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Disclaimer: The author is fully aware that health financing is but one means for tackling poverty and cannot be considered detached from other strategies for reducing deprivation and poor living conditions. In fact, various social policy mechanisms as well as general and other policy areas are closely interlinked with the health sector and particularly with pro-poor health financing. Nonetheless, for methodological and practical reasons the present paper tries to focus on specific aspects related to health financing.

Executive summary

Good governance has increasingly attained priority in international cooperation and health-system performance. Governance refers to all steering activities by public entities to influence the behaviour and activities of stakeholders involved. In the health sector, governance refers to a wide range of functions related to guidance and rule-making carried out by governments or other public decision-makers. More specifically, governance in the health-financing system applies to two different aspects: in addition to the approaches, strategies and policies determining how financial flows are implemented, managed and supervised according to rules- or outcome-based indicators, health-financing governance encompasses the question of how far resource generation, pooling and allocation are organised in an equitable, fair and sustainable manner. Individual and collective financial sustainability, burden sharing and social coherence or solidarity are essential parts of health-financing governance and depend deeply on societal priorities and values. Fairness of financing, transparent risk pooling and accountable purchasing of health services are intrinsic elements of governance in health financing and critical for achieving universal health coverage. The government is ultimately responsible for implementing an appropriate framework for a transparent, accountable and reliable health-financing system, for ensuring that the intermediate institutions can perform their functions, for executing effective and powerful supervision, and for providing civil society with the means to demand transparency and good financial governance.

Health-financing indicators show the system's ability to effectively mobilise and allocate resources, implement social protection and pooling schemes, and distribute the financial burden of care equitably. Essentially two groups of indicators exist for assessing governance in the health financing system: rules-based approaches consider the existence of appropriate policies, strategies, and codified approaches for governance; outcome-based indicators measure whether rules and procedures are effectively implemented or enforced and health-financing targets achieved.

Zusammenfassung

Gute Regierungsführung ist in der internationalen Zusammenarbeit und in der Bewertung von Gesundheitssystemen zunehmend in den Vordergrund getreten. Governance bezieht sich auf alle Lenkungsaktivitäten der öffentlichen Hand zur Beeinflussung des Verhaltens und Vorgehens beteiligter Akteure. Im Gesundheitswesen bezieht sich Governance auf ein breites Spektrum von regulierenden und steuernden Maßnahmen von Regierungen oder anderen Entscheidungsträgern der öffentlichen Hand. Speziell im Gesundheitsfinanzierungssystem bezieht sich Governance auf zwei verschiedene Aspekte: Neben Ansätzen, Strategien und Programmen zur Einrichtung, Verwaltung und Kontrolle von Finanzströmen nach gesetzlichen Vorgaben oder ergebnisorientierten Indikatoren umfasst Governance in der Gesundheitsfinanzierung die Frage, inwieweit die Ressourcengenerierung, -mischung und -allokation in sozial gerechter, fairer und nachhaltiger Weise organisiert sind. Individuelle und kollektive finanzielle Nachhaltigkeit, Lastenaufteilung und soziale Kohärenz oder Solidarität sind wesentliche Bestandteile von Governance in der Gesundheitsfinanzierung und hängen stark von gesellschaftlichen Prioritäten und Werten ab. Soziale Gerechtigkeit bei der Finanzierung, transparente Risikomischung und Rechenschaftspflicht beim Einkauf von Gesundheitsleistungen sind intrinsische Elemente von Governance in der Gesundheitsfinanzierung und entscheidend für die Erreichung des Ziels einer universellen Absicherung im Krankheitsfall. Letztendlich ist die Regierung dafür verantwortlich, einen geeigneten Rahmen für ein transparentes, rechenschaftspflichtiges und verlässliches Gesundheitsfinanzierungssystem, für das Funktionieren der verschiedenen Intermediärinstitutionen und für eine effiziente und leistungsfähige Beaufsichtigung zu schaffen und die Zivilgesellschaft mit Möglichkeiten auszustatten, Transparenz und gute finanzielle Steuerung (good financial governance) einzufordern.

Gesundheitsfinanzierungsindikatoren verdeutlichen die Fähigkeit des Systems, effektiv Ressourcen zu mobilisieren und bereitzustellen, soziale Sicherungs- und Umverteilungssysteme aufzubauen und die finanzielle Belastung durch medizinische Versorgungsleistungen fair zu verteilen. Für die Bewertung der Governance im Gesundheitsfinanzierungssystem gibt es im Wesentlichen zwei Gruppen von Indikatoren: Regelbasierte Ansätze untersuchen die Existenz geeigneter Programme, Strategien und definierter Governance-Ansätze, während ergebnisorientierte Indikatoren die effektive Um- oder Durchsetzung von Regeln und Verfahren und die Zielerreichung bei der Gesundheitsfinanzierung messen.

1 Introduction

For many years, social protection as a whole, and particularly social health protection (SHP) was seen as a privilege of industrialised countries and unachievable for the developing world. Credible and reliable social protection, however, has meanwhile come to be recognised as an essential instrument for poverty reduction in low- and middle-income nations (OECD 2009: 28). While ordoliberal economists used to and still do argue that social-protection contributions and other "welfare" payments are a drag on economic growth (e. g. Willgerodt 1955: 281; Levin 2011: 22; Blahous & Fichtner 2012), a growing body of evidence shows that well-designed social-protection programmes can be springboards for economic development and growth (e. g. Sachs 2001; Lindert 2004; Perlo-Freeman & Webber 2009: 966; UNRISD 2011: 6, 11) and, formerly, for achieving the Millennium Development Goals (MDG) (World Bank 2003: 7). As a consequence of this shift, social protection is now explicitly mentioned in the Sustainable Development Goals (SDG) as one essential means, among others, for eradicating poverty and reducing inequality within and among countries, among others (UN 2015: 12, 18).

There is no doubt that social (health) protection is a key condition for growth and development at household and country level since even minor health problems can have drastic consequences particularly for informal workers and their families. Health shocks have twofold negative consequences since they tend to lower the available income and require households to bear the costs of buying healthcare when income is unreliable due to physical vulnerability. Consequences of health-related shocks are particularly dramatic for women, who may lose their jobs through becoming pregnant, receive low-paid or even unpaid maternity leave and face lowered income when they are exposed to gender-related vulnerability associated with motherhood, which can imply loss of income and even of jobs (Lund 2009: 74).

Meanwhile growing evidence shows that fair distribution of income, well-being and development is extremely important for achieving social goals and good population health (e. g. Machinea et al. 2006: 21ff, Perry et al. 2006: 59f). The challenge for equitable development is not simply to reduce poverty as such but rather to tackle the social gradient in a society. The way in which social policy strategies in the developing world have previously placed their priority focus on the poor as the most important target group is outdated and insufficient as an approach for reducing poverty and social exclusion. A "proportionate-universalism" approach is required for the effective implementation of pro-poor policies including pro-poor health financing: "To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem" (Marmot et al. 2010: 16).

It will definitely remain insufficient to concentrate pro-poor health-financing strategies on the poor, who are usually identified according to their level of income and/or the commodities available to them. Focusing health-related interventions on the income poor is justified as long as poverty reduction is considered to be the overriding goal, while improvements in health and education are seen as means to achieve that goal. However, focusing health resources on the neediest, who are particularly deprived of

health benefits, is more effective for achieving the non-income development goals and combating non-income poverty (Klasen 2008: 440), yet promoting proportionate universalism.

Unlike the selective focus on the income poor that the state feels able to care for by means of social services, "proportionate universalism" providing support to different social groups according to their neediness implies greater efforts and more intensive action on behalf of the most disadvantaged groups without neglecting other population groups. This is the logic behind the social-protection mechanisms implemented in today's welfare states. To be effective and pro-poor, health financing has to rely on institutionalising socially fair burden-sharing and redistribution in order to comply with the requirements of proportionate universalism. In health financing, this idea is effectively implemented in the "principle of solidarity" that goes far beyond the usual understanding of solidarity as expression of empathy and charity (cf. Gebauer 2012: 19). Well-performing universal social health protection systems operationalise this principle by establishing entitlement to services regardless of people's ability to pay, while prepayment is exclusively related to income or purchasing power. This principle relates directly to social and societal inclusion and indirectly to redistribution: "It is neither acceptable nor necessary that the poor get poorer while the rich amass unheard-of riches but it requires action to make sure that a basic status of citizenship is guaranteed for all" (cf. Dahrendorf 2006: 15).

