

**Regional Network for
Equity in Health in east
and southern Africa**

DISCUSSION

Paper
NO. 119

Critical assessment of domestic health financing options in east and southern Africa

Jane Doherty

School of Public Health, University of the
Witwatersrand, South Africa

In the Regional network for Equity in Health
in east and southern Africa (EQUINET)

EQUINET DISCUSSION PAPER 119

June 2019

With support from IDRC (Canada)



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EXECUTIVE SUMMARY

The Regional Network for Equity in Health in east and southern Africa (EQUINET) commissioned this desk review paper. It aims to contribute to a regional understanding of the positive and negative implications of the different domestic health financing options being explored, advocated and implemented in the East and Southern African (ESA) region. It presents issues to be addressed in the implementation of these financing options from the perspective of equitable progression towards universal health coverage (UHC), to inform policy dialogue and decisions on domestic health financing in ESA countries. The paper considers only one aspect of health financing reform, namely, *revenue collection*. It distinguishes between *policy instruments*, i.e., the sources of finance, and *policy strategies*, i.e., how these instruments are deployed to achieve various objectives or to address contextual features. *Non-contributory sources* (essentially tax-financed) and *contributory* (employment-based) options are explored.

The paper presents:

- a. A typology of domestic revenue instruments and strategies;
- b. Domestic financing trends and options in place, or under consideration, in ESA countries;
- c. A review of low- and middle-income country experiences of domestic financing options;
- d. Conclusions on the findings and lessons for ESA countries.

The information is based on analysis of the 2015 National Health Accounts data for ESA countries, a rapid review of current and planned financing sources in mainly grey literature on ESA countries and a review of literature on lessons learned by low- and middle-income countries (LMICs) with respect to revenue collection reforms.

ESA countries intend to expand UHC within economic contexts that affect their choices with respect to increasing domestic financing. Out-of-pocket (OOP) payments, the most regressive source of financing, remain widespread, with some exceptions. OOP spending generally declines as government spending increases. Generally, ESA countries vary in the share of general government expenditure allocated to health, with this falling below the minimum target of 5% of GDP in thirteen of the 16 countries. While levels of mandatory, vs. voluntary, financing are generally below 50% of total financing, several ESA countries perform better than the average for their income category, except for upper-middle-income countries.

ESA countries are exploring diverse options to boost domestic financing, including indirect taxation on consumption, new indirect taxes, improved tax collection, and earmarking a share of existing taxes for health. Many ESA countries are exploring contributory financing options, either by attempting to incentivise informal employees to join existing social health insurance (SHI) or introducing new schemes. Some countries are exploring or widening voluntary prepaid options, whether community-based or commercial health insurance schemes.

Many countries in the region are grappling with difficult economic conditions and large informal sectors that are difficult to draw into taxation systems or contributory health insurance. However, it is still possible for all countries to take steps towards UHC. There is no single blueprint for doing this. What is politically acceptable and practically feasible is specific to each country's socioeconomic and political context. Given policy commitments to equity, efficiency and sustainability, countries need to consider the implications for these policy goals of the revenue collection choices they make, together with their fiscal implications, contribution to revenue, pooling, income and risk cross-subsidies; and the opportunity they provide for equitable resource allocation.

Countries need to position their choices in relation to their institutional resources and capacities, the efficiency and ease of their collection, the potential to avoid cost escalation and their political and social acceptability. The experience of other LMICs confirms the importance of mandatory, prepaid financing and the strengths of non-contributory, tax-financed systems for these goals, especially in providing financial protection and risk pooling. Experience also indicates that attempting to enrol the informal sector in employment-based schemes is not a successful strategy for improving revenue collection.

Direct taxes are the most progressive source and can generate large funding pools, depending on tax levels, the distribution of tax burdens relative to wealth, the efficiency of tax collection and the quality and equity of services funded. Direct taxes are vulnerable to economic downturns and more difficult to collect where informal employment is high.

Innovative indirect taxes on goods and services consumed by wealthier groups in the population, taxes on large, profitable companies and earmarking of certain tax sources for health provide new taxation opportunities, particularly if the form of indirect tax chosen for earmarking comprises a large portion of tax financing. Indirect taxes are administratively easy to collect and can play an important role where informal employment is high. Some gain political support where they can be linked to positive health impacts or used for underfunded areas of public health. Some indirect taxes may generate relatively little revenue, however, and some are susceptible to changes in consumption. As a flat rate charge, they may be less progressive than direct taxes, unless they are applied to luxury goods or lower income groups are exempted effectively.

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, or whether members face co-payments and the entitlements covered. Adequacy and pooling are enhanced when the scheme is large, but administration can be complex, especially where informal employment is high. SHI demands significant institutional capacities to implement strategic purchasing and control cost escalation, given the inherent incentives for overuse. When introduced first for the formally employed, SHI by definition extends cover for better-off population groups and carries a potential for resistance from these groups to widen cover and cross-subsidise membership for lower income groups in support of UHC. 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 the poor who are dependent on tax-financed services. Hence, where SHI is judged to be a more politically acceptable route for generating additional revenue than general tax financing, it is important that SHI funding be blended into a single financing system, if not a single pool, with tax funds, with common entitlements across the system. This is necessary to prevent further separation of the health system into tiers, with a better-resourced tier for the formal sector and a poorly resourced tier for others.

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. *OOP payments*, if a large part of a country's financing, may lead to catastrophic payments and impoverishment. The review suggests that ESA countries should aim to reduce the portion of revenue raised through user fees, eventually limiting user fees to nonessential or discretionary services, or to achieve policy objectives such as strengthening referral systems.

Reducing OOP spending would need to be done in tandem with increasing equitable sources of finance. All ESA countries would benefit from measures to strengthen tax collection and improve the share of government revenues devoted to health. Efforts to increase indirect taxes could desirably be linked to new, longer term sources from taxing wealth and natural resources. For UHC, employment-based SHI schemes need to be conceived as contributing to the creation of a truly national health insurance system. Some countries are in a stronger economic position to advance mandatory prepayment and universal entitlements, through consolidating SHI schemes and risk pools, standardising service entitlements and providing tax-based subsidies for poorer groups. It is well established that, to achieve UHC, private voluntary insurance can only be conceived as a complement to, rather than substitute for, mandatory financing.

Revenue collection measures need to be accompanied by measures to strengthen strategic purchasing and access to effective, quality care. Any immediate choices would need to consider and project long-term impacts on the system, and long-term funding demands, to respond to changes in population health, such as the emergence of chronic conditions. The options need to be considered in the context of wider political and policy objectives. Their potential impact needs to be carefully modelled and the costs and benefits of options effectively communicated to finance ministries and other stakeholders. The implementation of reforms needs to be monitored and reviewed, for adjustments to be made to address both positive and negative consequences.



1. INTRODUCTION

This desk review paper commissioned by the Regional Network for Equity in Health in east and southern Africa (EQUINET) aims to contribute to a regional understanding of the positive and negative implications of the different domestic, health financing options being explored, advocated and implemented in the East and Southern African (ESA) region. It presents issues to be addressed in implementing financing options from the perspective of equitable progression towards universal health coverage (UHC) and strengthening of universal, public sector-led health systems, and in informing policy dialogue and decisions on domestic health financing. It covers ESA countries, viz: Angola, Botswana, Democratic Republic of Congo, eSwatini, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

The paper focuses on only one specific aspect of health financing, namely **revenue collection**. This is to allow detailed reflection on possibilities for countries grappling with the challenge of extending UHC in contexts of constrained resources and shrinking external funding. Other components of health financing reform – revenue pooling, benefit design and purchasing mechanisms – are equally important for equity and other impacts, sometimes augmenting and sometimes nullifying the stated objectives of revenue collection and pooling policies (Cavangero et al., 2015).

In particular, it is difficult to discuss revenue options without considering the extent to which they are pooled in a single fund. Likewise, equitable access to relevant quality services is key for health systems to move towards UHC. The way these components are put together enables successful universal systems. While these points are discussed later in relation to implementation issues, this report focuses on the **sources of finance** with some reference to how they are pooled.

The paper distinguishes between **policy instruments**, defined here as the actual sources of finance, and **policy strategies**, which are the ways in which these instruments are deployed to achieve various objectives or take account of contextual features. These policy instruments and strategies are described separately for **mandatory** and **voluntary** financing systems. The paper acknowledges, as explained later, the now well-established evidence that financing systems seeking to achieve UHC can only do so through expanding prepaid sources (to achieve financial risk protection) and through mandatory methods (to achieve income- and risk cross-subsidies) (Kutzin, 2013).

Notably, it is not possible to identify in isolation what the impact and desirability of any single source of revenue might be. This is partly because the answer depends heavily on the specific political and economic features of each country. It also depends on how the other components of health financing – such as the scope and level of benefits, purchasing arrangements and service delivery – are designed and implemented. While it is possible to reflect broadly on the equity, efficiency and sustainability issues associated with each source of funding, the impacts differ between countries and systems. Each country therefore needs to analyse its own situation in-depth and interrogate its political perspective and priorities to make its policy choices on domestic revenue collection.

The paper presents:

- a. A typology of domestic revenue instruments and strategies;
- b. An overview of domestic financing patterns and options currently in place, or under policy consideration, in ESA countries;
- c. A review of low- and middle-income country experiences of mandatory domestic sources and briefly of voluntary sources; and
- d. Conclusions on the lessons for ESA countries from international experiences of these different domestic financing sources.

2. METHODS



The information in the paper is based, first, on the 2015 National Health Accounts matrix data for ESA countries, provided by the World Health Organisation (WHO). For the first time, this data distinguishes external funding flowing through government budgets (WHO, 2017). This allows a much more reliable estimate of governments' domestic commitment to the health sector.

The new dataset also differentiates between general tax-financed and mandatory, payroll tax-financed government expenditure (the latter called social health insurance [SHI] in the database). This allows for a more nuanced analysis of contributory versus non-contributory financing. Lastly, the database presents current expenditure separately, given that large, irregular (capital) expenditures can distort trends. This document reports only current expenditure.

The methods also included a rapid review of grey literature, mainly government, WHO and external funder reports, and published literature on ESA countries, using the terms 'health financing' and 'universal health coverage', combined with country names, to identify their current and planned financing sources. The same search terms were used to gather published and grey literature from low- and middle-income countries (LMICs) to identify lessons learned with respect to implementing revenue collection reforms. Given time constraints and recent burgeoning literature on this topic, priority was given to publications from 2010 and publications that reviewed the experience of multiple LMICs to capture recent developments and to identify general trends rather than individual country situations.

The methods faced various limitations. In some cases it appeared that the WHO data were incomplete. It was also not possible to look at all the available evidence from ESA countries or other LMICs. The impacts of many health financing reforms have not been extensively researched, and impacts are not always attributable to financing strategies given the complexity of large-scale reforms. Nonetheless, this paper identifies key concerns raised with various policy instruments and strategies that policy actors need to be aware of when seeking to extend UHC in ESA.

3. REVENUE COLLECTION INSTRUMENTS AND STRATEGIES EXAMINED

Box 1, below, presents a typology of the traditional sources of funds – or policy instruments – for funding health systems, noting the distinction between mandatory and voluntary instruments.

Box 1: Key sources of health financing (financing ‘instruments’) and strategies

MANDATORY, PREPAID FINANCING OPTIONS

Non-contributory financing options relate to various sorts of general government taxation, where the entire population benefits from the services funded through these taxes, at least in theory. For this category of financing, entitlement to health services is not dependent on having contributed funding, or the specific level of contributions. There are two main **sources** of taxation:

1. Direct taxes:

- *Personal income taxes* are levied directly on individual income, including income from a variety of sources, such as wages, salaries, interest on investments and rental income.
- *Company taxes* are levied on company profits. Governments set the average rate to achieve a balance between raising revenue and encouraging investment in the country.

2. Indirect taxes

are levied at the point of purchase of consumption items. The most common are:

- Taxes on consumption of *general items*, often known as Value Added Tax (VAT);
- Taxes on consumption of *luxury items*, such as yachts, high-end cars and fuel; and
- Taxes on *harmful substances*, such as tobacco, alcohol, sugar, road services and mining.

The main **strategies** for increasing this funding for the health sector are:

- For increasing general tax revenue, by reforming tax policy; strengthening tax collection capacity; and generating additional revenue from new, innovative sources (e.g., taxation of natural resource use, financial instruments and mobile phone use).
- For expanding the fiscal space for health, by negotiating an increased share of total government revenue and earmarking funds.

Contributory financing options are used in systems where beneficiaries (typically working in the formal sector) are legally obliged to contribute towards a specific scheme. Such mandatory schemes are known as ‘employment-based schemes’ or social health insurance (SHI).^{*} Employment-based insurance is funded by deductions from employee wages or salaries, known as ‘payroll taxes.’ Employers often make a contribution, too. Over time, the share paid by an employer sometimes increases and, in some cases, the employer takes over the full contribution.

The main **strategies** for increasing this funding for the health sector are:

- Raising the level of contributions
- Enticing the informally employed to join schemes voluntarily
- Subsidising membership
- Combining non-contributory and contributory revenue in a national health insurance scheme (NHI).

VOLUNTARY FINANCING OPTIONS

Prepaid voluntary options are schemes where individuals decide voluntarily to contribute in advance to a form of health insurance.

1. **Community-based health insurance schemes** are small schemes usually started by non-governmental or faith-based organisations to provide some financial risk protection and improved access, especially in rural areas.
2. **Commercial voluntary health insurance schemes** can be larger and tend to focus more in urban areas and on attracting members who are in employment. Employers may subsidise their employees’ contributions, and may require them to belong to a scheme.

Out-of-pocket payments are formal or informal payments by patients for services at the time of accessing care. They may cover the whole cost of provider fees and pharmaceuticals or, for costs covered by a scheme, may be co-payments (where the scheme does not reimburse the full cost).

^{*}The term SHI is often used interchangeably by countries with the term national health insurance (NHI) (or even social security), but the schemes are very different. NHI has a wider reach than employment-based schemes and includes those unable to contribute. The WHO Database uses the term SHI to refer to all schemes with a mandatory, contributory component, and does not make this distinction with NHI.

Mandatory instruments are set by governments and are all prepaid. As noted earlier, it is now well-accepted that to move towards UHC governments should seek to increase the share of health expenditure funded through compulsory, prepaid sources and this should, therefore, be a goal in ESA countries (Dmytraczenko and Almeida, 2015; Kutzin et al., 2016).

Compulsory prepayment provides financial protection, a cornerstone of UHC, prevents financial risk associated with seeking care and avoids people opting out from pre-funding their care while they are healthy (known as ‘adverse selection’). Experience shows that adverse selection can be the case when contributions are voluntary, resulting in high-risk pools with high expenditures and with rising premiums, unaffordable for lower income groups.

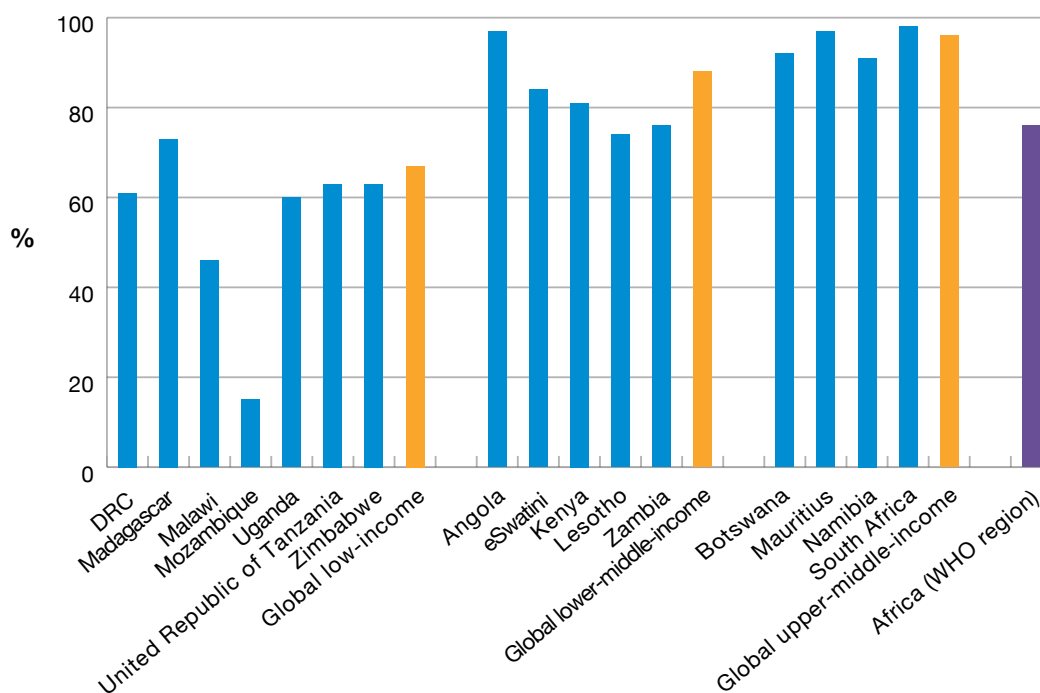
Box 1 also differentiates, within mandatory systems, between **non-contributory** (tax-financed) and **contributory** (employment-based) instruments. Many LMICs address the limitations of contributory systems in terms of achieving universality and sustainability by integrating them with, or strengthening, the tax-finance system, including introducing a number of **policy strategies** to enhance the effectiveness of the mandatory, prepaid instruments, outlined in *Box 1*. These recent strategies and lessons are important for ESA countries, and *Box 1* presents the headings under which they will be discussed.

