt that citizens are already over taxed in the Gambia. The Gambia Revenue Authority who were very grateful for being involved in formulating the HFS, promised that they would use the experience with tobacco tax and green tea tax in looking at other innovative financing mechanisms for health care .The MOH will advocate for ring-fencing and allocation of sin-taxes from tobacco, alcohol and other hazardous substances to health and work closely with the Ministry of Finance and Economic Affairs to get buy in and make this a reality. The GOTG can also consider introduction of taxes on mobile airtime and data and allocate them to the health sector as has been

done in Zimbabwe.[35]The GOTG can consider introducing third party insurance such as the Workers Compensation Fund and the Road Accident Fund[36]. The Government of The Gambia will continue to consider other innovative ways of increasing revenue from taxation for health, especially from the informal sector. In addition, there are cases where individuals and communities are interested in contributing to the health system. The government will establish formalised mechanisms that facilitate such contributions and partnerships with individuals and communities in strengthening the health system.

### 2.2.7 Improve Planning and Budgeting

MOH will work closely with the MOFEA to ensure that allocations to the health sector are made on time and that there is a better communication around what resources will be available to the health sector in the future. MOH will advocate for revising the budget development process so that MOH input is sought during budget revisions in response to Cabinet comments and then again based on National Assembly comments.

The MOFEA should allow MOH greater cross-program reallocation discretion based on under- and over- performance of program specific budget without requiring MOFEA approval.

MOH will assess the current expenditures tracking system, revise and institutionalize it within the DPI or another appropriate MOH unit to improve regular reporting and access to results.

MHOSW will conduct regional level health accounts analyses to map sources and uses of funds in each region and use results to identify region-level health financing gaps and to delineate needs, options and advantages for re-establishing direct funding to RHDs. MOH will concurrently re-institute regional RHD subventions and create capacity for strengthening financial planning and management skills. One possibility to improve the regional health financing environment would be to consider allowing a certain proportion of regional level DRF resources collected to be retained by RHDs for programming use, with a requirement for regular regional DRF accounts to be produced and transparently made accessible to the public. MOH will consider synchronization

[35] The Government of Zimbabwe introduced a 5% tax on mobile airtime and data in 2017 called the Health Levy Fund

[36] The National Social Security Authority in Zimbabwe administers the Workers Compensation Fund

of central MOH program level work plans with RHD work plans. This may be promoted by requiring that region-based activities organized by central MOH programs receive co-funding buy-in from respective RHDs. MOH will consider improving local government financial tracking systems and transparency in resource uses for local council finances, local DRF offices, and MOH expenditures through its central level Directorate for Health Services. In addition, MOH will ensure that there is clarity and consistency in the communication of priority needs to MOFEA. [37]

### 2.2.8 Institutional mechanisms for sustainable financing

The Gambia Revenue Authority during interviews recommended the use of Public Expenditure Review (PERs) by the MOH in making evidence based decisions for sustainable health financing. The MOH will ensure that routine information on health expenditure, including associated processes and outcomes are made available when they are due, and are used to inform decision making on issues relating to health financing. In addition, the MOH will ensure that information on financing and expenditure is routinely generated and used to inform health financing policy. MOH will respond to audit observations timely and effectively address audit observations.

### 2.2.9 Priority Strategies for Raising Revenue

Priority strategies for raising revenue achieve two important objectives in the short term. They increase fiscal space with minimal cost to the MOH, and improves public financial management necessary for increased efficiency and reduction in leakages within the public health system. These are:

1. MOH will ccomplete an in-depth analysis of international partner funding and trends and include in the analysis an assessment of means to increase the efficiency of international partner direct funding support to MOH programs including development of clear multi-annual; plans for the health sector
2. Conduct a Fiscal Space Analysis (FSA) to identify current and expected short- and mid-term resource pool changes and produce a Resource Mobilization Plan (RMP) to guide

[37] 4.1.7 are Recommendations from the Assessment of the Health System of The Gambia 2018

domestic public and private, and international resource mobilization efforts. As part of the FSA, place special emphasis on assessment of efficiency in current health resource use and to quantify resource mobilization potential by narrowing efficiency gaps

3. Conduct a comprehensive private sector assessment (including traditional providers), including mapping its current geographic coverage and distribution, services provided and a profile of its patrons (market segments). Examine the potential for public-private partnerships to close the large gap between resources needed to fully fund the BHCP and available public budget resources. Support development of a stronger private sector regulatory framework, especially regarding licensing and quality monitoring that incentivizes responsible and responsive private sector expansion.

These strategies can create fiscal space in the short term to allow for shifts in the pattern of health expenditure in greater favour of higher priority programmes and groups.

4. Advocacy for National Assembly and MOFEA to increase the funds allocated to MOH (fulfil Abuja targets)

5. Advocate 100% allocation of the Tobacco, alcohol tax and hazardous products (sin-tax) to the MOH.

6. Ring-fence taxes on airtime and internet data for health

7. Introduce mechanisms that allows communities to contribute to health system strengthening

8. Develop a framework for Public Private Partnerships

### 2.3. Strategic Intervention Area two: Pooling Resources for Health

Improving resource pooling for the health sector is mainly to:

1. Enhance financial and health risk redistribution,
2. Enable complementarity of different funding pools
3. Reduce fragmentation of pools, and

4. Simplify flow of funds for the health sector[38].

In many cases, improving resource pooling can be achieved by merging risk pools, introducing risk-equalisation mechanisms, redefine benefit packages, and creating incentives for better coordination and complementarity of pools. These strategies have been considered for the Gambian context and applied where appropriate. As noted in previous sections, the Government of The Gambia has a long-term vision to implement a mandatory health insurance scheme. Although, the exact nature of this scheme is still under consideration, this vision offers some guidance for the strategies employed for improving pooling arrangements. Pooling health financing resources into one main pool is a desirable target for managing health funds. This is because of the potential for efficiency gains from economies of scale, lack of duplication, easier coordination of resources and resulting monopsony purchasing. Consequently, reduction in risk pools is often proposed in the reform of pooling arrangements. Within the short-medium term, reduction of risk pools will be done within sub-sectors as this is more feasible, administratively and functionally. These sub-sectors are government, development assistance and private sector. Where appropriate, other initiatives for improving pooling arrangements are proposed.

