

Financing universal health coverage in East and Southern Africa

Financing universal health coverage (UHC) is not only about how to generate funds for health services. It is also about how these funds are pooled and used to purchase services. This policy brief explores options for financing UHC in East and Southern Africa (ESA). It presents learning from countries that have made progress towards UHC, including the need to increase domestic funding and to use mandatory pre-payment (tax and other government revenue, possibly supplemented by mandatory health insurance contributions) as the main mechanism for funding health services. The brief indicates the problems associated with introducing or expanding health insurance to fund UHC. With tax funding often the most equitable and efficient option, there is scope for increasing government revenue and health expenditure in many ESA countries.



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What do we mean by universal health coverage?

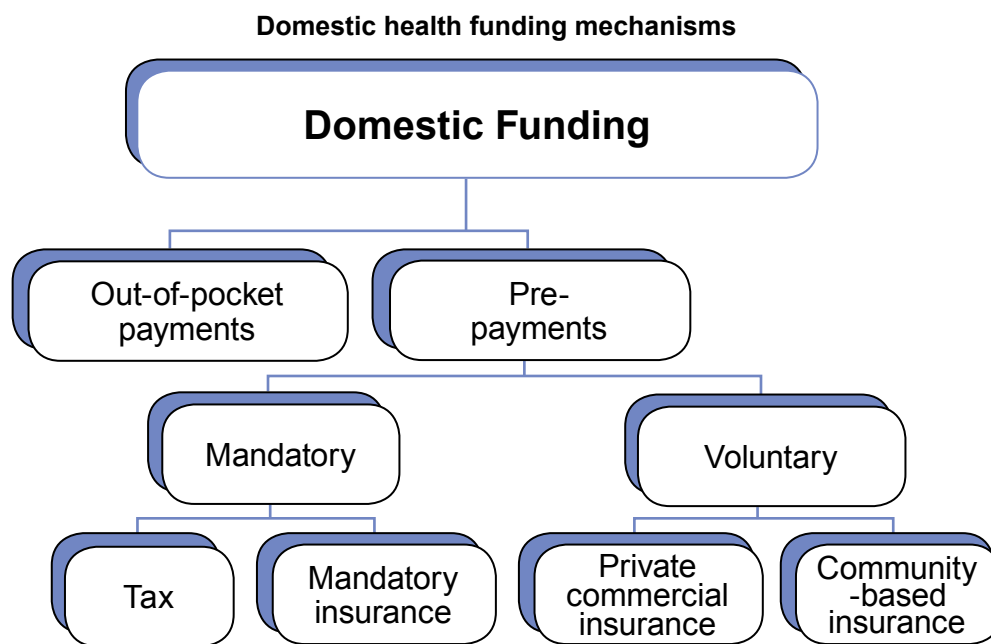
The 2010 World Health Report explained that UHC means that everyone in a country should be entitled to access the health services they need, that these services should be of sufficient quality to be effective, and that everyone should be protected against the costs of health services. From EQUINET's perspective, we believe that values of universality and social solidarity should be explicitly applied to interpreting the goal of UHC. By universality, we interpret UHC to mean that everyone should have the **same** entitlements in relation to financial protection and access to needed health services. The entitlement should be to the same range and quality of health services. Social solidarity requires that there are both income cross-subsidies (from the rich to the poor), with contributions to financing services based on ability to pay, and risk cross-subsidies (from the healthy to the ill) so that access to services is based on need and not ability to pay. Equity in the health system is thus integral to moving towards UHC.

What are the key functions of a health financing system?

Much of the UHC debate so far has focused on only one of the functions of a health financing system: revenue collection, or how to raise funds and from what sources. There are two other health financing functions, however. The first is pooling, or accumulating on behalf of the population the funds that are used to pay for services. The second is purchasing, or using pooled funds to purchase services from providers and to use available resources equitably and efficiently to provide good quality services.

How should we raise funds for UHC?

