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# Domestic revenue for universal health systems: a contribution to policy dialogue

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*This brief aims to present the positive and negative implications of the different domestic revenue sources being explored, advocated and implemented in the East and Southern African (ESA) region. It presents issues to be considered in choosing between, and implementing, the different non-contributory and contributory options for revenue collection, given the policy commitments in the region to equity and universal health coverage (UHC). The brief draws information from experiences of other low and middle income countries globally, including on the fiscal, revenue, progressiveness and acceptability implications of different options. The brief highlights that revenue collection measures need to be accompanied by measures to strengthen strategic purchasing and access to equitable, effective, quality care.*

## Domestic revenue collection instruments and strategies

Domestic funding of health systems can come from mandatory or voluntary sources. Mandatory forms of financing are set by government and are all pre-paid.

There are two forms of **mandatory pre-paid financing:**

- The first is **non-contributory financing**, and covers different types of taxes that should in principle provide services that benefit the entire population. They may be **direct taxes**, including personal income tax and company tax on profits, or **indirect taxes**, such as on consumption of: general items, often known as Value Added Tax (VAT); luxury items, such as airline travel, high-end cars and, more recently, mobile phone use; or harmful substances, such as tobacco, alcohol and sugar. Taxing the exploitation of natural resources, such as a carbon tax, is beginning to receive greater attention.
- The second type of mandatory pre-paid financing is **contributory financing**, where beneficiaries are legally obliged to contribute from their wages towards employment-based schemes or social health insurance (SHI). Employers often also contribute.

There are also different forms of **voluntary financing:**

- In **pre-paid voluntary financing** individuals voluntarily contribute in advance to a form of health insurance, that may be community-based or a larger commercial scheme.
- **Out-of-pocket (OOP) payments** are formal or informal payments paid at the time of using services, including co-payments not reimbursed by insurance.

## Motivations for policy attention to domestic health financing

According to World Health Organisation (WHO) 2015 National Health Accounts data, the per capita domestic government spending on health in ESA countries ranged from $5 in Mozambique to $594 in Namibia, with an average of $197 (in international dollars to achieve purchasing power parity, and excluding external grants). Thirteen countries fell below the minimum recommended target for government health spending of 5% of Gross Domestic Product (GDP), with eight contributing less than half of this in 2015. Clearly, domestic funding needs to improve, especially given rising levels of non-communicable diseases. This is true to ensure sustainable financing for all ESA countries, but especially for lower income countries, which generally fund less than two thirds of their health expenditure domestically.



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While external funding contributes to equity in meeting global commitments, a high external share can make it difficult for countries to plan and implement longer-term UHC interventions, as it is not always predictable or pooled with government funding. For higher income countries in the region, higher levels of domestic financing often come from voluntary private health insurance that covers only a small share of the population. Further, nine of the 16 ESA countries have OOP spending above the ceiling of 20% suggested by WHO to avoid catastrophic expenditures and impoverishment, seven of these considerably so. These features compromise both the sustainability and equity of health financing in the region.

Moving towards UHC implies increasing the mandatory pre-paid share of domestic revenue to provide financial protection. Mandatory prepaid financing avoids people opting out from pre-funding their care while they are healthy, a problem that occurs with voluntary schemes. Mandatory pre-paid financing enables larger financing pools that enable subsidies between richer and poorer groups and between people with different levels of health need.

Many ESA countries now have policy provisions for the right to health care, and all have committed to Sustainable Development Goal 3 to advance UHC. Most ESA countries are thus considering options for improving domestic health financing, sometimes under difficult macro-economic conditions and in parallel with discussions on identifying the health benefits to be provided to the whole population and on how to improve strategic purchasing.

The mandatory options under consideration in ESA countries include:

- Improving revenue from mandatory non-contributory financing options, through imposing new indirect taxes or earmarking shares of existing indirect taxes, together with improving tax revenue and tax collection.
- Introducing or expanding contributory financing, mainly through SHI covering some or all formal workers, with incentives to attract voluntary contributions from the informal sector and, in one country, covering the entire population through National Health Insurance.
- Introducing or expanding new voluntary options, including community based and commercial health insurance, or applying new exemptions on OOP payments.

*How far do these different financing options go in meeting policy commitments to equity and sustainable progress towards UHC?* The next sections present available evidence from low and middle income countries (LMICs) on the different options.

## Features of mandatory prepaid financing options

*Direct taxes* generate large funding pools and are the most progressive source of financing, depending on tax levels, the distribution of tax burdens relative to wealth, the efficiency of tax collection and the extent, quality and accessibility of services funded. The large risk pools they generate can be used for equitable resource allocation and strategic purchasing, improving the efficiency and quality of care. They are, however, vulnerable to economic downturns and more difficult to collect where informal employment is high. Strategies to improve direct taxes include: expanding the tax base through new taxes, such as on natural resource use; changing tax thresholds to more effectively tax wealth; simplifying tax systems; and strengthening tax collection capacities, all of which can improve the 'fiscal space' for public expenditure.

Indirect taxes form a higher proportion of total government revenue in countries with large informal sectors or where there are difficulties collecting direct taxes. *Innovative indirect taxes* on goods and services consumed by wealthier groups in the population, taxes on large, strongly profitable companies, and ear-marking of certain tax sources for health can provide new financing, particularly if the indirect tax chosen comprises a large portion of tax financing, such as VAT. Indirect taxes are administratively relatively easy to collect. Some, such as taxes on cigarettes, fuel, alcohol and sugar, may gain support where they can be linked to positive health impacts and used for underfunded areas of public health. Some indirect taxes may generate relatively little revenue, however, and may be susceptible to changes in

consumption. As a flat rate charge they may be less progressive than direct taxes, unless applied to luxury goods or where items consumed by lower income groups are exempted.