4. CURRENT AND PROPOSED DOMESTIC FINANCING IN ESA COUNTRIES

4.1 Current sources of domestic health financing

In 2015, the four upper middle-income countries (MICs) in the ESA region (Botswana, Mauritius, Namibia and South Africa) funded over 90% of current expenditure from domestic sources (both public and private) (*Figure 1*). Mauritius and South Africa funded almost all current expenditure domestically, in line with the average for upper MICs. Angola, a lower MIC, also reached this level, thanks to its strong trade in natural resources. Most other countries performed at levels slightly below global averages for their income category, except for Mozambique, which only funded 15% of its current expenditure from domestic sources. In reading *Figure 1*, it is important to recall that these 2015 figures no longer include external funds managed by governments. Governments may allocate more to public services, but not from domestic revenue.

Figure 1: Domestic current health expenditure as a percentage of total current health expenditure, by country, World Bank income group and WHO region (2015)



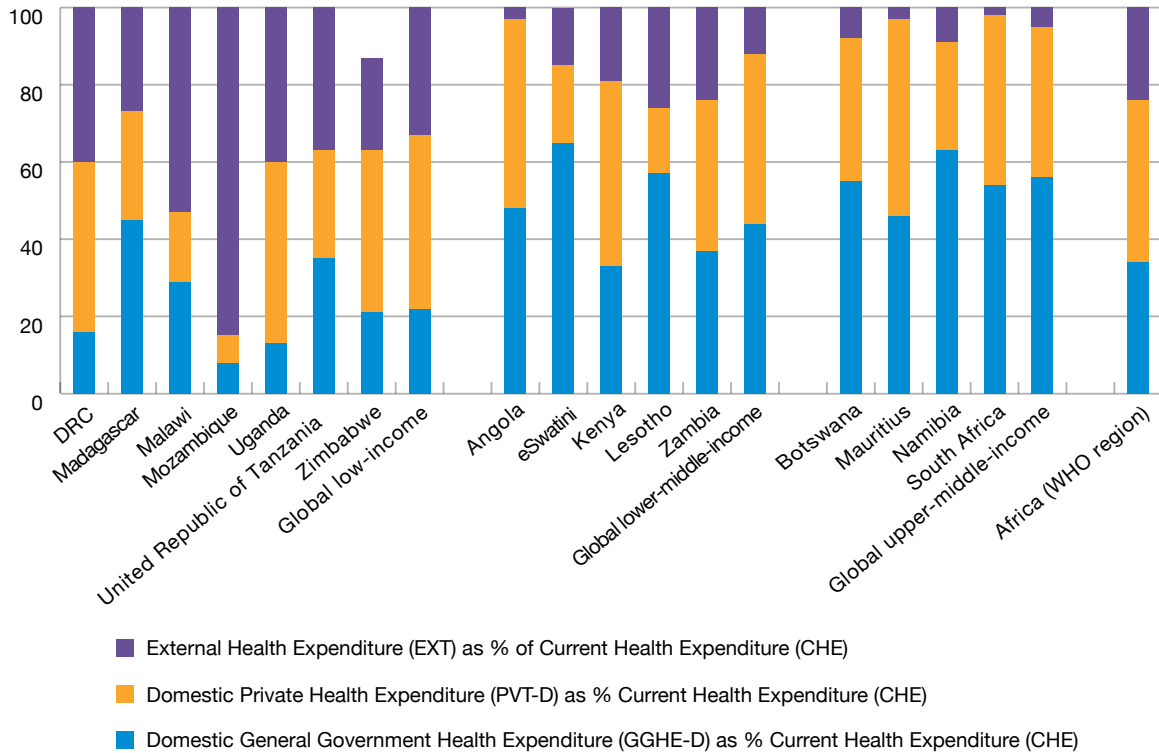
Source: Author's analysis of WHO (2017).

Note: Countries are arranged alphabetically, clustered in world income groups; dark columns represent the global average for that group

Figure 2 shows how domestic financing is divided between government and private sources, in terms of out-of-pocket spending, private insurance premiums and company contributions. The share from government sources grows as the income category of the country increases, albeit with exceptions. In Madagascar and Tanzania, both low-income countries, government expenditure dominates. In lower MICs, government expenditure dominates in eSwatini and Lesotho. In the higher MICs, private expenditure dominates in Mauritius.

In relation to government expenditure, a wide variation in the proportion of general government expenditure allocated to health suggests similar variation in the priority different governments give to the health sector, with Angola (4%) and DRC (5%) allocating the lowest proportion. No distinct pattern emerges of this in relation to the country income status (WHO, 2017). Eight ESA countries allocated more than the average for their income group, suggesting the priority they give to health, but only two countries, Madagascar and eSwatini, exceeded the African Union's 2001 commitment to 15% government spending on health (African Union, 2001).

Figure 2: Domestic general government, and private, expenditure as a proportion of current health expenditure, by country, World Bank country income group and WHO region (2015)

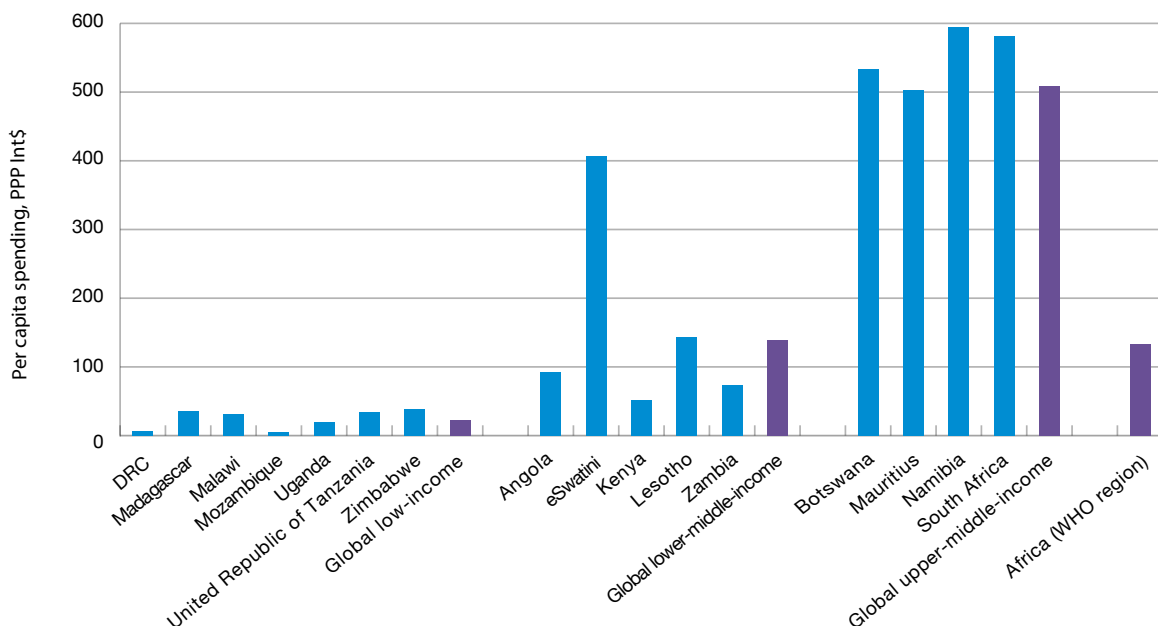


Source: Author's analysis of WHO (2017).

Note: It appears that some data is missing from Zimbabwe.

Another important indicator of governments' commitment to funding the health sector is the share of GDP this represents. Beyond how government revenue is divided, this measure incorporates elements of fiscal policy, such as tax levels and the efficiency of tax collection. The highest share of public health sector financing in the GDP was in eSwatini (5%), Namibia (6%), Lesotho (5%) and South Africa (4%), with 4% the average for upper MICs globally. Applying the 5% of GDP suggested by Chatham House as a minimum target (RIIA, 2014), thirteen ESA countries fell below this target, with eight contributing less than half of this proportion in 2015.

Figure 3: Domestic general government expenditure per capita, in PPP Int\$, by country, World Bank country income group and WHO region (2015)



Source: Author's analysis of WHO (2017).

Note: Countries are arranged alphabetically, clustered in world income groups; dark columns represent the global average for that group.

As percentages do not say anything about the absolute level of funding, and as the size of total government revenue and GDP varies between countries, a more useful indicator of the level of funding that takes into account the size of the population is per capita expenditure on health. To allow comparison across countries, this is adjusted in terms of purchasing power parity, expressed in international dollars (PPP Int\$). *Figure 3* shows the significantly higher per capita government spending enjoyed by the upper MICs. This spending was at, or above, the average for upper MICs. Namibia, with the highest per capita spending, spent over 100 times more per person than Mozambique or the DRC, and fifteen times more than all the low-income countries. eSwatini's per capita expenditure was notably high for its country income group. Again, these figures do not reflect the additional funding from external sources that these countries may spend on government services.

Across ESA countries, out-of-pocket (OOP) spending, an often regressive source, generally declines as government spending increases. Mauritius has high levels of out-of-pocket spending, as do the DRC, Uganda, Angola and Kenya. Nine ESA countries have OOP spending above the upper limit of 20% suggested by WHO to avoid catastrophic expenditures and impoverishment, seven of these considerably so (see *Table 1*) (The Global Fund, 2016). ESA countries with low shares of OOP spending of current health expenditure were Botswana (5%), Mozambique (7%), Namibia and South Africa (both 8%), eSwatini and Malawi (both 11%), and Lesotho (17%).

Table 1, below, shows the distribution of funds between different financing sources.

Table 1: The distribution of funds between different financing sources, by country (2015)

Countries	Government Financing Arrangements as % of CHE	SHI as % of CHE	Voluntary Health Insurance as % of CHE	OOP as % of CHE	Other Private Health Expenditure as % CHE	Total
Low-income countries						
DRC	44		13	37	5	99
Madagascar	53		3	22	22	100
Malawi	47	0	3	11	38	100
Mozambique	53	0	0	7	38	98
Uganda	28	0	2	41	29	100
United Republic of Tanzania	40	7	2	26	25	100
Zimbabwe	21	0	16	26	15	78
Lower-middle-income countries						
Angola	48	0	6	33	12	100
eSwatini	73	0	5	11	10	100
Kenya	35	4	10	33	18	100
Lesotho	70		0	17	13	100
Zambia	48	0	1	28	23	100
Upper-middle-income countries						
Botswana	54	0	33	5	8	100
Mauritius	48		0	51	1	100
Namibia	61	0	19	8	7	96
South Africa	43	0	47	8	3	100

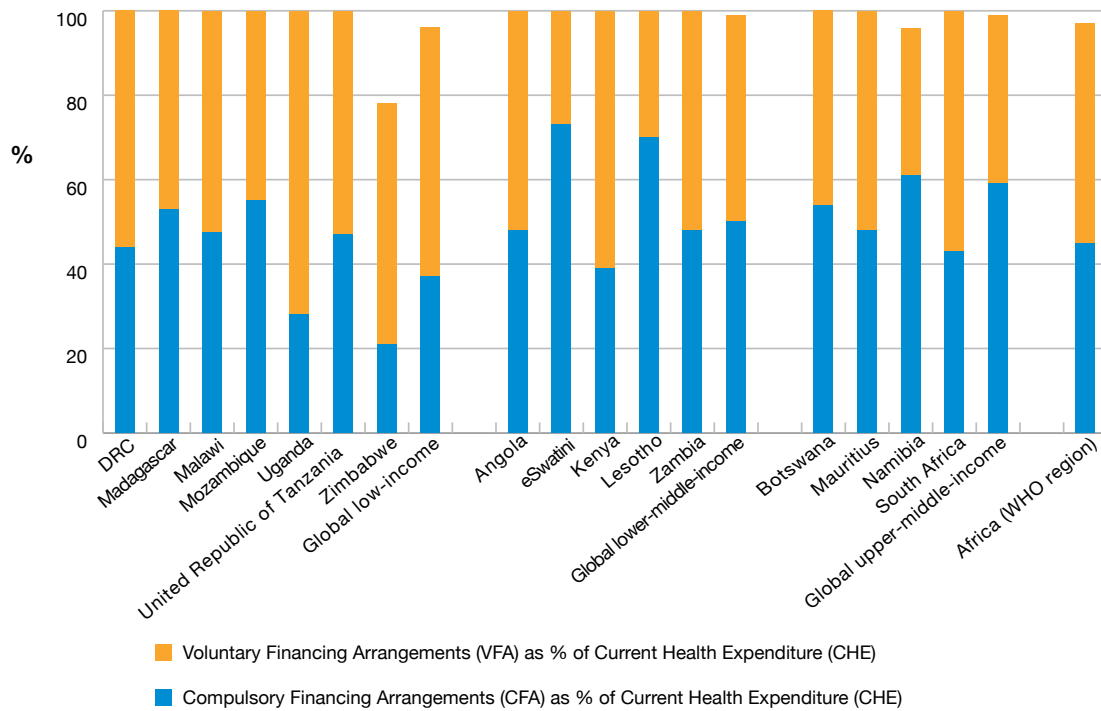
Source: Author's analysis of WHO (2017). CHE= Current Health Expenditure

Note: The term SHI as used by WHO refers to any contributory system (even when called National Health Insurance in-country); data appear to be missing for Zimbabwe but may depend on how the indicators are calculated. The data in this table differ from those in *Figure 2* because of differences in how indicators are calculated.

The category ‘other private expenditure’ is not easy to interpret as it includes companies and non-profit institutions receiving funding from external funders. The table shows that government-mandated social health insurance currently plays a small role in the region, while there is a high level of spending on voluntary, private health insurance (usually in a number of fragmented risk pools) in South Africa (47%), Botswana (33%), Namibia (19%) and Zimbabwe (16%).

Comparison of compulsory versus voluntary financing in *Figure 4*, noting the definitions of these terms provided earlier, shows that while levels of compulsory financing are below 50% of total financing, ESA countries generally perform better than the averages for their income category on the level of compulsory financing. South Africa is the only exception to this, albeit only slightly.

Figure 4: Compulsory versus voluntary financing as a proportion of current health expenditure, by country, World Bank country income group and WHO region (2015)



Source: Author’s analysis of WHO (2017).

Note: Namibia and Zimbabwe data appear to be incomplete.

Table 2, overleaf, presents a more detailed description of each ESA country’s financing sources, with the indicator from *Table 1*, a brief description of country features and planned financing reforms (highlighted in bold). As noted earlier, the table may not be comprehensive due to limitations of time and available evidence.

Table 3 on page 18 uses the evidence from *Table 2* to summarise the main domestic financing options that countries have relied on in the past and the options they are considering, using the typology of financing sources presented earlier in *Box 1*.

Table 2: Sources of finance in ESA countries, arranged by income category (CHE = current health expenditure)

COUNTRY	Government Financing Arrangements (GFA) as % of CHE	Social Health Insurance (SHI) as % of CHE	Voluntary Health Insurance (VHI) as % of CHE	Out-of-pocket (OOPS) as % of CHE	Other Private Health Expenditure as % CHE
LOW-INCOME					
DRC	44%	0%	13%	37%	5%
	The DRC has been destabilised by two decades of conflict. The state has lower presence in financing and regulating the health system, especially in certain zones, some of which receive no funding. Consequently, government funding represents a small proportion, and external sources a substantial portion (39%) of current health expenditure. There do not appear to be any earmarked taxes for health.	There is no social health insurance.	Community-based insurance is minimal (0.08% in 2008). There are no major formal, private insurance schemes. Nonetheless, spending on private health insurance is higher than in most other low-income ESA countries.	There is a large unregulated fee-for-service system. Patients pay for each service. There is a government policy to subsidise or remove user fees for certain vulnerable populations for certain services and in conflict zones, but these exemptions are not always implemented. There are stated intentions to pilot the removal of user fees through some externally funded projects.	Corporations contributed 12% of total health financing in 2008. This probably is through a mixture of direct provision and private health insurance contributions.
Madagascar	53%		3%	22%	22%
	Five years ago, government per capita expenditure on health, and health spending as a percentage of total government expenditure, declined, but levels have since recovered. Government finances around half of current health expenditure. A breakdown of direct versus indirect tax sources is not available and there is no information on whether there are earmarked taxes.	There is no social health insurance. WHO's country cooperation strategy includes implementing health financing strategies based on the principles of equity and financial protection.	There is no information on whether there is community-based insurance. There is no information on whether there is private, formal health insurance.	No details available.	No details available.
Malawi	47%	0	3%	11%	38%
	Malawi is fairly dependent on external sources. There is a stated intention in the latest Strategic Plan (2017) to raise additional resources from existing sources, introduce domestic financing mechanisms for health such as a Health Fund (presumably based on mandatory contributions), and design options for pooling financial resources. There do not appear to be any earmarked taxes for health.	The 2017 sectoral strategic plan calls for the development of a national health insurance scheme.	The 2017 sectoral strategic plan calls for the development of mechanisms for risk-pooling, including private health insurance.	OOP expenditure is low but could increase as patients seek alternative care where public services are of poor quality. Public services are free at the point of care, except for private wings in public facilities. The large network of Christian facilities charge fees, although heavily subsidised by external funders and the government.	In 2004, employers contributed to 4.7% of total health financing.

