

Regional Network for Equity in Health in East and Southern Africa (EQUINET)



Improving equitable domestic public financing to reach universal coverage in East and Southern Africa

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In most East and Southern African (ESA) countries, total health expenditure from all sources, including external resources, is still less than the US\$ 45 per capita per year needed to provide basic health services. This limits their ability to achieve universal coverage of basic health services. This policy brief draws policy makers' attention to the demands and challenges in health financing in meeting universal coverage, the demand for improved domestic public financing for health, and suggests options for doing this.

Key messages

1. Inadequate financing is limiting progress in achieving universal coverage of health services in the region. Governments should aim to meet the Abuja commitment and move rapidly towards reaching spending of at least \$45 per capita per year on health.
2. Universal coverage is not likely to be achieved without improved public domestic financing of the health sector. Domestic financing has however not increased and countries are currently too reliant on out of pocket spending, which creates catastrophic burdens for poor communities, and external funding, which is not reliable and often not delivered in a way that supports universal coverage.
3. Taxes and/or social health insurance (SHI) provide the most equitable way of raising domestic public resources for health. ESA countries have however made little progress in improving tax funding to health and while many countries have policies and designs for SHI, little progress has been made in implementing it.
4. Countries could improve progressive tax financing through ensuring that taxes are higher for higher income levels, collecting dedicated taxes ear-marked for health, and improving tax collections.
5. To encourage increased revenue to the public sector, Ministries of Health need to demonstrate the capacity to absorb and efficiently and accountably use resources in areas of health need. Monitoring and research need to be implemented to demonstrate health outcomes, encourage good practice and inform policy dialogue.

Key aspects of goals for universal coverage

ESA countries are aiming for universal coverage of their health services. In 2008 WHO defined this as “securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost”. In May 2005, the World Health Assembly adopted a resolution urging member states to work towards universal coverage and to ensure that their populations have access to needed health interventions without the risk of financial catastrophe. This means that people should be protected from financial burdens when they fall ill, that the whole population should access the services available that meet their health needs and demands, and that services meet conditions of quality, opportunity, and dignity, regardless of people’s ability to pay.

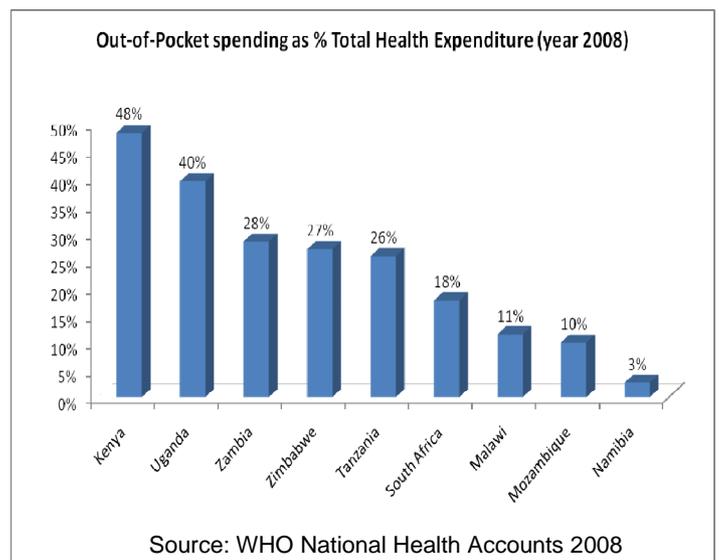
With high levels of economic and social inequality in ESA countries, ensuring universal coverage demands burden sharing, risk pooling, empowerment and participation. The International Labour Organisation (ILO) proposes that social health protection schemes include adequate benefit packages for protection against the risk of ill health and any related financial burden and catastrophe.

Fair domestic financing is essential for universal coverage

These outcomes cannot be achieved without adequate health financing, and services should be provided at affordable cost. A good domestic financing system should be able to efficiently raise sufficient revenue. The funds collected should cover the risks of all people, and should provide cross subsidies between rich and poor people. This demands some form of prepayment and the pooling of the collected revenues, while at the same time providing universal financial protection against the costs of illness. To address equity, households should make contributions in relation to their ability to pay (with the poor paying less and the rich more), and should have access to health services according to their need for care.