Many ESA countries are heavily reliant on external funding. In order to move towards UHC as rapidly as possible, it will be important to increase **domestic** funding for health services. The figure overleaf shows the different ways of generating domestic funds for health services.



It is important that domestic funds are generated in a way that is equitable and that protects people against financial risk. A key way of doing this is to reduce the reliance on out-of-pocket payments as a way of funding health services. Out of pocket payments refer to cash payments made to meet costs of and charges for health care. Many ESA countries are now removing user fees from public sector health services, and experience has shown that this must be planned carefully and accompanied by increased pre-payment funding, particularly from domestic sources.

What role does insurance play?

The 2010 World Health Report unequivocally states that it is not feasible to achieve UHC through voluntary enrolment in health insurance schemes. Voluntary health insurance schemes do not cover services for those who are too poor to pay insurance premiums. Also, if pre-payment is not mandatory, the rich and healthy will choose to not contribute to funding services needed by poor and sick people. It is only possible to achieve strong cross-subsidies through **mandatory** pre-payment mechanisms. Voluntary health insurance thus only has a limited role as a source of funds for services that are complementary or additional to the universal entitlements that are funded through mandatory pre-payment mechanisms.

One form of voluntary health insurance that has become increasingly popular in low- and middle-income countries is that of community-based health insurance (CBHI). There is considerable debate about the role of CBHI schemes. On the one hand, where mandatory pre-payment funding is limited, and households are faced with making out-of-pocket payments that may prevent them from being able to use health services when needed, CBHI schemes may be the only mechanism for promoting access to health services. On the other hand, CBHI schemes have achieved limited population coverage and usually cover a very limited range of health services. They generate very little revenue, as their contribution rates need to be low to be affordable to poor communities, but the costs of collecting these contributions can be quite high. The payments have been found to be very regressive, with poor people paying a higher percentage of their income on CBHI contributions than richer people. CBHI schemes should thus be seen as a temporary second-best option for providing some financial protection in contexts where government is not fulfilling its responsibility for funding health services.

The key focus in moving towards universal coverage should be on **mandatory** pre-payment mechanisms.



Many African countries are exploring introducing mandatory health insurance (MHI) schemes to cover formal sector employees. However, introducing MHI for formal sector workers can lead to reduced tax resources being available for publicly funded services. This is because the single largest group of formal sector employees in ESA countries is usually civil servants, and in some countries the MHI only covers civil servants. Government generally spends far more in making their employer contributions to MHI than they would have spent per capita on tax-funded services. MHI funds are also generally used to benefit only those who make MHI contributions. This creates a tiered and inequitable system and is not in line with the principle in UHC that all have the same service benefit entitlements. Some countries have explored introducing MHI contributions for those outside formal employment, to cover a larger section of the population. However, recent research has shown that MHI contributions by those who are not in formal employment are strongly regressive and generate very little revenue.

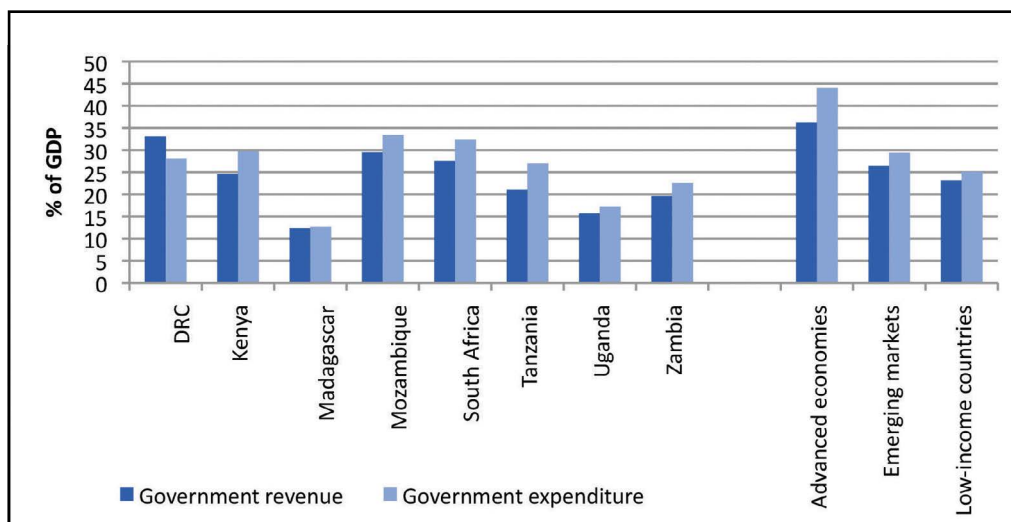
formal employment and paying personal income tax. If there is political insistence on generating funding from those outside the formal employment sector, then indirect taxes are a more equitable and efficient mechanism than MHI contributions. However, given the large income inequalities in many ESA countries, it may be more relevant to improve the collection of taxes from high net-worth individuals and high earning or multinational corporations or sectors.