COUNTRY	Government Financing Arrangements (GFA) as % of CHE	Social Health Insurance (SHI) as % of CHE	Voluntary Health Insurance (VHI) as % of CHE	Out-of-pocket (OOPS) as % of CHE	Other Private Health Expenditure as % CHE
Mozambique	53%	0%	0%	7%	38%
	<p>Mozambique is highly dependent on external funding. The government is expanding the tax base through expanding private sector investment and developing its extractive industries. The country has undergone major tax reform. The main contributors to domestic revenue are VAT, personal income and company tax, and import duties (5.4%, 2.5%, 2.4% and 1.5% of GDP respectively in 2008). There are taxes on beverages (including beer), tobacco and sugar. Generally, the government has difficulties with tax collection and there is considerable tax evasion. The Ministry of Health is committed to UHC and there is an intention to remove financial barriers for the poor and reduce catastrophic expenditure on health through exploring alternative financing mechanisms, including earmarked taxes, such as on harmful substances. In 2009, the Ministry debated developing a health financing strategy and conducting a study on the impact of user fees on the poor.</p>	<p>There is no social health insurance or mandatory national health insurance.</p>	<p>The development of a private health insurance market, and the creation of incentives for employers to subsidize their employees contributions, are being promoted by some external funders.</p>	<p>OOP spending is low. User fees vary depending on services</p>	<p>No details available.</p>
Uganda	28%	0%	2%	41%	29%
	<p>Government contributes a relatively small share to total health expenditure. Around two-thirds of government revenue is from indirect taxation. Government financing is progressive overall. There is a tax for health on mobile phone use and handset sales that raises 9.5% of total tax revenue, but this is not specifically targeted at the health sector. Overall, there is very little financial protection and risk cross-subsidisation in the Ugandan health system.</p>	<p>There has been extensive preparation for National health insurance but it has not yet been implemented. The intention is for employees and employers each to contribute 4% of the employee's salary. There will be no co-payments.</p>	<p>There is limited community-based and formal private health insurance (0.12% and 4.5% of private expenditure respectively). The latter covers less than 1% of the population. Voluntary insurance is highly fragmented. Many firms pay the full contribution of their employees but about 20% require employee contributions. Increased community-based insurance and medical savings plans have been suggested in a 2016 National Health Accounts report.</p>	<p>OOP expenditure is a high proportion of total health expenditure, and has increased in recent years. In 2012/13, 95% of private expenditure was from user fees. In the public sector, the basic package is supposed to be accessed free of charge, with user fees abolished in 2001, but resource shortages mean that patients may buy medicine from private pharmacies or make informal payments. The private sector relies heavily on fees.</p>	<p>In 2013/14, 0.45% of total private health expenditure was expenditure by employers, other than on health insurance contributions.</p>

COUNTRY	Government Financing Arrangements (GFA) as % of CHE	Social Health Insurance (SHI) as % of CHE	Voluntary Health Insurance (VHI) as % of CHE	Out-of-pocket (OOPS) as % of CHE	Other Private Health Expenditure as % CHE
United Rep of Tanzania	40%	7%	2%	26%	25%
	Tanzania is heavily reliant on external financing. With respect to government financing, one third is derived from direct taxes and two-thirds from indirect taxes. Overall, government financing is progressive. The government is committed to universal coverage and developing a health financing policy .	The National Health Insurance Fund, mandatory for public sector employees, in 2009/10 only covered 7% of the population (including voluntary or employer enrolled members). The government has committed to expanding health insurance coverage (12% overall in 2016), including by harmonising various schemes with the long-term intention to create a single national health insurer .	Formal private health insurance is minimal (1% of total health sector financing in 2012). There is a government-run, voluntary Community Health Fund that mainly targets the informal sector: it covered 8% of the population in 2009/10, and is the one source of government- financing that is regressive. There are a number of additional small, voluntary community-based schemes. All in all, the private health insurance market is highly fragmented.	There are user fees at all levels of care in government and non-government facilities. The fees at private for-profit facilities are higher than at government and non-profit facilities. At public and government-contracted non-profit facilities there are exemptions for pregnant women, children under five years old and the elderly. Some services are also free, including maternal services and chronic illnesses like HIV/AIDS, TB and cancer. Overall, out-of-pocket expenditure is regressive.	This level is high because of external financing and, together with out-of-pocket payments, means that the total level of private health financing in Tanzania is very high.
Zimbabwe	21%	0%	16%	26%	15%
	Government revenue collection in Zimbabwe is poor, with limited efficiency of tax collection and low corporate compliance, albeit improved with 2010 tax reforms. In 2016, the main sources of government revenue were VAT and personal income tax (28% and 21% of government revenue, respectively). The contribution of corporate tax was low (9%). Since 1999 Zimbabwe has had a 3% AIDS levy on the taxable income of formal sector employees and corporations. A 2008 evaluation found that hyperinflation led to a low contribution from the levy to health financing, but this improved after dollarization of the economy. A 3% earmarked levy for health was recently imposed on mobile airtime data. Health financing risk pools in Zimbabwe are fragmented. The National Health Strategy 2016-2020 commits to achieving UHC. A national health financing strategy developed in 2017, amongst other things, seeks to improve central and local government health spending, including through earmarked indirect taxes .	Zimbabwe has small, fragmented contributory schemes (Workers' Compensation Investment Fund, Motor Vehicle Insurance based health support). A national health insurance scheme for formal sector employees proposed in the early 2000s was rejected by Parliament until economic conditions improved. The new financing strategy seeks to assess options for increasing prepayment and review the issue of mandatory health insurance .	Private health insurance expenditure is relatively high for a low income ESA country. There are a number of voluntary private health insurance schemes: they are fragmented and cover around 10% of the population. Around a third of government financing is actually government's contribution to private health insurance for civil servants. The new financing strategy describes plans to review the efficiency of these schemes. Community-based health insurance is currently being piloted.	User fees were eliminated in 2013 at all public rural health centres and for pregnant women, children under 5 and people older than 65. Out-of-pocket payments remain the largest source of finance, despite these exemptions. There is a risk of informal charges because of the under-funding or services, and there are referral charges, even for those who are exempted from fees at clinic level. User fees are charged by private services but are regulated.	There are some employer-funded services.

COUNTRY	Government Financing Arrangements (GFA) as % of CHE	Social Health Insurance (SHI) as % of CHE	Voluntary Health Insurance (VHI) as % of CHE	Out-of-pocket (OOPS) as % of CHE	Other Private Health Expenditure as % CHE
LOWER-MIDDLE-INCOME					
Angola	48%	0%	6%	33%	12%
	<p>Angola has a high economic growth rate, and nominal GDP more than doubled 2009-2014. This tripled nominal per capita health expenditure over the same period, with additional investment in infrastructure. This suggests there is increased fiscal space for health. However, falling oil prices and other domestic constraints may make continued expansion difficult. The 2010 National Health Policy aims to progressively increase the proportion of government revenue that is allocated to the health sector. The main source of health financing in Angola, by far, is government revenue (external sources are very limited). Revenue generation mainly relies on trade in natural resources. Around half of this trade is the export of crude petroleum. There is a weak income tax and VAT collection system. The 2010 Constitution notes the state's responsibility to promote universal and free primary healthcare. The National Health Development Plan 2012-2025 sees the health system moving from one largely dependent on government financing to one with diversified revenue streams, except for PHC which would remain government-funded.</p>	<p>There is no social health insurance or mandatory national health insurance.</p>	<p>There appear to be no community-based insurance schemes. Private health insurance, provided by public and private organisations, started in 2005, mainly targeting company employees and high-income individuals, and serving inhabitants of the capital city.</p>	<p>Public PHC facilities stopped charging user fees in 2008, but funding to replace this source has not been allocated systematically, and there are particular problems funding non-personnel costs</p>	<p>Large employers tend to provide some on-site services, or contracted services, to employees and, sometimes, their dependents. Employer-based schemes and private health insurance schemes represent small and fragmented risk pools.</p>
eSwatini	73%	0%	5%	11%	10%
	<p>A high proportion of eSwatini's health expenditure is funded by government sources. 50% of government revenue is received from the Southern African Customs Union. The Ministry of Health is committed to developing a health financing policy. This will be based on the principles of prepayment and fairness.</p>	<p>Social health insurance has been proposed but has been deferred indefinitely as a result of economic conditions</p>	<p>No information on private health insurance.</p>	<p>Out-of-pocket expenditure is very low. Public health services are provided free of charge to eligible children, orphans the elderly and people with disabilities, but the national health policy aims otherwise to commercialise some aspects of health services, without preventing access to public health services and the essential package of clinical services.</p>	<p>No information on other private sources.</p>

COUNTRY	Government Financing Arrangements (GFA) as % of CHE	Social Health Insurance (SHI) as % of CHE	Voluntary Health Insurance (VHI) as % of CHE	Out-of-pocket (OOPS) as % of CHE	Other Private Health Expenditure as % CHE
Kenya	70%	0%	0%	17%	13%
	<p>The efficiency of general tax collection has increased considerably, following reform of the taxation system and tax collection agency. Kenya was heavily reliant on external sources but government revenue has grown as a proportion of current health expenditure over recent years. There is an intention to increase government revenue levels and sources for health. Achieving universal coverage is a major goal of the Kenyan government.</p>	<p>The mandatory National Health Insurance Fund is for formal sector employees and their dependents, and is the oldest government SHI scheme in Africa. Informal employees join voluntarily, and there are efforts to increase enrollment. Other schemes for civil servants, the military and teachers are being integrated into this scheme. The scheme contributed 4.6% of CHE in 2015/16. The latest national health policy seeks to establish a social health protection mechanism to achieve UHC</p>	<p>Private health insurance is relatively low but growing. There is both community-based and formal private health insurance</p>	<p>Out-of-spending is high in Kenya. User fees are charged by both public and private health facilities. There are exemptions for children under 5, as well as for services such as antenatal and psychiatric services, and TB and leprosy. The latest national health policy seeks to make services progressively free at the point of service.</p>	<p>There are employer-based services, as well as externally financed non-profit organisations.</p>
Lesotho	70%	0%	0%	17%	13%
	<p>External funding is relatively small. The government dedicates relatively high amounts to health (although spending per capita has declined in recent years). Payments from the Southern African Customs Unions made up around half (55%) of government revenue for health from 2004/05 to 2008/09; tax revenue was 32% and non-tax revenue 9%. These sources of revenue have experienced some volatility, as revenue from the Unions has declined significantly following new trade agreements, and the government has prioritised reducing corporate tax in order to attract investment. UHC is a goal of the Lesotho government. The Ministry of Health recognises that external funding will decline and acknowledges the need to identify alternative funding sources. This includes advocating for a higher budget.</p>	<p>There is no social health insurance or mandatory national health insurance. There is an intention to explore social health insurance.</p>	<p>As of 2010, there were no community-based insurance schemes. There are some formal, private health insurance schemes. Expanding private health insurance is one strategy of the government's to increase funds for health.</p>	<p>By 2012, public sector user fees had been abolished at PHC level, and standardised fees had been introduced at secondary level. It is intended to provide an essential set of services free of charge or at a highly subsidised rate.</p>	<p>Some employers provide services directly to their employees.</p>

COUNTRY	Government Financing Arrangements (GFA) as % of CHE	Social Health Insurance (SHI) as % of CHE	Voluntary Health Insurance (VHI) as % of CHE	Out-of-pocket (OOPS) as % of CHE	Other Private Health Expenditure as % CHE
Zambia	48%	0%	1%	28%	23%
	Zambia has high reliance on external sources, with government providing only half of CHE. In 2006, direct taxes comprised 48% of government expenditure and indirect taxes 52%. There are currently no earmarked taxes but, in 2003, a medical levy of 1% was imposed on all gross interest earned on savings and a variety of financial instruments (savings and deposit accounts, treasury bills, government bonds etc.), the proceeds from which were used to fund AIDS treatment. This raised around \$2 million annually but was abolished in 2013. The recent strategic plan aims to increase general government allocations to the health sector, including through new mechanisms (e.g., through removal of a fuel subsidy), and to develop a health financing strategy .	Social health insurance scheme is being developed, and a Bill submitted to Cabinet.	There is private health insurance but it is limited to urban areas, some employers and a few individuals. There is an intention to introduce community financing schemes .	Non-profit organisations are subsidised by government but also charge user fees. For-profit organisations charge fees but the levels are limited by government. In the public sector, user fees were removed for PHC services in rural areas in 2006. They remain for secondary and tertiary facilities, and for bypassing PHC facilities.	No information on other private sources.
UPPER-MIDDLE-INCOME					
Botswana	54%	0%	1%	28%	23%
	Government revenue is the main source of financing, with external financing being relatively low. Much of government revenue is generated from the sale of mineral resources, in particular, diamonds, the revenue from which Botswana has ensured is used for social spending. There are no earmarked taxes for health but the government intends to introduce taxes on harmful products earmarked for the health . Botswana recently developed a health financing strategy .	Government intends to develop essential health services free at the point of care , financed through a prepayment mechanism , including possibility social health insurance , and making public sector employee enrollment in a scheme mandatory.	There is ongoing debate about what sort of prepayment mechanism would be suitable for nonessential services, including various sorts of private health insurance . Spending on private health insurance is already high.	Reproductive health services and ART in the public sector are exempt from user fees. There are fees for other services, although these are small. The government also intends to increase user fee revenue from nonessential services provided at public facilities.	No information on other private sources.
Mauritius	48%		0%	51%	1%
	Mauritius is one of the ESA countries with very limited external funding. Government expenditure on health has increased in recent years, and government expenditure on health as a proportion of total expenditure is also increasing. The intention is to increase government spending . It is also intended to develop medical tourism further, presumably through the private health system.	It is intended to set up a government-run health insurance scheme for civil servants.	There is some private insurance but only a small portion (8.3% in 2011) of private health expenditure is prepaid by employers, individuals or both. 14% of households have a member with private insurance. Government is considering tax relief for people paying insurance premiums . [note: 2015 NHA data (at 0) for this component seems incorrect]	The public health system is free at point of care and meets most healthcare needs. High OOP spending is mostly on unregulated and rapidly increasing private sector fees. Government is considering regulating user fees in the private sector .	No information available.

COUNTRY	Government Financing Arrangements (GFA) as % of CHE	Social Health Insurance (SHI) as % of CHE	Voluntary Health Insurance (VHI) as % of CHE	Out-of-pocket (OOPS) as % of CHE	Other Private Health Expenditure as % CHE
Namibia	61%	0%	19%	8%	7%
	The Namibian government is the main funder of health services and government expenditure on health has increased considerably in recent year, but is declining as a share of total government spending. Per capita government expenditure is the highest in the ESA region. The government is seeking to strengthen social protection for health, and reduce barriers to financial access. It sees increasing private sector expenditure as an opportunity to diversify. Current spending is at 30% of total health expenditure in 2014/15, with households representing 10% and companies 20%.	There is a mandatory health insurance scheme for civil servants. The government is evaluating the possibility of introducing national health insurance.	There is relatively high expenditure from employee and employer contributions to private health insurance responsible for a lot of the growth in health expenditure. In 2006/7, 46% of total health expenditure was from private social insurance, and 11% from individual insurance. Private, for-profit health services serve 15% of the population	Out-of-pocket expenditure is very low and the government intends to keep this source low. User fees vary by facility and condition. Care is free for pregnant women and children under 5, preventive and promotive services notifiable conditions and HIV/AIDS.	There are some services funded directly by employers. Expenditure by companies amounted to 30% of total health expenditure in 2014/15.
South Africa	43%	0%	47%	8%	3%
	The efficiency of general tax collection has increased considerably, following reform of the taxation system and tax collection agency. Total health expenditure in the health sector is high, because of the large private sector. External financing is small. Government financing per capita increased in the period 2000-2015. In 2005/06, direct taxes were progressive and indirect taxes, including VAT, excise duties and a fuel levy, were regressive. There are no earmarked taxes, except a fuel levy for the Road Accident Fund, although there are taxes on harmful substances, including a recently introduced sugar tax.	There is currently no mandatory health insurance, but a National Health Insurance Bill was released in 2018. This intends to enroll the whole population into a single scheme.	Contributions to private health insurance schemes is higher than government sources. Private health insurance is highly fragmented. Under National Health Insurance, private health insurance is intended to remain, but only as top-up insurance.	OOP expenditure is low, about two-thirds by private health insurance members. Public PHC facilities have no fees and fees at public hospitals are on a sliding scale, depending on income, with possible exemptions for financial reasons, albeit difficult to access. Private facilities charge user fees only part of which is covered by private insurance schemes.	No details available

Sources: (MoH = Ministry of Health) Fafchamps and Minten, 2003; Malawi MoH, 2007, 2017; DFID, 2008; Mpofu and Nyahoda, 2008; WHO AFRO, 2009a, 2015, 2016a, 2016b, 2016c; WHO 2018a, 2018b; Botswana MoH, 2010, 2012; Connor et al., 2010; Mozambique MoH and EQUINET, 2010; Mwase et al., 2010; Health Systems 20/20 Project 2011; Lesotho MoH and Social Welfare, 2011, 2016; AFRODAD, 2011a; Ataguba and McIntyre, 2012; Lagomarsino et al., 2012; Uganda MoH et al., 2012; Elovainio and Evans 2013; Gerstl et al., 2013; ZEPARU et al., 2013; Dutta et al., 2014; Kenya MoH, 2014, 2017; McIntyre et al., 2014; Mtei and Makawia, 2014; TARSC and Zimbabwe MoH and Child Welfare, 2014; Zikusooka et al., 2014; Chitah and Jonnson, 2015; Stasse et al., 2015; West-Slevin, et al., 2015a,b; Chuma and Kirigia, 2016; Wang et al., 2016; Zimbabwe MoH and Child Care, 2016, 2017; Health Policy Project, 2016a, 2016b; James et al., 2018; Magagula, 2017; Mauritius MoH and Quality of Life, 2017; Namibia MoH and Social Services, 2017; Zambian MoH, 2017; Global Health Observatory, 2014; 2017a, 2017b, 2017c, 2018; Cali et al. 2018; Doherty et al., 2018; African Health Observatory and WHO AFRO 2018a, 2018b, 2018c, 2018d, 2018e, 2018f, 2018g, 2018h, 2018i, 2018j; Swaziland MoH and Social Welfare (undated).

