

Fair financing for health: mobilising domestic resources and managing commercialisation of health systems

REGIONAL MEETING REPORT

**Munyonyo, Kampala, Uganda
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**Health Economics Unit, University of Cape Town and
HealthNet Consult in
The Regional Network on Equity in Health in East and
Southern Africa (EQUINET)**

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1. Background

The promotion of universal coverage means that health systems should seek to ensure that all citizens have access to adequate health care (adequately staffed with skilled and motivated health workers) at an affordable cost and which improve both income cross-subsidies (from the rich to the poor) and risk cross-subsidies (from the healthy to the ill) in the overall health system. This stems from our understanding of equity, which requires that people should contribute to the funding of health services according to their ability to pay and benefit from health services according to their need for care. Prior work in the fair financing theme in the network indicates that there is still a heavy dependence on donor funding in some east and southern African (ESA) countries and heavy burdens on poor people through high levels of out of pocket financing. There have been efforts to increase domestic funding of health services, and a number of countries are increasing government funding of health services.

The Health Economics Unit, University of Cape Town (Di McIntyre) and HealthNet Consult Uganda (Charlotte Muheki-Zikusooka) used evidence from work done in the past 5 years on tax and mandatory health insurance sources of domestic resource mobilisation as inputs to a regional research and policy review meeting in September 2009. The purpose of this meeting was to present and review research, implemented in and beyond the network, on domestic public resource mobilisation; to examine policy options, and country experiences in and barriers to improving domestic public resource mobilisation, with a focus on 'success stories' where countries have been successful in motivating for greater allocation of public resources towards the health sector. The meeting was held in Uganda just prior to the EQUINET Regional conference to connect delegates to the conference and to input into the wider network of equity actors and debates at the conference. The meeting identified knowledge gaps for follow up research, including on gender dimensions. Further, the purpose of the meeting was to find out more about health care financing in countries in the ESA region, and to identify what we should be focusing on in future and to plan the way forward.

The objectives of the workshop were to:

- i. review research findings, examine policy commitments (particularly the Abuja commitment) and options and country experiences on improving domestic public resource mobilisation, with a focus on equity and 'success stories';
- ii. review trends, consequences and co-ordination of external financing in relation to its implications for domestic public resource mobilisation,
- iii. review trends in commercialisation of health systems;
- iv. review gender dimensions of fair financing and the progress markers for improved gender equity;
- v. review fair financing indicators in the EQUINET Regional Equity Watch (as outlined in the Equity Watch guidance provided) and options for enhancing country monitoring and reporting; and
- vi. identify knowledge gaps for follow up research on promoting domestic public funding for health care, including on gender dimensions, and plan for future EQUINET co-ordinated research projects on these issues.

2. Welcome and introductions

Di McIntyre, UCT HEU, introduced herself and asked people to say their names, areas of work and expectations of workshop (see *Appendix 1* for list of participants). Expectations included that people hoped to

- learn more about health financing in the region,

- look at how we can better advocate for equitable health financing, and
- explore what a basic package of financed health services should look like.

Di went over the programme (see *Appendix 2*) and indicated where expectations would be met.

3. EQUINET'S fair financing work

Di outlined past work in EQUINET. She noted that work on resource allocation has been done in South Africa, Namibia, Tanzania, Zambia (all through EQUINET), and Zimbabwe (in the Equity Gauge) and is being initiated with Mozambique through EQUINET, and that there are intentions of extending similar work to other countries in the region. However, the focus of this one-day pre-conference meeting on health financing was focusing on resource mobilisation issues, rather than resource allocation. Di reminded the participants that the meeting aimed to examine what is happening in terms of health financing in the region and what fair financing means for the region. She noted that EQUINET had previously provided small grants for specific work on resource mobilisation in countries and the work was extremely diverse, for example, removal of user fees in Zambia, the Zimbabwe AIDS levy, community based health insurance (CBHI) and private health insurance (PHI) in Uganda, and Malawi's funding of AIDS interventions. EQUINET then pulled in the teams and analysed in detail what was happening in different countries in terms of where money comes from (including global financing), how it is pooled, and how it is spent. EQUINET has also been trying to monitor progress to the Abuja target of 15% of government spending on health, to which heads of state committed themselves.

Di also noted that for the new phase of work for which some funding has been secured for 2010–2015 through IDRC Canada, while the broad framework has been developed, the outcomes of the one-day financing meeting would influence what work gets taken forward. In terms of future work, priority focus has been given to improving domestic public funding for health services, and tackling the commercialisation of the health sector and its impact on health systems.