One challenge that is often raised in tax funding is that of limited fiscal space for increased government spending in the health sector. However there is a basis to challenge this and to push the fiscal space envelop. The figure below shows that government revenue and expenditure as a share of GDP are lower in a number of ESA countries than the average for all low-income countries. In many ESA countries there is scope for increasing government revenue and expenditure as a share of gross domestic product (GDP). Even if a country has a low GDP, it does not automatically mean that its government revenue and expenditure as a percentage of GDP also has to be low. It is more feasible to increase government spending on health services if total government revenue is increased.

What options are there for increased tax funding?

Policy makers in many ESA countries see a need to generate some revenue from those working in the informal sector, given the small share of people working in

Government revenue & expenditure as % GDP



Source: International Monetary Fund, 2012.



How should funds be pooled?

The international consensus is that funding pools should not be fragmented if the goal is to achieve UHC. An integrated funding pool is necessary to achieve cross-subsidies. If there are separate funding pools for different groups, then this limits cross-subsidies between groups with different ability to pay or different need for services. It is often difficult to merge pools at a later stage. If countries pursue the option of a mandatory health insurance to generate additional revenue for health services, these funds should be pooled with funds from government revenue to avoid creating a two-tier system and to ensure that all receive the same service benefits.

How should funds be pooled?

Using limited funds equitably and efficiently, and ensuring that UHC is affordable and sustainable, is dependent on active or strategic purchasing of health services. Purchasing involves determining service entitlements – that is what services are purchased with the pooled funds and how people will be able to access these services. For example the evidence suggests that we should insist that primary health care facilities are the first point of contact and that referral routes are followed. It also concerns how service providers are paid. Increasing attention should be paid in ESA countries to promoting more active purchasing. This requires identifying the health service needs of the population, aligning services to these needs and ensuring that the services to which the population are entitled are available and of good quality. It also requires that ESA countries pay providers in a way that creates incentives for the efficient provision of quality services, monitor the performance of providers and take timely and decisive action against poor performance.

Is UHC only about financing?

Reforms in the health financing system, whether in relation to revenue collection, pooling and/or purchasing, are of no value if services are not available, not of adequate quality to be effective, or if they do not effectively inform and involve people in planning and delivery of services. Moving towards UHC requires wider improvements in service delivery and management. In particular, priority should be given to improving availability, accessibility, acceptability and quality of services at primary care level, given the role of these services in reaching poor people, in reducing cost barriers and in addressing most of the population health burden in ESA countries. Improving primary level health services offers the greatest potential for making affordable improvements in population coverage. It is also important to broaden the decision-space of managers at facility and district level to be more responsive to the needs of patients and staff and to the incentives created through active purchasing. This should be accompanied by mechanisms and processes that support accountability to the local community.

RESOURCES

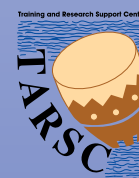
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