Table 3: Summary of existing and proposed financing sources in ESA countries

MANDATORY, PREPAID FINANCING OPTIONS	
<p><u>Non-contributory financing options:</u></p> <p>Sources</p> <ol style="list-style-type: none"> 1. Direct taxes 2. Indirect taxes <ol style="list-style-type: none"> a. VAT* b. tax on luxury items c. tax on harmful substances <p>Strategies</p> <ul style="list-style-type: none"> • for increasing general tax revenue: <ul style="list-style-type: none"> ◦ reforming tax policy ◦ strengthening tax collection capacity ◦ generating additional revenue from new, innovative sources: <ul style="list-style-type: none"> • natural resources • mobile phone use • for expanding the fiscal space for health <ul style="list-style-type: none"> ◦ negotiating an increased share of total government revenue ◦ earmarking funds 	<p>All countries</p> <p>All countries</p> <p>South Africa, Zimbabwe</p> <p>Mozambique, South Africa</p> <p>Kenya, Mozambique, South Africa</p> <p>Kenya, South Africa</p> <p>Angola, Botswana</p> <p>Uganda, Zimbabwe</p> <p>Zimbabwe, Mozambique</p>
<p><u>Contributory financing options (SHI/NHI)**</u></p> <p>Strategies</p> <ul style="list-style-type: none"> ◦ raising the level of contributions ◦ enticing the informally employed to join schemes voluntarily ◦ subsidising membership ◦ combining revenue from non-contributory and contributory sources 	<p>Botswana, eSwatini, Kenya, Lesotho, Malawi, Mauritius, Namibia, Tanzania, Uganda, South Africa, Zambia and Zimbabwe</p> <p>Probably in all with mandatory schemes</p> <p>Kenya</p> <p>Information not available</p> <p>Information not available</p>
VOLUNTARY FINANCING OPTIONS	
<p><u>Prepaid voluntary options:</u></p> <ol style="list-style-type: none"> 1. Community-based health insurance schemes 2. Commercial voluntary health insurance schemes. <p><u>Out-of-pocket payments</u></p>	<p>DRC, Kenya, Tanzania, Uganda, Zambia, Zimbabwe</p> <p>All countries</p> <p>Some exemptions: all countries, with some considering extending these</p>

Note: countries considering a new intervention are shown in green

*The information is incomplete for this item. ** Note WHO's use of the term SHI refers to all schemes with a mandatory, contributory component, without the distinction with NHI.

Table 3 presents a summary of the evidence in Table 2. It highlights the wide use of direct taxes, some use of indirect taxes and the various countries using strategies to increase tax revenue and expand fiscal space. It highlights the 12 ESA countries using contributory financing options and the more limited evidence on the strategies used to expand these. While all countries have some form of voluntary insurance in place, six ESA countries are also applying prepaid voluntary community insurance options. Out-of-pocket payments are a feature to varying degree in all countries.

4.2 Financing options under consideration

As shown in *Table 2* and the summary in *Table 3*, ESA countries generally intend to expand UHC, and, in relation to this, reduce financial barriers to access and improve financial risk protection. Many countries face difficult economic conditions and are constrained in their choices with respect to increasing domestic financing, even while they recognise the need to improve health spending and the health sector's share of total government revenue. Options raised for this include improving tax efficiency to increase government revenue as a whole and fiscal space, options for increasing the tax base from indirect, earmarked taxes and widening coverage of mandatory contribution schemes.

OOP payments are the most regressive source of financing. They are managed through: user fee policy reviews to increase user revenue from some aspects of services, without harming access to the essential set of services (Botswana and eSwatini); extending exemptions, albeit often unevenly implemented; reducing or lifting user fees in particular service levels (DRC, Mozambique and Lesotho); and regulating fees charged in the private sector (Mauritius).

Many countries are seeking to improve financial risk protection and pooling through creating or expanding social and national health insurance schemes. These terms are used interchangeably in the region, despite the fact that eligibility to the scheme, and hence the proportion of the population covered, can differ vastly. All countries seem to be envisaging contributory schemes. Although the funding mechanism for South Africa's scheme is not yet known, it seems that its proposed National Health Insurance is the only option being considered that meets the definition of a national health insurance, under which all members of the population would be enrolled (either through tax financing or a mixture of non-contributory and contributory financing).

Tanzania and Kenya have intentions to gradually expand their schemes, currently covering a subsection of the population towards this. Other proposed schemes, such as in Mauritius, are only for specific subgroups such as civil servants, and it is unclear whether these would be mandatory (membership of South Africa's civil servant scheme, for example, is not mandatory). In terms of new schemes, South Africa, Uganda and Zambia seem to be the most advanced in developing their policies, but none are implemented yet. In these and other countries, the form and acceptability of national or social health insurance schemes are still being subjected to political, technical and social dialogue.

Several countries (Botswana, Lesotho, Malawi, Mauritius and Mozambique) have raised the possibility of expanding the private health market, or specifically, the private health insurance market, as a strategy to improve the resources for health. Uganda, Zambia and Zimbabwe have referred to community-based health insurance as an option. Mauritius is explicitly seeking to expand medical tourism and has indicated an intention to introduce tax relief for people contributing to private health insurance. In other countries, there is an intention to better regulate and co-ordinate the private insurance market, to harmonise its providers (Tanzania) and review it (Zimbabwe). South Africa envisages a reduced role for private health insurance to a 'top-up' insurance following the introduction of the NHI.

The next section examines the extent to which these different financing options contribute to equity, efficiency and sustainability of the universal health systems needed for UHC. The options are examined in terms of their stability relative to macroeconomic contexts and fiscal implications; their contribution to revenue, their progressiveness and implications for pooling, income and risk cross-subsidies and equity and equitable allocation; the efficiency and ease of their collection methods; potential for cost escalation; and political and social acceptability. It draws on experience of these options in LMICs.

5. EXPERIENCE AND FEATURES OF FINANCING OPTIONS



This section looks at the features of instruments and strategies for strengthening mandatory financing, with the assumption that governments wishing to move towards UHC see this as their first concern. It reviews this in terms of the non-contributory and mandatory options used in ESA countries and considers the voluntary options. In each subsection, a summary table shows the implications of these options for the equity, efficiency and sustainability of universal health systems.

5.1 Non-contributory mandatory options

The various sources of and strategies for increasing non-contributory funds discussed earlier, while generally beyond the direct control of the health sector, are important for health financing for a number of reasons. How progressive or regressive they are and their proportion of total revenue influence the financial burden faced by different income groups and thus their degree of financial protection. Some sources of financing – whether new or specific health-related taxes – may be amenable to earmarking for the health budget, discussed further later.

Generally, non-contributory mandatory funding can create large risk pools that can be used for equitable resource allocation and strategic purchasing, improving the efficiency and quality of care. Realising this potential depends partly on the level and combination of taxes raised. Taxation is a particularly effective and sustainable source where the economy is large and relatively formal in nature. For economic and political reasons, relatively few developing countries have opted for a fully tax-financed system, although there are notable exceptions, such as Brazil, Fiji and Sri Lanka (Tangcharoensathien et al., 2011; Dmytraczenko and Almeida, 2015; Irava, 2015). Sri Lanka, a country with a relatively large informal sector and low per capita GDP, has been effective in providing UHC and improving health outcomes through a tax-financed health system, underpinned by positive socio-political pressures (Gilson et al., 2008).

Personal income tax is often the most progressive source of financing, if policy taxes higher earners proportionately more and an extended definition of income is applied (Bennet and Gilson, 2001). Company tax can be an important source of general government revenue, and there is debate on whether companies are taxed sufficiently within LMICs. Many countries are trying to limit (illegal) tax evasion and tax avoidance, where companies exploit loopholes in the laws.

Indirect taxes form a higher proportion of total government revenue in countries with large informal sectors or where there are difficulties collecting direct taxes because of weak tax collection systems. Indirect taxes are relatively easy to collect, as this is generally the responsibility of the retailer rather than government, although they also provide opportunities for fraud and can present equity concerns if too large a portion of total tax revenue is derived from this source, as in several LMICs. Their use for health is not administratively complex if a portion of an existing tax is levied. Consumption taxes, such as VAT, often form a high proportion of indirect taxes and are less progressive than direct taxes. As flat rate taxes they may be regressive, except where there are exemptions for goods consumed proportionately more by the poor.

Taxes on harmful substances such as sugar and tobacco can be an instrument for revenue collection and a negative incentive for consumption of these substances (Sugar Tobacco and Alcohol Taxes Group, 2018). This can make them socio-politically easier to earmark for health spending, as they are understood to have a negative impact on health. For example, Egypt has increased revenues from a tobacco tax (Elovainio and Evans, 2013). The taxes could, however, also be regressive, as was found with the South African alcohol tax (Ataguba, 2012) and with tax on cigarettes in India, where poorer people smoked more than the wealthier did. They can also lead to smuggling of poor quality versions of these substances. How inequitable these taxes are depends also on who accesses the benefits from their use (Tandon and Cashin, 2010). The Sugar Tobacco and Alcohol Taxes Group (2018) note that overall such taxes may be beneficial for poorer people, as they suffer disproportionately from ill-effects of harmful products.

In their fiscal policies, governments set explicit or implicit limits on the overall tax burden the economy should face, reflecting their macroeconomic and political intentions and concerns. The projected ratios of general government revenues (excluding grants) to GDP for ESA countries vary. In low-income ESA countries, they range from 8.8% in Zimbabwe to 23.9% in Mozambique. In lower MICs in ESA, they range from 17.5% in Zambia to 39.6% in Lesotho, while in upper MICs in ESA, they range from 20.9% in Mauritius to 29.7% in Namibia (IFC, 2019). For comparison, the average of this ratio (including grants) for emerging and MICs in Asia and Latin America was 27.5% and in advanced economies was 36.4% (IFC, 2019). As these countries are less reliant on external funding, they are a useful comparison for middle-income ESA countries, and the considerable variation between countries in this specific income category might perhaps reflect other issues, such as political choice. Soe-Lin et al. (2015) note, however, that most LMICs have not yet maximised their tax collection potential, collecting only two-thirds of what is possible, given their socioeconomic conditions and tax structures. Strategies to expand the tax base can improve the ‘fiscal space’ for public expenditure.

Strategies for improving non-contributory mandatory options: There are strategies for increasing such tax revenue, while noting an overarching principle that when pursuing these strategies:

...the emphasis should be on increasing revenue through the most progressive means possible; the purpose of raising government spending on health could be defeated if that spending were funded by increasing the relative tax burden of those who are meant to benefit. (Meheus and McIntyre, 2017:159)

The strategies include:

- a. *Reforming tax policy*, including changing tax thresholds and structures, such as shifting the tax burden across different income groups, taxing overall wealth as opposed to simply income, such as capital gains tax or estate duties, adding taxes, such as indirect taxes, removing subsidies and simplifying tax systems to make tax collection easier and tax avoidance more difficult. Sierra Leone introduced a single Goods and Services Tax that simplified tax collection and increased revenue as a share of GDP, from 11.7% to 14.9% in two years (Elovainio and Evans, 2013). Removing subsidies on fuel is promoted as it can lead to excessive consumption and tends not to benefit the poorest groups (Meheus and McIntyre, 2017). As introduced by Egypt, Zambia, Nigeria and Indonesia, fuel subsidies aimed to deal with price shocks and inflation, but were expensive and regressive. Consequently, in 2012, Nigeria re-directed these subsidies to other priorities, including maternal and child health. Zambia and Indonesia – where the fuel subsidy accounted for around a fifth of the total government budget - are similarly considering re-directing fuel subsidies to health services. There is, however, often considerable resistance towards the removal of subsidies from those benefiting from the arrangement. Resistance to tax reform by interest groups who feel they will be taxed more heavily under new tax regimes may deter governments from increasing taxation, particularly before elections, although delivering on UHC may provide a legitimate commitment to motivate for increased taxation.
- b. *Strengthening tax collection capacity*, together with efforts to simplify the tax system, improving compliance and enforcement can enhance revenue collection. By doing this, Indonesia managed to increase its tax to GDP ratio from 9.9% to 11.1% over four years (Elovainio and Evans, 2013). It is difficult for countries to increase tax revenue – through either tax policy or tax collection reform – when facing economic stagnation or servicing mounting debt. Many countries that have been successful in expanding coverage have done so during good macroeconomic climates (Kutzin et al., 2016), although this is not always the case. Countries with marked tax collection improvements such as Bosnia and Herzegovina, El Salvador, Georgia, Guatemala, Kenya, Lagos State (Nigeria), Mali, Namibia, Senegal, South Africa, Tanzania and Zambia are already operating close to their maximum tax collection capacity (Soe-Lin et al., 2015, Doherty et al., 2018). Mechanisms to improve tax collection capacity are fairly well established, but complex, and require capacity and good governance systems (Soe-Lin et al. 2015). For example in Kenya, Lagos State (Nigeria) and South Africa the factors that improved tax collection capacity were: external (political legitimacy and economic growth) and institutional (political support, sustained strong public leadership, tax policy reform rationalising rates and expanding the tax base, a level of administrative autonomy in the tax collection agency, including to hire and provide incentives to motivate and retain skilled staff and adequate funding of the agency). Collection capacities were strengthened by a clear vision and values, strategic use of external capacities and information technology, co-operation across public and private agencies, a streamlined organisational structure and new culture, a mix of promotive

and punitive strategies to promote tax compliance (RESYST, 2015). The large informal sectors in many ESA countries make it difficult to collect direct taxes from them, and some measures aim to incentivise more formal inclusion of enterprise and employment, such as Uganda's efforts to simplify business registration processes to encourage businesses to formalise (Elovainio and Evans, 2013).

- c. *Generating additional revenue from new, innovative sources* in line with the concept of taxing the wealthy proportionately more, such as special taxes on profitable companies, financial transfers, lotteries and airline travel (The Global Fund, 2016). For example, Bolivia has introduced a Hydrocarbons Direct Tax that contributes substantially to general revenue (Fuertes, 2016). Charging royalties and other taxes on the exploitation of natural resources are gaining significant attention in some countries. In Peru, around a third of total taxes is raised from a direct tax on hydrocarbons, for example (Fuertes, 2016). Botswana uses taxes on diamonds to substantially improve revenue for health and to promote equity (Elovainio and Evans, 2013). If state-owned companies control extraction, the revenue generated can be used more directly for public revenues. Ghana and Indonesia are considering directing revenue raised in this way towards social programmes, including health (Soe-Lin et al., 2015).
- d. *Negotiating an increased share of total government revenue* for health to receive at least a constant if not a growing share of total revenues (Kutzin et al., 2016). Chile raised the share of government spending on health sector from 12% in 2003 to 16% in 2010; Vietnam raised its share from 5% in 2004 to 8% in 2010, enforced through national legislation; Indonesia distributed a large share of its increased tax collection into health, and tax collection in Lesotho more than doubled between 2005 and 2010, with per capita government expenditure on health following suit (Elovainio and Evans, 2013; Soe-Lin et al., 2015). Health ministries have to compete with other ministries, including those contributing to the social determinants of health, as for example was the case in Ethiopia where agriculture and education were prioritised as beneficiaries of improved tax collection (Soe-Lin et al., 2015). Health also competes with claims from economic sectors that are seen as productive against a perception of health as a 'consumption' item, by showing the productive and investment returns on investment in health (Elovainio and Evans, 2013). The share of revenue to health is also constrained by how much of the government budget is discretionary, given fixed commitments to public sector wages, other legislated expenditure and debt repayments. Empirical data from 188 countries between 1995 and 2012 found that 'increased tax revenues do not necessarily translate to increased health spending' (Soe-Lin et al., 2015:1). In Kenya, Lagos State (Nigeria) and South Africa sharp increases in government revenue led to a decline in the share of the government budget allocated to the health sector, even though the sector was viewed as a priority (Doherty et al., 2018). Economic growth, improved tax collection, political prioritisation, legal consolidation and politically and socially supported goals such as UHC have supported increased shares of government spending on health (Dmytraczenko and Almeida, 2015). Soe-Lin et al. (2015) and Doherty et al. (2018) thus note that these gains are more likely where there is: political leadership, technical capacity and strong bargaining power in the health ministry; effective communication with the finance ministry to convince them of the economic and social merits of investing in health and the debilitating effects of underfunding the health sector; a good track record on budgeting and expenditure that shows the health ministry is able to absorb and use new funding effectively and evidence on the positive outcomes of health spending.
- e. *Earmarking funds*. Rather than relying on annual political processes, negotiations and compromises for public health spending, countries can earmark funding from specific, growing indirect taxes, introducing some certainty into the health ministry planning. At least 80 countries globally earmark indirect taxes for health revenues. Of these, 35 countries earmark revenues from tobacco taxes; 10 on other goods that harm health (such as sugar-sweetened beverages); 9 all or a portion of revenues from alcohol sales; 5 from general revenue for health causes; 4 a portion of their VAT; 2 all or a portion of revenue from lotteries; and one, Gabon, introduced an earmarked levy on foreign personal money transfers and mobile phone company revenue (Cashin et al., 2018). It may be easier to gain acceptance for earmarking, when this is linked to a new tax or to a good or service that impacts negatively on health to fund underfunded public health programmes (Tandon and Cashin, 2010). For example, a 2% earmarked tax on tobacco and alcohol entirely funded the Thai Health Promotion Foundation. In Nepal, all earmarked tobacco tax goes towards cancer control. Several countries (Colombia, Egypt, Guatemala, Mexico, Philippines, Turkey, Burkina Faso) use earmarked taxes on harmful substances to help scale up, or even launch UHC (Elovainio and Evans, 2013; Cashin et al., 2018).

