

B2 | FINANCING HEALTH CARE: AIMING FOR LONG-TERM SOLUTIONS

In Chapter B1 we discuss the progress (or lack of it) in the introduction of policies that promote primary health care (PHC). A subject of considerable debate has revolved around how health systems would be financed, so that they can sustain themselves. Whilst funding for health has increased significantly, rising from US\$5.6 billion in 1990 to US\$21.8 billion in 2007 (Ravishankar et al. 2009), it has so far remained insufficient for meeting the high burden of disease in the developing world.

Various attempts have been made to estimate the funding gap for the achievement of the MDGs. The High-level Taskforce for Innovative Financing (HLTF), for example, has estimated the cost of reaching the health-related MDGs at between US\$112 billion and US\$251 billion between 2009 and 2015.¹ As the HLTF has proposed, if all donors respect their previous commitments and if all LICs allocate at least 12–15 per cent of their GDP to health, the financing gap would be minimal. In comparison with today's high-income OECD (Organisation for Economic Co-operation and Development) countries, LICs should not need to grow and transform their economies, which only happens after long periods of time, in order to achieve significant improvements in health outcomes. Indeed, the progress attained by a large majority of developing countries in terms of health outcomes and access to health has been much more rapid than that achieved by today's rich countries through their processes of economic development. This is, to a large extent, because improvements in technologies for health care, in available treatments and preventative measures, can be potentially diffused globally despite massive income gaps across countries. In other words, today the potential for convergence among countries in achieving health outcomes is much greater than the potential for convergence in achieving income per capita.

One problem with a system that is premised on international aid is that the level of promised commitment is not forthcoming, both at the international and national levels. In the current climate of fiscal restraint and economic recession, we can also expect that the exponential increases in aid to health that we have witnessed in the past are under threat. Innovative financing mechanisms have the potential to make a valuable contribution to filling this gap, yet they remain an insufficiently tapped resource.²

In addition to the insufficiency of funding for health, its inequitable distribution between countries and between horizontal and vertical priorities

remains a concern. As analysed by the Countdown group to 2015, targeting of aid to maternal, newborn, and child health, for example, has improved, although several countries with high morbidity and mortality rates have seen a reduction in the aid allocated to them (Greco et al. 2008). Certain diseases have also received a disproportionate share of resources. For example, between 2002 and 2006, 75 per cent of the additional funding to health was allocated to HIV/AIDS (Isenman and Shakow 2010). An analysis of the health funding of the Gates Foundation, the Global Fund to Fight AIDS, TB and Malaria (GFATM), the US government, and the World Bank found huge variation in the funding per death across diseases, from US\$1,029.10 for HIV to US\$3.21 for non-communicable diseases (Sridhar and Batniji 2008), despite the reality that more deaths occur in the developing world from the latter (England 2007).

Moreover, LICs cannot hope to deliver on most of the promises for improvements on health outcomes and access only on the basis of aid flows, despite their obvious contribution at present. Indeed, health service delivery can be seen as part of a social contract between states and societies, so that bold efforts to mobilise domestic resources are made with a long-term horizon. The volatility of aid and the growing complexity and fragmentation of aid delivery systems make the need for greater reliance on more sustainable domestic sources a long-term priority. Currently, the delivery of aid in general, and of health in particular, suffers from institutional dysfunctions associated with the coexistence of different mechanisms of aid allocation, monitoring, and evaluation, ranging from traditional ‘project’ approaches, implemented by both state and non-state actors, to programme aid to general budget support more recently. Health ministries in aid-dependent countries are hugely overburdened with complex aid systems and a multiplicity of actors and projects. For example, in Mozambique, over 400 separate projects were located in the Ministry of Health in recent years, a situation that is not uncommon in the social sectors of aid-dependent countries (Riddell 2007). Therefore, donor proliferation and the fragmentation of aid delivery systems with their considerable transaction costs have substantially increased the bureaucratic burden that governments in LICs face in managing aid flows, thereby making policy processes excessively driven by the day-to-day demands of the management of aid (Oya and Pons-Vignon 2010).

Pledges to increase aid commitments have abounded in the past decade, but the current context of global stagnation and severe fiscal austerity programmes in OECD countries may result in these promises remaining unfulfilled. A number of OECD donors have already started reversing increases in aid flows, notably Italy, France, Spain, and Ireland. More may follow in the medium term. This situation adds to the unpredictability of aid flows, whose volatility often exceeds that of export and fiscal revenues in LICs (Fielding and Mavrotas 2005).

Governments facing volatile aid flows and unfulfilled aid commitments

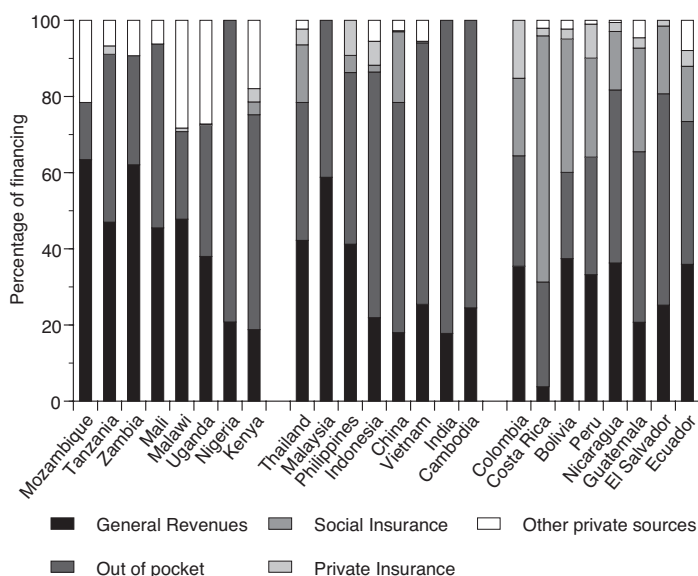
may not be in a position to make substantial commitments to expand health systems through public investment and permanent hiring of health workers, and may therefore be inclined to increase reliance on vertical programmes and temporary work arrangements. This may run against the commitments to achieving sustainability of access to health and health systems (see more below). In addition, many of these countries have programmes with the International Monetary Fund (IMF), usually in the form of Policy Support Instruments, which are now essential for attracting funding from other donors. The IMF has expressed reservations about the scaling up of aid owing to the inherent volatility of aid flows, and therefore has induced caution in aid-recipient governments, which unavoidably affects plans to expand health service delivery via permanent recruitment of health workers (Heller 2005). This can present an additional constraint on long-term health system strengthening based on foreign aid. In sum, if donors do not address the problem of volatility of aid flows, LICs may take much bolder steps to reduce aid dependence and mobilise domestic resources, particularly through taxation, which remains woefully low, especially in least developed countries.