There are limited options for achieving this. The range of alternatives for financing health services include tax-based funding, contribution-based mandatory social health insurance, mandated or regulated private non-profit health insurance schemes and mutual and non-profit community-based health insurance. Finally, people may pay directly through out of pocket financing. Tax based financing offers most opportunity for pooling and cross subsidy, while out-of-pocket payments are least desirable as poor people, who get sick more frequently, end up paying relatively more for health care.

ESA countries have become more reliant in recent years on out of pocket funding, and external financing. As shown in the figure, in 2008, out-of-pocket payments ranged from 3% to 48% of total health expenditure in the region. Out-of-pocket payments prevent some people from seeking care and result in financial catastrophe and impoverishment for others who do obtain care. WHO estimate that every year about 100 million people are pushed under the poverty line as a result of out-of-pocket payments for health care. Others suffer financial hardship because they are unable to seek care and suffer an extended period of ill-health as a result.

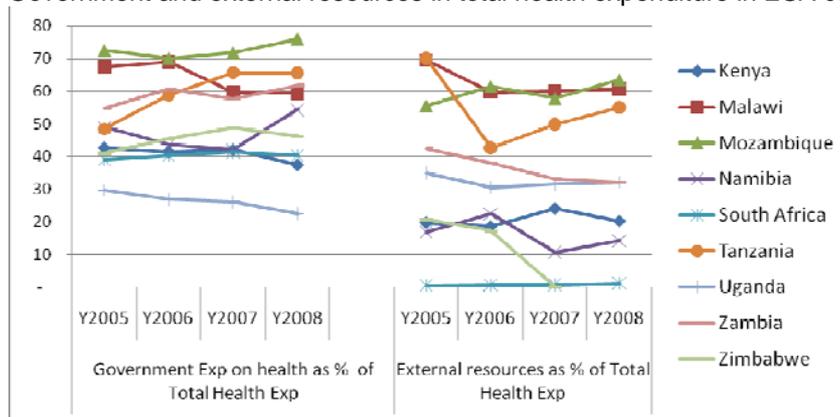


External funding sources have played an important role, and have been given significant attention in resource mobilisation. But significant increases in external funding have not been matched by a similar level of progress in health outcomes and the health Millennium Development. Many external funds do not identify universal health care coverage as a primary goal and come in irregular and unsustainable ways and with conditions that do not help achieve universal coverage, such as through vertical programs. . Goals. External resources are important, especially if they are channelled in a way that strengthens domestic financing capacities and institutions, as noted by the 2005 Paris Declaration on Aid Effectiveness. But governments need to ensure adequate domestic public finances to support a national health system’s institutional framework, regardless of the amounts of funding coming from external sources, if they are to reach universal coverage.

So limited growth in domestic financing for health is a problem

Most ESA countries still raise less than the US\$ 40–45 per capita per year required to provide basic health care services to their populations. As the figure below shows, there has been little growth in the proportion of domestic public resources spent on health in ESA countries, and a downward trend in some. Growth in domestic public resources spent on health has been limited or negative, while external resources have fluctuated, highlighting the unreliable nature pointed to in the previous section.

Government and external resources in total health expenditure in ESA countries



Source: WHO National Health Accounts

While tax and social health insurance provide the widest and most equitable forms of financing, few ESA countries have yet used these to increase domestic public funding. Further, many countries are making slow progress in achieving the Abuja target of 15% of total government spending going to the health sector. Countries which have made progress have noted the contribution of monitoring and support from parliament.

Several barriers have been raised to improving domestic financing. Several countries, including among others Kenya, Mozambique, Uganda, South Africa, Tanzania, Swaziland, have made a policy decision, are considering or have designed mandatory social or national health insurance. Some countries have raised SHI-related technical and governance challenges, and none have yet overcome the opposition to its introduction. For example, in Kenya under-spending of the allocated budget deters further allocations. Tanzania has initiated a Community Health Fund which covers people outside the formal sector on a voluntary basis. However, only 1% of the population are covered by this.