When it comes to achieving the societal goal of inclusive social health protection, good will and charity are definitely insufficient. Beyond the principle of solidarity, good governance at national level is a cornerstone for countries' move to universal health coverage (UHC) (Reis 2016: 558). For including the poor in nationwide social health protection systems, legally binding rights to health and irremediable entitlements are indispensable.[1] Public health laws also illustrate the obligation of States to fulfil the right to health, because the State cannot discharge its obligation to respect, protect or enforce impose that right in a systematic and sustainable manner without good governance (WHO 2017: 74). Hence, social protection and welfare has to go beyond charity and be organised in such a way that everybody pays his/her dues in exchange for entitlements. Social (health) protection has the potential to play a twofold role in poverty reduction. On the one hand, it prevents people from becoming (further) impoverished due to ill health and health-related shocks; and on the other hand, it helps to partly redistribute unevenly spread income. The second argument is particularly relevant today since income inequalities tend to be growing in most countries worldwide (cf. Birdsall 1998; OECD 2011, Ortiz & Cummins 2011) and threatening social cohesion (e. g. Kawachi & Kennedy 1997; Nowatzki 2012, and more specifically for developing countries Rajan et al. 2013).

In order to tackle this almost ubiquitous challenge, pro-poor policies will have to overcome the conventional approach of targeting the poor. Entitlement of all citizens, regardless of their income and purchasing power, has to replace the traditional charitable thinking of providing those socio-economic groups with earmarked support that qualify as "poor enough" to deserve it. For the successful design of pro-poor health financing strategies, it is indispensable to target prosperity rather than poverty. Instead of

[1] The right to health has been articulated in numerous international and regional human rights conventions and treaties and enshrined in national constitutions all over the world (e. g. Grover et al. 2012: 24f). Meanwhile, international and global health perspectives are increasingly influenced by the increasing focus on health security, which tends to human rights, including principles of equality, participation, and accountability, should be their foremost guide (Gostin & Friedman 2017).

dealing only with socio-economic deprivation, the whole distribution within and between societies has to be carefully analysed and taken into consideration (Marmot 2013: 1091). Social protection and income distribution are core automatic stabilisers, cushioning the impact of crises on people while maintaining aggregate demand and enabling workers and their families to overcome poverty and social exclusion (Stiglitz 2009: 4f). Moreover, they are pillars of social justice and peace (ILO 2011: 2); reduced inequality and sustained growth have proven to be two sides of the same coin (Berg & Ostry 2011: 8f, 14f).

Health financing refers to the question "how financial resources are generated, allocated and used in health systems. Health financing policy focuses on how to move closer to universal coverage with issues related to: (i) how and from where to raise sufficient funds for health; (ii) how to overcome financial barriers that exclude many poor from accessing health services; or (iii) how to provide an equitable and efficient mix of health services" (WHO 2017). The overall purpose of health financing is to make revenue available, to collect funds in an equitable manner and to set the right financial incentives to providers in order to ensure that all individuals have access to effective healthcare. Therefore, good financial governance is an essential prerequisite in order to preventing leakages and misuse of funds collected for the provision of healthcare, since the governance function refers to a set of processes to distribute responsibility and accountability among the stakeholders of the health sector (Reis 2016: 558).

The 2017 World Development Report defines governance as "the process through which state and nonstate actors interact to design and implement policies within a given set of formal and informal rules that shape and are shaped by power" (World Bank 2017: 3). In more concrete terms, governance means all 'steering' carried out by public entities for constraining, encouraging or otherwise influencing the activities and behaviour of both public and private actors (Chanturidze & Obermann 2016: 508). However, in the context of marketisation and privatisation of the healthcare sector a large share of political measures envisages rather the consumer side and particularly patients, for example by urging countries to implement user fees or insurance schemes to charge co-payments.[2] There is a general consensus that health systems financing should not only seek to raise sufficient funds for health, but should do so in a way that allows people to use the needed services without the risk of impoverishment. This involves the accomplishment of two related objectives: raising sufficient funds and providing effective financial risk protection to the population.

The health financing system is often divided conceptually into the functions of revenue collection, fund pooling, and purchasing of health services. Despite the obvious interrelation between the three functions of health systems financing, it has to be pointed out that they are basically independent from each other, and the particular form of resource generation for health does not predetermine the mechanisms whereby funds are allocated.[3]

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[2] Health-sector reforms often tend to target mainly the consumer side - insurees and/or patients – and leave the supply side - healthcare providers and/or insurance funds/companies – relatively unaffected. A typical example for the trend is the easiness to introduce or raise OOP payments while e. g. strengthening the regulation of pharmaceuticals by means of positive lists is a major challenge for policy makers. Political viability, however, is inversely proportional to cost-containment effectiveness of health-sector reforms.

[3] By way of example, tax-based health systems can apply vertical integration by running their own provider networks (e. g. the National Health Service in the United Kingdom) or purchasing health services with public and/or private providers (e. g. Medicare in Canada and the Sistema Único de Saúde in Brazil); likewise Social Health Insurance can pay for health services in kind (e. g. the *Gesetzliche Krankenversicherung* (Statutory Health Insurance) in Germany or the *Fondo Nacional de Salud* (FONASA) in Chile) or through reimbursement mechanisms (e. g. the *Sécurité Sociale* in France and the *Mutuelles* in Belgium).

On the one hand, the extension of social protection in health needs to be embedded in a comprehensive strategy for health sector reform (cf. Hörmansdörfer 2009: 148; Holmes et al. 2011: 15). The complexity of the health and social sectors and the strong interrelations between political measures at different levels make it very challenging to assess whether or not, or to what extent, a single financing mechanism promotes proportionate universalism and is conducive to reducing poverty. Assessment of the redistributive effects of health financing strategies must be carried out with respect to the complete mix of financing mechanisms and their interaction with resource allocation approaches and organisational contexts.

Beyond conceptual and technical criteria that are important in order to deploy the redistributive and pro-poor potential of health financing, transparency, reliability, and accountability also matter a great deal. Good governance ensures that the public sector including the government is ultimately accountable to its citizen. Here the objective should be to strengthen the role of state and other public authorities in setting directions for the health sector as a whole in a participatory, inclusive process (WHO 2014: 18). Good financial governance is crucial for all three basic functions of health financing since misuse of funds and corruption can occur during revenue collection, pooling and allocation. The pooling of resources earmarked for health might offer the highest risk of a diversion of funds, since good internal management and control of funds is likely to create major challenges, particularly for the public sector. Revenue collection from health-insurance enrolees or companies as well as provider payment to physicians, clinics and hospitals involve external stakeholders. Thus, the greater number and variety of interest groups to be satisfied makes it more challenging to prevent corruption and poor financial governance in these latter functions than in the pooling process.[4]

Not only do the ways in which countries collect, pool and allocate revenue for healthcare differ, but so do the respective legal and regulatory frameworks as well as public-policy structures and the distribution of power. By way of example, some countries allow earmarked taxes (e. g. France, Chile) while others exclude them by law (e. g. Germany). Likewise, some countries offer broader autonomy to public bodies, be they health-insurance funds or healthcare providers, while many others heavily restrict the freedom of public institutions to operate their own financial management. Given the variety of settings in health financing it is quite challenging to distil a manageable number of relevant factors that are important for achieving good financial governance. However, as for all public finance systems, clear-cut criteria are also essential for achieving good governance in health finance. These criteria should be internationally agreed, universally applicable and useful for all types of public financing. The Fiscal Transparency Code developed by the International Monetary Fund defines some essential guidelines for GFG that are also applicable for health financing.

[4] This paper will not refer to the complex topic of provider payment, which is a main focus or hurdle of all health-sector reforms and usually quite regulated; however, misuse tends to be a major issue where a broad grey area exists between intelligent use of provider-payment mechanisms and open abuse.