Training and Research Support Centre (TARSC) is leading work with the EQUINET steering committee on monitoring progress on equity through an Equity Watch, and this includes analysis of indicators of fair financing to monitor and report on health financing in countries and in the region, on a regular basis. This specific focus on financing indicators, which will be co-ordinated by HNC, will need to identify a core set of indicators to monitor health financing — to find out if we are promoting equity.

Therefore in this workshop we will work towards defining our research priorities.

The EQUINET working definition of fair financing is:

People should contribute to health financing according to income level and should benefit according to need for health services.

If we look at user fee removal and the lack of implementation of this, those with greatest health needs have least ability to pay. This suggests the type of health care financing we should have, which should provide financial protection, so that people are not impoverished by paying for health care. Therefore, we need prepayment mechanisms for health financing, instead of user fees and out-of-pocket (OOP) payments. Prepayment can come from two sources — either tax funding or health insurance, however, as experience from South Africa shows, private health insurance schemes only cover the richest, healthiest people as private insurers exclude sick

people, and therefore PHI is highly inequitable. What we want is as big a pool as possible of prepayment funds to benefit all citizens from rich to poor and healthy to ill through cross-subsidies. Hence we have derived EQUINET's focus on domestic funding and our concerns about private health care.

Many countries are considering the possible introduction of mandatory health insurance (sometimes called social health insurance (SHI) or national health insurance (NHI)); contributions are usually only made by formal sector workers. However, everyone pays tax through VAT, fuel levies etc. Therefore using tax revenue to fund health care ensures that everyone contributes. However, if you have tax and SHI, it could create two separate pools, although some countries like South Africa have said they will put tax funds and mandatory contributions in one pool, as has also been done in some Asian and central European countries.

Pooling prepayment funds allows for cross-subsidies with as little fragmentation as possible. Although many African countries are still heavily dependent on global funding, but this source of funds cannot be relied on in the long term. This is why we need to lay the foundations of strong sustainable domestic funding mechanisms now to provide financial protection and achieve equity goals. This is particularly important if we are to remove user fees, which must be supported by additional resources being allocated to public sector health services.

4. Review of country experiences

4.1 Domestic public resource mobilisation

How do we move towards the vision of universal health systems funded through prepayment mechanisms, and what are the incremental building blocks to move towards this? Is there fiscal space opening up and are we looking at insurance options, and will the insurance options proposed move us in the right direction? Ghana wanted to achieve universal coverage, and considerable progress has been made by having strong political leadership. South Africa is also moving towards NHI with mandatory contributions and tax. There is a lot of opposition to this and many challenges, but the decision to pursue NHI is again a political one.

Participants suggested that resource mobilisation needs be seen in the context of a specific benefit package, as it won't necessarily be possible to cover all health services. However, this would not be discussed in the workshop due to time constraints; instead using the Kutzin framework (see below) the workshop will focus mainly on revenue collection and pooling of funds.

A framework that is increasingly being used for the evaluation of health care financing options, and which provides the structure for the analysis presented here, identifies the key functions or components of a health care financing system, which are revenue collection, pooling of funds and purchasing (Kutzin, 2001; WHO, 2000).

Revenue collection refers to:

- who health care funding contributions are collected from (e.g. whether funds are secured from external and/or domestic sources and the extent to which contributions are spread between firms or employers and individuals or households);
- the structure of these contributions (e.g. whether pre-payment is involved or not and the relative progressivity of the contributions – where progressivity refers to

the extent to which the rich contribute a greater share of their income than the poor); and

- who collects these contributions (i.e. the type of collecting organisation, especially whether it is a government, parastatal or private organisation and if the latter, whether it is for-profit or not).

The function of **pooling of funds** addresses the unpredictability of illness, particularly at the individual level, and the inability of many individuals to be able to mobilise enough resources to cover health care costs without forewarning, and hence the need to spread these risks over as broad a group as possible and over time. This is the core of the concept of risk-pooling; individuals contribute on a regular basis to a pooled fund so that when they fall ill, the pool will cover their costs. The key issues that are of importance with respect to the fund pooling function are:

- the size of the population and which groups are covered by the financing mechanism; and
- the allocation mechanisms for distributing pooled resources.