Table 4 summarises the range of factors to be considered in introducing selected earmarked options for health (ZEPARU et al., 2013). These include negative implications such as rigidity in budget allocations, constraints to shifting spending according to changing needs and reduced allocative efficiency. Generally, earmarking funds for a broader, rather than a narrower, purpose allows some room to adjust priorities with changing needs and circumstances (ZEPARU et al., 2013).

Table 4: Benefits and risks of common earmarked taxes for health, Zimbabwe

Tax area	Possible benefits	Possible risks
Earmarked portion of cigarette excise duty	<ul style="list-style-type: none"> • Not administratively complex. • A flat rate so those who smoke more will pay more. • May reduce consumption of a health hazard. • May be politically more acceptable because of the negative impacts on health. • May not reduce employment in countries where there is a large share of imported brands. • May not be a heavy financial burden on consumers where cigarettes are relatively cheap. 	<ul style="list-style-type: none"> • Leakages may result through smuggling. • Revenue falls as smoking declines • May not reduce consumption. • May affect local employment. • Some argue that should not be for specific tobacco-related programmes but for general health interventions.
Earmarked portion of alcohol excise duty	<ul style="list-style-type: none"> • Not administratively complex. • A flat rate so those who drink more will pay more. • Select alcohol type to reduce impact on poorer groups. • May reduce consumption of a health hazard. • May be politically more acceptable because of the negative impacts on the health. 	<ul style="list-style-type: none"> • If too high, may encourage use of informal, low-quality products. • May reduce employment. • Should not be seen as a remedy as alcohol consumption is inelastic: still need public health intervention.
Earmarked portion of road tax	<ul style="list-style-type: none"> • A good source for under-funded emergency services. • Progressive where those with cars in higher-income groups (unless public transport systems are weak). • Not administratively complex. • If a new tax, could be administratively simple through raising tax at the fuel pump or as road tolls. • Could use a levy on car insurance, as for carbon taxes. • May be politically more acceptable because of the negative impacts of road accidents on health and perceived under-funding of emergency services. 	<ul style="list-style-type: none"> • Revenue base depends on rising vehicle use. • May trigger a general price increase in the economy. • May be opposed politically if it leads to price increases elsewhere. • Other traffic control measures should be strengthened.
Earmarked portion of mining sector taxes	<ul style="list-style-type: none"> • This is a high growth sector. • Administratively simple as all minerals pay royalties at point of export or disposal. • Can be applied to higher income mines, or to higher surpluses, to avoid over-burdening smaller mines. • Complements other tax exemptions in the mining sector that should not cover health programmes. • May support corporate responsibility requirements. • Can support relevant services (e.g., healthcare costs of retired workers, public health needs of mining communities, health problems from environmental risks associated with mining). 	<ul style="list-style-type: none"> • Minerals are a finite resource. • Mineral prices are subject to international fluctuations. • Could be resisted by the mining sector, or more generally as a precedent for other sectoral taxes. • Depends on declared revenue. • Difficult to tax small/ illegal miners. • May reduce the competitiveness of the mining sector. • Smuggling may cause revenue leaks.

Source: ZEPARU et al., 2013.

Earmarked funds on more limited areas of indirect tax revenue may not be substantial, and if not sufficient it may be difficult for the health ministry to ask for more funds from the finance ministry, or lead to off-sets elsewhere in the health budget (Cashin et al., 2018).

Smaller levels of earmarking on larger indirect tax sources, like VAT, may thus be easier to manage and sustain for pooled funding than multiple smaller earmarked funds. Where VAT forms a large and rising portion of indirect taxes, earmarking enables pooling with income tax. Chile earmarks 1% of VAT to finance a guaranteed set of services, Ghana earmarks 2.5% of VAT to help fund the National Health Insurance Scheme, and Iran earmarks 1% to help finance its Health Sector Evolution Plan (Garshong and Akazili, 2015; Cashin et al., 2018).

In negotiating earmarked funding, some countries have earmarked government expenditure rather than revenue on certain activities. *Table 5* shows the areas countries have identified for this. The scope of this varies and the larger the scope the greater the potential to contribute to UHC. For example, this form of earmarking protects all public health spending in Brazil, but only that for immunisation in Bolivia (Cashin et al., 2018).

Table 5: Earmarking expenditure for health

CATEGORY OF EXPENDITURE EARMARKING	COUNTRY
Specifying the proportion of total government health expenditure that should be devoted to the health sector	Brazil, Indonesia, Vietnam
Specifying the proportion of total government health expenditure that should be devoted to a specific activity	Bolivia (for immunisation)
Specifying the minimum rate of growth of the public health sector's share to ensure it cannot decrease	Vietnam
Earmarking national transfers to lower levels of government for the health sector generally (in federal or quasi-federal systems)	Bolivia, Brazil, Colombia, India, Indonesia, Mexico, Uganda
Earmarking general revenue for spending on priority health activities (in a quasi-federal system)	South Africa, conditional grants for specific services, including HIV

Source: Cashin et al., 2018.

Table 6, overleaf, summarises the implications of mandatory non-contributory options for the equity, efficiency and sustainability of universal health systems. The columns show the features of the funding mechanisms discussed, covered by each of these three major categories. In this table, the comments on efficiency relate to the efficiency of the general government revenue-collection system as a whole, rather than the health system.

In addition, although not recorded in the table, tax-funded government services have strong bargaining power with providers to improve quality and reduce prices through strategic purchasing, which can render the health system more efficient, depending on government's capacity to take advantage of this opportunity.

Table 6: Summary of features and strategies for non-contributory mechanisms

MECHANISM	Contribution towards an equitable health system	Contribution towards an efficient health system	Contribution towards sustainable health system
Sources			
Direct taxes	<ol style="list-style-type: none"> 1. Generally, have the potential to achieve good financial protection as they ensure prepayment (although this depends on tax levels, the level and quality of services covered, and the remaining OOP charges on patients). 2. As mandatory for the whole country (except those exempted due to low incomes), have the potential to be progressive, depending on tax brackets, rates, ceilings, allowable deductions and the level of tax evasion or avoidance. Companies may pass on tax burdens to consumers as higher prices reducing equity impacts. 3. Tax-financed health systems achieve health risk cross-subsidies, if offer services according to need. 	<ol style="list-style-type: none"> 1. Tax-financed systems create large risk pools. The pool is smaller in countries with small formal economies. 2. Effective collection is complex and requires a strong tax collection system, including measures to achieve compliance. 3. The impact is not known. 	<ol style="list-style-type: none"> 1. These can represent relatively large sources of funds, especially in large, formal economies, but the share flowing to the Ministry of Health is dependent on Cabinet decisions. In countries with large informal sectors where the health sector is not prioritised by government, direct tax financing can be limited. 2. This source is vulnerable to economic downturns.. 3. Resistance to taxation, and high levels of tax avoidance and evasion, may threaten countries' ability to rely on these taxes.
Indirect taxes	<ol style="list-style-type: none"> 1. Similar impact on financial protection to direct taxes, especially where a large portion of total public revenue. 2. Tend to be less progressive as a flat rate charged across all income groups, except where there are exemptions for goods purchased disproportionately by the poor. Regressive a problem where a large portion of general revenue derives from indirect taxes unless mitigated if the indirect tax is on luxury goods, services are used more extensively by higher-income people, or a higher share of employment is in the informal sector. 3. Tax-financed health systems achieve health risk cross-subsidies, if offer services according to need. 	<ol style="list-style-type: none"> 1. Create large risk pools. The contribution of indirect taxes is larger in countries with large informal economies. 2. Easy collection as mainly from retailers. 3. An efficient way to tax the non-poor informal sector. However, they could have distortionary effects. 4. Taxes on harmful substances can prompt smuggling and the consumption of inferior quality goods, which in turn can have a negative health impact. 	<ol style="list-style-type: none"> 1. These provide a significant source of revenue where a large proportion of employment is in the informal sector, but the share flowing to the Ministry of Health is dependent on Cabinet decisions. 2. This source is vulnerable, however, to changes in consumption patterns. 3. These may be more politically acceptable to the populace as their impact on individuals' income is less obvious than direct taxes, and some of them are linked to goods that clearly incur costs to government.
Strategies to expand general revenue			
Reforming tax policy	<ol style="list-style-type: none"> 1. Can improve financial protection. 2. Provides scope to improve equity of tax financing, especially when taxing the entire income of individuals and closing down loop-holes used by individuals / companies. 3. Can improve risk cross-subsidy from increased revenue. 	<ol style="list-style-type: none"> 1. This increases pooling. 2. Taxes may become easier or harder to collect, depending on the reform. 3. Simplification of tax laws can improve efficiency. 	<ol style="list-style-type: none"> 1. Tax reforms can increase the tax base, but the share flowing to the Ministry of Health is dependent on Cabinet decisions. 2. Reforming tax policy difficult where a large informal economy. 3. Attempting to increase taxation of higher earning individuals and companies can lead to a political back-lash.

MECHANISM	Contribution towards an equitable health system	Contribution towards an efficient health system	Contribution towards sustainable health system
	<ol style="list-style-type: none"> 1. Financial protection 2. Equity in financing (progressivity) 3. Health risk cross-subsidisation 	<ol style="list-style-type: none"> 1. Revenue pooling 2. Ease of collection 3. Potential to reduce cost escalation 	<ol style="list-style-type: none"> 1. Revenue-raising potential 2. Macroeconomic feasibility and stability 3. Political/social acceptability
Strengthening tax collection capacity	<ol style="list-style-type: none"> 1. Can improve financial protection. 2. Can improve the equity of the financing system, especially when compliance is improved. 3. Tax-financed health systems achieve health risk cross-subsidies, provided they offer services according to need. 	<ol style="list-style-type: none"> 1. Increases pooling. 2. Makes taxes easier to collect. 3. Increases efficiency. 	<ol style="list-style-type: none"> 1. Can increase revenue considerably, but there is no guarantee that allocations to the Ministry of Health will increase. 2. Can be difficult where a large share of the economy is informal. May be difficult to improve in periods of economic downturn. 3. Can be political resistance to increased resistance, especially when the government lacks legitimacy.
Generating revenue from new, innovative sources	<ol style="list-style-type: none"> 1. Can improve financial protection 2. Will tend to improve progressivity as often directed at taxing the wealthy more effectively, directly or indirectly through use of luxury goods and services. Removing subsidies eg on fuel can to impact positively on equity. 3. Achieve health risk cross-subsidies, provided they offer services according to need. 	<ol style="list-style-type: none"> 1. Increases pooling. 2. May add complexity to the tax collection system. 3. Impact on efficiency generally not known. Removal of fuel subsidies may drive up prices generally, including in the health sector. 	<ol style="list-style-type: none"> 1. Open new sources of revenue for the health sector. Taxes on the exploitation of natural resources can bring in substantial revenue, but no guarantee that the health sector will benefit. 2. The macro-economic concerns are mixed and/or unclear. 3. There may be political resistance to imposition of new taxes, and the removal of subsidies.
Strategies to expand the fiscal space for health			
Negotiating a greater share of total public revenue	<ol style="list-style-type: none"> 1. Can improve financial protection 2. Will tend to improve progressivity. 3. Will tend to improve health risk cross-subsidies. 	<ol style="list-style-type: none"> 1. This increases pooling. 2. Ease of collection is not affected. 3. This does not affect efficiency. 	<ol style="list-style-type: none"> 1. Has potential to improve the level of funding for health. 2. Has no economic repercussions. 3. Difficult to achieve without strong political support for health.
Earmarking government sources and expenditure	<ul style="list-style-type: none"> • The same equity-related concerns apply as discussed for direct and indirect taxes in general. 	<ol style="list-style-type: none"> 1. This increases pooling, except in cases where earmarking results in an offset elsewhere in the health budget. 2. This may make collection more complex. 3. This may reduce the responsiveness of budgeting to priority health and other needs 	<ol style="list-style-type: none"> 1. A useful tactic for ensuring that the Ministry of Health receives some guaranteed funding, or for funding programmes that have traditionally been under-funded, such as health promotion and the control of chronic diseases. Monies raised may be small, unpredictable or diverted. Earmarking may lead to general budget reductions to offset the additional revenue raised. 2. Macro-economic concerns are mixed and/or unclear. 3. May be politically easier to achieve, especially when the goods and services are linked directly to health, or when a new tax.

Sources: Bennet and Gilson, 2001; Tandon and Cashin, 2010; Tangcharoensathien et al., 2011; Ataguba, 2012; Elovainio and Evans, 2013; ZEPARU et al., 2013; Dmytraczenko and Almeida, 2015; Garshong and Akazili, 2015; Irava, 2015; Soe-Lin et al., 2015; Fuertes, 2016; Kutzin et al., 2016; The Global Fund, 2016; Meheus and McIntyre, 2017; Cashin et al., 2018; Doherty et al., 2018; Sugar Tobacco and Alcohol Taxes Group, 2018.

5.2 Contributory mandatory systems

Employment-based schemes arose in Western Europe and later in Latin America in the 1900s as a result of workers' organisation to extract better employment benefits from employers (Kutzin, 2013). Contributory schemes had duties to create only one risk pool for that company or union. Only contributing members benefited from the services funded. Providing access and financial protection to the broader, non-contributory population was not a prime motivation for these schemes, except for dependents of the main beneficiaries.

As countries sought to improve better healthcare for their populations, governments began to legislate obligations for those in formal sector employment to belong to one single scheme, or to one of several schemes, the latter providing less opportunity for risk pooling. Employment-based schemes thus became mandatory as 'social health insurance' (SHI), although, as indicated earlier, the terminology is not standardised. Currently, 62 countries use income or payroll taxes to fund healthcare for the population or formal sector workers through a publicly managed scheme (Cashin et al., 2018).

Mandatory employment-based schemes are more common in upper middle-income countries as they depend on a sizeable formal sector, and thus play a much smaller role in LMICs. SHI is difficult to institute in settings with large rural populations, a large informal sector, low salary and wage levels, high poverty rates and a high ratio of dependents to earners (Tandon and Cashin, 2010). In subSaharan Africa these schemes have not generated substantial revenues for healthcare: mandatory contributions only generated 3.4% of current health expenditure for the 16 countries with available data in 2015 (McIntyre et al., 2018). In Kazakhstan, introduction of a new payroll tax resulted in a greater reduction in the health budget than the money it raised (Elovainio and Evans, 2013).

This makes it challenging to use SHI as an instrument to achieve UHC in ESA countries. Affordability can lead to a two-tiered system, one for formally employed and already advantaged people able to afford insurance, and another, less well resourced, government-funded health system for poor and uninsured people. In subSaharan Africa, evidence shows that SHI schemes are pro-rich (McIntyre et al., 2018).

Once implemented, SHI schemes tend to become entrenched as they serve a politically and economically powerful section of the population that is keen to preserve its privileges. This happened in Mexico and Thailand. It has taken these two countries about fifteen years to address the resulting inequities in financial protection and access, and neither has yet been able to integrate those outside the formal workforce into pre-existing schemes (Kutzin, 2013). In SHI schemes for civil servants, government, as the employer, often ends up subsidising its own workers at higher rates than it contributes to the general population. This was the case in Thailand in 1992, before its UHC reforms, where subsidies to members of the civil servants' and private workers' schemes were four times and twice that, respectively, for informal sector and poor people (Kutzin et al., 2016).

SHI schemes are administratively complex, requiring enrollment and tracking mechanisms that ensure that those accessing benefits are indeed contributors or their dependents. They require good governance to ensure efficiency in the face of high demand from members and to avoid cost escalation, including from rising medical prices and ageing membership. Many countries in Latin and Central America, best known for their reliance on SHI, have grappled with these problems for decades in trying to improve financial protection and access for poorer people (Dmytraczenko and Almeida, 2015).

There is only weak evidence that SHI and community-based health insurance, discussed later, improve social inclusion, that is, enrollment and utilisation by vulnerable populations. Kutzin (2013:608) concludes that social health insurance schemes "can contribute to system-wide UHC goals, but they need to be explicitly designed to do so. Otherwise, increased population coverage with health insurance can actually become a potential obstacle to progress towards UHC." For example, the organisation of SHI can impact on the pooling of funds and the fragmentation of risk pools (Kutzin, 2013). As a demonstration of this, despite its almost universal coverage in terms of membership, the continued fragmentation of China's three social health insurance schemes has led to continued inequities in financial protection and access (Meng et al., 2015).