Summary of Main Principles of the Fiscal Transparency Code

I. Clarity of Roles and Responsibilities

- Roles and responsibilities within government, and between different levels of government should be clear, with a clear definition of the boundary between the government and the private sector.
- There should be a clear legal and administrative framework for fiscal management.

II. Public Availability of Information

- The public should be provided with full information on the past, current, and projected fiscal activities of government.
- Governments should make a public commitment to the timely publication of fiscal information.

III. Open Budget Preparation, Execution and Reporting

- Budget documentation should specify fiscal policy objectives and the macroeconomic framework.
- Budget data should be presented in a way that promotes accountability.
- Procedures for the execution and monitoring of approved expenditures should be clearly specified.
- Fiscal reporting should be timely, comprehensive and reliable.

IV. Independent Assurances of Integrity

- The integrity of fiscal information should be subject to public and independent scrutiny.
- A national audit body should be appointed by the legislature with the responsibility to provide timely reports to the legislature and public on the financial integrity of government accounts.

Source: IMF 2007

The present paper aims at further developing and clarifying the concept of health-financing governance as an integrative part of governance in health. As the design of health-financing policies and practices is a relevant condition for achieving good governance in the health-financing system, the paper starts with a detailed analysis of existing health-financing mechanisms with a particular focus on their impact on distribution, fairness of financing, efficiency and effects on governance. This is followed by a brief presentation of the most common measures of (in)equality, provides an overview on progressivity and redistribution of health financing and discusses equity issues. As key conditions for good financial governance, the paper hereafter depicts the most relevant public health-financing mechanisms (taxation and social health insurance) as well as private health insurance and reviews the respective inherent

(re)distributional effect and potential. Finally, the paper develops a practice-based theoretical approach to financial governance in the health sector, points out a number of experiences with and conditions for governance in health financing, and discusses pro-poor effects of health financing and provision. Finally, seven country-cases provide an overview of concrete situations regarding health-financing governance in different parts of the world.

2 Resource generation for health

2.1 Traditional health-financing methods

The commitment of health systems to provide equal availability, accessibility, acceptability, and quality of healthcare goes beyond examining service delivery alone; the financing of health systems is also substantial for achieving equality and safeguarding the right to health (Yamin & Norheim 2014: 303). Funds for health services are extracted mainly from households through a variety of means such as payroll deductions, income and value-added taxation, private and public, mandatory and voluntary insurance contributions, and out-of-pocket payments (cf. Murray et al. 1999: 3). Beyond the various strategies of revenue collection for healthcare, basically four sources exist for financing healthcare:

- Tax revenue,
- Social health insurance contributions,
- Private health insurance contributions,
- Direct payments.

Unlike the first three means of resource generation for health, direct payments are principally due at the point of service and have to be paid out of pocket (OOP) in order to receive health services. This implies a fundamental difference from the first three health-financing strategies, which represent pre-payment mechanisms, where people contribute independently from the use of health services and in advance for potential future medical needs. In health financing, direct and pre-payment exhibit a series of basic conceptual discrepancies with regard to risk sharing and pooling, redistribution and fairness of financing. The following section provides an overview of the most important features of the four above-mentioned sources of health financing.

2.1.1 Tax-based health financing

In tax-based health financing systems, health services are paid for out of general government revenue, of which tax revenues, e.g. from income tax, corporate tax, value-added tax, import duties, grants and other revenues, e.g. from natural resources, represent the largest share. Depending on effective legislation there may also be special taxes earmarked for healthcare: different types of sin taxes such as those on tobacco products and alcoholic drinks are highly appreciated among governments. Not only do they generate additional revenue for healthcare but they also seem to have an inherent logic and are hence popular as levies on unhealthy behaviour.

Taxation offers a series of advantages and strengths for health financing. Though often not sufficient, tax revenue offers greater sustainability in terms of resource mobilisation than e.g. overseas development aid (ODA) or other external financing sources, and therefore better ensures that the government will have the financial means to address the health challenges the country is facing. Additionally, a publicly funded health sector can – by financing services for the poor and by providing universal financial protection – help improve equity of access to health services and at the same time provide incentives

that are attractive to both the consumers of health goods and service providers. On the other hand, tax-based health financing requires governments to regularly revise and define the budget share allocated to health; this condition might reduce the stability and reliability of resources since budgetary priorities can change over time and end up competing with others.

2.1.2 Social health insurance

Financing healthcare through social health insurance (SHI) means that health services are paid for through obligatory contributions to a public but non-government insurance fund. The most common basis for contributions is the payroll, with both employer and employee commonly paying a percentage of salary. SHI funds are usually independent from the government but work within a tight framework of regulations. Contributions are linked to the average cost of treatment for the group as a whole, not to the expected cost of care for the individual. Hence there are explicit cross-subsidies going beyond the principle of (health) insurance. In general, membership of social health insurance schemes is mandatory for the whole population or at least for some population groups (in low-income countries typically public and/or private-sector employees and workers) and can be voluntary for other groups such as the self-employed.

SHI contributions are often defined as labour taxes earmarked for healthcare since they are mandatorily deducted from the payroll. Although this might be correct from a merely technical point of view, with regard to the features of revenue collection some basic differences should not be neglected. The tax-collecting agency is typically the state and its fiscal institutions such as tax offices and ministries of finance. Contribution collection for SHI, in contrast, is one of the essential responsibilities of SHI funds, which are - at least in theory – endowed with a certain level of autonomy from the state and the government (cf. Wendt & Rothgang 2007:5). However, the concept of self-governed, para-statal, not-for-profit public bodies, which are regulated by public laws but independent from short-term government decisions, is not very well understood (e. g. Acharya et al. 2011: 2), even less adequately described (e. g. McIntyre 2007: xii) and poorly implemented in a number of developing and transitional countries. In some countries, SHI funds rather play the role of a governmental financial corporation, and investment return seems to be the most important objective.[5]

Adequate and effective legislation is indispensable for establishing a health insurance commission to manage public health insurance schemes, including registering members, accrediting health service providers, processing claims and managing a national health insurance fund (WHO 2017: 16). However, SHI are or ought to be legally and formally independent from the government and also from tax revenue; this makes SHI contributions in principle more independent from short-term policy measures as well as yearly budget decisions. Although policy-makers have a say on resource collection, pooling and allocation of SHI funds via the respective legislation, as well as on possible changes of the regulatory framework and particularly on cross-subsidisation from tax revenue, SHI revenue is not easily and di-

[5] To quote an example, the Annual Reports of the Philippines Health Insurance Corporation provide primarily financial information on cash flow, investments, returns, and account statements. 20 out of a total number of 37 net pages of the 2009 Annual Report (PhilHealth 2010) contained merely financial data. The structure and layout of the most recent available 2011 Annual Report (PhilHealth 2012) had fundamentally changed with more information on the new corporative leadership and strategies, but still 16 out of 52 pages present financial data while information regarding services and benefits are still lacking.

rectly at the disposal of politicians to pay for specific interests or agenda topics. Nonetheless, diversion of SHI revenue according to political and/or personal interests does occur, and presents a relevant challenge to health financing governance.

Concerning social health protection through SHI, a major concern in countries with existing SHI systems as well as in low- or middle-income countries that plan to set up SHI schemes usually relates to the assumed negative effect of employers' contributions on labour costs, the labour market and economic growth. The financial burden of mandatory employer contributions on labour costs and its negative effect on competitiveness is a key argument of entrepreneurs' associations and many economists in European countries with Bismarck-type social-protection systems (e. g. SVR-W 2002: 223f; Gallois 2013: 22ff; WKO 2013; IW 2004). With regard to low- and middle-income countries it is also argued that employer contributions for health insurance may be offset through smaller salary increases than would have been paid in the absence of these contributions (cf. McIntyre & Kutzin 2011).