The **purchasing** function refers to transferring pooled resources to health service providers in a way that ensures that appropriate services are available when and where they are needed by the population. While the term 'transfer' implies quite a passive approach, there is growing awareness that the organisation transferring funds should be an active purchaser of services for the beneficiaries of these pooled resources. The key issues of importance in the purchasing function of health care financing are:

- the choice of benefit package to which beneficiaries would be entitled, including the type of service and the type of provider as well as the route by which different services should be accessed; and
- provider payment mechanisms, or the precise way in which resources are transferred from purchasers to providers.

From: McIntyre D, Govender V, Buregyeya E, Chitama D, Kataika E, Kyomugisha E, Kyomuhangi R, Mbeeli T, Mpofu A, Nzenze S, Walimbwa A, Chitah B (2008) 'Key issues in equitable health care financing in East and Southern Africa,' *EQUINET Discussion Paper Series 66*. Health Economics Unit, UCT and EQUINET: Harare.

A participant commented that political leadership in developing NHI in Ghana was also supported by donors and the complementarities of the financing strategies with the poverty reduction strategy papers. With regard to financial protection, when we look at tax revenue as an alternative to or complement to SHI, government needs to appreciate the benefits of health care to general public — it is not just a private good and promotes social solidarity and cohesion.

The discussion explored the extent to which tax funding is going to health in countries, whether there had been an increase in public prepayment; progress in terms of more tax funds being allocated towards health and what has been happening that has prompted this? The participants reported their experience of trends in the countries, as recorded below.

Hon Mtukula (Malawi) reported that in **Malawi** in 1999, parliamentarians put forward a private members bill to move towards to Abuja target of 15% government spending on health. There was initially some resistance and questions about who had signed the Abuja declaration. It was explained that Heads of State had signed the declaration and the private members bill served to create greater awareness and

support for the Abuja target. After the bill was passed, there were improvements in budget allocations and movement towards the 15% target. He noted that it is still not clear if Malawi was achieving the 15% target with government funds alone, or if donor funds are included in that. He also noted that in the last budget there was decreased funding for health and an increase in funding of official residences.

Thomas Mbeeli, Ministry of Health Namibia, said that in **Namibia** there has been economic growth and good revenue collection, but with the economic down-turn, there is a deficit for this financial year. In the last four to five years, Namibia achieved about 12% of the national budget, including donor funds, being allocated to the health sector. This level of funding is the result of government making health, education and housing the key priorities. In 2009, more funds have also been allocated to upgrading health facilities. In addition there are funds from PEPFAR and the Global Fund (GFATM) which go directly to civil society organisations. The burden of disease requires Namibia to expand capacity in clinics and hospitals especially for ARV provision. There is a commitment from the president, the health minister and the Parliamentary Portfolio Committee of Health, and good co-operation between the health minister and parliamentarians around improving the health system. Where ministers and parliamentarians speak the same language it is very powerful. The Abuja Declaration was meant to show a domestic commitment to health financing and therefore we should remove the donor component when measuring progress towards the 15% target.

Amon Mpfu said that in **Zimbabwe**, in 2008 about 14% of the government allocation from tax went to health, and some funds also came from other sources. Donors weren't channelling funds through the government, but through civil society organisations (which is difficult to monitor). He noted that Zimbabwe is now seeing substantial external funders starting to fund government programmes such as the Global Fund for AIDS, TB and Malaria (GFATM), which has agreed to fund human resources for health. Such positive changes need to be monitored.

Although the health budget increased as a percentage of government funds after 2000, it was meaningless with the declining value of Zimbabwe dollar. In the 2009 budget, health funding was down from 14% to 11%. The AIDS levy adds another 2% to the total health funding. The AIDS levy (which is an additional 3% on individual and company income tax) lost value because the fund is dependent on ability to collect tax, and this has fallen as economic activity has become more informal, given the difficulty with collecting taxes from the informal market. He noted that to be accurate it is better to assess health spending in terms of expenditure rather than budget allocations. He also noted that the budget is now based on US dollars, as the economy has 'dollarised', so that the estimates are now more stable.

Hon Chebundo, Parliament of Zimbabwe, said from the lens of parliament the political commitment was there, but hyper inflation eroded the level of real spending on health. However, he noted that there does now seem to be an improvement in, for example, medicine supply.