**Table 4.2:**

| Pooling | Priority Interventions | Timeframe | Responsible Entity |
|---|---|---|---|
| **1. Pooling and Decentralizing Government Health Funds** | 1.1. Strengthen equalisation mechanism across local authorities.<br>1.2. Strengthen integration of | Medium Term<br><br>Short Term | PS 1/DPI<br><br>Director of Planning/Head Int. Audit |

[38] Kutzin J; Witter S; Jowett M; Bayarsaikhan D (2017) Developing a national health financing strategy: a reference guide. Health Financing Guidance Series No 3. World Health Organisation

| | | | |
|---|---|---|---|
| | monitoring and reporting of the DRF and MOH funds.<br><br>1.3. Ensure reporting of funds used for foreign medical trips on MOH funds<br><br>1.4.Establish a virtual basket of all public funds | Short Term<br><br>Short Term | Director of Planning/Head Int. Audit<br><br>PS/DPI |
| **2.Pool Donor and Non-governmental Organisations Health Funds** | 2.1Establish a virtual sector-wide coordination of all donor and non-governmental organisations health funds.<br>2.2Develop virtually integrated monitoring and reporting of the funds. | Short Term<br><br>Short Term | PS<br><br>PS |
| **3. Private Health Funds** | 3.1Quantify and map the potential of private funds<br><br>3.2.Develop regulation framework for the medical schemes environment | Short Term | Principal Planner |

| | | | |
|---|---|---|---|
| **4.Pooling Government, Donor and Non-Governmental Health funds** | 4.1Establish a virtual basket of all public and donor health funds.<br>4.2Develop joint accounting, monitoring and reporting of the funds. | Long Term | PS/Minister |

### 2.3.1.Pooling of government resources

A single pool of government resources such as a mandatory health insurance scheme, has the potential for significant efficiency gains. This is the objective for the long-term. As the overall resource envelop grows, pools can be merged with the larger main health pool .MOH will seek support for feasibility analyses for launching a national Social Health Insurance (SHI) scheme and directly budget funds to be managed by a SHI agency to reimburse for health services to beneficiaries. MOH will explicitly assess costs and approaches to identifying and enrolling low income Gambians as a measure to increase the degree of financial protection accorded the country's large poor population. The GOTG should consider alternative financing sources to expand resource pools, such as charging premiums to civil servants for SHI and providing access to SHI for formal sector employees, sin tax earmarks, etc. especially to subsidize premiums for the poor and informal sector workers. MOH will conduct a formal audit of the DRF, from the health facility level to the central office at the National Treasury that includes identification of sources and uses of revenue and a map of the flow of funds into and out of the DRF system. Create a formal accountability framework for resource inflows (user fee tracking) and outflows (where the funds are spent, including costs of administering the DRF). Conduct an analysis of the DRF policy and regulatory framework to identify reform needs to improve transparency and accountability at all levels. MOH will conduct a formal study of user fee policy implementation including consistency

of application, incidence of waivers provided, the formal and informal criteria used to determine for whom the waivers are provided, when and for what services, and incidence and circumstances of informal fees paid by clients. The MOH pool will have to include the DRF, Local Government pool and Uniformed Forces pool. The MOH may even allow RHDs and facilities to retain a certain proportion of the user fees fund. Pools that are merged in the short-medium term will continue to maintain their 'separate' sources of funds but would collapse into a single virtual pool at the purchasing stage, thus respecting existing mutual and statutory boundaries, but however, working with a common framework and standard operating procedures. In addition to pooling government funds, an equalisation mechanism is proposed to ensure that lower revenue generating capacity for local authorities does not impede their ability to provide equal quality and quantity of health care services.

### 2.3.2.Pooling of donor funds

In the short to medium term, the objective is to increase the number and proportion of donor funds that are pooled together in the PCU. The success of the PCU, which as a pooled fund of different donors, shows that multiple pools can coexist without fragmentation if there is commitment to work together and share common plans and frameworks. It is envisaged that in the short to medium, membership and participation of donors and Non-Governmental Organizations should be mandatory. Financial and organizational autonomy of the partners would be respected in as far as reporting and accounting for their funds, while the disbursements of the pooled funds would be coordinated by the coordination units. In the long term though, this virtual pool should morph into the fund for the proposed mandatory health insurance scheme.