However, negative effects on productivity and labour market are nothing but a persistent myth since empirical evidence for the underlying assumptions is weak, at best. In European welfare states with SHI systems, it has been repeatedly shown that the impact of employer contributions for health insurance, as an element of so-called ancillary labour costs on the overall production costs is minimal and ranges from 1 to maximum 5 per mille (Holst 2012a). Moreover, OECD countries do not provide evidence of a significant relationship between structural unemployment and labour costs, neither for labour income alone nor for combined labour and consumption tax ratios (Carey & Rabesona 2002: 142). One can argue that the impact on production costs of income-based contributions for social health protection is likely to be higher in developing countries, where manpower plays a more important role in the production of goods and services compared to more sophisticated production chains in industrialised countries. In any event, decisions on social policy strategies should not be based on perceptions or beliefs but rather on realistic estimations of the real impact on production costs, productivity and the labour market. Evidence-based policymaking together with transparency is a crucial precondition for good governance in health financing: countries should not take theoretical assumptions for granted as long as they have not proven to be realistic and true in a given national context.

2.1.3 Private health insurance

For-profit and non-profit private health insurance funds can look back on a long history and have become a ubiquitous arrangement for financing healthcare, although the role and importance of private health-insurance (PHI) within a national health-financing system depict a large variety from one country to another. In the Global South, PHI has become fashionable latest since the 1980es when structural adjustment policies have started to play an important role in international cooperation. Some development partners have been supporting private health-financing institutions as one means for expanding social health protection (cf. Pauly et al. 2006). At the same time, policy-makers in partner countries are sometimes prone to let private health insurance develop in a setting where essential conditions are not met. "The magic of marketisation often seduces governments into action without a critical understanding of the conditions required for efficient markets and with no reference to empirical evidence." (Hsiao 1994: 351).

PHI is predominantly voluntary (except in the Netherlands and Switzerland) and provides a certain package of benefits in return for contributions to insurers paid by individuals. The term PHI refers mainly to for-profit commercial health-insurance schemes in which people pay contributions related to the expected cost of providing services to them (cf. Sekhri & Savedoff 2005: 128) and hence apply the principle of equivalence where the price depends on the individual risk and/or the scope of the benefit package. In the Global South, government control and regulation of social health protection provided by PHI is often weak and relies on other bodies than public health authorities.[6] Cross-subsidisation and societal redistribution are limited to the core principle of (health) insurance since it only takes place from the healthier to the less healthy and hence between people with different risks of ill health.[7] Large and relevant private health-insurance funds are held by for-profit companies either as one of several business branches or as fund holders within a vertically integrated design.

Besides "typical" commercial funds, not-for-profit private health insurance schemes exist in the form of charitable prepayment schemes, community-based health insurance (CBHI) or company health-insurance funds. As in former times, in today's welfare states in Europe, faith-based and other charitable organisations have been setting up micro-insurance schemes in order to allow low-income users of health facilities to prepay for healthcare that they might need in the future. These schemes can be vertically integrated to healthcare providers or exist as stand-alone organisations. For many years, local prepayment schemes at community, cooperative or other small-scale level were fashionable as a part of the worldwide hype of micro-insurance, and many developing countries with support of all relevant donors started to set up CBHI (e. g. Ekman 2004). These schemes set contributions commonly as flat rates according to the expected expenditure for covering the insured overall risk faced by the average community member. In contrast to commercial SHI there is usually no distinction in contributions between wealthier and poor community members, and compared to PHI no distinction between high- and low-risk groups. Enrolment is generally not linked to work or income and funds are administered by a private non-profit entity at the local level.

Company-based health-insurance schemes represent another type of not-for-profit social health protection schemes. Mainly larger companies provide their staff with self-financed health protection in order to assure access to adequate healthcare and effective recovery of the workforce. In countries without universal coverage, companies have implemented their own health-insurance funds in order to fulfil the legal requirements established by the International Labour Office (ILO) Social Security Convention No. 102 on Minimum Standards (ILO 1952). Company-based health-insurance funds are usually part of profitable public or private companies but do not pursue profits in themselves.

In order to assess the financial and redistributive effects of private health insurance, some further clarification is required. There is currently a trend to focus rather on mandatory versus voluntary insurance

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6 In many cases, licensing and regulation of commercial health insurance companies is under responsibility of the ministries of finance, commerce, economy or others. The lack of linkage to the public healthcare sector and deficiency of health-related supervision by the Ministry of Health are often major obstacles to integrating the private and public health sectors and implementing effective national health policies.

7 With regards to redistribution and pro-poor effects it has to be mentioned that theoretically this might also imply a certain cross-subsidisation from the wealthier to less wealthy individuals or households since the latter are at higher risk of ill health and, thus, of needing healthcare services; however healthcare utilisation tends to vary between higher and lower socio-economic groups and the higher need does not necessarily translate into higher demand.

and no longer on public versus private health insurance. The concept of public versus private has been questioned and partly reassessed by WHO and other international institutions, which have started to introduce the alternative dichotomy between mandatory and voluntary health insurance (e. g. Mathauer 2012). One argument is that the line between SHI and PHI is blurred since mixed forms are assumed to exist. The lack of clarity, however, is partly due to imprecise or even misleading definitions of SHI, which is often defined as government-provided health insurance for low- and middle-income populations that tends to be mandatory but can also be voluntary in the case of non-government organisations at the community level (e. g. Acharya et al. 2011: 2).

As mentioned above, one of the indispensable features of the SHI concept is the principle of solidarity since contributions are calculated according to ability to pay – be it as a percentage of the wage or as another form of payment related to people's purchasing power – and provide entitlement to a uniform benefit package according to individual need and independently of the amount contributed (cf. also Wagstaff & van Doorslaer 1992: 363).[8] Private health insurance (PHI), in contrast, does not apply the principle of solidarity.[9] While commercial PHI is based on the principle of equivalence – contributions depend on the individual risk or the breadth of the benefit package or both – not-for-profit PHI such as CBHI is usually based on flat-rate contributions, which makes it regressive and prevents vertical fairness. Based on this essential conceptual difference, this paper sticks to the characterisation of public and private health insurance rather than mandatory and voluntary insurance.[10]

2.1.4 Direct payments

Unlike the above-mentioned health-financing mechanisms, direct or out-of-pocket (OOP) payments are due at the point of service and thus, when health services are required. Although it might be evident, it is worth pointing out the basic conceptual difference that exists between prepayment and OOP. All types of prepayment for healthcare entail foreseeable, calculable and normally affordable expenditures, which individual households have to pay independently of acute health needs and hence under normal income conditions. Out-of-pocket payments are due in case of a given health need, which might at the same time reduce the available income. They are not predictable, are incurred in conditions of necessity

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8 "A common basis for contributions is an income or payroll tax, which may entail contributions from both employer and employee based on salary" (Normand & Weber 2009: 27).

9 It is often argued that private funding support is essential for sustainable healthcare systems (see e. g. Gottret et al. 2008: 132). On the one hand, this argumentation tends to define health-financing mechanisms as private that are usually seen as public (for instance mandatory SHI contributions, see WHO 2003b: 42ff). On the other hand, mainly economists tend to perceive private expenditure on health as promising for enhancing sustainable health financing; but see the further remarks in footnote 10.

10 The most confusing case with regard to public versus private is certainly the arrangement where mandatory social health protection (SHP) contributions or tax revenue earmarked for health is pooled and / or administered by PHI institutions. Some countries allow (for-profit) PHI institutions to be health-insurance providers within a compulsory SHP system (e. g. Germany and Chile). In other countries, the government channels SHP resources through (commercial) health insurance funds (e. g. the RSBY scheme in India). In these cases, in which tax revenue or mandatory SHP contributions are channelled through private enterprises, the question is whether health expenditure is public or private. The fact that resources are either directly generated from tax revenue or from compulsory, tax-like contributions provides a strong argument for classifying them as public expenditure, particularly when mandatory contributions to PHI are wage-related as it is the case in Chile.
The fact that mandatory resources are pooled and administered by private enterprises does not change the public character of health expenditure. However, it makes a big difference whether and to what extent horizontal and vertical fairness are present in revenue collection for health. Only SHP arrangements based on the principle of solidarity can assure substantive vertical fairness, and the principle of equivalence practically excludes horizontal equity. The legal position concerning property determines the mode of operation of SHP schemes and does matter. Hence it is not an issue of mandatory versus voluntary but still mainly about public versus private.

and financial constraints, and affect only the ill. OOP payments do not provide any risk sharing and horizontal redistribution.