Kenya has been moving away from the Abuja target with only 6.8% of the government budget allocated in 2008 and only 5.8% allocated in 2009, although the absolute amount went up. However, there are also additional funds (under the capital or development budget) to build more health centres. Further 'constituency funds' can be used flexibly and up to 40% is sometimes spent on health. The Ministry of Health is concerned about allocating additional funds to the health sector as the MoH has not been able to spend all of the additional funds allocated to it. The National Health Insurance Fund (NHIF) has existed since independence as a para-statal. In

2002 the Minister of health wanted to expand the scope of this fund, but this was opposed by the World Bank and parliament subsequently rejected it, weakening solidarity based financing, and the minister was transferred to another sector. There are concerns about the NHIF where about 50% of the revenue is devoted to administrative costs and providers are not reimbursed in a timely fashion by the NHIF. There is little public confidence that this will change. In Kenya, commercialisation of health care has been undermining equity, with much of the NHIF resources being directed to covering services in private sector facilities. The situation demands strong political will to achieve changes. The private medical care sector has strongly resisted measures to challenge commercialisation or improve public leadership, and has taken members of parliaments on retreats to lobby their position. The private health care sector is worth billions and is backed by international organisations. Mass mobilisation is needed to ensure inclusion of the informal sector in the NHIF system. In Kenya tax revenue collection has increased, but with 30% budget support by external funders, there is significant donor influence. Lack of political will is apparent in the lack of provision of direct facility grants. Revenue collection is directed to debt repayment narrowing the fiscal space, and national health insurance continues to be resisted by the World Bank and the private sector.

In **Tanzania**, 12% of the government budget goes towards health, but this represents only 1% of GDP. There is now mandatory health insurance: a NHIF for civil servants and via the National Social Security Fund (NSSF) for employees in private businesses. These schemes only cover a few select hospitals, however, and the benefits are restricted. There is also the Community Health Fund (CHF) which covers people outside the formal on a voluntary basis. However, only 1% of the population are covered by CHF. Community based schemes often excludes the poorest people; 25% of Tanzanians live below the poverty line. There are inefficiencies in translating financial resources into health workers and medicines. The funding system is therefore quite fragmented in Tanzania. The reason for a separate insurance pool for private sector employees is because private firms did not trust the government with the funds, but this affects possibilities for risk pooling. In Tanzania, some companies use private insurance, with most private insurers being foreign companies. The private sector is seen to have a level of over prescription and diagnostic testing in private hospitals, raising the costs of care. It was felt that regulation of the private health sector is necessary.

In **Swaziland**, there was a deliberate decision by government to gradually increase the health budget towards the Abuja target and this year allocation is at 11.2% from 10% last year. If donor funds are included, spending on the health sector is 17% of combined government and donor funds. The largest donors are GFATM and the European Community (EC). While there is a commitment to increased tax funding of health services, there are also competing priorities and 10% of this year's budget also went to agriculture to promote food security. In health, the government is trying to achieve more from the dollar than it is currently achieving, with better procurement procedures. SHI is being discussed after a feasibility study undertaken together with WHO found the option to be feasible. Unions and workers have been engaged on the proposal, as have the non-profit providers. However, at the same time as the study was undertaken, there were moves to introduce private health insurance for government workers. It was noted that the two cannot co-exist and private insurance is now on hold as people are beginning to understand the benefits of SHI.

In **Uganda**, the government budget for health care increased by 70% between 2001/02 and 2004/05. By 2004/05, the share of the government budget for the health sector was 11.2%. This dramatic improvement happened at a time when debt

cancellation came into effect. Tax collection has also improved. However, by 2007/08, the health sector share had decreased to 9.6% and now is at 8.3%. The increasing budget share did not produce a noticeable growth in terms of per capita expenditure on health. Lots of money goes into health sector off-budget and an argument that funding for the health sector is coming from elsewhere is being used to reduce government health budgets. Government also says funds are not being used efficiently and that if efficiency is not improved funding won't increase.

There have been consultations around SHI in Uganda and it was originally planned to be introduced in 2009. Strong opposition to the scheme and questioning of its feasibility has been raised. Employers and workers have resisted SHI due to past experience of corruption, so workers perceive that benefits won't flow to them. In the recent past, however, increased tax revenue has been achieved by improved management in the revenue authority. While the system has improved there is still a trust issue around SHI, and without trust it will not be possible to take the scheme forward. People have also questioned the motive and intention of technocrats pushing SHI and as these debates were picking up, corruption around GFATM was exposed. The Federation of Uganda Employers was opposed to SHI because they were not consulted and questioned how well it would be implemented. SHI is still being pursued and a further feasibility study is now being done. There is political will for it. There is also, however, a question of ownership, and people look at such schemes as being for political dividends, such as when remove user fees were removed before the previous elections for the party to promote itself.