Strategies for improving contributory mandatory options: The problems associated with SHI schemes have led countries interested in UHC to review the design and implementation of their schemes, to pair employment schemes with others covering other segments of the population and to diversify financing sources. The strategies used to address features of the schemes that are problematic for UHC include:

- a. *Increasing the level of contributions*, usually in response to threats posed to schemes by cost escalation. This measure, however, could jeopardise the ability of certain members to afford the scheme and reduce access, especially where this is accompanied by shrinking benefits. Including other income sources such as rental income and investment interest has been proposed as a better measure of wealth for improving the progressivity of SHI contributions, rather than increasing the levels across the board (Dmytraczenko and Almeida, 2015).
- b. *Incentivising informally employed workers to join SHI schemes voluntarily*. Many mandatory employment-based schemes make provision for informally employed people to enrol. Several countries, e.g., Ghana, Kenya, Nigeria, the Philippines, Rwanda and Vietnam, are making efforts to strengthen this voluntary enrollment (Tangcharoensathien et al., 2011; Lagomarsino et al., 2012)). Kenya has an innovative scheme using mobile phones to collect contributions from the informal sector, while the Philippines has innovative mechanisms for enrolling taxi drivers and street vendors (Tangcharoensathien et al., 2011).

However, enrolling the informal sector remains costly and complex to administer and difficult to enforce. Full coverage remains elusive and enrollment patterns show signs of adverse selection. Many countries, Ghana and Indonesia for example, have faced problems in scaling up their contributory schemes in a context of a large informal sector (Tangcharoensathien et al., 2011; Tandon and Cashin, 2010; Lagomarsino et al., 2012; Trisnantoro et al., 2014). There is a risk of adverse selection in voluntary enrollment. Under Indonesia's new UHC programme, for example, 23% of self-enrolled members only enroll once, and 28% do not routinely pay their contribution (Agustina et al., 2019). In Ghana, difficulty in determining the socioeconomic status of informal sector members led to the charging of a flat rate, rather than income-related premiums, burdening poorer members disproportionately and reducing equity in Ghana's National Health Insurance Scheme (Garshong and Akazili, 2015).

Kutzin et al. (2016: 301) conclude that it is wasted effort to try to improve enrollment of the informal sector in employment based schemes: "Expecting that a large percentage of persons in the informal sector can be made to contribute most of the premium for their coverage is a pitfall that flies in the face of both theory and evidence." Thailand has used a different approach to covering the informal sector, namely, mandatory non-contributory tax financing, discussed earlier, as more successful in achieving complete coverage of the informal sector (Tangcharoensathien et al., 2011).

- c. *Subsidising membership of SHI schemes* has been implemented on an incremental basis in some Latin and Caribbean countries and in Ghana, Rwanda and Mali (McIntyre et al., 2018). This extends coverage to vulnerable groups through targeting and subsidising people unable to contribute, after their enrollment. Ghana's National Health Insurance Scheme, covering about a third of the population in 2012/13, is funded mainly by payroll deductions from formal sector workers and premiums paid by informal workers topped up with the 2% levy on VAT, discussed earlier. Chile has a system for subsidising inclusion of poor people in its mainly public insurance by not charging co-payments, as do Thailand and the Philippines (Gottret et al., 2008; Spaan et al., 2012).

At the same time, these subsidies can increase rapidly as enrollment of poor beneficiaries increases and require administrative and enforcement capacity (Meng et al., 2015). Subsidising membership was used in Latin American and Caribbean countries with well-established SHI schemes to move away from problematic two-tiered systems in Chile, Costa Rica, Brazil, Colombia, Argentina, Guatemala, Jamaica, Mexico, Peru and Uruguay (Dmytraczenko and Almeida, 2015). In Colombia, for example, the different schemes for different groups in its system were re-structured to create a complex but comprehensive 'patchwork' of cover, using a number of financing sources (Meng et al., 2015).

It augmented its mandatory insurance contributory scheme for formal sector workers with capacity to pay with a non-contributory subsidised scheme for unemployed, informal sector workers and poor people and built in cross-subsidies across the schemes through a variety of mechanisms. For example, 11% of payroll funds the contributory regime, while 1.5% cross-subsidises the subsidised regime to deliver, since 2012, the full mandatory health plan (Guerrero et al., 2015). This example shows the link between financing reforms and the design of benefits. However, these reforms and the subsequent financing system are highly complex, with continuing challenges of affordability and inequities, as for many countries with contributory schemes (Guerrero et al., 2015). Similar efforts to delink entitlement to benefits from employment status and contributions were implemented in Mexico and in Thailand, in both cases through gradually expanding schemes and benefit packages through general taxes (Kutzin et al., 2016). Despite these efforts, segmentation with discrepancies in benefits and quality persist in Latin American countries (Gottret et al., 2008). In Peru, for example, over a third of the population remains uncovered; OOP payments account for over a third of healthcare financing and more than 75 000 households are impoverished annually as a result of healthcare payments (Seinfeld and Besich, 2014). Chile, Colombia and Uruguay have mitigated these problems by increasing risk pools and cross-subsidies, equalising benefit packages, guaranteeing timely access and setting standards for quality of care (Dmytraczenko and Almeida, 2015).

Xu et al. (2018) note that with budgetary transfers accounting for 20-50% of SHI spending, budgetary transfers from taxes are probably essential if SHI is to play a role in LMICs. There is also a challenge in identifying those qualifying for partial or total subsidies. Means tests are costly, complex to administer and vulnerable to leaks and abuse, and participatory engagement by local communities is seen to be important to address this (Tangcharoensathien et al., 2011). Extending coverage can also meet resistance from interest groups such as formal sector employees and the private insurance sector, as was the case in Malaysia (Tangcharoensathien et al., 2011).

- d. *Combining payroll taxes and general tax revenue in a single pool* can be used to create a synergy between SHI and other revenue sources, using employment-based contributions to strengthen tax financing. In contrast to the above measures, this strategy combines payroll tax contributions and general revenue transfers into one fund, creating one large risk pool and a single payer to purchase services for the entire population. This is being implemented, for example, in Kyrgyzstan and Republic of Moldova, two LMICs (Titelman et al., 2015). This strategy seeks to improve equity, with resource allocation based on needs rather than on pre-existing infrastructure, essential services enjoyed by the whole population, and providers incentivised to improve productivity and quality (Kutzin et al., 2009). This approach is similarly informing financing reforms in Indonesia's new UHC programme and Costa Rica's single insurance fund for the whole population (Trisnanto et al., 2014; Agustina et al., 2019; Slon, 2017). This approach avoids many of the constraints faced by separate mandatory schemes, such as means testing and maximises cross subsidies between richer and poorer groups or with different levels of health need.

Table 7, overleaf, summarises the implications of mandatory contributory options for the equity, efficiency and sustainability of universal health systems. The columns show the features of the funding mechanisms covered by each of these three major categories.

As mentioned earlier, to achieve UHC mandatory prepaid financing needs to be the core funding mechanism. For the sake of completeness, however, a brief description of voluntary financing mechanisms and their features in relation to equity, efficiency and sustainability of universal health systems is provided on page 32.

Table 7: Summary of broad features in and strategies for contributory mechanisms

MECHANISM	Contribution towards an equitable health system	Contribution towards an efficient health system	Contribution towards sustainable health system
Sources			
Mandatory employment-based health insurance (SHI) based on pay-roll contributions by employees and employers	<ol style="list-style-type: none"> 1. The extent of financial protection increases based on the level of entitlements covered by a scheme and whether members face co-payments. It is difficult to extend schemes to other members once existing members' interests have become entrenched. 2. Progressivity only enhanced where contributions are income-based. SHI schemes are otherwise often pro-rich. Schemes for civil servants benefit from government contributions (as employer) higher than per capita funding received by poorer populations. 3. Health risk cross-subsidies are achieved for beneficiaries, but this is lower for systems where there are multiple, fragmented schemes. These schemes contribute to the tiering of the health system into better-resourced services for wealthier people and less resourced services for poor people. 	<ol style="list-style-type: none"> 1. Pooling is achieved within the scheme, especially when it is large, but these schemes often fragment the health system overall, and divide risk pools. 2. Collection is relatively easy as it is payroll-based. 3. Within the scheme, efficiency may improve as the scheme pools resources and, using its bargaining power with providers, can create mechanisms to incentivise provider behaviour (providing it has the capacity to do strategic purchasing). However, cost-escalation is often a feature of these schemes, due to the incentives for beneficiaries to increase their utilisation, given that enjoy financial protection, as well as demographic and technological changes. The governance and administration of these schemes is complex and expensive. 	<ol style="list-style-type: none"> 1. Rely on a sizeable formal sector, and are less viable where there are large informal sectors, rural populations, poverty and a high ratio of dependents to earners, where their revenue-raising is low. 2. Vulnerable to economic downturn, population ageing. 3. A payroll tax is essentially an earmarked tax, with all the associated limitations, but can be more palatable to members than an increase in general tax, because they see it as purchasing a specific, work-related benefit. Often these benefits are more extensive, or provided through higher quality providers, than those available to the general population, which is an added incentive. Entrenchment of the interest groups benefiting from these schemes can be a stumbling block to reform of the health system as a whole.
Strategies to expand employment-based systems			
Increasing the level of contributions	<ol style="list-style-type: none"> 1. Financial protection could be jeopardised if the increases are unaffordable to some members, and accompanied by shrinking benefits. 2. If contributions are based on total income vs. wages or salaries may be more equitable. 3. No substantial change. 	<ol style="list-style-type: none"> 1. No substantial change. 2. No substantial change. 3. No substantial change. 	<ol style="list-style-type: none"> 1. Achieves a small increase in revenue to counter the impact of cost escalation. 2. No substantial change. 3. No substantial change.
Enticing the informally employed to join SHI schemes voluntarily	<ol style="list-style-type: none"> 1. A weak mechanism to expand the numbers with financial protection, given implementation problems. 2. A weak mechanism to improve progressivity, given implementation problems, although may be easier to attract working non-poor than other informal workers. 3. A weak mechanism to expand health risk cross-subsidisation, given implementation problems. 	<ol style="list-style-type: none"> 1. A weak mechanism to expand risk pooling, given problems with its implementation. 2. Complex and costly to administer and, even with intense efforts, coverage of the informal sector remains low. 3. Participation of the informal sector in SHI schemes is subject to adverse selection and, hence, cost escalation. 	<ol style="list-style-type: none"> 1. Revenue-raising potential is low and the sustainability is threatened by the adverse selection. 2. Unreliable as economic downturns affect the informal sector adversely. 3. Buy-in to joining voluntarily is low, as there are few incentives except for higher-income earners who can afford the premiums and want access to better-resourced services on a regular basis.

MECHANISM	Contribution towards an equitable health system	Contribution towards an efficient health system	Contribution towards sustainable health system
Subsidising membership of SHI schemes	<ol style="list-style-type: none"> 1. Financial protection 2. Equity in financing (progressivity) 3. Health risk cross-subsidisation 	<ol style="list-style-type: none"> 1. Revenue pooling 2. Ease of collection 3. Potential to reduce cost escalation 	<ol style="list-style-type: none"> 1. Revenue-raising potential 2. Macroeconomic feasibility and stability 3. Political/social acceptability
Combining payroll taxes and general tax revenue in a single scheme	<ol style="list-style-type: none"> 1. Financial protection is improved, especially if benefits are standardised. Coverage of vulnerable populations can be patchy because of difficulties enrolling eligible people for financial support. 2. Progressivity of the health financing system as a whole is improved, sometimes considerably, but the tiered, dual system often remains in place, with core SHI schemes remaining pro-rich. 3. Health risk cross-subsidisation can improve where benefits are standardised. 	<ol style="list-style-type: none"> 1. Improves risk pooling, depending on whether subsidised members form part of the same scheme or not. 2. Mechanisms to means-test non-formally employed prospective members to join these schemes are complex and costly. 3. Some wealthier individuals may capture cross-subsidies intended for poorer people. 4. The impact on cost escalation is not known. 	<ol style="list-style-type: none"> 1. Does not raise additional revenue but attempts to create synergy between different sources, making the health system overall more effective and sustainable. 2. Combining contributory and non-contributory mechanisms, reflects the macroeconomic strengths and weaknesses of these mechanisms. 3. Can be considerable resistance from the original beneficiaries to opening up the scheme to the informal sector and poor. Means-testing can be perceived as demeaning.
	<ol style="list-style-type: none"> 1. Financial protection is improved. 2. Progressivity is improved. 3. Health risk cross-subsidisation is improved. 	<ol style="list-style-type: none"> 1. A large risk pool is created. 2. Would be much easier to administer as it does not require means-testing. 3. Creating one large risk-pool improves efficiency, as discussed under non-contributory systems. 	<ol style="list-style-type: none"> 1. The revenue impact is similar to the above option. 2. The macro-economic strengths and constraints are similar to the above option. 3. It is not clear what the political acceptability for such an option. Contributors may resent cross-subsidising non-contributors, but this depends on whether they previously belonged to a SHI scheme or the scheme is completely new, as well as other contextual factors.

Sources: Frenk et al., 2006; Tandon and Cashin, 2010; Tangcharoensathien et al., 2011; Lagomarsino et al., 2012; Spaan et al., 2012; Atun et al., 2013; Kutzin, 2013; Seinfeld and Besich, 2014; Trisnantoro et al., 2014; Dmytraczenko and Almeida, 2015; Garshong and Akazili, 2015; Guerrero et al., 2015; Meng et al., 2015; Titelman et al., 2015; Kutzin et al., 2016; Slon, 2017; Cashin et al., 2018; McIntyre et al., 2018; Xu et al., 2018; Agustina et al., 2019.

5.3 Prepaid voluntary options

All health systems that employ voluntary contributions towards some form of health insurance scheme suffer from ‘adverse selection’, which refers to the tendency of members to only contribute towards a scheme when they expect they will need services (Kutzin et al., 2016). This leads to rising premiums and reduces risk cross-subsidisation, resulting in higher healthcare costs to the scheme than would have been the case if the whole population had contributed. Voluntary prepayment thus remains a small component of most country health systems and cannot, on its own, form the basis for UHC (Kutzin et al., 2016).

Sources of voluntary prepaid financing

- a. *Community-based health insurance schemes* are small, usually started by non-governmental or faith-based organisations to provide some financial risk protection and to improve access to services, especially in rural areas. While these objectives are achieved in some subSaharan African schemes, their coverage is generally limited, often less than 1% of the population and seldom more than 10% (McIntyre et al., 2018). Membership often fluctuates depending on a household’s finances and is not enjoyed by the poorest. Schemes face high administrative costs and many sustainability challenges, particularly because of adverse selection (Tangcharoensathien et al., 2011). Despite this, they are sometimes promoted in contexts with small formal economies to build towards a universal contributory insurance system, as was the case in Thailand (Tangcharoensathien et al. 2011). In Ghana, incentives were created for small, local-level schemes to link together to form district mutual health insurance schemes that were in turn linked to NHI (Kutzin et al., 2016). Rwanda combined national-level funding with local level community-based schemes, with some redistribution between geographic areas, to create mandatory cover for the entire population (Kutzin et al., 2016; McIntyre et al., 2018). Even this scheme struggles with sustainability, however, with population coverage declining from 91% in 2011 to 75% in 2015 (McIntyre et al., 2018).
- b. *Private voluntary health insurance* plays a role in many LMICs, existing alongside other financing mechanisms. Population coverage is relatively limited because membership is relatively expensive and these schemes are often predominantly urban. Competing schemes fragment the health system, creating small risk pools. They face cost escalation due to adverse selection and supplier-induced demand. Apart from unaffordability, promoting private health insurance as a means to extend cover may draw personnel out of the public sector, undermining public services, as has been the case in South Africa, for example (Doherty and McIntyre, 2013). Privately insured members often capture government subsidies through a variety of mechanisms (Bennet and Gilson, 2001). These features worsen inequities between the care enjoyed by richer and poorer people. When private voluntary health insurance is designed as a complementary part of the financing system, wealthier individuals can use it to access extra benefits or hotel services, but should not be able to opt out of the major risk pool(s) covering the bulk of the population with a fairly comprehensive set of services (Doherty and McIntyre, 2013).

5.4 Out-of-pocket payments

Out-of-pocket (OOP) payments refer to formal or informal fees paid by patients to healthcare providers or for pharmaceuticals, or co-payments for services not fully covered by insurers. In the 1980s, the World Bank promoted user fees as a mechanism to supplement declining revenues following economic downturns. Subsequent evaluations found that only 5% of revenues in subSaharan Africa could be raised through this mechanism, that collecting user fees was costly for the health system and that OOP payments tend to be the most regressive mechanism for financing healthcare, acting as a barrier for the poorest patients to access needed healthcare (McIntyre et al., 2018). WHO recommends that countries reduce OOP payments to 20% or less of total healthcare expenditure (WHO, 2010). This is the level below which households no longer experience catastrophic expenditure and impoverishment due to the costs of seeking healthcare. McIntyre et al., (2018) report that seventeen African countries have removed some or all user fees since 2001, although this has not been without some negative impacts, such as drug stock-outs and poor staff morale as a result of increasing workloads. Such impacts of fee removal thus need careful planning around how services will deal with increased utilisation, with alternative financing mechanisms to replace lost revenue. There may still be a place for some user fees within a UHC system, most notably to incentivise appropriate use of referral systems, such as by charging a ‘bypass’ fee to those who want to access specialised services directly. However, UHC-related financing reforms seek to reduce OOP payments and the impoverishment they can cause.

6. DISCUSSION

Table 8, below, broadly summarises the positive and negative features of the various financing sources and strategies used in LMICs to improve revenue generation, as discussed in Section 5. It does not show the voluntary private financing sources noted earlier, as these have a limited role in UHC.