Nonetheless, from the early 1980s until the 1990s, most international organisations and national governments had strongly favoured user fees and required low and middle-income countries to finance a considerable share of overall health spending from OOP payments (e. g. Akin et al. 1987). Due to the growing evidence of the impoverishing effects of OOP payments (e. g. Holst 2012c) combined with the wide-spread focus on poverty issues in heavily indebted poor countries (HIPC), international consensus has meanwhile shifted towards supporting and implementing health prepayment schemes (McIntyre et al. 2008: 874; see also WHO 2010). Hence, it is no coincidence that all over the world, government taxation and social health insurance schemes are important sources of healthcare funding according to the amount of resources committed: they account for 35 % and 25 % of worldwide spending on health, respectively (WHO 2013).

As early as in its Annual Report 2000, the World Health Organization qualified prepayment as the best form of revenue collection for health (WHO 2000: xviii). The WHO argues that prepayment costs are much more predictable than OOP payments (cf. ibid.: 35), that prepayment leads to greater financial fairness, and provides policies and budgets of public entities and insurance funds with greater and broader influence (ibid.: 26). Besides horizontal equity and risk sharing, OOP payments also impede vertical redistribution from happening, since everybody has to pay for his or her individual healthcare regardless of the available income or purchasing power.[11]

One might argue that at the end of the day, all funding for health services ultimately comes from households or firms, and it is important to note that the burden of payments that appear to be made by firms is in fact often passed on to households. Employers' tax payment and contributions towards health insurance, for example, are accounted for as a part of the overall production costs and incorporated into the final price of the products. Disaggregating the sources of health financing further by considering where and to what extent direct expenditures on prepayment for health services are transferred to other payers, however, is a major challenge and extremely cumbersome, particularly in a globalised world where many goods and services are exported abroad.

2.1.5 Conclusions

Healthcare can be financed by different means, mainly from tax revenue and health insurance contributions. While taxation and social health insurance offer broad options for universal health coverage, private health insurance is usually restricted to better-off population groups. Alongside with the abovementioned prepayment mechanisms, health financing worldwide and particularly in low-income countries also relies on out-of-pocket payments, that is the least foreseeable and most inequitable way to pay for healthcare.

[11] For further details see below.

2.2 Innovative health financing models

2.2.1 Health savings accounts

This relatively new health-financing mechanism refers to an either mandatory or voluntary form of self-insurance where individual households save regularly towards the cost of paying for health services in case of need. Health Savings Accounts (HSAs) might provide significant government subsidies to the poor for highly expensive services, but even then, the standard of service is much lower than the upper income groups receive. If HSAs are compulsory, as in Singapore, they become a form of health insurance except that it is more inequitable, since there is no pooling of risk, and many of the poor may be unable to afford contribution payment at all – thereby losing access to services (Akal & Harvey 2001: 11).

A HSA can be defined as a personalised savings account, on which compulsory or voluntary contributions are accumulated strictly to cover healthcare expenses so that the financial risk of illness is spread over time (Dixon 2002: 409). Health savings accounts are assumed to contain healthcare costs by reducing demand-side moral hazard through cost-bearing and by making consumers conscious of cost. Critical assessments of HSAs refer to the fact that HSAs shift responsibility from the collective to individuals, prevent both vertical and horizontal redistribution and hence erode solidarity (Hsu 2010: 8). In a nutshell, HSAs do not provide any potential to be progressive even if contributions are related to income because no cross-subsidisation between different households occurs. Hence, in the case of HSAs, redistribution of income or services does not exist.

2.2.2 Donor funding

In addition to domestic sources of healthcare revenue, many low- and middle-income countries (LMIC) also benefit from external or donor funding. There are considerable debates about the advantages and disadvantages of financial support from abroad and the form that it should take. The concerns about the predictability and long-term sustainability of donor funding highlight the importance of giving rigorous consideration to ways of mobilising more domestic funds even in countries that are currently aid-dependent. Assessing the level of progressivity in the resource generation of donor funding is extremely challenging, if it can be done at all, due to the broad variety of donors and sources such as government spending, NGOs, private corporations and multinational donors with very different ways of collecting and allocating ODA funds. On the other hand, providing donor funds to developing countries implies redistribution between wealthier and poorer countries.

2.2.3 Global resources for health

From the point of view of how donor resources are utilised in the recipient country and from a good-financial-governance perspective it is important to see how and to what extent donor funds are integrated into the national health-financing system. A plethora of donor accounts needs to be managed, requires capacity development of national health-financing systems in the line ministry and sometimes even diverts attention away from business as usual. Funds can be on budget and contribute to financing government policy, but in practice they are often still controlled and managed by the funding institutions. Moreover, donors might follow their own political interests and earmark resources to priority

health strategies such as fighting infectious diseases or reducing poverty. If donors phase out support, there is a high risk of resources being redirected from priority areas to other fields of healthcare and disproportionately affecting the poor.

Beyond funding challenges, there is growing international consensus that health has to be recognised as a human right that is enshrined by several international treaties and reinforced repeatedly by United Nations declarations, most recently in the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health approved at the sixty-seventh session of the UN General Assembly. The declaration states the following: "Realization of the right to health in the developing world is thus also dependent upon the availability of sustainable international funding for health, which should ultimately be realized through an obligatory, treaty-based regime founded upon the principle of global solidarity" (UN 2012: 10).

Human rights are relevant for specifying the universal right to health and ensuring that a rights-based understanding of equality and fairness is essential on the path to universal coverage since inequalities in health are a sensitive marker of inequalities in other domains (Yamin & Norheim 2014: 232f). The principle of fairness makes a significant contribution to good governance because it encompasses the related human rights of equality and non-discrimination. As discrimination entrenches health inequalities and undermines the capacity of governments to pursue the right to health for all society members, States have the mandate to combat discrimination in order to ensure fair health financing as well as equal access to health services and to the resources needed for a healthy life (WHO 2017: 76).

At the global level, environmental crises such as the Ebola outbreak in Western Africa and the Zika virus endemic in parts of Latin America have called for intensifying medical aid, disaster relief and lately focusing more and more on health security (Gostin et al. 2015: 6f); the hosting German Federal Government recommended health security to be included to the agenda of the G20 meetings in 2017 (Ahern 2016). The focus on global health security leads to clashes with prevalent interpretations of human rights, including the right to health (Lautensack 2015: 11f). If people do not have the financial means to exercise their rights, however, their actions and access are constrained; in today's hierarchical society with increasing inequality and limited social mobility, these limitations and exclusions produce a situation described as a new form of serfdom (Komlos 2017: 500). In view of this global trend, the focus on redistribution does not seem to go far enough; a strong move towards a fairer distribution not only of resources but also of power and influence is required.

But this does not mean to go without the demand for redistribution in the health-financing sector. The World Health Report 2010 on health financing and universal health coverage lists a number of innovative financing options for raising additional domestic resources for healthcare, namely a special levy on large and profitable companies; a levy on currency transactions; a financial transaction tax; tourism tax; a mobile phone solidarity contribution; and taxes on tobacco, unhealthy food, etc. (WHO 2010: 29). While levies on company profits and financial transactions tend to be progressive since they tax well-funded and profitable sectors of the economy and can be adapted to business volume or return, consumption taxes are rather regressive. This applies to flat-rate levies on mobile phones in developing countries where even the very poor rely on cell phones for basic communication and increasingly for individual

banking issues; and even more to the so-called "sin taxes" such as tobacco and alcohol tax that represent a higher share of available household income for poor people (cf. Martínez 2004: 18f).

Increasing labour migration in the globalised world has generated a relevant new resource flow. Remittances sent by migrants have become a massive additional source of revenue particularly for developing countries. The idea of taxing migration came up 40 years ago as the "Bhagwati tax" on emigrants (Bhagwati & Dellalfar 1973) and contributed to initiating a shift in the debate on migration from the developmentalist theory[12] and the neoclassical[13] reasoning of the 1950s to 1970s towards the dependency school of development that did not only see migration as detrimental to underdeveloped economies. Since then migration has increasingly been considered "as a livelihood strategy to overcome various market constraints, potentially enabling households to invest in productive activities and improve their livelihoods" (de Haas 2007: 6). In this respect, remittances channelled to perform a social-protection function have the potential to contribute to poverty alleviation and improve the level of income in recipient societies. Since the financing of social protection is based on available income, revenue from remittances should be taken into consideration when it comes to defining the assessment basis (Riester 2009: 23). However, there is no easy answer to the chicken-and-egg question of whether remittances can support the implementation of social protection in recipient countries or if "the best policies for optimizing remittance impacts are general development policies aimed at restoring political trust, creating a stable investment climate and offering social protection to people (de Haas 2007: 26).