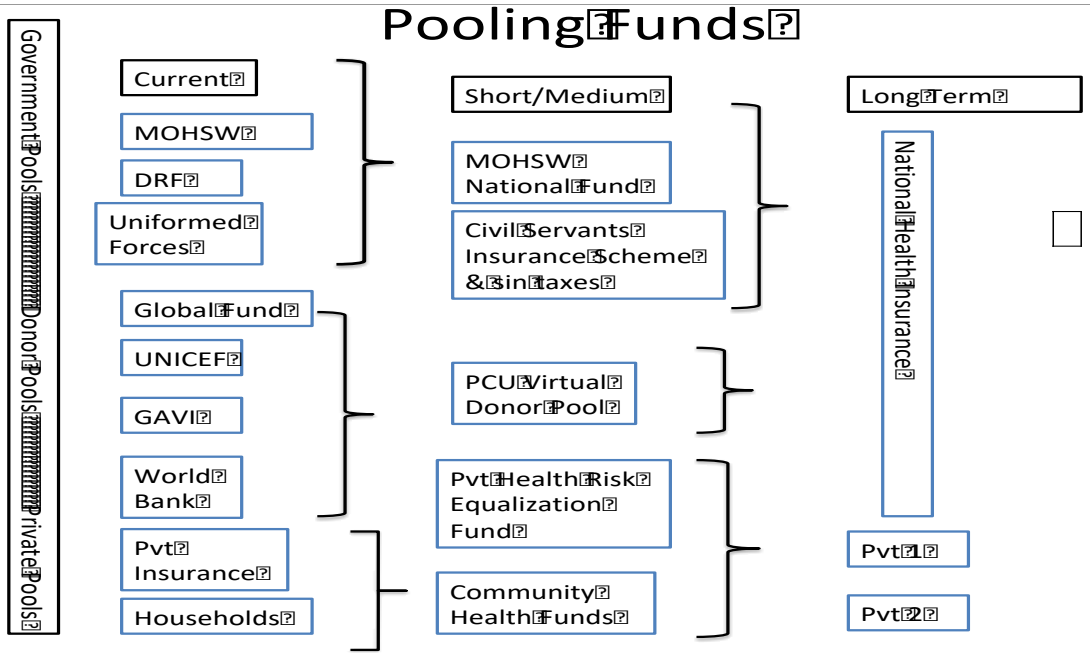
### 2.3.3. Pooling of private funds

The private health insurance environment is very small in The Gambia although it has grown remarkably between the NHA 2013 and NHA 2015. The MOH will conduct a comprehensive

private sector assessment (including traditional providers), including mapping its current geographic coverage and distribution, services provided and a profile of its patrons (market segments). MOH will examine the potential for public-private partnerships to close the large gap between resources needed to fully fund the BHCP and available public budget resources. MOH will also support development of a stronger private sector regulatory framework, especially regarding licensing and quality monitoring that incentivizes responsible and responsive private sector expansion.

Figure 8 provides a diagrammatical representation of a generic progression from the current state to short-medium term objectives and the long-term goal of a mandatory health insurance scheme. The long term objective is depicted as a mandatory Health Insurance Scheme which pools resources from the government, donors, private health insurance, communities and households. A single fund would require that the pooling of funds be done at source rather than at purchasing stage. Unlike the virtual pool, this fund would involve a structural integration of all the funding pools and a simplified general tax financed scheme. For the mandatory health insurance scheme to operate effectively, some level of fiscal decentralisation may have to be sacrificed. A purely unitary fund would require that there be a single comprehensive benefit package and a single payer organisation purchasing services and using uniform rates. However, private health insurance will remain a supplementary option, specifically for higher and more sophisticated levels of care.

**Figure 8. Diagrammatical representation of generic progression from current state to long term goal of mandatory health insurance scheme**




Source: Adapted from Authors of The Zimbabwe National Health Financing Strategy 2018

## 2.4. Strategic Area three: Purchasing of Health Services

Under the very constrained economic and fiscal environment, improving efficiency in the use of available pooled financial resources for health care is of critical importance to the MOH. The MOH intends to continuously improve purchasing arrangements to maximise health system performance by adopting a more strategic approach. The MOH will be more purposeful in creating the necessary incentives to promote efficiency, sustainability and equity around how financial resources are allocated and how health services are paid for; both in the public and private sector. This includes ensuring that resources are allocated according to need and in line with health system priorities.

The main purchasers of health services are the government (MOH and DRF), development partners and NGOs, and the private sector (medical insurance and households/individuals). In improving the purchasing of health services, the Government of The Gambia moved away from

input-based line item budgets in 2015 as they entrench and exacerbate inequities in access to care, without creating necessary incentives for delivery of high quality health care in a cost-effective manner and is using Program Based Budgeting. Program Based Budgeting needs to be supported by strategies that are designed to hold providers more accountable for the services they deliver and to be more responsive to the often unique health needs of the different (geographic, demographic, and socio- economic) population groups.

The main areas of focus for reform purchasing arrangements and specific interventions are described the in Table 4.3 below.

Table 4.3: Priority Strategies for Purchasing Health Services

| Area of intervention | Priority interventions | Timing | Institution responsible |
|---|---|---|---|
| **1.Improve utilization of the Drug Revolving Fund** | 1.1 Strengthen capacity and improve governance of Central Medical Stores to procure, store and distribute medicines and pharmaceutical supplies to all health facilities in the country<br>1.3 Implement sector-wide approach to use of donor funds in procuring medicines and pharmaceutical supplies | Short Term<br>Short Term | PS/Dir NPS<br>Dir Planning |
| **2. Introduce strategic purchasing** | 2.2 Strengthen capacity for strategic purchasing within MOH and establishment of a dedicated purchasing unit | Short Term | PS/DHRH |
| **3. Strengthen Results Based Financing** | 3.1 Build Capacity for full institutionalisation of RBF across levels of care and services<br>3.4 Ensure sustainability of RBF through innovative financing mechanisms | Medium Term<br>Medium Term<br>Short Term | PS/DHRH<br>PS<br>PS |

| | | | |
|---|---|---|---|
| | 3.5 Ensure Implementation of the RBF Sustainability Roadmap | | |
| **4. Equitable Resource Allocation** | 4.1Develop and implement needs-based resource allocation formula | Short Term | Principal Planner |
| **5.Ensure equitable and efficient delivery of Benefit Package** | 5.1Articulate the Benefit Package on a realistic resource envelope<br>5.3 Strengthen referral system by using financing incentives to improve quality | Medium Term<br>Short Term | PS Program Manager QA |

*Improve Utilization of the Drug Revolving Fund*

The MOH has moved from fragmented purchasing of drugs that is inefficient to a sector wide international tender system. However accountability for users fees collected and utilization of the centralized DRF remain a major challenge. MOH will conduct a formal audit of the DRF, from the health facility level to the central office at the National Treasury that includes identification of sources and uses of revenue and a map of the flow of funds into and out of the DRF system. There is need to create a formal accountability framework for resource inflows (user fee tracking) and outflows (where the funds are spent, including costs of administering the DRF). Conduct an analysis of the DRF policy and regulatory framework to identify reform needs to improve transparency and accountability at all levels. MOH will conduct a formal study of user fee policy implementation including consistency of application, incidence of waivers provided, the formal and informal criteria used to determine for whom the waivers are provided, when and for what services, and incidence and circumstances of informal fees paid by clients.