Table 8: Summary of positive and negative features of various instruments and strategies for mandatory prepayment

CONTRIBUTORY MECHANISMS	Financial protection	Progressivity	Health risk cross-subsidisation	Revenue pooling	Ease of collection by government	Cost control*	Revenue-raising potential	Macroeconomic feasibility and stability,**	Political/social acceptability
NON-CONTRIBUTORY MECHANISMS									
Sources									
Direct taxes	●	●	●	●	●	●	●	●	●
Indirect taxes	●	●	●	●	●	●	●	●	●
Strategies to expand general revenue									
Reforming tax policy	●	●	●	●	●	●	●	●	●
Strengthening tax collection capacity	●	●	●	●	●	●	●	●	●
Generating revenue from new, innovative sources	●	●	●	●	●	●	●	●	●
Strategies to expand fiscal space for health									
Negotiating a greater share of total government revenue	●	●	●	●	●	●	●	●	●
Earmarking government sources and expenditure	●	●	●	●	●	●	●	●	●
CONTRIBUTORY MECHANISMS									
Source									
Mandatory employment-based contributory SHI with pay-roll contributions from employees and employers	●	●	●	●	●	●	●	●	●
Strategies to expand employment-based systems									
Increasing the level of contributions	●	●	●	●	●	●	●	●	●
Enticing the informally employed to join SHI schemes voluntarily	●	●	●	●	●	●	●	●	●
Subsidising membership of SHI schemes	●	●	●	●	●	●	●	●	●
Combining payroll taxes and general tax revenue in a single scheme	●	●	●	●	●	●	●	●	●

Key: Green circles refer to positive features with dark green being more strongly positive. Orange and red refer to negative features with red being more strongly negative. Grey circles refer to neutral features, or features that could be positive or negative. Black circles refer to features where a generalisation cannot be made.

*For non-contributory mechanisms, cost reduction refers to the efficiency of government's tax collection system, whereas for contributory mechanisms it refers to the efficiency of the health system.

**This column refers to the macroeconomic features on which the reform relies to be successful. It does NOT refer to the impact of the reform on the economy (such as employment levels, level of private investment etc.). This is beyond the scope of this report.

While the above judgement on where a source falls in the spectrum from strongly positive to strongly negative could be challenged, *Table 8* shows that generally the mandatory non-contributory options do well in supporting the financial protection, equity, good revenue-raising potential, progressivity and revenue pooling objectives associated with UHC. Mandatory contributory SHI schemes can achieve these objectives where tax financing is used to subsidise the membership of poorer people, or where tax financing and contributions to SHI are combined in one central fund. These do not appear to be options ESA countries are exploring at present.

Table 8 also shows the policy options that have serious failings or challenges, as those with red-coloured dots amongst their features. This includes stand-alone SHI schemes, which are in place or being considered in a number of ESA countries, trying to attract members of the informal sector into SHI schemes, and, to a lesser extent, expanding SHI schemes through offering subsidised membership to those unable to afford the premiums independently.

Each ESA country is, however, different, growing its health financing system from its own historical context and adapting it according to various local enabling factors and barriers (Lagomarsino et al., 2012). *Box 2*, below, presents the enabling features found in nine country case studies from LMICs that had made significant progress in achieving UHC and good health outcomes, i.e., Chile, Colombia, Costa Rica, Estonia, the Kyrgyz Republic, Sri Lanka, Thailand, Tunisia and Vietnam (Gottret et al., 2008). These conditions are similar to those identified in other sources and are important for countries to consider before making their policy choices (Atun et al., 2013).

Box 2: Enabling conditions for effective health financing reform

- Contextual factors (economic, institutional and societal factors):
 - strong and sustained economic growth
 - political stability
 - sustained political commitment
 - strong institutional and political environment
 - well-educated population
- Policy factors:
 - financial resources committed to health, including private financing
 - commitment to equity and solidarity
 - health coverage and financing mandates
 - consolidation of risk pools
 - recognised limits to decentralisation
 - focus on primary care
- Implementation factors:
 - sequenced healthcare delivery and provider payment reforms
 - good information systems and evidence-based decision-making
 - strong stakeholder support
 - efficiency gains and co-payments used as financing mechanisms
 - flexibility and mid-course corrections

Source: Gottret et al., 2008.

While the level of per capita health spending generally increases with the GDP level as does the share that is prepaid and the share that is government financed, as more funds are available and as social demand grows, there is considerable variation between countries on this. (Dieleman et al. 2016; Tandon and Cashin 2010). For example, while in India health spending as a share of GDP remained stagnant during a period of rapid economic growth, Thailand moved towards tax-financed universal coverage in 2001 at a time of economic downturn, low gross national income and a low tax revenue share of GDP (Tandon and Cashin 2010; Tangcharoensathien et al. 2018). Countries that fund health expenditure largely from non-contributory sources may also not be able to provide universal and equitable access. The level of funding could be too low, the allocation of revenue inequitable and the range and quality of services could be poor (Lagomarsino et al. 2012, Garshong and Akazili 2015).

Other contextual factors have an impact, including political dynamics (Dieleman et al., 2016; Tangcharoensathien et al., 2018). As raised in *Box 2*, sustained political commitment is a key enabler, especially where supported by legal rights. In many Latin and Central American countries, health financing reforms during times of stable economic growth occurred within a broader context of democratisation, a more empowered electorate that demanded improvements in health and social systems and in addressing social inequalities and social reforms that created opportunities for greater investment in health (Cavangero et al., 2015). At the same time some successful reforms, such as in Thailand, survived political turmoil over fifteen years (Tangcharoensathien et al., 2018).

Other policies and internal conflicts can play a role. Decentralisation, a policy priority of many countries, can make it politically and practically difficult to move towards equitable financial protection and access. While decentralisation reforms intend to improve the responsiveness of health services, they can also hinder implementation of financing reforms, given that they make it more difficult for central governments to ensure that local-level governments are promoting equity, as was found in Brazil and Colombia (Esteves, 2012). The creation of purchaser-provider splits can create contesting responsibilities and power within the public health system (Tangcharoensathien et al., 2011). Many countries have chosen to establish a semi-independent authority with stronger governance, but with more operational flexibility than ordinary public sector institutions, to manage new funding arrangements (Tangcharoensathien et al., 2011).

Poor management of contextual factors and a misalignment of the components of financing reforms can torpedo efforts to achieve UHC, whatever the individual features of the financing source. For example, Peru introduced financing reforms in the context of a large informal labour market, a fragmented health system, weaknesses in health services and strategic purchasing, the absence of a risk-pooling mechanism for different insurance plans and an inefficient and inequitable distribution of human resources. This raised a number of challenges for its financing reforms (Seinfeld and Besich, 2014). In contrast, Indonesia implemented a new UHC policy in a diverse, decentralised system in the context of strong economic growth, political stability and sound economic institutions. A semi-independent authority administers a new UHC programme, including contributing and non-contributing members, that has grown rapidly. It is now the largest single-payer system in the world in terms of the number of people covered, although with challenges in achieving coverage for ‘the missing middle’ and young children (Agustina et al., 2019; Trisnantoro, et al., 2014).

This implies that any choices on financing options must be accompanied by measures to improve the prioritisation, quality and accessibility of services and by a fair distribution of resources (Kutzin, 2013). This review identified that in implementing financing reforms attention also needs to be paid to how to: improve equitable entitlements for beneficiaries served by the variety of funding mechanisms; increase pooling of financing sources; strategic purchasing mechanisms that incentivise efficiency and quality on the part of service providers; and dialogue between health and finance ministries on how to reconcile fiscal constraints with health system objectives.

Equally, the processes by which policies are designed and choices are made are important to achieve input and buy-in from the range of actors who will implement them. Drawing lessons from Bangladesh, Botswana, Cambodia, Nigeria, Tanzania and Vietnam, Makinen et al. (2018) found that such support was enabled when financing strategies were developed in multisectoral, multi-actor committees, working towards clear, agreed-upon objectives, such as how to improve financial protection, and in consultation with key stakeholders. Such dialogue needs high level support, such as that provided by the Prime Minister and Cabinet in Turkey’s reforms (Atun et al., 2013). It also requires a two-way sharing of information with public, technical and local health personnel, including on the necessary support for implementation.

7. CONCLUSIONS



There is no single blueprint for the choice on what domestic financing options to blend in designing and implementing financing reforms in support of UHC. What is politically acceptable and practically feasible is specific to each country's socioeconomic and political contexts. At the same time, countries have policy commitments to ensure equity, efficiency and sustainability in these choices as they move to UHC and thus need to know the implications of the choices they make. Equally, the options chosen have macroeconomic and fiscal implications; can make different levels of contribution to revenue, pooling, income and risk cross-subsidies and create different levels of opportunity for equitable allocation. Countries need to put the choices in the context of their institutional resources and capacities, the efficiency and ease of their collection and the potential to avoid cost escalation and their political and social acceptability.

The evidence presented in this report as summarised in *Tables 6 and 7* indicates that:

- **Prepaid mandatory payments** and general revenue are central to any financing policy for UHC, as they offer the greatest possibilities for equity, efficiency and sustainability, for pooling, cross subsidies and equitable allocation. This can be achieved through fully tax-financed systems, using a mix of direct and indirect taxes, or by combining contributory and non-contributory options, with various strategies for inclusion of low-income groups from subsidising their participation in a single system to targeting them through a separate system.
- **Direct taxes** have greater potential to support financial protection, equity, pooling and cross subsidies and provide large revenue streams, but depend on tax levels, the distribution of tax burdens relative to wealth, the efficiency of tax collection and the quality and equity of services funded. They are vulnerable to economic downturns and more difficult to collect where informal employment is high.
- There are numerous options for earmarking or applying **indirect taxes for health**. They too have potential to support financial protection, equity, pooling and cross subsidies, especially when pooled with direct taxes. They are administratively easy to collect, can play an important role where informal employment is high and some can be linked to health impacts or used for underfunded areas of public health. They may generate less revenue and some are susceptible to changes in consumption. As a flat rate charge, they may be less progressive than direct taxes, unless a large share of public revenue is applied on luxury goods or exempting lower income groups.
- **Mandatory contributory payments (SHI)** have variable implications for equity, efficiency, sustainability, adequacy, fiscal policy and administration, depending on their design, on whether contributions are income/wealth related, whether members face co-payments and the entitlements covered. Adequacy and pooling are enhanced when the scheme is large, but administration can be complex, especially where informal employment is high, and demands significant institutional capacities to avoid cost escalation given the inherent incentives for overuse. When introduced first for the formally employed, schemes tend to extend cover for better-off population groups, often drawing higher per capita contributions from government as the employer than is spent by government on public services. SHI carries the potential of resistance from these groups to widen cover and extend cross-subsidies to other lower income groups in support of UHC.
- **Private voluntary health insurance** extends cover for elites but may impact negatively on the public sector's sustainability and set back efforts to achieve universalism, especially in the context of a weakly regulated for-profit private sector.
- **OOP payments**, if a large part of a country's financing, may lead to catastrophic payments and impoverishment.
- **The more these different sources can be pooled and publicly managed**, the more equitable, efficient and sustainable the financing. How these instruments are combined within a coherent system and designed in tandem with other key features of the financing system – pooling, benefit design and purchasing arrangements – is almost as important as the choice of revenue collection instrument itself.

The review suggests, as summarised in *Table 3*, that ESA countries are exploring diverse financing options, including new or earmarked indirect taxation (e.g., on natural resources, mobile phone use), improving tax collection and earmarking a share for health of existing taxes. Many ESA countries are exploring contributory financing options, either by introducing new SHI schemes or incentivising informal employees to join existing SHI. A number of countries are exploring or widening voluntary prepaid options, whether community-based or commercial schemes. The review suggests a caution on voluntary mechanisms and on

generating new segmented arrangements, as experience indicates that it leads to a wealth-related tiering of the health system that can be difficult to reverse.

The experiences of other countries provide some strategic learning that may be useful for the ESA region in considering and introducing domestic financing options, noting that any options have to take into account countries' specific contexts, opportunities and socioeconomic objectives, the way they interact with other policies, including on pooling, strategic purchasing and the design and delivery of service benefits. This implies that a health financing policy and financing reform objectives should always be located within wider socioeconomic, population health and health system objectives. Reforms that are considered or implemented piecemeal, especially when they respond to the demands of more vocal, advantaged population groups, can undermine UHC. Taking this into account and that there is no blueprint for an ideal revenue collection system in support of UHC, there are some broad lessons from international experience:

- a. A significant shift needs to be made from voluntary contributions, especially OOP payments, to mandatory, prepaid mechanisms.
- b. General government revenues have an essential role in achieving UHC, especially in prioritising or targeting populations that are not able to pay and given the difficulty in collecting contributions from a substantial portion of the informal sector. Expanding government revenue demands tax reform, collection and capacity measures beyond the health sector, but health ministries could strengthen their influence on fiscal policy debates, especially on improving the progressivity of taxation and on the macroeconomic, production, and employment role of the sector to mobilise support within Cabinet and Treasury for a greater share of general revenue for health.
- c. Mandatory non-contributory systems can be promoted through an array of direct and indirect tax options, the latter being useful where there is a high level of informal employment and earmarking portions of certain indirect taxes. Direct taxes need to be monitored to ensure that the working poor have adequate financial protection and access. Earmarked indirect taxes need to be monitored regularly to ensure they are not offset by health budget reductions and do not have negative equity impacts or distort consumption. Earmarking for specific purposes may be politically acceptable, but is more sustainable where the purpose is not over-specific and requires transparent reporting on use of funds.
- d. Contributory SHI schemes serving the formally employed can absorb public subsidies, generate barriers to extending coverage to other groups, unless blended with tax financing to support financial protection and access for these groups. They can present problems downstream when integrating and harmonising funding and benefits within larger pools. This is more equitably, sustainably and efficiently achieved by integrating SHI within a single funding pool based on general government revenue and used to fund universal benefits for all than by providing public subsidies to segmented SHI schemes.

ESA countries that are grappling with lower GDPs, underfunding, small tax bases and large informal sectors could reduce OOP spending in tandem with seeking other equitable sources of finance. More immediate choices on indirect taxes would need to link with and complement new longer term sources of general revenue, such as from taxing wealth and natural resources. Formal-sector SHI schemes need to be conceived of as contributory to NHI, contributing into single pooled funding and benefits, or with government subsidies that incentivise this. Some ESA countries are in a stronger economic position to move towards mandatory prepayment and universal entitlements; to consolidate risk pools, including by integrating contributory schemes into a NHI with common entitlements and tax-based subsidies for poorer groups.

All ESA countries would benefit from measures to strengthen tax collection and improve the share of government revenues devoted to health while ensuring that financing measures are accompanied by measures to strengthen strategic purchasing and delivery of and access to effective, quality care. Any immediate choices would need to project and consider longer term impacts on the system and longer term funding demands to prevent and respond to projected changes in population health, including chronic conditions. All ESA countries could be building on achievements made in reducing OOP, aiming to limit it to nonessential or discretionary services or to achieve policy objectives such as strengthening referral systems. For all, private voluntary health insurance with the risks identified above makes it complementary to rather than a substitute for mandatory financing. In considering any of these options, their potential impact needs to be modelled and reforms monitored so that adjustments can be made to address positive and negative consequences.

7. REFERENCES



1. African Health Observatory and WHO Regional Office for Africa (AFRO) (2018a) 'Namibia: Factsheet of health statistics 2018' (draft). Available at: www.who.int/afro (accessed 31 October 2018).
2. African Health Observatory and WHO AFRO (2018b) 'Mauritius: Factsheet of health statistics.' Available at: www.who.int/afro (accessed 31 October 2018).
3. African Health Observatory and WHO AFRO (2018c) 'Democratic Republic of Congo: Factsheet of health statistics.' Available at: www.who.int/afro (accessed 31 October 2018).
4. African Health Observatory and WHO AFRO (2018d) 'Madagascar: Factsheet of health statistics.' Available at: www.who.int/afro (accessed 31 October 2018).
5. African Health Observatory and WHO AFRO (2018e) 'Uganda: Factsheet of health statistics 2018.' Available at: www.who.int/afro (accessed 31 October 2018).
6. African Health Observatory and WHO AFRO (2018f) 'Tanzania: Factsheet of health statistics.' Available at: www.who.int/afro (accessed 31 October 2018).
7. African Health Observatory and WHO AFRO (2018g) 'Mozambique: Factsheet of health statistics.' Available at: www.who.int/afro (accessed 31 October 2018).
8. African Health Observatory and WHO AFRO (2018h) 'Kenya: Factsheet of health statistics.' Available at: www.who.int/afro (accessed 31 October 2018).
9. African Health Observatory and WHO AFRO (2018i) 'Botswana: Factsheet of health statistics.' Available at: www.who.int/afro (accessed 31 October 2018).
10. African Health Observatory and WHO AFRO (2018j) 'South Africa: Factsheet of health statistics' (draft). Available at: www.who.int/afro (accessed 31 October 2018).
11. African Union (2001) 'Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases'. African Union: Abuja.
12. AFRODAD (2011a) 'What has tax got to do with development?: A critical look at Mozambique's tax system.' AFRODAD: Zimbabwe.
13. Agustina RT, Dartanto R, Sitompul K et al. (2019) 'Universal health coverage in Indonesia: concept, progress and challenges,' *Lancet* 393:75-102.
14. Ataguba J (2012) 'Alcohol policy and taxation in South Africa: An examination of the economic burden of alcohol tax,' *Applied health economics and health policy* 10(1):65-76.
15. Ataguba J and McIntyre D (2012) 'Paying for and receiving benefits from health services in South Africa: Is the health system equitable?' *Health policy and planning* 27:i35-i45.
16. Atun RS, Aydin S, Chakraborty S et al. (2013) 'Universal health coverage in Turkey: Enhancement of equity,' *Lancet* 382: 65-99.
17. Bennet S and Gilson L (2001) 'Health financing: Designing and implementing pro-poor policies.' DFID Health Systems Resource Centre: London.
18. Botswana Ministry of Health (2010) 'Integrated health service plan: A strategy for changing the health sector for Healthy Botswana 2010-2010.' Government of Botswana: Gaborone.
19. Botswana Ministry of Health (2012) 'National Health Policy: Towards a healthier Botswana, December 2011.' Republic of Botswana: Gaborone.
20. Cali J, Makinen M and Derriennic Y (2018) 'Emerging lessons from the development of national health financing strategies in eight developing countries,' *Health systems and reform* 4(2):136-45.
21. Cashin C, Sparkes S and Bloom D (2018) 'Earmarking for health: From theory to practice.' World Health Organisation: Geneva.
22. Cavangero E, Almeida G, Seely E et al. (2015) 'Setting the context for universal health coverage reforms in Latin America and the Caribbean' in Dmytraczenko T and Almeida G (eds) (2015) *Toward universal health coverage and equity in Latin America and the Caribbean: Evidence from selected countries. Directions in Development*. World Bank: Washington DC.
23. Chitah B and Jonnson D (2015) 'Universal health coverage assessment: Zambia,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
24. Chuma J and Kirigia D (2016) 'Universal health coverage assessment: Kenya,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).