In **Mozambique** domestic funds have been increasing slowly. A 60% donor contribution to the health budget makes it difficult to motivate for increased government money for the health sector. Money is directly controlled by the donors and not necessarily aligned to national priorities. The Minister of Finance also alleges there is limited ability for the health sector to absorb additional funding. Revenue collection is very weak and there is not a lot of capacity in that regard. Civil servants are covered by mandatory health insurance, but it only covers treatment at public hospitals and civil servants have to queue for a long time to access care. They thus query why they are paying when they get little benefit as they regard public hospitals as providing poor services. The possibility of a broader spread of NHI to other sectors is being investigated, but needs to confront this negative perception.

Di asked where progress has been made in increasing funding, what has led to this and what has stopped mandatory insurance proposals going through? Abuja can be useful as an advocacy tool as the heads of state agreed to this. Monitoring is, however, difficult as donor money for general budget support goes to Ministries of Finance, making it difficult to see what is "government money" and what is "donor money". Even if the Abuja target share is met, the absolute budget may be small. The 15% allocation is thus not enough for adequate health systems. In countries where progress towards the Abuja target has been made, Ministries of Finance may not be happy about the increased allocation and there is a need to engage Ministries of Finance on this. In Namibia, prominent people championed increased health sector funding — with a specific policy commitment to social services — and there is a good relationship between the Minister of Health and parliamentarians, which helped to leverage additional funds.

Dedicated taxes can also draw tax funds into the health sector. We need to not just focus on what share of the budget goes to the health sector, but also to explore what can be done to strengthen tax collection, given that when tax revenue is increasing it is easier to motivate for more funds for health. With the global economic downturn,

there is a great constraint on tax revenue and we need to think about strategies for improving tax revenue.

Some countries in the region have been able to increase tax revenue dramatically. For example, in **South Africa**, tax revenue increased even though the tax rate decreased, due to increased ability to collect. We therefore need to push for improved tax collection.

We need to have a champion for increased funding, and push for more monitoring if we are going to expand the pool of public funds. Although a lot of countries are looking at mandatory insurance, not a lot of progress has been made, not least of all because the private sector opposes such reforms. In some cases (e.g. South Africa) people employed in the formal sector, particularly high income earners, are not happy about NHI proposals. In many countries, the Ministry of Finance opposes NHI proposals. Meanwhile, in South Africa, tax funds — in terms of a rebate to those who contribute to private health insurance and in terms of employer contributions to private insurance for government employees — are subsidise private health insurance.

Debt repayments are further reducing the fiscal space for increasing health budgets. In countries where there is a heavy reliance on donor funds to fund the health system, governments use this as an excuse to reduce their own spending on health. The Abuja Declaration of 15% share to health does not always produce the WHO Macroeconomic Commission on Health recommended per capita figure of US\$34 for basic health interventions, including for AIDS, TB and Malaria. At the same time an argument is raised that expenditures on other sectors impact on the social determinants of health, such as education and agriculture. These sectors too need protection and we are not spending enough on ALL social services. The Abuja target, while relevant to prioritisation for health, is not adequate, and we should perhaps also be using a target relating to public spending as a percent of GDP.

There is a lot of activity in the region around mandatory insurance. However there are clear problems in moving to implementation. Process issues are really important in introducing mandatory insurance, and tax payers also want accountability in terms of how money is being spent. We need to assess whether mandatory insurance is appropriate in the country context and if it will take us forward in terms of equity issues and in achieving universal coverage. We also need to demonstrate that the health sector can absorb more resources and improve efficiency in the use of resources.

4.2 Commercialisation of the health sector

Delegates noted the increasing pressure to promote the private health sector in Africa, particularly from the IFC and Gates Foundation. We are seeing the growth of private-for-profit providers, who focus on curative care and maximising profit. Prior evidence in EQUINET indicates that if the goal of governments is to maximise health outcomes and provide health for all, it needs to invest more in preventive care and focus on public sector leadership in health. Delegates discussed the trends they observed in commercialisation, as reported below.

In **Namibia** a small state-of-the-art private sector is reported to be driving inequities in the availability of health workers and in increasing out of pocket payments.

In **Zimbabwe** it was observed that there has been an increase in private sector activity, with medical aid societies acquiring more clinics and hospitals and

government ceding its 34% shares in pharmaceutical companies to private players. There is also evidence of large private hospital groups like NetCare exploring expansion into the region, including Zimbabwe. In **Uganda** there is increased commercial provision and financing, with medical doctors starting up private practices, and coming together as specialists to set up in hospitals, with a prepayment scheme that is poorly regulated with limited benefits. Out of pocket payments (OOP) to private providers are increasing, in spite of the removal of user fees at all public sector facilities. The government has a policy of private sector- led growth and private operators are getting funding from government to build hospitals. The government then reduces the health budget by the amount invested, and the private sector gets tax waivers on imports of machinery and equipment. In **Uganda** only 1% of people pay into prepayment schemes, and there are high OOP payments which are highly inequitable. Private expenditure is higher than government spending.