There is a need to press for more international aid, and for international commitments in this regard to be honoured (See Box B2). The international context, however, will increasingly mean that funding at the domestic level must be harnessed. The aim of this chapter is, therefore, to assess how money should be raised at the domestic level to finance universal coverage of a package of health services: What is the best financing mechanism? What are the acceptable current trends that address concerns about equity and universal coverage? Is there one 'best' way of financing health care? Have all the options been given a fair trial or are ideologies getting in the way of finding progressive solutions?

Why we must move away from user fees

The health sector as a whole has gone through a series of reforms in the past four decades at least that saw a shift from comprehensive primary health care (as epitomised by the Alma-Ata Declaration in 1978) to selective primary health care, focusing on a series of cost-effective interventions (Bhatia and Rifkin 2010). The latest wave of health sector reforms, driven by the World Development Report 1997, have been particularly focused on introducing market mechanisms into the health sector, in the belief that the competitiveness and efficiency of the private sector would benefit the achieving of health outcomes.

These reforms had an impact on the methods of delivery (a shift from public to private provision), the role of the state (a shift from provider to steward), among other things, and also on the type of health financing mechanisms implemented in countries (from free care at the point of use to user fees). By definition, health financing systems have three functions: revenue raising,



B2.1 Sources of health care financing, selected low and middle income countries, 2000 (source: Hsiao and Shaw (2007: 6))

pooling of resources, and purchasing of services (WHO 2000). Ideally, these financing mechanisms should fulfil these three roles whilst promoting equity and efficiency.

To date, the dominant form of financing health care in Low and Middle Income Countries (LMICs) is direct out-of-pocket payments, of which user fees are a part (see Chart B2.1). These user fees – the individual payments made for services at the point of use – have been the subject of much high-profile debate in the past few decades. The World Bank used to not only encourage this financing mechanism as a source of income, but even made it a condition to receiving funds at the time of the Structural Adjustment Programmes (SAPs) in the 1980s. The main justification for the introduction of user fees was twofold: to reduce moral hazard – that is, to discourage unnecessary utilisation of health services; and to generate additional revenue. However, in the provision of health care, the underlying market-based assumptions do not hold.

The reality of asymmetric information between the health care provider and the patient, whereby a patient is not fully informed of their needs, means that the purchaser of health care does not know how serious their condition is, nor how much it will cost. Thus, the economic argument fails. User fees deter patients from accessing both necessary and unnecessary health care. Frivolous use of health services is unlikely given the high additional costs of seeking care, such as transport and time. In delaying treatment, conditions may worsen and costs may inflate, thereby undermining the efficiency objective.

This eventuality is more common amongst the poor, for whom access is determined by capacity to pay. Owing to the stochastic, unpredictable nature

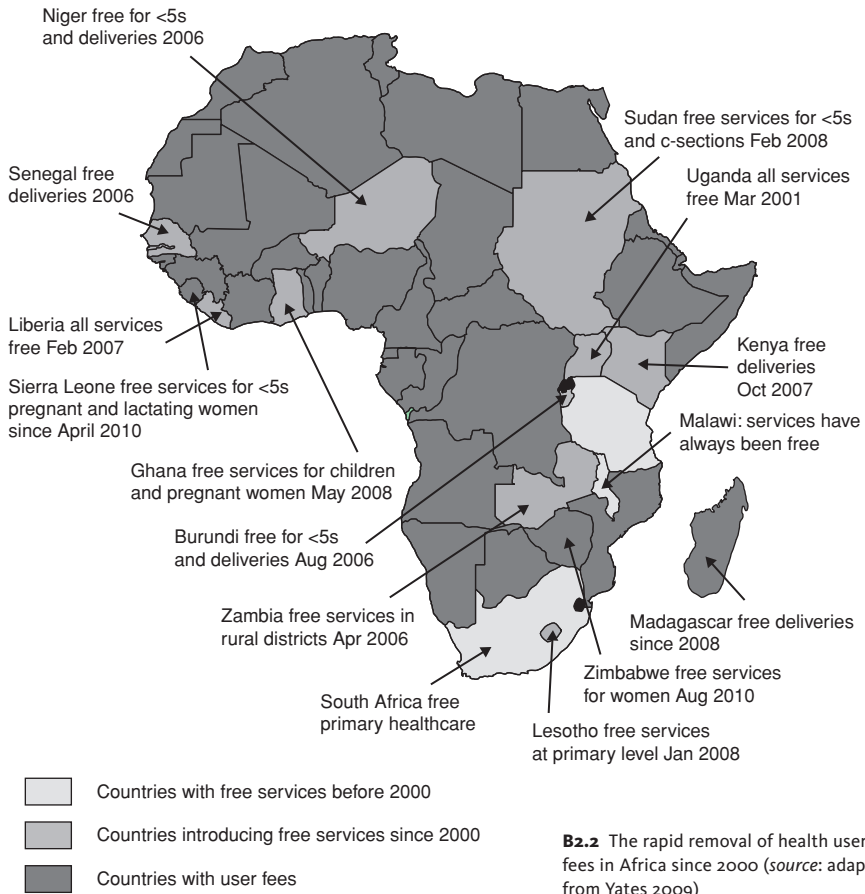
of ill-health and its associated potentially exorbitant costs, making individuals bear the financial burden of their ill-health is regressive and simply unfair. For those who do seek care, the incidence of impoverishment and catastrophic expenditure disproportionately affects the poorest. Health care is also a ‘public good’, with high externalities – that is, with spill-over benefits for the wider society.