### 2.4.1 Introduce strategic purchasing

The MOH will conduct an assessment of various aspects of its current system responsible for purchasing functions to identify areas that require improvement in order to effectively institute strategic purchasing. This will include a review of skills, financial management regulations, data requirements, levels of autonomy of providers, etc. Based on this assessment, specific activities will be outlined to improve the ability of the MOH to strategically purchase health services. These activities will address weak control mechanisms around compliance and performance, and will precede the establishment of a dedicated unit responsible for strategic purchasing. Establishment of a Strategic Purchasing Unit, will also create a clearer distinction between provider and purchaser roles within the MOH. Key areas of oversight and enforcement for strategic purchasing functions include price regulation, provider-payment mechanisms, accreditation of service providers, and innovative purchasing mechanisms. This Unit will also be responsible for strategic purchasing from the private sector. The development of strategic purchasing capacity and the establishment of a Strategic Purchasing Unit will be coordinated with the progression in pooling arrangements. The responsibilities and scope of operations of the Strategic Purchasing Unit will expand with the merging of health resource pools.

### 2.4.2 Strengthen Results Based Financing

Following the positive impact of current RBF projects on health system performance, the GOTG is committed to establishing performance based mechanisms as a core approach to health service delivery. Strategic direction for the implementation of RBF within the public health system has already been mapped out in the RBF Sustainability Roadmap[39]. The regulatory function of RBF remains embedded in the overall regulatory function of MOH to ensure quality of services, within the context of governmental laws and policies and its decentralized structure. The Roadmap spells out that action is required to review and strengthen the regulatory capacity of the MOH and in particular the RHDs.

The management and purchasing function for RBF will be established in a newly formed RBF Unit at MOH. The RBF Unit will be the backbone of the system and would need a minimum of 8

[39] Results Based Financing Sustainability Roadmap 2018

staff. Its actual position in the organogram of the MOH will be decided upon by MOH. The RBF Unit is responsible for the overall management of RBF, entailing - inter alia - the coordination of RBF execution, RBF progress monitoring and reporting to MOH, MOFEA, and the National Steering Committee (NSC) (the RBF Unit would become Secretariat of the NSC), and mainstreaming RBF knowledge among other governmental bodies (MOFEA, other line ministries, politicians) and partners. Furthermore, the RBF Unit will be tasked with purchasing services through contractual arrangements, including regulatory services by the RHDs, specific tasks laid down in operational plans of the Directorates of the MOH, external verification or other services. The RBF Unit would also purchase services from the Contract Development and Verification Agent (CDV) that is operational and builds capacity at the regional level.
The MOH will link functions of the RBF Unit to the operational planning, budgeting and health information tasks of the Directorate of Planning and Information of MOH (DPI). Noteworthy is that, given the existing RBM concept and the adoption of Performance Based Budgeting (PBB), the operational and budget planning framework will need to be aligned to RBF principles and tools, and supported by a strengthened M&E Unit at the DPI.

To ensure full segregation of functions fund holding and payment functions will be within the already existing MOH Program Coordination Unit (PCU) at MOH.

In terms of governance the RBF stewardship and oversight function will be conducted by the RBF National Steering Committee (or Health/Medical Board) and by the Regional Steering Committee (RSC), both of them becoming strong bodies with multiple representation and sufficient skills. The transition from a project approach to a national approach in RBF is clearly articulated in the RBF Sustainability Roadmap report that will be used for implementation. The RBF Sustainability Roadmap provides a clear view on what needs to be done to transition from the current RBF arrangements to a mature RBF system in the health sector in the Gambia that is institutionally, financially and operationally sustainable. The Roadmap is guided by 14 objectives and 34 key activities. It is estimated that the transition process will take 2 years or even longer and the short term process will cost an estimated GMD 5,676,675 and the cost for medium term and long term transition still remains to be quantified.

Key initiatives identified for RBF in chronological order are as follows (RBF sustainability Roadmap)

i) a critical path analysis to guide the timing of activities in the medium and long run;
ii) a coordinated review of the package of primary and secondary health care services in order to strategically purchase health services; and
iii) a forecasting analysis of the resource envelop to sustain the program's outputs for the next 3 to 5 years.

### 2.4.3 Allocate resources according to need

A needs-based resource allocation formula to guide the distribution of public health funds will be developed. This formula will embody the major geographic indicators of health needs such as population size, socio-economic characteristics and supply-side capacity. Implementation of a resource allocation formula is usually more feasible when the overall resource envelope is increasing. The MOH will progressively implement the needs-based formula as additional resources are available to the public health sector.

### 2.4.4 Ensure equitable and efficient delivery of Essential Benefit Package

An Minimum Benefit Package that includes secondary and tertiary levels of care will be defined and costed. This will provide guidance to health planning and service delivery to prioritise these services. Guiding frameworks such as basis for inclusion or exclusion from the Minimum Benefit Package will be developed by the MOH. This will require modernization of the HMIS to use the International Classification of Diseases version 10 (ICD 10) .As the resource envelop for the health sector increases, the benefit package will be revised accordingly. Improving the quality of care at the primary care level is critical to improving the operation of the referral system. The MOH will use innovative purchasing arrangements to improve quality of care. Other demand-side incentives to encourage the use of primary care facilities as the first point of contact with the health system will also be explored.