*Mandatory contributory payments (SHI)* have variable implications for equity, efficiency, sustainability, adequacy, fiscal policy and administration, depending on their design, whether contributions are income/wealth-related, whether members face co-payments and the entitlements covered. SHI depends on a sizeable formal sector. When introduced first for the formally employed, however, SHI tends to entrench cover for better-off groups with potential resistance from these groups when efforts are made to widen cover and cross-subsidise membership for lower income groups. Where these schemes cover civil servants, government's share of contributions as an employer often results in per capita subsidies higher than those available to poorer people using tax-funded services. SHI requires effective enrolment, tracking and management to avoid cost escalation. These equity and efficiency problems have preoccupied many countries with longer histories of implementing them. SHI is thus difficult to effectively implement in settings with large rural populations, a large informal sector, low salary and wage levels and high poverty and dependency ratios. It has not generated substantial revenue in Africa, generating 3.4% of current health expenditure in ESA countries in 2015.

## Features of voluntary options

*Private voluntary health insurance* extends cover for elites, but may impact negatively on efforts to achieve universalism, especially in the context of a weakly regulated for-profit private sector. *Community-based health insurance* schemes have provided some financial risk protection and improved access to services in rural areas, but with limited coverage, a fluctuating membership, high administrative costs and equity and sustainability challenges. *OOP payments* potentially recover only 5% of public expenditure, are costly to collect relative to their revenue and are the most regressive option, posing a barrier for the poorest patients with greatest need. If forming a large part of health financing, they may lead to catastrophic payments and impoverishment.

## Implications for policy choices in domestic health financing

There is no single way of combining domestic financing options to design and implement financing reforms. The choices depend on socio-economic and political contexts and institutional resources and capacities. However, experience points to the implications of some choices, and issues to be considered in their implementation.

In relation to *mandatory non-contributory financing*, all ESA countries would benefit from strengthening tax collection and improving the share of government revenues applied to health. Mechanisms for the former are well-established, but improving health's share requires extensive Cabinet support. There is also potential to introduce new taxes, such as on financial transactions or on the exploitation of natural resources. Countries may enhance the predictability of budget spending on health by earmarking portions of direct and indirect taxes for health, particularly if allocated to key and underfunded areas. This has, for example, been done for HIV/AIDS (in Zimbabwe), for public health in Thailand or in many countries to meet defined gaps for UHC. While earmarking for broader purposes can leave room to adjust priorities with changing needs, earmarking can constrain future choices and lead to budget offsets elsewhere.

In relation to *mandatory contributory financing*, SHI has been judged in some settings to be a more politically acceptable way of generating additional revenue than direct taxes. It can, however, separate the health system into a better-resourced tier for the formal sector and a poorly resourced tier for others. Increasing contribution levels to meet rising costs may further jeopardise inclusion. Attempting to enrol the informal sector in SHI is administratively complex and is not a successful strategy for significantly improving revenue. For UHC, SHI funding would need to be blended with tax funds into a single financing system, if not a single pool, with common entitlements across the system, in a National Health Insurance scheme. ESA countries with existing SHI should thus plan measures to consolidate existing SHI schemes and risk pools, standardise service entitlements and provide tax subsidies for poorer groups. The costs and benefits of this approach should be carefully weighed against a purely tax-funded system, which poses fewer equity and administrative challenges.

The table below summarises how these different options perform relative to key features for UHC.

Key: For the feature in the column, the circle reflects the extent to which the option addresses that feature: Green circles = positive; Orange to red = negative with red more strongly negative. Grey = neutral or variable; Black = generalisation cannot be made.

| FEATURE: | Financial protection | Progressive-ness | Risk / income cross-subsidy | Revenue pooling | Ease of collection for government | Cost control | Revenue-raising potential | Macro-economic feasibility / stability | Political / social acceptabilty |
|---|---|---|---|---|---|---|---|---|---|
| **MANDATORY PRE-PAID MECHANISMS** | | | | | | | | | |
| Direct taxes | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Indirect taxes | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Mandatory SHI | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Tax + SHI in one fund (NHI) | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **VOLUNTARY MECHANISMS** | | | | | | | | | |
| Voluntary health insurance | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| OOP payments | ● | ● | ● | ● | ● | ● | ● | ● | ● |

It is well-established that *private voluntary insurance* can only be a complement to, rather than substitute for, mandatory financing for UHC. ESA countries should all aim to reduce the share of *OOP funding* to 20% or less of total health care expenditure, a recommended target by WHO, in tandem with increasing other, more equitable sources of finance. User fees may be limited to non-essential services, or to achieve policy objectives such as strengthening referral systems.

These revenue collection measures will not have their intended impact unless accompanied by measures to strengthen strategic purchasing and access to effective, quality care. Any immediate choices would need to consider and project longer-term system impacts and funding demands, to respond to changing health issues, such as the rise in chronic conditions. The potential impact of options being considered needs to be modelled and their costs and benefits communicated to all stakeholders. The implementation of reforms needs to be monitored and reviewed, to make adjustments to address positive and negative consequences.

## References

The detailed evidence and country experiences that this brief draws on can be found in Doherty J. (2019) Critical assessment of different health financing options in East and Southern African countries. EQUINET Discussion paper 119, EQUINET, Harare.

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