As for the second justification – that of the potential of user fees to raise revenue – the evidence is weak. Relative to overall health expenditure, user fees tend to contribute a small share, approximately 5 per cent of recurrent costs after the deduction of administrative costs. Whilst this might facilitate some cost recovery at the facility level, it is inadequate to bring about significant quality improvements, and can actually exacerbate geographic inequity as the quality gap in service provision between wealthier and poorer areas widens (Gilson 1997). In addition, implementing user fees comes with considerable administrative costs, and weak financial management capacities and audit systems at the facility level reduce efficiency further (*ibid.*). Thus, the motivations for introducing user fees at the point of service prioritised efficiency over equity. As the evidence demonstrates, in practice user fees for health services are both inefficient and regressive.

Today, these negative effects are well understood and recognised. Over the past few years, the governments of many LICs, concerned with the implications of these negative effects for their populations, have either totally (as in Uganda or Liberia) or partially (as in Burundi and Sierra Leone) eliminated user fees (see Chart B2.2).

Donors and international institutions have also, sometimes half-heartedly, started to acknowledge the evidence. The UK Department for International Development (DfID) had been for the past five years at least a champion of the removal of user fees, and it is hoped that this commitment will be upheld and will grow under the new coalition government. The World Bank has softened its position from ‘user fees are a must’ to ‘Upon client-country demand, the Bank stands ready to support countries that want to remove user fees from public facilities *if ...*’ (The World Bank Strategy for Health Nutrition and Population Results, 2007, para. 105³). ECHO (Humanitarian Aid department of the European Commission) and the European Union have recommended the replacement of user fees in LICs. The World Health Assembly (WHA) passed a resolution in favour of the abolition of user fees (WHO 2005). The Global Consensus on Maternal, Newborn and Child Health (MNCH), recognised at the L’Aquila 2009 G8, has also supported the removal of user fees.

This could seem like an overwhelming victory for free health care at the point of use. In practice, however, user fees continue to limit the ability of the poorest to access health care. Children are still dying because their families cannot afford the few cents or dollars necessary to see a doctor, and mothers are still dying during delivery because they cannot afford to pay for a C-section



B2.2 The rapid removal of health user fees in Africa since 2000 (source: adapted from Yates 2009)

when they need one. Indeed, whilst the academic argument has been won, the practical implementation of free care at the point of use is proving to be a barrier. Internationally, the debate has moved on from *whether* to remove user fees to *how* to remove them (Save the Children UK 2008).

Further, in the absence of broader social protection policies, the costs of seeking health care for households are not limited to official fees. As mentioned above, transportation is another major expense, especially for poor and remote populations. For instance, in Mpumalanga, South Africa, transport costs accounted for 62 per cent of total household expenditure when treating malaria (Castillo-Riquelme et al. 2008). Other indirect costs include the transport, accommodation, and food expenses for accompanying relatives, which can be particularly high, especially for inpatient care. Unanticipated charges for supplies and drugs, as well as unofficial fees charged by health care providers or ancillary staff, push up overall costs for the household. In Ghana, drugs and medical supplies made up 79 per cent of the total costs for obstetric care (Borghini et al. 2003). There is also the opportunity cost of the time taken to

seek care, which is hard to quantify and often overlooked. In LICs, where large proportions of the population are informally employed, time away from work may deprive a household of their daily income, which is required to feed the family. In some cases, these additional indirect costs can exceed the cost of the user fee, thus becoming more significant barriers to access.

For poor, and often rural, households, the expenditures associated with accessing health services can be catastrophic, and plunge families into poverty. In the event of a complicated delivery, costs to households in Nepal increased tenfold. For the wealthier families, this amounted to 113 per cent of household income, reaching 366 per cent for the poorest households (Borghi et al. 2006). Assets that are essential for a family's livelihood – such as cattle or farmland – may be sold, and huge debts incurred, perpetuating the cycle of poverty. Whilst removing user fees may not be enough to address the variety of barriers to access, and whilst further investment is required to understand better how to alleviate this wider burden on households, where other safety nets do not exist, making health care free at the point of use is a vital first step to increasing coverage.

Private alternatives to user fees

Countries do not finance their health systems through a single mechanism, but rather uses a combination of approaches. There are two broad types of financing mechanisms available: first, private ones (that is, the source of finance is the individual, as is the case for community-based health insurance [CBHI], medical savings accounts,⁴ and private health insurance [PHI]); and second, public ones (that is, services are paid for through taxes or compulsory health insurance), and, of course, a combination of any or all of these.

Private health insurance (PHI) Could PHI provide part of the answer to replace user fees? It only plays as yet a limited role in LICs, although some donors would like to see its importance increase (the International Finance Corporation [IFC] or USAID, for example). PHI currently plays a marginal role in LICs, with coverage usually under 10 per cent of the population (Drechsler and Jütting 2005). Zimbabwe was the only LIC where PHI accounted for more than 20 per cent of total health expenditure in 2001 (Sekhri and Savedoff 2005). However, although this represents a large share of total expenditure (23 per cent), it only applies to a small share of the population (8 per cent), which is likely to have belonged to the wealthiest tiers and those employed in the formal sector (ibid.).