In terms of regulation of the private sector, participants noted that in **Kenya** you can open a pharmacy without having a pharmacy qualification. The private sector has multiple registration bodies with no co-ordination between them. It is thus difficult to assess quality of care.

In **Malawi**, the private sector is predominantly private not-for profit, contributing 40% of health care provision. Paramedics and doctors in the private for-profit sector are however mushrooming. These are mostly urban based where health need is lower. Government is trying to be involved in the church hospital sector to encourage free care and to make them function as part of the referral system. Plans are underway to extend public funding to private sector providers, to encourage them to extend into rural areas. However the health providers are arguing that this can only be done if other services are also extended, such as roads.

In **Zambia** it was reported that there has been an increase in OOP payments, which demonstrates increased commercialisation. This raises issues around health outcomes and quality of care as an unregulated private health sector is difficult to monitor in terms of health outcomes. It is also important to assess how increased commercialisation is increasing household poverty.

As **South Africa** moves towards NHI, the South African private medical insurance hospital industry are looking for opportunities to expand into the rest of Africa. It was raised that we need to think about how the introduction of NHI in South Africa will impact on the rest of Africa.

In the general discussion it was noted that there can be useful public-private initiatives which improve cross-subsidisation, but in general, the for-profit sector seems to take us away from equity. In **Zimbabwe**, the private sector has been involved in health promotion and could be helpful in that regard. Some public-private-partnerships have also provided specialised services at a subsidised cost.

It was noted that people are using informal private care, raising concerns about the quality of care they are getting. This includes general stores and co-operatives selling medicines and traditional healers. Questions were raised about what this meant for the quality of care we are aiming for in our health system.

The key issues arising from the discussions on health sector commercialisation include:

- There is very low coverage by private health insurance
- OOP payments are often greater for those with private health insurance, due to high levels of co-payments
- Faith-based facilities are key providers in many countries – a distinction should be drawn between not-for-profit and for-profit providers
- In most African countries, the population frequently uses informal private providers and there are serious quality concerns about these providers
- Private for-profit sector providers usually only focus on curative services
- Private for-profit services are heavily concentrated in urban areas
- A commercialisation trend in some countries has been that private doctors group together to establish a private hospital and then also set up some form of pre-payment scheme for people to access services at their hospital (but with very limited benefits and large OOP payments)
- It is critical to put regulatory mechanisms in place, but there are high transactions costs involved in regulation and there is a lack of co-ordination between different regulatory mechanisms and authorities
- There is limited information on the extent of the private health sector, which also constrains regulatory interventions
- The issue of tax rebates and concessions to private for-profit providers requires reconsideration
- The question should be posed as to why international organisations such as the IFC focus on promoting private sector growth and not on strengthening the public sector
- Macro-economic policies often underlie moves to commercialisation – e.g. a policy of private-led economic growth allows private health care groups to get support from government – it is very concerning that sometimes, subsidies to private providers are deducted from the government health budget

5. Monitoring adequacy and equity in domestic public resource allocation

In 2007, EQUINET produced an analysis of health equity in the 16 countries of east and southern Africa covered by EQUINET that:

1. Mapped, outlined and analysed determinants of the major dimensions of and trends in equity in health and health care in the region;
2. Discussed the economic and policy context for these trends, from country to global level;
3. Examined key policies and measures for reducing inequalities in health, generally and particularly by the health systems of the region, and the opportunities and challenges for implementing these responses.

The full book can be downloaded at

<http://www.equinet africa.org/bibl/docs/EQUINET%20Reclaiming%20the%20Resources%20for%20Health%20in%20ESA.pdf>

The analysis proposed that health equity is advanced when:

- i.* Health is integrated within and occupies a central position in national, regional and global goals, as a fundamental right and a development goal; and that is operationalised in practice. This means that all policies, particularly economic and trade policies protect and promote health.
- ii.* Equity is given profile and monitored in health and health sector advocacy and strategic reviews at country, regional level and in international partnerships:
- iii.* There is a wider understanding of, advocacy for and effort to operationalise fair resourcing of health systems through progressive public tax and social health insurance financing with resources allocated in line with health needs.
- iv.* The role of people – communities and health workers- is recognized, valued, supported and programmed in equitable health systems.