25. Connor C, Averbug D and Miralles M (2010) 'Angola Health System Assessment 2010,' Health Systems 20/20. Abt Associates Inc.: Bethesda MD.
26. DFID (2008) 'Democratic Republic of Congo Country Plan 2008-2018.' DFID: Kinshasa.
27. Dieleman J, Templin T and Sadat N, (2016) 'National spending on health by source for 184 countries between 2013 and 2040,' *Lancet* 387:2521-35.
28. Dmytraczenko T and Almeida G (2015) 'Toward universal health coverage and equity in Latin America and the Caribbean: Evidence from selected countries. Directions in Development.' World Bank: Washington, DC.
29. Doherty J and McIntyre D (2013) 'Addressing the failings of public health systems: Should the private sector be an instrument of choice?' in Surender D and Walker R (2013) *Social policy in a developing world* 101-24. Edward Elgar: Cheltenham UK.
30. Doherty J, Kirigia D, Okoli C et al. (2018) 'Does expanding fiscal space lead to improved funding of the health sector in developing countries? Lessons from Kenya, Lagos State (Nigeria) and South Africa,' *Global health action* 11(1):1-11.
31. Dutta A, Perales N, Silva R et al. (2014) 'Estimated resource needs and impact of Mozambique's Plano Estratégico do Sector Saúde, 2014-2019.' Futures Group, Health Policy Project: Washington DC.
32. Elovainio R and Evans D (2013) 'Raising and spending domestic money for health.' Chatham House: London.
33. Esteves R (2012) 'The quest for equity in Latin America: A comparative analysis of the healthcare reforms in Brazil and Colombia,' *Int Jo for equity in health* 11(6):1-16
34. Fafchamps M and Minten B (2003) 'Public service provision, user fees and political turmoil,' CSAE Working Paper Series 2003-15. Centre for the Study of African Economies, University of Oxford: Oxford.
35. Frenk J, González-Pier E, Gómez-Dantes O et al. (2006) 'Comprehensive reform to improve health system performance in Mexico,' *Lancet* 368:1524-34.
36. Fuertes C (2016) 'Universal health coverage assessment: Bolivia,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
37. Garshong B and Akazili J (2015) 'Universal Health Coverage assessment: Ghana,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
38. Gerstl S, Sauter J, Kasanda J et al. (2013) 'Who can afford healthcare? Evaluating the socio-economic conditions and the ability to contribute to healthcare in a post-conflict area of DR Congo,' *PLoS One* 8(10):e77382.
39. Gilson L, Doherty J, Loewenson R et al. (2008) 'Challenging inequity through health systems. Final report of the Health Systems Knowledge Network, World Health Organisation Commission on the Social Determinants of Health.' Centre for Health Policy, EQUINET, London School of Hygiene and Tropical Medicine: London.
40. Global Fund (2016) 'Innovative and domestic financing for health in Africa: Documenting good practices and lessons learned.' Available at: [/au.int/sites/default/files/pages/32895-file-lessons_learned_health_financing_in_africa.pdf](http://au.int/sites/default/files/pages/32895-file-lessons_learned_health_financing_in_africa.pdf) (accessed 16 January 2019).
41. Global Health Observatory (2014) 'WHO Country Cooperation Strategy at a glance: Madagascar.' Available at: www.who.int/gho/en/ (accessed 15 October 2017).
42. Global Health Observatory (2017a) 'WHO Country Cooperation Strategy at a glance: Malawi.' Available at: www.who.int/gho/en/ (accessed 15 October 2017).
43. Global Health Observatory (2017b) 'WHO Country Cooperation Strategy at a glance: Namibia.' Available at: www.who.int/gho/en/ (accessed 15 October 2017).
44. Global Health Observatory (2017c) 'WHO Country Cooperation Strategy at a glance: Uganda.' Available at: www.who.int/gho/en/ (accessed 15 October 2017).
45. Global Health Observatory (2018) 'WHO Country Cooperation Strategy at a glance: Mauritius.' Available at: www.who.int/gho/en/ (accessed 15 October 2017).
46. Gottret P, Schieber G and Waters H (2008) 'Good practices in health financing: Lessons from reforms in low- and middle-income countries.' World Bank: Washington DC.
47. Guerrero R, Prada S, Perez A et al. (2015) 'Universal health coverage assessment: Colombia,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14/7/2018).
48. Health Policy Project (2016a) 'Health financing profile: Angola.' Health Policy Project: Washington DC.
49. Health Policy Project (2016b) 'Health Financing Profile: Botswana.' Health Policy Project: Washington DC.


50. Health Systems 20/20 Project (2011) 'National Health Accounts 2008-2009: Executive summary,' Health Systems 20/20 Project. Abt Inc.: Bethesda MD.
51. International Finance Corporation (IFC) (2019) 'IMF Data Mapper.' Available at: www.imf.org/external/datamapper/datasets (accessed 23 March 2019).
52. Irava W (2015) 'Universal Health Coverage assessment: Fiji,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
53. James C, Gmeinder M, Vammalle C et al.(2018) 'Health financing and budgeting practices for health in South Africa,' *OECD Journal on budgeting* 17(3):95-126.
54. Kenya Ministry of Health (2014) 'Kenya Health Policy 2014-2030.' Kenya Ministry of Health: Nairobi.
55. Kenya Ministry of Health (2017) 'Kenya National Health Accounts FY 2015/16.' Republic of Kenya: Nairobi.
56. Kutzin J (2013) 'Health financing for universal coverage and health system performance: Concepts and implications for policy,' *Bulletin of the World Health Organisation* 91:602-11.
57. Kutzin J, Ibraimova A, Jakab M et al. (2009) 'Bismarck meets Beveridge on the Silk Road: Coordinating funding sources to create a universal health financing system in Kyrgyzstan,' *Bulletin of the World Health Organisation* 87:549-54.
58. Kutzin J, Yip W and Cashin C (2016) 'Alternative financing strategies for universal health coverage' in Scheffler R (ed) (2016) *World Scientific Handbook of Global Health Economics and Public Policy. The Economics of Health and Health Systems* 1:267-309.
59. Lagomarsino G, Garabrant, Adyas A et al. (2012) 'Moving towards universal health coverage: Health insurance reforms in nine developing countries in Africa and Asia,' *Lancet* 380:933-43.
60. Lesotho Ministry of Health and Social Welfare (2011) 'Lesotho Health Policy 2011.' Government of Lesotho: Maseru.
61. Lesotho Ministry of Health and Social Welfare (2016) 'National Health Strategic Plan 2017-2022 (final draft).' Government of Lesotho: Maseru.
62. Magagula S (2017) 'A case study of the essential healthcare package in Swaziland,' Discussion Paper 112. Zimbabwe, Swaziland Ministry of Health, IHI and TARSC, for EQUINET: Harare.
63. Makinen M, Cali J and Derriennic Y (2018) 'Developing and implementing health financing strategies,' *HFG series: Advances in health finance and governance, Health Finance and Governance Project, USAID.* Available at: www.hfgproject.org (accessed 12/3/ 2019)
64. Malawi Ministry of Health (2007) 'Malawi National Health Accounts 2002-2004.' Malawi, Malawi Department of Health and Policy Development: Lilongwe.
65. Malawi Ministry of Health (2017) 'Health Sector Strategic Plan II (2017-2022).' Government of the Republic of Malawi: Lilongwe.
66. Mauritius Ministry of Health and Quality of Life (2017) 'Draft health sector strategy 2017-2021.' Republic of Mauritius: Port Louis.
67. McIntyre D, Doherty J and Ataguba J (2014) 'Universal health coverage assessment: South Africa,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
68. McIntyre D, Obse A, Barase E et al. (2018) 'Challenges in financing universal health coverage in sub-Saharan Africa,' *Oxford Research Encyclopedia, Economics and Finance* 1-80. Oxford University Press: Oxford.
69. Meheus F and McIntyre D (2017) 'Fiscal space for domestic funding of health and other social services,' *Health economics, policy and law* 12:159-77.
70. Meng Q, Fang H, Liu X et al. (2015) 'Consolidating the social health insurance schemes in China: Towards an equitable and efficient health system,' *Lancet* 386:1484-92.
71. Mozambique Ministry of Health and EQUINET (2010) 'Launch of the Mozambique Equity Watch: Report.' Mozambique Ministry of Health with EQUINET: Maputo.
72. Mpofu A and Nyahoda P (2008) 'National health financing in Zimbabwe 2005: Contribution of the national AIDS level to national healthcare support.' *Discussion Paper Series 54.* EQUINET: Harare.
73. Mtei G and Makawia S (2014) 'Universal health coverage assessment: Tanzania,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
74. Mwase T, Kariisa D, Doherty J et al. (2010) 'Lesotho Health Systems Assessment 2010,' Health Systems 20/20. Abt Associates Inc.: Bethesda MD.
75. Namibia Ministry of Health and Social Services (2017) 'Namibia 2014/15 Health Accounts Report.' Namibia Ministry of Health and Social Services: Windhoek.

76. RESYST (2015) 'Raising domestic resources for health: Can tax revenue help fund Universal Health Coverage?' RESYST: London.
77. Royal Institute of International Affairs (RIIA) (2014) 'Shared responsibilities for health: A coherent global framework for health financing.' RIIA: London.
78. Seinfeld J and Besich N (2014) 'Universal health coverage assessment: Peru', Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
79. Slon P (2017) 'Universal Health Coverage assessment: Costa Rica,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
80. Soe-Lin S, Frankel S, Heredia E et al. (2015) 'Tax reform and resource mobilisation for health,' Health Finance and Governance Project. Abt Associates Inc.: Bethesda MD.
81. Spaan E, Mathijssen J, Tromp N et al. (2012) 'The impact of health insurance in Africa and Asia,' *Bulletin of the World Health Organisation* 90:685-92.
82. Stasse S, Vita D, Kimfuta J et al. (2015) 'Improving financial access to healthcare in the Kisantu district in the Democratic Republic of Congo: Acting upon complexity.' *Global health action* 8:25480.
83. Sugar, Tobacco and Alcohol Taxes Group (2018) 'Sugar, tobacco and alcohol taxes to achieve the SDGs,' *Lancet* 391:2400-01.
84. Swaziland Ministry of Health and Social Welfare (undated) 'National Health Policy.' Swaziland Ministry of Health and Social Welfare: Mbabane.
85. Tandon A and Cashin C (2010) 'Assessing public expenditure on health from a fiscal space perspective.' World Bank: Washington DC.
86. Tangcharoensathien V, Patcharanarumol W, Ir Pi et al. (2011) 'Health-financing reforms in South-East Asia: Challenges in achieving universal coverage,' *Lancet* 377:863-73.
87. Tangcharoensathien V, Whittayapipopsakul W, Panichkriangkrai W et al. (2018) 'Health systems development in Thailand: A solid platform for successful implementation of universal health coverage,' *Lancet* 391:1205-23.
88. Titelman D, Cetrángolo O and Acosta O (2015) 'Universal health coverage in Latin American countries: How to improve solidarity-based schemes,' *Lancet* 385:1359-63.
89. Training and Research Support Centre and Zimbabwe Ministry of Health and Child Welfare (2014) 'Zimbabwe Equity Watch 2014.' TARSC, MoHCC and EQUINET: Harare.
90. Trisnantoro L, Marthias Y and Harbianto D (2014) 'Univeral health coverage assessment: Indonesia,' Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
91. Uganda Ministry of Health, Health Systems 20/20 Project and Makerere University School of Public Health (2012) 'Uganda health assessment 2011,' Health Systems 20/20 Project. Abt Inc.: Kampala and Bethesda MD.
92. Wang W, Temsah G and Carter E (2016) 'Levels and determinants of out-of-pocket health expenditures in the Democratic Republic of Congo, Liberia, Namibia and Rwanda,' *DHS Analytical Studies* 59. ICF International: Rockville, MD.
93. West-Slevin K, Barker C, Hickmann M et al. (2015a) 'Snapshot: Tanzania's health system.' Health Policy Project: Washington DC.
94. West-Slevin K, Dutta A and Health Policy Project, Futures Group (2015b) 'Prospects for sustainable health financing in Tanzania.' Health Policy Project: Washington DC.
95. World Health Organisation (WHO) (2010) 'Health systems financing: The path to universal coverage: Executive summary.' World Health Organisation: Geneva.
96. WHO (2015) 'WHO Country Cooperation Strategy 2015-2019: Mauritius'. Available at: apps.who.int/iris/handle/10665/246298 (accessed 13 October 2018) - .
97. WHO (2017) 'Global Health Expenditure Database.' Available at: apps.who.int/nha/database (accessed 6 October 2018).
98. WHO (2018a) 'WHO Country Cooperation Strategy at a glance: Zimbabwe.' Available at: apps.who.int/iris/handle/10665/136992 (accessed 13 October 2018).
99. WHO (2018b) 'WHO Country Cooperation Strategy at a glance: United Republic of Tanzania.' Available at: apps.who.int/iris/handle/10665/136888 (accessed 13 October 2018).
100. WHO Regional Office for Africa (AFRO) (2009a) 'WHO Country Cooperation Strategy 2008-2013: Malawi.' Available at: www.afro.who.int/publications/malawi-country-cooperation-strategy-2008-2013 (accessed 10 October 2018).

101. WHO AFRO (2009b) 'WHO Country Cooperation Strategy 2009-2013: Mozambique.' Available at: apps.who.int/iris/handle/10665/135983 (accessed 9 October 2018).
102. WHO AFRO (2010) 'WHO Country Cooperation Strategy 2010-2015: Namibia.' Republic of Congo: Brazzaville.
103. WHO AFRO (2016a) 'WHO Country Cooperation Strategy 2015-2019.' WHO Country Office in Angola: Luanda.
104. WHO AFRO (2016b) 'WHO Country Cooperation Strategy 2016-2020: United Republic of Tanzania.' WHO Country Office in Angola: Luanda.
105. WHO AFRO (2016c) 'WHO Country Cooperation Strategy 2016-2020: South Africa.' WHO Country Office in Angola: Luanda.
106. Xu K, Soucat A, Kutzin J et al. (2018) 'New perspectives on global health spending for universal health coverage.' World Health Organisation: Geneva.
107. Zambian Ministry of Health (2017) 'Zambia National Health Strategic Plan 2017-2021.' Zambia Ministry of Health: Lusaka.
108. Zikusooka CM, Kwesiga B, Lagony S et al. (2014) 'Universal health coverage assessment: Uganda', Global Network for Health Equity. Available at: gnhe.org/blog/uhc-assessments/ (accessed 14 July 2018).
109. Zimbabwe Economic Policy Research Unit (ZEPARU), TARSC and MoHCW (2013) 'Literature review on earmarked taxes for health in Zimbabwe.' ZEPARU, TARSC, MoHCW: Harare.
110. Zimbabwe Ministry of Health and Child Care (2016) 'National Health Strategy for Zimbabwe 2016-2020. Equity and quality in health: Leaving no-one behind.' Zimbabwe Ministry of Health and Child Care: Harare.
111. Zimbabwe Ministry of Health and Child Care (2017) 'Zimbabwe health financing strategy 2017.' Zimbabwe Ministry of Health and Child Care: Harare.

ACRONYMS

DRC	Democratic Republic of Congo
ESA	East and Southern Africa
GDP	Gross Domestic Product
LMICs	Low- and middle-income countries
MIC	Middle-income country/ ies
NHI	National Health Insurance
PPP Int\$	Purchasing power parity in international dollars
SHI	Social Health Insurance
UHC	Universal Health Coverage
VAT	Value Added Tax
WHO	World Health Organization



Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town, South Africa; CEHURD, Uganda; University of Limpopo, South Africa; SEATINI, Zimbabwe; REACH Trust Malawi; Ifakara Health Institute, Tanzania; Malawi Health Equity Network, University of Zambia; SATUCC and NEAPACOH

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