PHI theoretically enables the health care of the relatively affluent to be self-financed, and frees up public resources for those unable to purchase PHI. It can mobilise additional resources for infrastructural development that benefits poor and rich alike, and holds the potential to encourage innovation and efficiency, which may catalyse the reform of the public sector whilst increasing choices

for the consumer (Maynard and Dixon 2002). However, PHI discriminates in favour of the healthy and young adults with low utilisation levels (Baeza and Munoz 1999; Maynard and Dixon 2002; Oxfam International 2009; Mills 2007). The elderly tend to drop out of these schemes after retirement (as seen in South Africa and Chile), returning to the public sector. As these schemes are based on an individual's ability and willingness to pay,⁵ they lead to obvious inequality in access, market segmentation,⁶ cream skimming,⁷ and exclusion of vulnerable groups (such as the poor, the ill, and the elderly).

South Africa has the most extensive PHI schemes in sub-Saharan Africa. Analysis there has shown that these schemes (a) cover only a small proportion of the population; (b) have led to fragmentation of the risk pools; (c) have led to an increase in expenditures; and (d) increasingly capture tax resources (McIntyre et al. 2005: 26). In light of these significant risks, the government must have the capacity to develop robust regulatory frameworks that are able to set the standards and rules by which PHI can operate (Drechsler and Jütting 2005).

This last point – the national cost associated with supporting PHI schemes – is often ignored. In South Africa, for example, the tax deductibility of private scheme contributions reduced government tax revenue by over US\$1 billion in 2001 and higher income earners received a much greater share of the tax benefits (McIntyre et al. 2005). Furthermore, in South Africa, as in LICs in general, the government is the main employer, and a substantial amount of tax resources is devoted to purchasing medical scheme cover for civil servants. 'For example, the South African government spent 12 times more paying for medical scheme cover per civil servant than it spent on funding public sector health services per person dependent on these services in the early 2000s' (ibid.: 26).

It seems obvious, therefore, that PHI can only play a limited role in LICs, one which focuses on catering to only a small segment of the population – the rich.

Community-based health insurance (CBHI) The enthusiasm for CBHI is growing, particularly in sub-Saharan Africa, where the introduction of CBHI schemes is sweeping across the region. CBHI is defined as 'any scheme managed and operated by an organization, other than a government or private for-profit company, that provides risk pooling to cover all or part of the costs of health care services' (Bennett et al. 2004); they are normally voluntary. CBHI differs from PHI in that the administration of the scheme is undertaken by an association or a community rather than a commercial institution.

CBHIs are seen as a positive progression away from user fees towards national health insurance systems because they collect revenue, pool funds, and ensure strategic purchasing to encourage financial protection, equity in utilisation of services, and financial sustainability. These schemes are expected

to 'reach population groups that market based health financing arrangements do not', such as populations in the informal sector and socially excluded groups (Jakab and Krishnan 2001: 53). These schemes used to be widespread in some developed countries such as Germany or Japan, but have since totally disappeared and are now found only in LICs (Rannan-Eliya 2009).

There is some evidence that CBHI schemes provide effective protection to their members by significantly reducing their level of out-of-pocket payments for care (Ekman 2004). Studies comparing the level of financial protection of scheme members with that of non-members have found that belonging to some form of pre-payment scheme reduced the financial burden of seeking care (Arhin-Tenkorang 2000; Pradhan and Prescott 2002; Diop et al. 1995). In that sense, CBHI should be welcomed as an improvement over user fees.

However, even in areas that are 'success stories', such as the Thies and Bwamanda regions, evidence suggests that the poorer segment of the population is much less likely to join CBHI schemes than people with an average or high income, as the poor have no financial means to pay the required insurance premium (Jütting 2003: 284). The same conclusion applies to Rwanda, where, despite exemption systems to protect the most vulnerable, this group remains excluded (Musango et al. 2004).

Therefore, whether the poorest will be able to obtain financial protection will depend on whether or not their premium will be subsidised (by the state or by donors) and on how successful this subsidisation will be in targeting those most in need.

The pooling power of CBHIs has also been mixed. Since membership of the schemes is normally voluntary (aside from the case in Rwanda), adverse selection has led to the fragmentation of pools (various funds for different categories of people), resulting in the wealthiest groups having access to better quality and more comprehensive health care services. (Carrin et al. 2005: 801).⁸

Furthermore, people's willingness to pay the CBHI premium is dependent on a combination of variables: health care prices, disposable income, trust, original quality of care, and who pays the premium in the household.⁹ The extent and level of the benefit package also play an important role in the decision to subscribe. Some schemes offer a basic primary-level health care package, while others cover catastrophic expenditures only. Which is best? Which will attract the most individuals? Setting a premium of about US\$1 per capita per year may well enable the entire population to join (as in the case of Rwanda), but would not buy any meaningful benefit package. On the other hand, offering only catastrophic coverage (for HIV/AIDS, for example) could make the scheme more financially sustainable, leaving the enrollees to continue to cope with the most basic of services (often but not always subsidised by the state), while offering them protection for those events that

would undoubtedly throw them into extreme financial hardship or for which they would be unable to pay. Which solution is the most appropriate is difficult to assess, particularly since the majority of the schemes have defined their benefit packages only vaguely and improperly.

Because the majority of CBHI schemes have been unable to attract large populations, with the exception of schemes in China and a few schemes in India (Rannan-Eliya 2009: 73), they have not been able to bear the financial risks of their members. Hence, they require support from central and local governments; 89 per cent of the schemes investigated by the International Labour Organization (ILO) were subsidised by the government, as 70 per cent of these schemes collected less than 50 per cent of the needed revenue to be sustainable (ILO 2002). This is also the case in China, where the study by Zhang et al. (2006) found that only half of the farmers were willing to join the voluntary CBHI scheme, despite a government-subsidised premium.