### 2.4.5 Priority Strategies for Purchasing Health Services

Priority strategies for purchasing health services are as follows:

1. Strengthening the capacity for Strategic Purchasing within the MOH
2. Ensure sustainability of RBF through innovative financing

Current RBF initiative improves the financing and provision of priority health care services namely reproductive, maternal and child health care services. Strengthening capacity for strategic purchasing is fundamental to the successful implementation of all other purchasing initiatives planned in the short, medium and long term.

## Chapter 3: Governance and Institutional Arrangements for the Health Financing Strategy

One of the policies in the GNHFP aims to strengthen the health sector stewardship, oversight, transparency, accountability through separation of functions of fundholding, strategic purchasing of services, provision of services, regulation and verification and counter-verification of results within and outside MOH and through the enforcement of existing rules and regulations to prevent wastage of health resources.

MoFEA reported a high rate of budget execution by the MOH with small budget variances at the end of each fiscal year. For the purpose of informing the annual budget development process, public expenditures reviews **(**PERs) are conducted on a quarterly basis by the MOH and annually by the MOFEA. The MOFEA key informant acknowledged however that MOH budget and expenditures tracking and monitoring systems need strengthening. It was noted that there is a particular need to strengthen the tracking system's ability to reach down to the program level where most of the public budget spending occurs. It is perhaps noteworthy that in December 2017, The Gambia was selected as a Millennium Challenge Corporation (MCC) threshold country. The selection criteria for threshold eligibility includes aspects of PFM, indicating that at least one international agency considers The Gambia's PFM performance to be improving.

The Assessment of the Health System of The Gambia noted that the current MOH structure presents considerable challenges to cross-program planning, coordination and collaboration. Most agree that ten health directorates and the large "proliferating and fragmented" number of programs under each directorate, coupled with non-technical leadership at the top of the structure does not promote strong governance and leads to considerable inefficiency in resource use. International partners estimate that 75% of MOH activities implemented were not included in work plans. The assessment report also noted that partners have poor access to MOH senior management coupled with poorly articulated and end up working primarily with sub-directorate program units to implement their own work plans. MOH directorate leaders on the other hand stated that international partners do not seek out and coordinate their plans with MOH management, preferring to approach program units directly. Senior MOH officials described the management environment with the MOH and between international partners and MOH as "chaotic" and eroding

efficiency of resource use. The revised Gambia IHP+ Country COMPACT should be implemented to address some of coordination issues.

### 3.1 Legislation

Health sector legislation in The Gambia is outdated. Most legislation dates back from the 1980s and provides broad powers to the MOH and the regulatory councils. The Ministry of Health will update legislation to better address emerging priorities, including the commitment to achieve UHC, regulating the health professions, and address financial and operational sustainability issues. The Public Health Act is the major piece of legislation that defines the health sector in The Gambia. The Act outlines the responsibilities of the MOH including establishing "health and sanitation district within any…area," creating "health services institutions in any area," regulating environmental health in residences and workplaces, and quarantining people suspected of having an infectious disease. Under this Act, the MOH, under the direction of the Minister of Health and the Director of Health Services is the sole regulator of the health sector. The Act will be revised and consolidated to address disease prevention and promote, safeguard, maintain and protect population health.

The Local Government Act (2002), though not health specific, is another critical piece of legislation for the health sector. It outlines the roles and responsibilities of the national, as well as the local councils as well as funding mechanisms. Local councils, in theory, receive funding from the Ministry of Local Government and are technically able to raise own-source revenue. Though these are de facto council responsibilities, in practice, Regional Health Directorates, which report directly to the MOH, oversee health services at the sub-national level. There are many restrictions on how funding is raised and spent at the subnational level, as well as sharing requirements between the national and subnational governments and budgeted funding is rarely transferred to the regions. The Local Government Act will be fully implemented to achieve decentralization and to strengthen governance. The Health Services Act whilst in existence is not being enforced for registration of health professionals and health institutions and it's enforcement will be mandatory in order to achieve the policy objectives of governance for health financing

## 3.2 Institutions for Implementing the Health Financing Strategy

### 3.2.1 The Ministry of Health

The MOH will continue to play the overall oversight and stewardship for regulation of the health sector; both public and private through the Director of Health Services. The Directorate of Planning and Information will continue to exercise the function of results based planning. Internal Audit will continue to exercise its functions and an Audit Regulatory Framework will be developed for this HFS. A Strategic Purchasing Unit will be created within MOH that will include the RBF Purchasing Unit and the already existing PCU. The MOH will revise and update all laws for regulation of both the public and private health sectors and make sure that they are enforced. This unit may in future be integrated in the National Health Insurance Scheme when its finally formed.

### 3.2.2 The Ministry of Finance and Economic Affairs

The MOFEA will continue to be fund holder of GOTG funds for the MOH by doing annual budget planning and allocations and disbursements to the MOH. The Joint Sector Committee for implementation of the COMPACT and the PCU Steering committee will continue to provide oversight on donor funding and its utilization.

### 3.2.3 The Ministry of Local Government

Local Authorities will be empowered by the operationalization of the Local Government Act of 2002 that will ensure decentralization. However local councils will have to build the capacity for the administrative functions that come with decentralization including tax collection, planning and budgeting, financial management and regulation of health service provision.

### 3.2.5 Private Players

The private medical industry is currently poorly regulated. Whilst laws such as the Medical Services Act of 1988 and The Health Policy of 2001 exist, they are not being enforced because health service providers are allowed dual practice and argue against enforcement of standards in the private sector that are non-existent in public institutions. However with the gradual move to National Health Insurance that will require definition of benefit packages and registration and accreditation of health service providers, the private medical industry will have to cooperate and align themselves with revised MOH laws and regulations and professional standards of professional associations. Some medical insurance companies have become bankrupt because of oversupply of service by providers and supply induced demand in the absence of enforcement of regulation.