In the regional equity analysis the EQUINET steering committee noted that while knowledge and evidence are important for advancing health equity, there is need to give visibility to this evidence to motivate policy attention and reinforce good practice. This is especially important for policy measures that are identified from prior research and practice to improve health equity.

An **Equity Watch** thus provides evidence to

- Track, make visible and support engagement by key national (and regional) institutions (government, parliament, health worker, civil society) on priority dimensions of equity in health and in health systems;
- Organise and give visibility to evidence on health equity and measures for improving it, as an input to strategic planning;
- Monitor progress on actions taken to improve health equity, particularly against commitments made and goals set;
- Promote dialogue to draw perspective, evidence and experiences on priorities and options for strengthening health equity;
- Point to areas for deeper research; and
- Share evidence for regional compilation and exchange across countries, including on promising practices.

Based on this the EQUINET steering committee has proposed to take forward the production of an **Equity Watch** at country and regional level to gather evidence on, analyse and promote dialogue on equity in the context of country and regional opportunities and challenges. The country analysis follows a standard regional framework, adding further information as relevant to that country. The country analysis is implemented by national institutions with support from TARSC and the EQUINET steering committee, and the regional analysis is compiled by TARSC.

The meeting was asked to review specifically the fair financing indicators included as markers of progress towards equity in the Equity Watch. In groups delegates explored how we can monitor equitable financing, and reviewed the existing indicators for the equity watch and added additional indicators.

Progress markers relevant to fair financing in the equity watch (note the Equity Watch has a range of other indicators relevant to other aspects of equity in health)

1. Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in ESA)
2. Abolishing user fees from health systems;
3. Achieving the Abuja commitment of 15% government spending on health
4. Achieving the WHO target of \$60 per capita spending on health systems in the public sector;
5. Increasing progressive tax funding to health; reducing the share of out-of-pocket financing in health;
6. Harmonising the various health financing schemes into one framework for universal coverage;
7. Establishing a clear set of comprehensive health care entitlements for the population;
8. Allocating at least 50% of government spending on health to district health systems (including level 1 hospitals) and 25% of government spending on primary health care;
9. Implementing a mix of non-financial incentives agreed with health workers organisations
10. Formally recognising in law and earmarking budgets for training, communication and functions of mechanisms for direct public participation in all levels of the health system.
11. Debt cancellation negotiated;
12. Allocating at least 10% of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers;

The groups reported back on their discussions and the following points were made:

On resource mobilisation:

- The Abuja target is good at showing government commitment but doesn't necessarily show equity, which depends on issues such as whether money is going to primary or tertiary care. It is important to see how the 15% is allocated, e.g. to young people, women, the elderly, etc. We need to monitor what percentage of the health budget goes to primary care, and how much goes to drugs and human resources.
- We need to establish for each country the cost of an essential health package and find out how this is being met; at the same time the entitlements must be monitored to see if they are delivered on the ground.
- The number, types and beneficiaries of insurance schemes and the geographic and socio-economic distribution of schemes must be monitored.
- We also need to establish the level of privatisation, commercialisation and OOP. We should monitor OOP by looking at the number of people pushed into poverty as a result of catastrophic health care spending, and the coverage of public and private health insurance.
- The influence of global health institutions (GHIs) must also be monitored.

On resource allocation:

- We need to track both financing and delivery as resource allocation does not necessarily translate into benefits.
- We need to monitor levels of spending at district, provincial and national levels, and see if government spending is based on the relative need for health care.

- We should monitor incentives to motivate health workers and the geographical distribution of health workers. (Note this parameter is indeed included in the watch but was not included in the discussions at the meeting)
- We need to look at the number of new health centres and how much is going to capacity building over time.

On the process generally:

- We need to marry basic indicators to financial indicators, although this can be problematic depending on where the figures come from.
- The selection of indicators must be guided by feasibility – some household surveys such as DHS are undertaken routinely and give information on some indicators, but not necessarily on OOP payments.
- We need to have a balance between input and output indicators. The focus at the moment is on input indicators; but we need more indicators on the distribution of benefits from resources (e.g. benefits from using services across SES, gender, ethnic groups, rural-urban areas, etc). Refining the indicators will be an iterative process of identifying indicators and assessing feasibility of collecting this data.
- The forms of collaboration and who takes the lead should be decided within the specific country context.
- We need to check whether there is a demand for an Equity Watch in different countries. It would be good to draw in a wide group of institutions, but budget constraints are key. However, it should be a participatory process and it is critical for ministries of health to be involved, so that it is regarded as acceptable.
- The report needs to do more than just document progress in terms of descriptive statistics but also provide insights into what needs to be done to move forward.
- We also need to incorporate gender into our analyses and highlight gender sensitive budgeting as important.