Nonetheless, the Rural Mutual Health Care (RMHC) initiative in China, a form of CBHI, was found to increase outpatient utilisation by 70 per cent. This was facilitated by a mixture of demand- and supply-side interventions to provide individuals with first dollar coverage for inpatient and outpatient care, and to link provider payment to service quality rather than drug sales (Yip et al. 2008). The impact of such supply-side interventions may be felt by the entire population, which suggests that RMHC had a spill-over effect on the uninsured population too (*ibid.*). Successful experiences in India include the CBHI offered by the Self-Employed Women's Association (SEWA) in Gujarat, through which the number of patients facing catastrophic health expenditures was reduced from 35.6 per cent to 15.1 per cent. This was facilitated by high pre-payment ratios, as well as a benefit package inclusive of costly inpatient care (Carrin et al. 2005).

Mechanisms to ensure sustainability of individual schemes have been attempted in numerous countries but can conflict with equity concerns: exclusion of high-risk individuals from scheme membership will affect the sickest and most vulnerable members of the population; increasing premium levels will discourage the poor from joining; and placing limitations on a benefit package will enable better financial sustainability but will limit the attractiveness of the scheme (Bennett et al. 2004).

Overall, CBHI offers only a marginal improvement over user fees in terms of financial protection and provides no prospect of universal coverage. We must also recognise that any community approach presents technical solutions and eschews social relations as if all decisions were made by individuals only. Yet power relations within communities exist, and the decision to join a CBHI scheme or not may be forced upon individuals rather than be the result of an individual's choice. It seems that the choice of CBHI relies mostly on a culturally appealing morality tale, but it is no panacea for tax-financed health systems aimed at achieving universal coverage.

Public financing methods: why tax-financed systems offer greater potential

The public mechanisms for financing health care, social/national health insurance, and tax-financed systems (TFSs) are widely recognised as holding greater potential of achieving universal coverage (McIntyre et al. 2005; Mills 2007). Yet the discussion on these approaches is rather limited and revolves around a key argument: progressive taxation in LICs is argued to be extremely complex to implement for various reasons (discussed below), hence social health insurance (SHI) is the only realistic public financing option afforded to LICs today. In May 2005, for example, WHO passed a resolution encouraging its member states to move ahead with this system, promising to provide technical support to help nations develop it.¹⁰ We argue that this is a short-term view, which actually harms the potential for achieving longer-term sustainability.

Comparison between a tax-financed system (TFS) and social health insurance (SHI)

What is a tax-financed system and social health insurance? Tax-financed systems (TFSs) are systems where government revenues raised through various forms of taxation are the main source of financing for government health care expenditures. Social health insurance (SHI) refers to systems where ‘only certain groups are legally required to become members and where only those who make insurance contributions are entitled to benefit from the insurance scheme’ (McIntyre et al. 2005: 25). National health insurance systems, on the other hand, refer to a universal insurance system in which the entire population is covered, independently from contributions, with generally heavy government subsidisation.

Equity and financial protection Both tax-based financing and SHI are a form of tax, the first on general wealth whilst the second focuses only on wages. They relate the initial payment to income rather than risk, detach payment from the experience of ill-health through a pre-payment system, and can create large risk pools, and hence hold redistribution potential. In terms of equity and financial protection, they both represent an indisputable improvement over private mechanisms.

There are, of course, nuances. Whether or not an SHI system will be progressive will depend on the structure of the contribution rates. Will there be a ceiling rate? Will the contribution be flat or will it increase with income? How will the funds be pooled? Will there be a central pooling fund (which would ensure subsidisation across scheme members) or will there be multiple funds (which would limit the subsidisation potential)? The smaller the pool of contributors, the lower the cross-subsidisation that can be achieved, and the less impact of equity and sustainability on the health system (*ibid.*).

As to a TFS, its relative merit will depend on whether the personal income tax will be structured progressively, whether the overall tax burden will fall on

households or whether it will be widened to include corporations (national and international), and on the relative role of indirect taxes (the lower the VAT, for example, the more progressive the system). Financial protection will be more or less equitable depending mainly on whether government funds are allocated according to the relative needs of the population. For example, various studies on the distribution of benefits from publicly (tax)-funded services in African countries have shown that the rich benefit most from these services (Castro-Leal et al. 1996; Castro-Leal et al. 1999; Demery 1995). This usually occurs when a major ‘share of tax funding is allocated to large, expensive, urban based hospitals rather than to primary care services and services in rural areas’ (McIntyre et al. 2005).

The Equitap project has shown that, overall, where general tax-funding mechanisms are the predominant form of financing health care (such as in Hong Kong, Thailand, and Sri Lanka), the pattern of health financing is more progressive than in countries dominated by a mandatory SHI system (O’Donnell et al. 2005). Where SHI has been introduced in African countries (such as Tanzania or Kenya), it has created ‘a deep divide between the insured, who have excellent access to a wide range of high quality health services, and the uninsured[,] who often are consigned to under-resourced public sector services for the poor’ (ibid.).

The only LICs that have achieved universal coverage and pro-poor access to health services through effective risk protection have done so through a tax-financed, government-delivered approach, complemented by other private mechanisms (Rannan-Eliya 2009: 71).

Efficiency: why taxation offers greater potential SHI is a tax on employment and has often been blamed for leading to higher labour costs (Mossialos and Dixon 2002; Wagstaff 2009) and for encouraging informality in the labour market (Baeza and Packard 2006). Who actually pays the tax, however, is not a straightforward matter. There might be a division between employer and employee. Indeed, it actually depends on the level of competition between products and in labour markets. If markets are highly competitive, then firms will contain the costs of employment and pass on the expenses of contributions to employees through a wage freeze, for example (Normand and Busse 2002). The collection of resources through SHI mechanisms is also more costly, and so is the cost associated with the purchaser–provider split that is typical of SHI (Wagstaff 2009).