## 3.3. Complementary Initiatives

In addition to the changes outlined above, other activities will be carried out in order to support the successful implementation of the Health Financing Strategy. The MOH will ensure that relevant information concerning the strategies proposed will be communicated to key stakeholders to elicit buy-in and support in order to successfully implement the strategies proposed. The capacity of the MOH and other institutions will have to be strengthened to ensure that they are able to carry out the roles they are to perform. Important areas for capacity development include PFM, Strategic Purchasing and Results Based Financing. The Directorate of Planning and Information will require capacity development in the areas of health economics and financing, public health statistics and demography. The MOH will require capacity building for infrastructure for health financing such as hardware, software, connectivity and financing information systems. These activities and their sequence are detailed in the implementation matrix and monitoring and evaluation framework.

Chapter 4: Monitoring and Evaluation of the Health Financing Strategy

The systematic tracking of the execution of planned activities as well as periodic review of progress towards the realization of desired results is critical to the success of the Health Financing Strategy. Regular review of progress on activities outlined in this Health Financing Strategy allows for corrective measures to be taken in a timely manner, where challenges are encountered. This Chapter provides a description of the approach to be used in monitoring and evaluating the performance of the strategy.

## 6.1 Overview of the Monitoring and Evaluation Mechanism

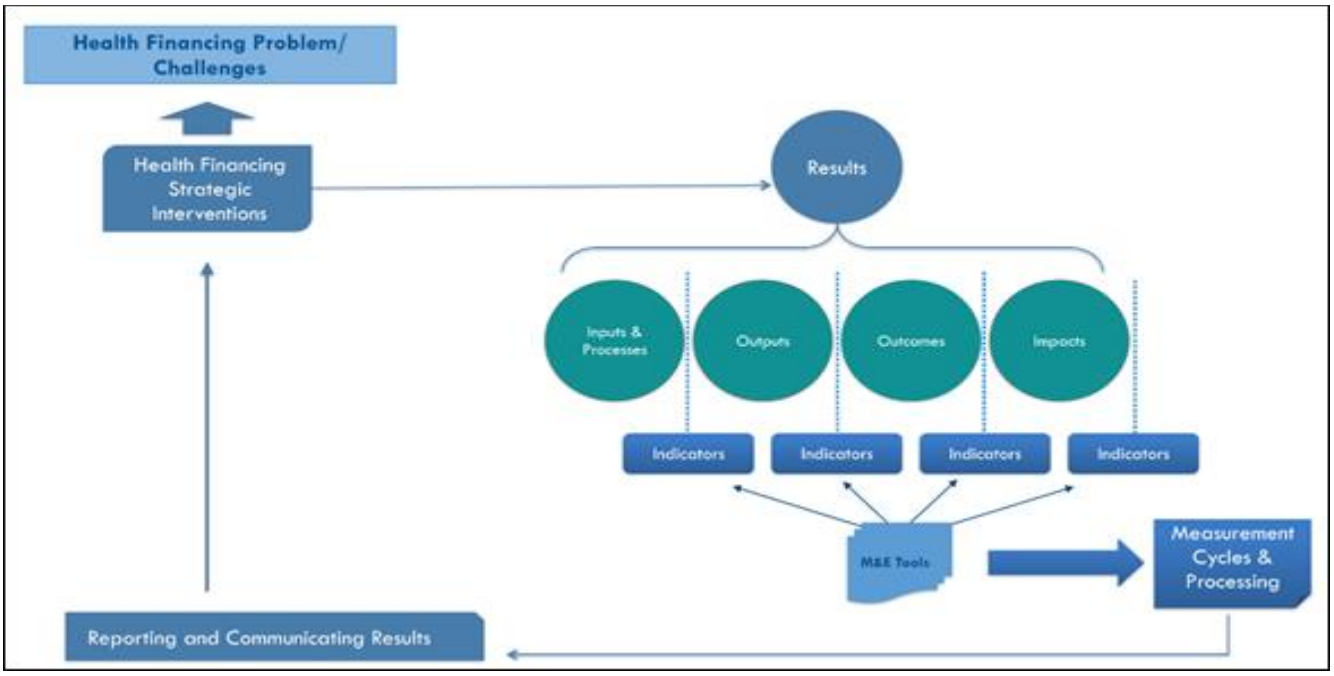
A Results Based Monitoring, Evaluation and Reporting (RBMER) approach has been adopted to track performance and ensure efficient and effective delivery of the intended goals of this strategy. The approach recognizes that the implementation of the strategies outlined in Chapter 4 should produce certain desired results; some in the short term, some in the medium term and others in the long term. These results can be differentiated along four core levels of the results chain: Inputs and Processes, Outputs, Outcomes and Impact.

The **Inputs** refers to additional resources such as human resources, machinery and finances that are required for strategy implementation. **Processes** refer to the specific activities that are to be carried out. These include the setting up of units and committees or training of health workers. **Outputs** are the direct short term results of implementing the activities outlined in the overall strategy. With the contribution of other factors within the operating environment, the strategy envisages medium term effects or **Outcomes** that are aligned to the goals of health financing such as the reduction in catastrophic health payments. The outputs and outcomes should have a longer term effects that are referred to as **impacts**.

The RBMER approach will entail conducting periodic measurement of performance indicators that are mapped to each of the four levels of the results chain at intervals during the implementation life of the strategy. The measurement of the lower level results (Processes and Outputs) will be

more frequent and will make use of routine trackers to assess timeliness and completion of planned intervention strategies. Relatively more advanced mechanisms such as national health surveys, Resource Mapping, National Health Accounts and Expenditure Tracking Surveys will be used to measure progress on outcome and impact indicators. A strategic dissemination approach will be used to ensure that all relevant stakeholders are informed of progress on the activities of the financing strategy, and promote adaptive learning during implementation. Figure 6.1 provides a schematic of the RBMER approach adopted for this Health Financing Strategy.