The delegates from countries noted ongoing activities that could be supportive in taking forward an Equity Watch at country level:

- In Malawi, MHEN does budget tracking working with ministry of health, researchers such as REACH Trust and other stakeholders.
- In Zimbabwe, TARSC, Ministry of Health, Community Working Group on Health and the parliamentary portfolio committee formed an Equity Gauge and have since co-operated in equity monitoring.
- In Tanzania researchers work with MoH and other stakeholders.
- In Kenya researchers have a good collaboration relationship with the MoH. It would be good to get researchers to take responsibility for collecting the information and ensure there is good collaboration with the MoH in the process.
- In Uganda researchers in a range of institutions collaborate with the MoH.
- In Swaziland there is a technical working group of researchers and MoH , but the process needs to sensitise the Ministry and get buy-in.
- In Namibia this should be an initiative of MHSS, drawing in researchers from universities.
- In Zambia, UNZA and the MoH can work together, but with some independence to provide a mechanism for academics being able to hold government to account.
- In Mozambique, the MoH (Planning Directorate) should lead it; with the involvement of researchers in the Institute of Health (and University) as well as other stakeholders such as Institute of Statistics.

These inputs will be taken forward through the next steps in the process of development of the Equity Watch.

6. Research gaps on fair financing

To conclude the meeting participants reviewed the knowledge gaps and identified the following research priorities on fair financing:

- Benefit incidence analysis, i.e. identifying which groups (specified in terms of socio-economic status, gender, area of residence, etc.) are getting what benefit from health services
- Resource allocation, particularly in terms of how funds are being absorbed; whether resources are being allocated appropriately and how they are promoting improved health outcomes;
- How to move from fragmented to integrated pools of health care funds;
- The policy processes and roles of key actors in promoting improved public funding;
- Issues relating to the public-private mix, such as how to ensure that private sector services contribute to public policy goals;
- Evaluating alternative models of funding, particularly donor funding, to identify those that most improve health services;
- Identifying good practice in translating funding into services that reduce maternal and infant mortality and that address HIV and AIDS;
- Work on the social determinants of health in the African context and funding of the full range of social services and interventions that address these social determinants (and the trade-offs between funding health services and funding other interventions that address social determinants);
- The benefits and disadvantages of using insurance as a health funding mechanism in low- and middle-income countries and how to implement insurance for equitable financing in low-income countries
- OOP payments and catastrophic spending – maximising the use of information on these issues in ways that are accessible to policy-makers;
- Regulation of private for-profit health sector activities and commercialisation;
- Costing of health services (and considering the outcomes) to feed into the design of benefit packages;
- How to improve purchasing within mandatory health insurance;
- Drivers of increased tax allocations to the health sector and how some countries have managed to improve tax collection.

It was noted that these knowledge gaps could be taken up through follow up research, including on gender dimensions. Through mentoring, the fair financing programme in EQUINET will support the development of selected proposals for follow up work, with resources sourced from national and country bilateral support funds and mentoring and regional review through the network.

The meeting was then closed.

Appendix 1: Participants List

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Appendix 2: Programme

8h30-9h00	Registration and admin
9h00-9h30	Welcome and introductions Brief overview of EQUINET work on fair financing to date Review of objectives and agenda
9h30-11h00	Review of country experiences with: <ul style="list-style-type: none"> • domestic public resource mobilisation (including impacts of external resources) • commercialisation of the health sector
11h00-11h15	Tea
11h15-13h00	Unpacking success factors in improved domestic public resource mobilisation
13h00-14h00	Lunch
14h00-15h00	Monitoring adequacy and equity in domestic public resource mobilisation: <ul style="list-style-type: none"> • discussion on the tracking of the Abuja commitment and of the indicators in the Equity Watch • Options for improved monitoring and reporting
15h00-15h15	Tea
15h15-17h00	Next steps: <ul style="list-style-type: none"> • Research gaps on domestic public funding and taking forward EQUINET co-ordinated financing research • Monitoring fair financing (including gender issues), particularly equitable domestic resource mobilisation and health sector commercialisation, in the equity watch