What options for improved domestic public financing for health?

If ESA countries are to achieve universal coverage, there needs to be renewed advocacy for strategies to improve domestic public resources for health. Governments need to **meet and go beyond the 2001 Abuja commitment** of allocating 15% of government budgets to the health sector. EQUINET policy brief 20 provides more information on this. While meeting the Abuja commitment shows prioritisation of health, it is not adequate on its own. There is also a need to ensure public spending on health grows over time to nearer 5-6% of Gross Domestic Product (GDP), as international analyses have shown that at this level of public funding, out of pocket payments can be substantially reduced. Governments should also aim to move towards the target of \$45 or more per capita per year to meet basic services.

Governments can review and improve the collection of **progressive taxes**. Emphasis should be on improving collections on personal income taxes, where people contribute a higher percentage of their incomes as incomes increase, rather than a flat rate across all

incomes. Value-added tax, which is charged at a flat rate across all income groups is often regressive and tends to be an inequitable method for mobilising public resources, especially when applied to goods that are purchased by poor people. This means that VAT could be restructured with higher percentages for commodities mainly consumed by high income groups and lower percentages for commodities consumed by poor people.

Countries can raise the share of revenue by improved **tax collection**. When tax revenue is increasing it is easier to motivate for more funds for health. ESA countries like South Africa, Namibia and Uganda, among others have increased tax revenue dramatically by improving compliance rates, such as by offering amnesties to those who had previously not paid tax where legal action would not be taken against them for past transgressions if they fully complied in future. Countries can also aggressively pursue non-compliers and expand the tax base by encouraging processing and manufacturing, including for the export market, rather than relying on export of raw materials and agricultural commodities.

Countries can identify areas for **dedicated taxes** to draw additional ear-marked tax funds into the health sector. One example is the AIDS levy in Zimbabwe, charged additional to income tax and ear-marked for spending on AIDS. Other sources of dedicated taxes could include proportions of taxes on tobacco and alcohol. Further, a dedicated percentage of tax collections by local governments and/or municipalities could be earmarked for health, especially in countries where collections at these levels are significant.

Whatever the revenue options, achieving universal coverage is more likely if funds from different sources are increasingly pooled to create larger income and risk subsidies across a group of people. Governments need to design and effectively implement such **pooled funding mechanisms** and ensure that they visibly demonstrate the transparency, good governance and accountability, sound financial management, oversight and audit to give confidence in them. Institutional, technical and administrative capacities should be strengthened to achieve this, where needed.

The health sector also needs to **demonstrate the capacity to absorb, allocate and effectively and efficiently use** additional resources with impact on health. This calls for improved monitoring, and if needed research, of how improved financial and other resources are translating into health and health systems outcomes. If resource allocation and use are more efficiently directed to areas of high health need and gain, this improves efficiency in use of existing resources. Countries thus need to monitor and implement research on this.

We encourage governments, parliaments and civil society to assess their financing situation and explore appropriate options for improving domestic public financing for health.

Additional resources

1. Carrin G, Evans B, Xu K (2007): Designing health financing policy towards universal coverage; *Bulletin of the World Health Organization*: Volume 85, Number 9, September 2007, 649-732;
2. Carrin G, Mathauer I, Xu K, Evans B (2008): Universal coverage: tailoring its implementation; *Bulletin of the World Health Organization*: Volume 86, Number 11, November, 2008;86: 857–863.
3. Health Economics Unit, University of Cape Town; TARSC, EQUINET (2008): Meeting the promise: Progress on the Abuja commitment of 15% government funds to health EQUINET Policy Brief 20, EQUINET, Harare
4. WHO (2005): Designing health financing systems to reduce catastrophic health expenditure; Technical Briefs for Policy-makers; Number 2; 2005. WHO/EIP/HSF/PB/05.02

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