**Figure 9: Results based M&E mechanism for health financing strategy**




Source: Authors of the Zimbabwe National Health Financing Strategy

## 6.2 The Results Framework and Performance Indicators

Progress on input and output indicators will be monitored on a regular basis by a detailed Implementation Plan. As part of its quarterly meetings agenda, the Health Financing Technical Working Group will review progress on activity implementation and resource availability/usage for the Health Financing Strategy. A Health Financing M&E Sub-Unit will be setup within the

Health Financing Unit primarily to collect and consolidate data on the indicators; and reporting back to the HFS TWG.

A Quarterly Progress Checklist will be developed to collect data on the status of input and output indicators, which is consolidated into a Quarterly Dashboard used for review by the HFS TWG. The TWG Chair will also routinely brief MOH Top Management and other stakeholders that are not represented in the TWG on the progress.

Table lists outcome indicators that will be used to evaluate progress towards achieving the objectives of the HFS. The first column of the table lists the five main objectives of the HFS. Outcome indicators have been listed for each of them. It is worthy of note that there are certain indicators that cut across more than one objective.

The status of the outcome indicators relative to their Baseline GDHS 2013 and targets will be used to inform an independent Mid-Term Review (MTR) that will be undertaken in Year 3, and an Independent End-Term Evaluation, which will be planned at the end of the five-year implementation period. Additional reviews /evaluations will also be conducted for specific reforms. Annual Joint Sector Reviews of the strategy will be conducted and chaired by the Permanent Secretary or designate.

**ANNEXES 1: Monitoring and Evaluation Framework for the monitoring of the Gambia Health Financing Strategic Plan 2019-2024**

| NATIONAL HEALTH FINANCING STRATEGIC PLAN | | | | | | | |
|---|---|---|---|---|---|---|---|
| **M&E Framework for the operationalization of National Health Financing Strat** | | | | | | | |
| **Monitoring and Evaluation Matrix** | | | | | | | |
| **OUTPUT** | **Intervention/Activity** | **Indicators** | **Baseline 2019** | **Target 2024** | **Data source** | **Frequency** | |
| **Institutional Capacity enhanced for greater Efficiency** | 1.1 Build institutional capacity for sustainable health financing at all levels of the health system-program planning, budgeting and coordination | Number of staff trained on Result Based Management(RBM) | 0 | 100 | Training Reports | Annually | |
| | 1.2 Review of structures of the MOH to elicit greater efficiency | Availability of an approved MoH organogram | 1 | 1 | Copy of approved organogram | Every 10 years | |
| | | Number of budget committee meetings | 4 | 12 | Meeting Minutes | Monthly | |
| | 1.3Place greater emphasis on investment in and implementation of interventions targeted at prevention-Revitalize PHC | number of villages with access to Primary Health Care Services | 891 | 1889 | PHC Unit updated Report | Quarterly | |
| | | Services Availability and Readiness Assessment (SARA) Conducted | 0 | 1 | Assessment Report Produced | Every 2 years | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1.4. Conduct a private sector assessment and examine potential for public-private-partnerships | | | | | | |
| **2. Increased reliance on public resources for the health sector** | 2.1. Conduct a Fiscal Space Analysis | Total government expenditure on health as % of GDP | 4.6 | 5 | NHA Report | Annually | |
| | 2.2. Advocacy for National Assembly and MOFEA to increase the funds allocated to MOH (fulfil Abuja targets) | General government expenditure on health as % of general government expenditure | 7.94% | 15% | Approved National Budget Estimate & Expenditure | Annually | |
| **3. Innovative health financing mechanisms** | 3.1. Advocate 100% allocation of the Tobacco, alcohol tax and hazardous products (sin-tax) to the MOH. | % of Sin Tax Allocated to MoH | 0 | 100% | GRA Revenue report | Quarterly | |
| | 3.2 Ring-fence taxes on airtime and internet data for health | % of Airtime and Internet data tax Allocated to MoH | 0 | 5% | GRA Revenue report | Quarterly | |
| | 3.3 Introduce mechanisms that allows communities to contribute to health system strengthening | Availability of Community Based Insurance Scheme(CBIS) | 0 | 50 | Established functional CBIS. | Annually | |
| | 3.4.Develop a framework for Public Private Partnerships | Availability of a Public Private Partnerships(PPP) framework | 0 | 1 | Copy of a PPP framework | Every 5 years | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 3.5 Raising revenue from the informal sector | % of revenue collected from the informal sector(eg. GSM, electricity) | 0 | 0.5% | GRA revenue report and PURA report | Annually |
| | 3.6Factor in costs of health care in environmental impact assessments for new businesses | Environmental impact Assessments Conducted | 0 | 2 | Assessment Report Produced | Biennal |
| | | % of environmental tax collected from businesses with potential health Hazard | 0 | Subject to assessment report | Assessment Report Produced | Every 3 years |
| **4.Program planning and Budgeting** | 4.1 Advocate for improved predictability and availability of public resources | Number of advocacy meetings conducted | 0 | 2 | Report produced | Semesterly |
| | 4.2Strengthen capacity to monitor performance around PFM and enforce lines of accountability | Number of personnel trained on PFM monitoring | 1 | 30 | Training Reports | Annually |
| **5.Improve the predictability and level of external resources** | 5.1Strengthen mandate and capacity of the PCU for donor coordination (revisit Compact) | TOR of the PCU reviewed and updated | 1 | 1 | Copy of review and updated TOR | 5 years |
| | | Number of PCU Staffs trained on Project Management | 0 | 4 | Training Reports | Annually |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Number of Donor Coordination Meeting | 0 | 4 | Meeting Minutes | Quarterly |
| | 5.2Set up virtual pool of funds for donors and make sure external assistance is reported on the budget | Availiability of pool of donor funding reported on the budget | 0 | 2 | IFMIS report/ | Bi-annually |
| **6.Improve efficiency of external assistance on health** | 6.1Use donor mapping to identify redundancies and underfunded programs | Donor mapping conducted | 0 | 1 | Donor mapping reports | Biennal |
| | 6.2Develop clear multiannual plans so that development partners can align on planned activities | Availability of annual plans of all health stakeholders | 0 | 2 | Available Plans | Every 2 years |
| | 6.3Assessment of other prepayment schemes to raise revenue | Prepayment scheme assessment conducted | 0 | 2 | Assessment Report Produced | Biennal |
| | 6.4 Assessment of appropriateness of a mandatory National Health Insurance scheme | Health Insurance Scheme assessment conducted | 1 | 1 | Assessment Report Produced | Every 5 years |
| **7. Increase the contribution of prepayment to the health sector** | | | | | | |
| **8.0 Capacity for Strategic purchasing** | 8.1 Strengthen institutional capacity for strategic | strategic purching unit established | N | Y | Appointment letters/process purching | one off |