2.2.4 Globalising social health protection

Global financial initiatives have the potential to both strengthen and catalyse health governance, provided that countries are politically committed to ownership, multi-stakeholder participation and inclusiveness in governance structures through civic participation in the policy-making processes. Achieving those goals is the reason why the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) implemented Country Coordinating Mechanisms (CCMs) for making fund flows reliable and stakeholders accountable (Gómez & Atun 2012: 2). Although health-systems strengthening (HSS) is part of the activities supported by the GFATM, broader development plans for healthcare systems are rarely included (Dräger et al. 2006: 5). Moreover, the GFTAM did not go into directly financing social health protection except for one case, namely supporting the set-up of health insurance in Rwanda (Kalk et al. 2009: 95ff). Reviews show a marginal allocation of GFATM Round 8 funding to governance and health financing. Approximately 5 percent of HSS resources went to governance topics with less than one percent allocated to functions related to coordination and harmonisation. Also, less than one percent went to health financing issues, overwhelmingly to financial incentives such as PBF; GFATM funding for financial transparency and social protection was negligible (Warren et al. 2013: 10f).

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[12] The developmentalist theory prevailing in the 1950s and 1960s assumed that a policy of large-scale capital transfer and industrialisation would catapult poor countries to jump on the bandwagon of rapid economic growth and development. In this context, large-scale labour migration from developing to developed countries began to gain momentum and was considered as a contribution to developmentalism (de Haas 2007: 3).

[13] Neoclassical theory considered "migration as a process that contributes to the optimal allocation of production factors for the benefit of all, in which the process of factor price equalisation will lead to migration ceasing once wage levels are equal at both the origin and destination. From this perspective, the re-allocation of labour from rural, agricultural areas (within and across national boundaries) to urban, industrial sectors is considered as an essential prerequisite for economic growth and, hence, as an integral component of the whole development process (ibid.: 4).

If global social protection is conceptualised as a human rights paradigm and a socio-economic right, there is legitimacy for universal risk sharing and for revenue generation from international cooperation that would allow states to come together to pool resources. International or global financing can be achieved in two ways: raising new funds for health and implementing new ways of linking funds to results. On raising new funds, international examples include solidarity taxes on airline tickets to improve access to essential drugs and commodities for HIV, tuberculosis and malaria; product franchising where a portion of the price of a branded product goes to the GFATM; and converting national debt to GFATM grants to health. International examples of linking funds to results include: frontloading donor investment through the Global Alliance for Vaccines and Immunisation (GAVI) to disseminate new and existing vaccines; various forms of performance-based financing; and different types of incentives to stimulate private-sector engagement, develop markets for new products, and provide subsidies to increase access to new, expensive drugs (Waris 2012: 126). Other forms of tax being proposed for achieving international social policy objectives include a tax on very high wealth or incomes and on financial sector activities; a value-added tax on financial services; a broad financial transaction tax; a nationally collected single-currency transaction tax; or a centrally collected multi-currency transaction tax (ibid.: 128).

Taxation of international financial transactions is promoted by the Leading Group on Innovative Financing for Development (2010) as a solution for overcoming the global solidarity dilemma where the growth of global economies has not been matched with effective mechanisms to pay for global public goods (Denys 2012: 112). The funding gap for development, environment, health and other public goods is one of the major challenges highlighted in the report Globalizing Solidarity: the Case for Financial Levies; moreover, the report identifies a global solidarity dilemma where the financial resources to pay for global public goods have not kept pace with the growth of global economies (Leading Group 2010: 11). The expert group recommends a global solidarity levy as a centrally collected international transaction tax on exchanges of currencies; such a levy is innovative, technically and legally feasible and ready for implementation. Even charging an extremely low tax rate (e. g. USD 1 per USD 20,000) the very large current turnover of USD 800,000 billion per year would generate revenue of USD 30-50 billion every year. This amount would stem from the hitherto under-taxed global finance sector that benefits most from the global economy and whose participation in global burden-sharing is overdue (Denys 2012: 113f). Unlike direct taxes on bank activities as proposed by the International Monetary Fund (IMF) and discussed at G20 and EU level, taxing the capital market would be a stable and sustainable mechanism providing significant revenue that comes directly from the globalised economy and would not depend on domestic fiscal policies (ibid.: 115).

2.2.5 Conclusions

A number of innovative strategies for generating resources earmarked to health at individual (e. g. Health Savings Accounts) and societal or global levels have meanwhile accomplished traditional health-financing mechanisms. Besides migration-borne remittances and overseas development aid, expanding taxation to international economic and financial activities is most promising to generate substantial resources for healthcare.

3 Distributive effects

3.1 Measuring inequalities and redistribution in health

Various strategies exist for measuring and evidencing income inequality. The Gini coefficient is certainly the most commonly used means for measuring inequality of income and wealth; it can also be applied to measure any form of uneven distribution. However, it may not be the most sensitive one in relation to the empirical findings of studies using other techniques. Health researchers tend to use the Gini coefficient at the expense of other, more nuanced measures. The second most frequently used indicator for measuring inequality and particularly redistribution through taxation has so far been the Kakwani index, applied since the early 1990s in comparative studies of industrialised countries (see Wagstaff & van Doorslaer 1992) but also in selected countries in transition (e. g. Castaño et al. 2002). The following paragraphs provide a brief overview of measures applied in the context of health financing for assessing inequality and redistributive effects.

Gini coefficient

The Gini coefficient compares the income or wealth distribution of a population to a perfect state of equality in which every citizen has equal wealth. To compute the Gini coefficient, it has to be measured how far the actual Lorenz curve for a society's real income or wealth is from the line of equality. Mathematically the Gini coefficient corresponds to the area between the two graphs divided by the total area under the line of inequality; it can have a value between 0 and 1, where 0 corresponds with perfect equality and 1 corresponds with perfect inequality.[14] The Gini coefficient exhibits the following characteristics:

- The Gini coefficient is a measure of inequality, not a measure of average income or some other variable that is unrepresentative of most of the population, such as gross domestic product.
- Gini coefficients allow income distributions to be compared across different population sectors as well as countries (e. g. the coefficient for urban areas differs to that of rural areas).
- The Gini coefficient is simple enough to allow comparisons to be made across countries and be easily interpreted.
- The Gini coefficient can be used to indicate how the distribution of income has changed within a country over a period of time, thus it is possible to see if inequality is increasing or decreasing.
- The Gini coefficient features the advantages of anonymity, scale interdependence, population interdependence, and the transfer principle, which states the level of income transferred from rich to poor.

On the other hand, the Gini index only maps a number to the properties of a diagram, but the diagram itself is not based on any model of a distribution process: the meaning of the Gini index only can be

[14] The Gini index is the Gini coefficient expressed in percentage form, and is equal to the Gini coefficient multiplied by 100.

understood empirically. Additionally, the Gini does not capture where in the distribution the inequality occurs. As a result, two very different distributions of income can have the same Gini index.

20:20 ratio

The 20:20 or 20/20 ratio compares how much richer the first quintile of a population is compared to the lowest quintile; this can be more revealing of the actual impact of inequality in a population as it reduces the effect on the statistics of outliers at the top and bottom and prevents the middle 60 % from statistically obscuring inequality that is otherwise obvious in the field. The measure is used for the Human Development Indicators applied by the United Nations Development Programme (UNDP). The 20:20 ratio shows for example that Japan and Sweden have a low equality gap, where the richest 20 % only earn 4 times as much as the poorest 20 %, whereas in the UK the ratio is 7 times and in the United States of America 8 times. Some believe the 20:20 ratio is a more useful measure as it correlates well with measures of human development and social stability including the index of child well-being, index of health and social problems, prison population, physical health, mental health and many others (Wikipedia 2013).