Evidence has also crucially shown that SHI systems may not generate enough revenues to achieve universal coverage (ibid.). The fact that the tax base of SHI is limited to the formal sector of employment necessarily limits the resources collected. This is particularly relevant in LICs with large informal sectors.

What matters most in reaching universal coverage in any given country is the size of the pool. The greater the risks and the larger the resources pooled

together, the wider the coverage, the greater the financial protection, and the greater the chances of achieving financial sustainability. By its very nature, the pool of resources and risks of SHI schemes is smaller than that of TFSs, and hence affords less financial protection to its population and is less financially sustainable. Theoretically, therefore, TFSs should be the preferred option in LICs that are attempting to achieve universal coverage. Yet the opposite is true.

The reasons for this preference might lie in the practical difficulties associated with implementing a tax system in LICs.

A way forward for tax-financed systems (TFS)

Political feasibility and desirability The revenue of SHI schemes is determined by earmarked contributions that are collected by independent quasi-public funds. The process is, therefore, perceived to be transparent and independent from political interference (Normand and Busse 2002). The allocation of general tax revenue, on the other hand, is an inherently political activity.

The apparent international preference for SHI over TFS may be rooted in this particular point. If governments in LICs are assumed to suffer from high levels of corruption, or actually do so, the earmarked element of SHI will make it more acceptable, both socially and politically.

A related point is the nature of the relationship between the state and society, its fiscal contract, which will determine the feasibility of implementing a tax system. Tax compliance is based on an exchange between the government and its people. The collection of tax requires substantial coercive power and for the state to be legitimate, since most of the tax is collected where there is a high level of voluntary compliance (Di John 2009: 1). No country, no matter how rich, has sufficient resources for penalising all those who do not respect the tax laws.

The level of social cohesion across socio-economic groups is also an important constraint to the successful implementation of tax systems, particularly in countries with high levels of income inequality, where the rich may feel that they pay too much to subsidise others. For a TFS to function, the crucial group to capture is the middle class, whose needs must be met, or must at least be perceived to have been met (Carrin and James 2002).

To conclude from these political considerations that TFSs are too obscure, cumbersome, or complicated to implement, however, perpetuates this status quo and undermines state-building efforts. Indeed, taxation and tax reform are central to state-building efforts and to increasing the level of accountability of the state towards its citizens.

Taxation is the main nexus that binds state officials with interest groups and citizens. Not only can taxation enhance government accountability, it also provides a focal point around which interest groups [...] can mobilize to support, resist and even propose tax policies. (Di John 2009: 2)

Various studies (Ross 2004; Mahon 2005) have found a strong correlation between increases in the general tax burden and increases in the level of democracy within a few years, and an even stronger correlation between the general tax burden and the extent of liberalism, understood as the existence of constraints on state powers. Timmons (2005) has shown that the more a state depends for revenues on taxing its richer citizens, the more it is likely to pursue policies that are beneficial to the rich to persuade them to continue to part with their money. In the Democratic Republic of Congo, Rwanda, and Uganda, for example, 'large' payers contribute between 40 and 70 per cent of the domestic revenue collection (Di John 2008). On the other hand, the more the state depends for revenues on taxing its poor citizens, the more it is likely to pursue policies that are beneficial to them (Moore 2004: 38).

A solution to this transparency concern and sometimes faltering fiscal contract could be the establishment of an earmarked tax for health. This hypothecated tax would ensure a stable and increasing revenue base for health, would address the transparency issues that mar the perception of taxation in LICs, would improve accountability by separating health from competing national priorities (provided that the hypothecation was more than cosmetic), and would be less susceptible to political manipulation (Mossialos and Dixon 2002).

Since health is a wanted public good, the establishment of a health-specific tax might be more acceptable to the population and might lead to greater tax compliance, thereby strengthening the fiscal contract between the government and its citizens.

Size of the informal sector The large informal sector prevalent in LICs limits the tax base and generally leads to the conclusion that TFSs cannot be put in place. Indeed, the larger the informal sector, the more difficult it is to assess the resources that can be taxed and the more difficult it is to undertake the collection of these resources.¹¹ In those African and Asian countries attempting to implement SHI or TFSs, the biggest concern remains how to extend coverage beyond the formal sector (Hsiao and Shaw 2007: 25).¹²

Yet it is recognised that in developing countries, the informal sector is not only here to stay but is also expected to grow. The persistent failure to tax the informal sector is leading to the perception among formal sector workers that the state is unfair in pursuing only them for the collection of taxes. The informal sector is also not as averse to taxation as may be expected (Joshi and Aye 2008: 187), and taxing this group would re-engage the state with those workers and would potentially increase the legitimacy of the state in their eyes. The question, therefore, should be how to tax the informal sector despite its heterogeneity and complexity.

