Parliament Briefing 2

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Fair Financing for Health

Parliaments play an important role in health. Generally and through their specialised committees, they can scrutinise and ensure that national budgets meet national policy goals, debate and pass laws that institutionalise social goals and provide leadership, representation and space for public participation in health. Parliaments can also provide oversight of the executive in terms of how this arm of government is implementing national policy. This brief explores how these parliamentary roles can be applied to strengthen the fair financing of health systems.

Adequate Resources, Allocated Fairly

Poor households in east and southern Africa (ESA) spend more of their income on health care than wealthy ones do. The way health services are financed can protect against poverty, especially when health resources are allocated to those with highest health needs, and to the district and primary health care systems that serve them. This calls for adequate and fair financing for health. In 2001, African Heads of State made a commitment to allocate at least 15% of total government expenditure to national health sectors (Abuja Declaration). Using tax funding alone and excluding donor resources, however, none in the ESA region have been able to meet this commitment so far and no public sector health services are adequately funded.

Recommendations

Achieving the 2003 Abuja commitment of 15% government spending on health reflects the priority governments give to health systems. Parliaments can monitor delivery on this AU commitment, especially during budget debates. With other actors, parliaments can press for the unconditional cancellation of African governments' external debt and monitor to ensure that tax revenue spent on debt servicing is reallocated to health care and other social spending.

Parliaments can promote policies and budgets that mobilise improved health financing and that do not burden the poorest through:

- Moving away from out-of-pocket funding of public sector health, especially user fees, and actively pursuing other funding mechanisms;
- Increasing tax revenue through improved tax collection methods and more appropriate strategies for corporate and wealth taxation;
- Exploring, evaluating and implementing national social health insurance mechanisms to supplement tax-revenue finance;
- Actively managing donor funding, to ensure that it contributes to achieving national health priorities, for instance through sector-wide approaches; and
- Ensuring that health resources are fairly allocated, particularly to the primary health care and district services that have greatest benefit for the poorest.

Parliaments can promote public support for fair financing through dialogue on these issues with civil society and with health workers. Parliaments can monitor the implementation of finance policies and measures to ensure 'early learning' as implementation proceeds.

Review current health financing

Understanding the current financing situation is important to promote fair financing. Parliaments may request for information:

- Have national health accounts studies been done and what were their findings?
- What does national research show on the strengths and weaknesses of current financing?

Health sectors receive a relatively low proportion of government revenue, generally below the Abuja target of 15% of total government expenditure. In nearly two thirds of African countries, the health sector share is below 10% of government spending.

In east and southern Africa, some governments spend as much or more on interest payments on debt than the 15% promised in Abuja on health. In 1997-98, for example Zambia spent 12% of total government expenditure on debt, and Kenya 26%

In about a third of African countries, donor funding accounts for over 25% of total health care funding, while in 5% of countries, more than 50% of all health care funding comes from external sources.

Insurance coverage is limited in African countries, especially mandatory health insurance. Community pre-payment schemes have increased in recent years but have a poor record in covering communities and in financial sustainability.

Out-of-pocket payments exceed 25% of total health care expenditure in more than three quarters of sub-Saharan African countries. These are made up of user fees at public sector facilities and direct payments to private providers (missions, private doctors, informal drug sellers, traditional healers and so on).

Increase health funding

Interest and repayments on external debt consume a considerable share of government budgets. Parliaments can call for debt cancellation, linked to improved health spending, to improve financing for health. There has been increased international commitment to debt relief, but most efforts to date have been inadequate and limited by conditionalities and extended timeframes. Parliaments can monitor where resources freed from debt financing are going, and pressure for them to be spent in social services, including health.

Kenya, Tanzania, Zimbabwe, South Africa and Namibia have health insurance policies inplace or are exploring them. Kenya for example has mandatory health insurance for formal sector employees and their families. From this, the Kenyan government intends to establish a national health insurance (NHI) system.

International evidence overwhelmingly indicates that health care systems that are mainly funded from taxes are the most equitable. Tax financing is usually progressive (charges more to higher than lower income groups); easier to administer; and allows for solidarity (support for those with need by those with resources). The tax base is severely limited in most African countries, However tax revenue can be increased by:

- Improving tax collection systems;
- Improving the assessment and collection of company taxes from multinational and national corporations, with measures to prevent tax fraud and transfer pricing; and
- Increasing or charging wealth taxes (for example on financial transactions, luxury airline travel and currency exchanges). In Zambia, for example, taxes on financial transactions are used to finance HIV and AIDS interventions.

Many countries are now exploring health insurance. Models include private schemes, community-based insurance, mandatory health insurance, social health insurance or a combination.

Private voluntary insurance schemes often cover wealthy individuals and formal sector workers. Parliaments can be cautious in expanding these as they segment rich from poor; and rapid, uncontrolled cost increases in health services can threaten their sustainability. Some schemes 'cream' the healthiest and richest groups and only fund these, leaving the poorest underfunded.

Community-based health insurance (CBHI) schemes (also called community pre-payment schemes or mutual health organisations) are funded by regular contributions, and do not require payments at the time of using health services. They lower the financial barriers of charges when people need to access care and the healthy do cross-subsidise the ill to some degree. However, the evidence so far indicates that they have low coverage, and that the most vulnerable households are usually not incorporated.

A growing number of African countries are considering or implementing mandatory or compulsory health insurance. Social health insurance (SHI) relieves the burden on publicly funded health services as SHI members use private services or the SHI reimburses the full cost of public services.