Hoover index

The Hoover index is the simplest of all inequality measures to calculate: it is the proportion of all income, which would have to be redistributed to achieve a state of perfect equality. A Hoover index of 0 corresponds to a perfectly equal world, where no resources would need to be redistributed to achieve equal distribution. In a world in which all income was received by just one household, almost 100 % of that income would need to be redistributed (i.e., taken and given to other families) in order to achieve equality. The Hoover index then ranges between 0 and 1 (0 % and 100 %), where 0 indicates perfect equality and 1 (100 %) indicates maximum inequality (Wikipedia 2013).

Kakwani index

The Kakwani index builds upon the Gini framework and was originally devised to measure the progressivity of a tax system (Kakwani 1977); it is also used to examine equity in healthcare expenditures. In this case, the Kakwani progressivity index is the difference between the Gini coefficient for incomes and the concentration index for out-of-pocket healthcare payments. In theory, Kakwani index values range from –2 (indicating severe regressivity) to +1 (indicating strong progressivity) (de Maio 2006: 851). The Kakwani index of overall progressivity can be calculated as a weighted average of the indices for the payment components, where weights are equal to the proportion of total payments accounted for by each source. Thus, overall progressivity is dependent both on the progressivity of the different sources of finance and on the proportion of revenue collected from each of these sources (World Bank 2006: 7).

Being a measure of tax progression, the Kakwani index focuses on whether the tax system is progressive, or regressive. It considers the inequality of health expenditure and income distribution simultaneously in evaluating health inequality. This property is advantageous but introduces some difficulties with respect to decomposition into subpopulations. When applied to health inequality, it cannot determine correctly whether accessibility to the healthcare system is equal or unequal, viz. all households or indivi-

duals can afford the same level of healthcare services in case of need. The Kakwani measures "income-related" health inequality since it is based on a comparison of the inequalities of expenditures for healthcare and income.

With regard to access inequality for medical services, however, there is one aspect on which the Kakwani measure cannot differentiate between the case where people pay for medical services according to their incomes and the case where people pay a fix amount of medical expenditure. When considering access inequality for medical services, there are two extreme and characteristic situations. One is the case where people pay medical expenditures proportional to their incomes. The other is the case where people pay a constant amount of medical expenditure. The Kakwani index is unable to differentiate between these two situations (Fukushige et al. 2012: 2). Using the ratio of the concentration index to the Gini coefficient instead of the difference between them would overcome this relevant restriction (ibid.). An innovative approach for assessing the distributive effects of health financing is to measure inequality by the ratio of the concentration index to the Gini coefficient instead of the difference between them. This modified index could also be seen as measure of the income or total expenditure elasticity for healthcare expenditures. It can be interpreted as the income or total consumption expenditure elasticity evaluated at the mean (ibid.).

3.1.1 Trade-off between progressivity and redistribution

In a progressive income tax system, a high-income earner will pay a higher tax rate than a low-income earner. The difference between the Gini index before and after taxation is an indicator for estimating the redistributive effects of taxation. The further tax collection pushes the income Lorenz curve toward the line of equality, the more progressive it is supposed to be. The magnitude of this movement, measured as the difference between the Gini coefficients of pre-tax and post-tax incomes, is known as the redistributive effect, and the greater the tax progressivity and the average tax rate, the larger the redistributive effect will be (Kakwani 1977).

The progressivity of taxes also depends on the inequality of taxable income; the effective progressivity of a given tax schedule will be greater in a country with a more unequal distribution of taxable income. Progressivity can also be achieved if the poor receive more than the rich from a given transfer system or other social services. In this context, progressivity refers to the profile of benefits compared with market or disposable incomes and depends on how large a share of benefits is received by different income groups. Benefit-related progressivity can be found to differ from income-related progressivity, as was shown for example in a comparative analysis of consecutive national household surveys in Colombia. In relation to income, the Kakwani indices showed a regressive impact while the trend was slightly progressive when using expenses (Castaño et al. 2002: 8).

Progressivity is not an end in itself but a means to an end, where the end can be to reduce inequality or alleviate poverty (Whiteford 2010: 532). It has to be pointed out that progressivity is not the same as redistribution. Progressivity measures how the distribution of the tax or levy burden is shared, while redistribution measures how much the tax or social-protection system reduces inequality. Redistribution refers to the outcomes of different tax and benefit systems and depends on the extent to which a benefit system actually changes the distribution of household income (cf. ibid.: 535ff). Hence the level of

redistribution depends essentially on two different factors, namely the level and progressivity of taxes (cf. OECD 2008: 100ff) or contributions, and the spending and revenues collected and allocated for social benefits.

Hence, measurable progressivity in a health-financing system does not necessarily imply pro-poor redistribution. A comprehensive analysis of the distribution of health-care financing contributions in relation to ability to pay in several Asian countries provides evidence that the better off in low- and lower-middle-income countries spend proportionally more of their household resources on healthcare because of higher direct payments (O'Donnell et al. 2008a: 467f). If direct payments for healthcare increase proportionally to households' ability to pay, they are progressive according to the conventional definition of progressivity whereby payments as a proportion of income increase as income rises, but fail to contribute to redistribution.

Progressivity or proportionality of direct payments in developing and particularly in emerging countries are attributable to the fact that the better-off make more direct payments for healthcare than the poor because they use more health services. Thus, progressivity of a health-financing system that relies to a relevant extent on OOP payments does not imply fair financial burden sharing but is rather an expression of social exclusion: lower socio-economic groups cannot afford health services and thus do not have the opportunity to spend a relevant share of their household income on health.

It has to be pointed out that progressive health financing requires universality in order to ensure effective redistribution. The fact that better-off socioeconomic groups spend a higher share of their available income for health will not favour the poorer population groups unless overall pooling of health funds is in place. Hence progressivity needs universality either in terms of resource generation or of access to benefits to cause redistributive effects. Moreover, to make inferences about the equity of healthcare financing it is not sufficient to examine the distribution of the total financing burden. Under usually complex fiscal conditions, the relationship between inequality outcomes and the size and progressivity of fiscal interventions is complex and sometimes counter-intuitive (Enami et al. 2017: 25). The structure of financing, in particular the balance between instruments that make utilisation contingent on payments and those that do not, and the impact of financing on the utilisation of healthcare should also be considered (O'Donnell et al. 2008a: 469).

3.1.2 Prepayment versus out-of-pocket payment: Horizontal and vertical equity

Sudden health shocks can expose households to unexpected expenditures that are extremely difficult to schedule. Paying out of pocket is not only unforeseeable but can expose families to costs they cannot afford. In contrast to all types of advanced payment for healthcare, user fees are due in the moment of need and at the point of service when patients pay directly and out of their own pockets, according to a set tariff, for the healthcare services they use. User charges or fees are commonly levied for consultations with health professionals, medical or investigative procedures, medicines and other supplies, and for laboratory tests. There is no prepayment involved and hence no risk sharing or mutual support. OOP payment is the most common way of paying for privately provided services in developing countries, and is also used as a component of financing for public sector services.

The assumed indirect pro-poor effect of OOP payments in low-income countries – based on the assumption that the higher use of health services by the better-off would cross-subsidise health services for the poor if the latter are exempted (e. g. Gilson et al. 1997: 372f) – proved not to work out: broad evidence exists that waivers and exemptions create major challenges regarding effectiveness and equity, are difficult to implement, and often fail to effectively protect the neediest from paying out-of-pocket for healthcare (for a comprehensive overview see Holst 2012c: 36ff).