Ghana, Senegal, and Tanzania offer ideas about how to address this issue. In Ghana, the government delegated responsibility for collecting income tax

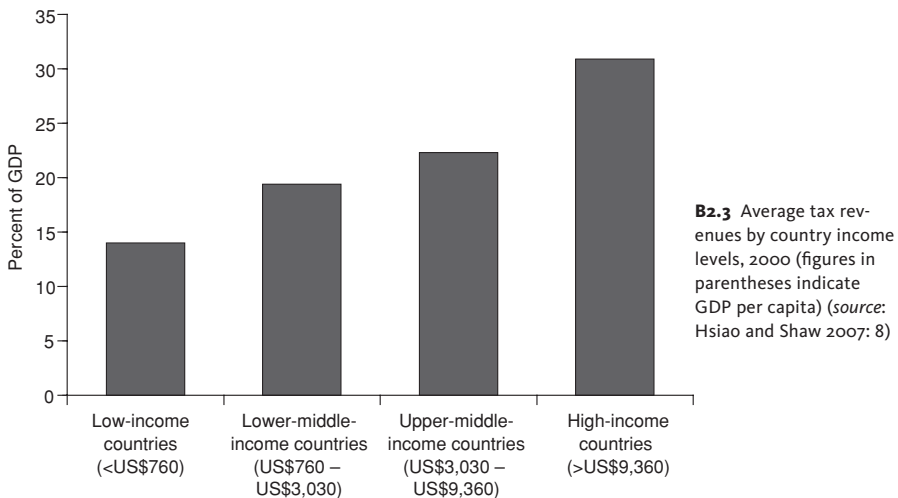
from informal passenger transport operators to their unions (ibid.: 184). As the unions had detailed knowledge of the activities of their members and could easily collect taxes, the scheme was quite easy to administer. ‘Operators were liable for taxes only on the days they actually worked, taxes were collected at the lorry park and the union got a 2.5% share of the total collection’ (ibid: 196). The government has also sought to determine VAT obligations by checking the registration of the value of vehicles (McKinley 2009).

Based on various research studies, it is seen that the ability to tax the informal sector (either employers or workers) depends on the extent of revenue pressure being faced by the government, the degree and nature of association-ism within the informal sector, and the channels of interaction with state institutions (Joshi and Aye 2008: 209).

Crucially, recognising that informal does not mean poor or disorganised might go some way in debunking the myth that informal sectors cannot be taxed.

Economic growth Some economists (Newbery and Stern 1987, for example) argue that economic development is the most important factor affecting the range and size of the tax base. The scarce economic resources, modest economic growth, and economic structure (large share of subsistence farming, large informal sector, and many small establishments, for example) that are typical of LICs imply that resources collected by the state will necessarily be limited.

The level of revenue raised through taxation in LICs is very limited. Total tax levels stagnated during the 1990s in LICs (McKinley 2009).¹³ This reinforces how vital it is that donors provide long-term and predictable ODA (official development assistance) to LICs, whilst the tax base is being developed to eventually allow for domestic sustainability.



Box B2 The politics of aid

Though international aid forms an integral component of several discussions on policy environments at the global level, it is surprising how relatively small the actual quantum of such flows really is. Global flows of overseas assistance are often just enough or less than what poor countries need to pay back to developed countries to service existing debts. It is important to remember that these debts were incurred, largely, because multilateral agencies such as the World Bank and the IMF advised poor developing countries to access loans at high interest rates from capitalist banks in the developed countries. Worldwide, the amount of money returned to high-income countries dwarfs the amount received in development assistance: donor countries receive back many times over in debt repayments what they give in aid.¹⁴ Journalist Ken Wiwa, son of Ken Saro-Wiwa, the activist hanged for opposing Shell Oil's destruction of Nigerian homelands, noted: 'You'd need the mathematical dexterity of a forensic accountant to explain why Nigeria borrowed \$5 billion, paid back \$16 billion, and still owes \$32 billion.'¹⁵

In the aftermath of the devastating earthquake in Haiti, the IMF rescinded an emergency loan of \$100 million to Haiti and reoffered it as a grant. What is, however, not debated adequately is how did Haiti get into a situation where taking on another loan could put millions of lives in jeopardy. It is estimated that, by 1999, the country was paying \$38 million in debt service; while the health budget the same year was \$26 million. Between 1995 and 1996 in particular, Haiti paid 900 million gourdes (approx. US\$25 million) in debt service. During the same period, only 120 million was invested in agriculture. According to the Haitian Central Bank, in 2006 alone, total debt service paid was \$57 million, with 47 per cent going to the International American Development Bank (IADB), 30 per cent to the World Bank, and 10 per cent to the IMF.

The inflow of international aid in many cases is much less than the outflow from developing countries as a result of their trade deficit, largely with developed nations. Of the three regions of the developing world, only in the case of Africa is the inflow of aid higher than the outflow due to trade deficit.

However, just prior to the onset of the global financial crisis, export revenues of many developing countries had risen and the burden of servicing external debt for the developing countries had fallen from almost 13 per cent of export earnings in 2000 to below 4 per cent in 2007. This has now been reversed as developing country exports and commodity prices have fallen starkly as a consequence of the crisis.

The quantum of international aid in the form of development assistance has been a cause for considerable debate, and repeated commitments have been made pledging 0.7 per cent of rich countries' gross national product (GNP) to official development assistance (ODA). First pledged 40 years ago in a 1970 General Assembly Resolution, the 0.7 target has been affirmed in many international agreements over the years, including the March 2002 International Conference on Financing for Development in Monterrey, Mexico, and at the World Summit on Sustainable Development held in Johannesburg later that year. However, most developed countries are nowhere near reaching the 0.7 per cent target, though there has been an increase in the absolute quantum of ODA since the 1980s. Total bilateral ODA commitments from OECD members have increased by more than 50 per cent in real terms since 1980–84, from an annual average of US\$70.5 billion in the period 1980–84 to US\$108.7 billion in the period 2002–06.¹⁶

While the meagre allocation to development assistance is a matter of concern, perhaps of even greater importance is the way such assistance is often linked with the political and economic interests of the donor countries. Aid has often served the political, strategic or commercial interests of donor nations. Aid is often tied to the purchase of goods and services (in the form of technical cooperation) from donor countries, and similar criticisms are made of debt relief priorities.¹⁷ Aid is also accompanied by conditionalities – the 2003 US commitment to increase its annual aid spending to US\$15 billion by 2006, by way of its Millennium Challenge Account, made new funds conditional on 'sound economic policies that foster enterprise and entrepreneurship, including more open markets and sustainable budget policies'¹⁸ (in other words, greater market and investment opportunities for US-based firms).