| | | | | | | |
|---|---|---|---|---|---|---|
| **within MOH Strengthened** | purchasing within MOH | Number of staff of the purching unit trainined on health financing | 0 | 10 | training report /certificate | annual |
| | | Number of staff at the HF unit trainined on purchasing | 0 | 4 | training report /certificate | Annual |
| **9.0 Institutional capacity on RBF enhanced across all levels of care and services delivery points** | 9.1 Build capacity for full institutionalisation of RBF across levels of care and services | Number of facilities using RBF as a payment machanism | 0 | 50 | performance contract document | quarterly |
| | | Number of health facility staff trained on RBF concept | 0 | 150 | training report | annual |
| | | Number of HF unit & M&E staff trained on RBF concept | 2 | 6 | Training Report | Annual |
| | 3.2 Ensure sustainability of RBF through innovative financing mechanism | % of sin tax (tobacco and alcohol ) allocated to health | 0 | 25 | GRA remitance report | quarterly |
| | | % of tax on hazardous products allocated to health | 0 | 15 | GRA remitance report | quarterly |
| | | % of other earmarked taxes allocated to health | 0 | 15 | GRA remitance report | quarterly |

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| **10.0 Resource allocation formula Developed and implemented** | 10.1Develop and implement needs-based resource allocation formula | Needs base resource allocation formular reviewed | n | y | Resource allocation formula | one off |
| | | Number of budget committee members oriented on the revised resource allocation formular | 0 | 15 | Training report | annual |
| | | number of hospital chief executive oriented on the revised allocaion formular | 0 | 6 | Training report | annual |
| | | number of regional health directors trained on the revised resource allocation | 0 | 7 | Training report | annual |
| **11.0 referral system strengthened to improve** | 11.1Articulate the Benefit Package on a realistic resource envelope | revised minimum basic package | 0 | 1 | benefit package document | one off |
| | | availibility of a comprehensive benefit package | 0 | 1 | benefit package document | one off |

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| **quality of services** | 11.2 strengthen referral system by using financing incentives to improve quality | availibility of a quality assessment tool for apppropiatness of referral | 0 | 1 | quality assessment tool for referral | one off | |
| | | Number of appropriate referrals made | 0 | 100 | report on appropiatness of referral | Quarterly | |
| | | Equitable availibility of ambulances wth the required equipment and man power | | | distribution list | when necessary | |
| **Orientation of Executive and Health select committee at the National Assemble and Stakeholders on Health Financing** | Orientation of Executive and Health select committee at the National Assemble and Stakeholders on Health Financing | Number of orientation held | 0 | 30 | orientation report | annual | |
| | Recruitment, and train staff on Health Financing | Number of staff recruited | 4 | 6 | appointment letters | one off | |
| | | Number of staff trained | 4 | 6 | Training report | annual | |
| | Retraining of middle/senior level managers on Health Financing | Number of middle /senior level managers trained on healt financing | 3 | 45 | Training report | annual | |

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| **Motivation and Retention package Reviewed for utilization** | Regional or International study tour for senior management on Health issurane Scheme | number of studies tour conducted | 0 | 2 | study tour report | one off |
| | Revised motivation and retention package (reward for services) | availibility of the revised motivation and retention package | 0 | 1 | motivation and retention package | one off |
| | Develop an appraisal system | availibility of an appraisal system | 0 | 1 | appraisal form | one off |
| **National Health Insurance Act developed** | Develop a module for health financing information system link to the DHIS2 | availbility of health financing module in the DHIS2 | 0 | 1 | DHIS2 | one off |
| | Review and amend all health related Acts. | availability of reviewed act ( Public health, Medical Service Act , Nursing and Midwifery Act ) | 0 | 3 | National Gazzets | when necessary |
| | Conduct Advocacy Meetings for the operationalization of Local Gov't Act | Number of Advocacy Meetings conducted | 0 | 4 | meeting report | quarterly |
| | Conduct consultative meeting with the executive and lawmakers on the development of the National Health Isurance Act. | number of consultative meeting conducted | 0 | 4 | meeting report | quarterly |

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| | Develop and enforce National Health Insurance Act. | Availability of National Health Insurance Act | 0 | 1 | National Gazzets | one off |
| | Conduct sensitization meeting on the Health Insurance Act with lawmakers and the executive | Number of law makers and executives sensitized on NHI Act | 0 | 45 | Reports | Annual |
| | Conduct Community/private sector/stakeholder sensitization on NHI Act. | Number of sensitization meetings held | 0 | 4 | Reports | quarterly |

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