Some countries, such as Ghana, plan to combine SHI for formal sector workers with district-wide CBHI schemes in order to implement a universal national health insurance (NHI) system. The contributions of low-income households will be partly or fully subsidised out of tax and pooled donor funds. The major benefit from an equity perspective is the political intention to achieve universal coverage in an integrated health system in the shortest possible period.

Parliaments could raise questions and promote public dialogue on SHI to make sure that the schemes do achieve universal coverage in an integrated health system in the shortest possible period:

- Does the design of SHI entrench a two-tier health system, dividing the insured with good access to quality health services, and the uninsured, relying on under-resourced services? How is this being avoided?
- Is use of state funds for the SHI, such as to pay for civil servants as an initial target group, reducing government resources for publicly funded services?
- Do we have the administrative systems and resources in place for the SHI?
- Are we prepared for the increased use of services that may arise after financial barriers to accessing services are removed?

Tanzania's social health insurance (SHI) covering civil servants is being extended to workers in the private sector. Likewise, South Africa's preparations for a future SHI include mandatory insurance

Protect poor households

User fees were often lifted after independence at primary and district level and then re-imposed during periods of market reforms and structural adjustment. There is substantial evidence that while user fees may provide some local resources if retained locally, they are also impoverishing for poor households, discourage early use of services and pose barriers for the poorest. Some African countries have recently removed user fees for some or all health services, and for some or all users. This has resulted in rapid and substantial increases in utilisation, especially by the poor. Parliaments can raise debate on user fees and their removal. Parliaments can raise questions on current systems:

- Where user fees are implemented, how effective are exemption systems, especially for poor households?
- Where user fees are removed how well prepared are health workers for increased workloads and resource shortages as public use increases?
- Is the lifting of user fees being done together with increased district health service funding, as was done in Uganda, for instance?

Manage external resources

Some sources of international aid fund the entire health sector through a Sector-Wide Approach (SWAp). This has improved coordination and management in line with domestic policy priorities, although there may be concerns around ensuring equity.

Some agencies fund the Treasury in what is called General Budget Support (GBS). The relationship between ministries of finance and health and their shared understanding of health financing becomes more important in this situation. Parliaments can monitor how donor aid is being channelled, through what mechanisms and to what services. If donor funds are applied through budget support, parliament can raise questions on the level of funds going to the health sector.

Some donors fund vertical programmes, like special programmes for AIDS, that may or may not be integrated within the essential health care services. Parliaments can monitor through community visits, hearings and questions whether these programmes are supporting the health system, or whether they are drawing health workers and other resources away from the public health system. They can also monitor how sustainable these programmes are.

Distribute resources fairly

If resources mobilised are to be used equitably, they should be preferentially allocated to those with the worst health status. For example, countries with low per capita GNPs, such as Kerala and Sri Lanka in Asia, and Zimbabwe (in the 1980s) and Botswana in southern Africa, made above average allocations to primary health care, prevention and early management of illness, and the widespread training and deployment of health workers. They also promoted the effective use of services. Parliaments can promote such allocations through the budget. Many countries, such as Zimbabwe, Namibia, South Africa and Tanzania, have included measures of equity and poverty into their resource allocation formulae. Budgets are thus not simply allocated according to demand from plans, or existing bed establishments, but also include a measure of need through indicators of poverty or health status. Parliaments can promote equity in resource allocation formulae, overseeing allocations and spending and assessing how far they support strategic health priorities.

Follow-Up

Parliaments can thus monitor spending, raise questions and call for evidence on a number of areas:

- Is health sector's current share of government spending above 15% and rising?
- How much does government spend on servicing debt? Is debt relief going to health?
- How can tax revenues for health be increased, especially through wealth taxes?
- How far are the gains of improved tax collection being shared with the health sector?
- What legal and policy measures have been taken to ensure that private insurance covers essential services, insures beyond wealthy groups only and includes cross subsidies between the rich and the poor?
- What steps have been taken to explore, consult on and establish social health insurance? Who will be covered? Do the benefits include essential health services? Is it sustainable? Will the contributions be fair? Will they be easily administered?
- Is there a plan for combining health financing measures (tax, insurance, etc.) to make up a universal national health insurance?
- Are there effective measures to identify poor households and other vulnerable groups, through services provided free at point of care or subsidy within health insurance?
- Are there effective mechanisms for ensuring that health resources are allocated to those districts and households with highest health needs?
- Are the health budget shares to primary healthy care, prevention and district services adequate and rising?

These questions and laws and policies that address them should reflect the principles that underlie all fair financing mechanisms:

- No one who needs health services should be denied access because they can not pay. Nor should household livelihoods be threatened by the costs of health care. This means avoiding making payments at the time of service use, as far as possible.
- Those with greater ability to pay should contribute a higher proportion of their income than those with lower incomes.
- The healthy should subsidise the ill, and the wealthy the poor, across the health system. Fragmentation between and within financing mechanisms should be reduced, to allow cross-subsidies across all financing mechanisms.

Resources

McIntyre, Di, Lucy Gilson and Vimbayi Mutyambizi (2005) 'Discussion Paper 27: Promoting equitable health care financing in the African context: Current challenges and future prospects,' *EQUINET Discussion Paper Series*. EQUINET: Harare.

EQUINET Steering Committee (2000) 'Policy Series 7: Equity in Health in Southern Africa: Turning Values into Practice,' *EQUINET Policy Series*. EQUINET: Harare.

These resources are available on the EQUINET website. *For further information on health financing, see www.equinetafrica.org or contact EQUINET at admin@equinetafrica.org*