While the average tax-to-GDP ratio in sub-Saharan Africa has increased from less than 15 percent of GDP in 1980 to more than 18 percent in 2005, the bulk of the tax revenue increase in the region came from natural resource taxes. Nonresource-related revenue increased by less than 1 percent of GDP over 25 years. Even in resource-rich countries, non resource-related revenue has essentially been stagnant. (Di John 2009; Gupta and Tareq 2008)

Some LICs, however, have succeeded in raising their tax-to-GDP ratio. Ghana's direct taxes, for example, rose substantially from 2.7 per cent of GDP during 1990–94 to 6.3 per cent during 2000–06. During the 2000s, Ghana was able to push corporate tax revenue up to about 3 per cent of GDP, and revenue from wages and salaries up to about 2.4 per cent (McKinley 2009).

Unlike the situation in many other LICs, revenue from trade taxes increased significantly in Ghana between the early 1990s and the 2000s.

During 1990–94, trade taxes accounted on average for 3.6 per cent of GDP, whereas by 2000–06 they rose to account for 4.5 per cent. During the 2000s, import duties continued to rise to about 3.5 per cent of GDP. Ghana's tariffs still ranged between 5 per cent and 20 per cent. But Ghana also continued to impose levies on some of its exports, mainly cocoa. As a result, export taxes continued to contribute about 1 per cent to GDP in revenue (*ibid.*: 18).

This demonstrates that whilst economic growth might play a role in raising tax revenue, LICs could improve their tax collection record through a diversification of their tax base. There is clearly an enormous potential to increase tax revenues. Part of this additional revenue could be allocated to health and could help achieve universal coverage.

What Next?

We have argued in this chapter that the move away from user fees is essential if we want to achieve universal coverage. We recognise that any given country will use a combination of mechanisms, and that there is no single best approach. Nevertheless, we warn against relying too heavily on alternatives to user fees that are little more than short-term solutions that offer little prospect of universal coverage. We have argued in favour of public financing approaches, for considerations of both equity and efficiency, and have highlighted the need to oppose the dismissal of TFSs as an unfeasible option in LICs.

Of course, taxation is a long-term issue, and its successful implementation implies structural changes in the relationship between the state and its population. Such structural changes require long-term efforts. We should strive today to build equitable and efficient health financing mechanisms that will enable us to reach universal coverage tomorrow. All these short-term experiments have a value only as short-term bandages and as long as the longer-term goals of universality and equity are worked towards.

Notes

1 For 49 LICs only.

2 The currency transaction levy alone has been estimated to raise an additional US\$33 billion per year off as small a rate as 0.005 per cent (Schmidt 2007).

3 Available at: siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1154048816360/HNPStrategyFINALApril302007.pdf.

4 Medical Savings Accounts (MSAs) may be compulsory or voluntary contributions of payments by individuals, households or firms into individual accounts aimed at covering payments for episodes of illness. There are

many issues pertaining to MSAs, not least their negative impact on equity, the absence of resource pooling, and their attempt to control costs through the demand side. They have been implemented mainly in Singapore, South Africa, and China, and have not as yet been attempted in other LICs, and therefore are not pursued in this discussion.

5 Willingness to pay (WTP) refers to the maximum sum that an individual is willing to pay to acquire some good or service or to avoid a prospective loss.

6 The act of dividing an overall market into groups, or segments, of consumers with similar

characteristics, such as age or average health status. It is usually done to engage in price discrimination.

7 The practice in PHI markets by which insurers select only those individuals with a low probability of needing care or those likely to need only low-cost care.

8 In Rwanda, for example, health centres working with smaller CBHI reported higher levels of use (up to three visits per member per year), suggesting that adverse selection is indeed a risk with low enrolment.

9 A study in Ghana, based on a hypothesised WTP, estimated a linear correlation between the price of health care and the percentage of people excluded from the schemes. In this study, data predicted that 'the highest revenue generated for CBHI was achieved when a household premium was approximately US\$2.77, a sum only 35% of the population was ready to invest' (Schmidt et al. 2006: 1327). In Rwanda, any contribution to CBHI greater than US\$1 per year per capita would exceed the monthly income of the poorest stratum. Clearly, the level of income and the price of health care are closely associated in determining the WTP of the population.

10 For full resolution, see apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_33-en.pdf.

11 Whilst this problem is common to SHI and TFSs, it is, of course, much worse for SHI systems.

12 The distinction between formal and informal is sometimes misunderstood. The informal sector here is understood as non-tax-registered business.

13 'While statutory rates for corporate taxes were dramatically reduced, an IMF study finds that the tax base did not increase. In fact, it decreased, and thus corporate taxes fell overall' (UNCTAD 2009).

14 People's Health Movement, Medact and Global Equity Gauge Alliance (2006), *Global Health Watch 2. Health and Globalization, an Alternative World Health Report*. London/New York, Zed Books.

15 Wiwa, K. (2004). 'Money for nothing – and the debt is for free'. *Globe and Mail*, 22 May.

16 Piva, P. and R. Dodd (2009). 'Where did all the aid go? An in-depth analysis of increased health aid flows over the past 10 years'. *Bull World Health Organ*, 87: 930–39.

17 People's Health Movement, Medact and Global Equity Gauge Alliance (2006). *Op. cit.*

18 UN Secretary-General (2002). *Outcome of the International Conference on Financing for Development*. New York, United Nations (Report no. A/57/344 – 57th Session). www.un.org/esa/ffd/a57-344-ffd-outcome.pdf (accessed 1 February 2005).

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