OOP payments are considered a very regressive form of financing due to two complementary effects. It is usually argued that OOP payments are regressive because the share of available household income spent out of pocket on healthcare is higher for lower socio-economic groups compared to the better-off, meaning that those who are less able to pay are charged relatively more (McIntyre 2007: 10; Akazili et al. 2001: 6; Odeyemi & Nixon 2013: 6). This relative inequality is aggravated by the well-proven relationship between socio-economic conditions and health (e. g. Wilkinson 1997; Marmot et al. 2008; Wilkinson & Pickett 2005; for developing countries Rice & Steinkopf-Rice 2009 and Worku & Woldesenbet 2011; see also Rohregger 2009): the lower the income, the larger the burden of ill health. As OOP payments are directly linked to the need for, and thus the use of, health services, they are most detrimental for low-income groups due to the combination of the higher relative financial burden and the higher need for health services.[15]

Hence, out-of-pocket payments have a pro-rich redistributive impact. This is intuitively comprehensible, and clear empirical evidence exists, for example, for 12 OECD countries (van Doorslaer et al. 1999: 303; Prah-Ruger & Kim 2007). Unlike the findings in industrialised countries with universal population coverage, however, macro-economic estimations of the redistributive effect of OOP payments based on the Gini and/or Kakwani coefficient show that direct payments can be slightly regressive, proportional or even progressive (O'Donnell et al. 2008a: 468, 471). As described above, these findings are, however, attributable to large social inequities, somewhat misleading, and do not really reverse the analysis for industrialised countries.

One of the essential preconditions for reducing the most detrimental undesired effects of user fees and other direct payments for health is an effective and socially balanced system of waivers and exemptions in order to prevent, or at least reduce, the exclusion of those who cannot afford to pay anything for healthcare. However, the available evidence shows that exemption mechanisms are inherently difficult to design and implement, and deserve much greater priority than they have received to-date (e. g. Bitrán & Giedion 2003). But even if there was a "perfect" system in place, exemptions and waivers could only reduce the level of vertical inequity but not overcome the intrinsically unfair character of OOP payments, which are by nature fully independent from people's ability to pay or their purchasing power. Wage-related OOP ceilings do not reduce the regressive character of OOP payments up to the respective threshold since they only apply to health expenditures beyond the ceilings, which tend to be relatively high (e. g. 2 monthly incomes per year in Chile). The only way to ensure fair out-of-pocket financing would be through income-related co-payments; this charming idea, however, is extremely challenging

[15] It should be mentioned that low-income individuals tend to take out less health services than the better-off, both in absolute and relative terms. An equity point of view, however, requires health systems to provide services according to need and without excluding people from health services.

when it comes to converting economic theory into practice. Moreover, it would require a level of fiscal infrastructure that is partly or fully absent in the Global South, and would definitely overstrain the fiscal and managerial capacities in developing and indeed in most transitional countries.[16]

When access to and utilisation of needed healthcare depends on people's ability to pay, health financing is unfair because households facing similar health needs have to pay different proportions of their incomes. As long as income is not homogeneous in a society, all applicable types of OOP payments bring about essential problems with regard to horizontal fairness because they run counter to the requirement that persons in equal need ought to be treated the same. User-fee exemptions for selected population or income groups cannot resolve the issue of horizontal unfairness even if the neediest are correctly targeted because thresholds for exemptions are necessarily arbitrary, and the OOP share for those slightly above the respective limit is much higher than the OOP share for all households below the threshold.

OOP payments are mostly unexpected and their impact on poor households is likely to be different from the impact of taxation or health-insurance contributions. In particular, taxes and SHI contributions are predictable, related to ability to pay, and usually lower than payments that are due at the point of service; hence they display vertical fairness (cf. Xu et al. 2003: 562). Financial fairness is best served by more, as well as by more progressive, prepayment in place of out-of-pocket expenditure (WHO 2000: 35). Moreover, the financing would be unfair if the poor spent a larger share of their household income than the wealthier socio-economic groups, either because they were less protected by prepayment systems and therefore had to pay relatively more out of pocket, or because the prepayment arrangements were regressive (WHO 2000: 36) although the level of regressivity might vary between different national health-financing systems (Cissé et al. 2007: 66).

The World Health Report 2010 on universal coverage follows this argumentation more explicitly: "Moving away from direct payments at the time services are received to prepayment is an important step to averting the financial hardship associated with paying for health services. Pooling the resulting funds increases access to needed services, and spreads the financial risks of ill health across the population" (WHO 2010: 2). The report also highlights risk pooling through prepayment as the only way to reduce reliance on direct payments and as the path chosen by most of the countries that have come closest to universal coverage (ibid.: xiv).

As mentioned above, out-of-pocket payments are due at the point of service and do not imply any kind of risk sharing between different individual households. According to an often-cited international comparative study from the 1990s, out-of-pocket payments had a pro-rich redistributive impact in OECD countries. Moreover, the negative impact of OOP payments on income distribution was far greater than the impact of the portion of indirect taxes used for financing healthcare. The highest values of the pro-rich redistribution effect of out-of-pocket payments were found in Portugal and the US (van Doorslaer 1999: 303). As direct payments do not provide any redistributive potential and do not contribute to pro-

[16] There is some academic discussion among health economists about "optimal co-payments" for health care (e. g. Hoel 2005 and Levaggi & Levaggi 2005); however the debate is restricted to highly developed countries, and even there the approach is rather theoretical and far from being operationalised in practice. In less developed countries where the implementation of user charges and particularly of adequate exemption schemes is already a major challenge (e. g. Bitrán & Giedion 2003), the approach of "optimal co-payments" lacks practical relevance.

portionate universalism, the present study abstains from any further analysis of OOP payments for healthcare and their impact on fairness of financing and equity. The focus is therefore put on the various types of prepayment for health, which offer different potentials for redistribution in the sense of proportional universalism and variable levels of fairness.

3.2 Prepayment for healthcare and redistribution

3.2.1 Taxation

Resource generation through taxation has the potential to be progressive and is often seen as the most equitable health-financing mechanism. In fact, individual income taxes, corporate taxes as well as all other types of income- or profit-based tax collection tend to be progressive; i.e. their tax rate rises as the taxable amount (wages, income, profit etc.) increases. To the extent to which taxation applies to income and profit, it is conducive to being progressive and enhancing equity. Taxation has first of all a redistributive effect by making of post-tax income less unequal than the pre-tax income distribution (Enami et al. 2016: 8); and is supposed to be universal since it is mandatory for everybody. However, not only most developing countries and many countries in transition but increasingly also the countries of the Global North fail to achieve the full redistributive potential of income taxation. This is due to different reasons such as institutional weaknesses in tax collection, widespread tax evasion, and the problems in taxing large international companies.

Table 1 Tax revenue as a share of GDP according to national income level

Country income group	Total tax revenue	Taxes on int. trade	Excise duties	General sales tax	Social security
Low-income (< 760 $ per capita)	14.0	4.5	1.6	2.7	1.1
Lower-middle income (761-3,030 $ per cap.)	19.4	4.2	2.3	4.8	4.0
Upper-middle income (< 3,031-9,360 $ per capita)	22.3	3.7	2.0	5.7	5.6
High income (> 9,360 $ per capita)	30.9	0.3	3.1	6.2	8.8

Source: Wagstaff & Claeson 2004: 148

International experience shows that it is more difficult and rather cumbersome to generate tax revenues from direct taxation of individuals or companies in developing countries. Technical and institutional capacities are often weak, political will is lacking, and the political economy is unfavourable towards effective taxation, particularly of top earners and profitable multinational enterprises. High-income earners tend to under-declare their earnings, and low-income earners often switch to the shadow economy in order to reduce or avoid tax payment. Corporate income taxes constitute a relative high share of total government revenue in developing countries, although business tax rates are increasingly under pressure from global tax competition. Yet corporate tax revenues tend to suffer from aggressive tax planning by transnational companies, which makes them a rather unreliable or unpredictable source of government revenue (e. g. Creedy & Gemmell 2008: 37) and prompts relevant concerns regarding the sustainability of their pro-poor effects (Akazili et al. 2011: 3). Moreover, corporate income tax might lose

progressivity as it is assumed to be shifted backward to the workforce and forward to consumers (Martínez 2011: 18).

Given the described challenges of taxing income or profits, low- and also middle-income countries often prefer to implement or increase indirect or commodity taxes. In fact, the introduction of value-added taxes (VAT) has been globally associated with a significant rise in the tax revenue being collected. Moreover, countries that employ indirect taxes generally raise more fiscal revenue than those which do not (Keen & Lockwood 2010: 145ff). Indirect taxation and particularly VAT are also explicitly recommended by the IMF, World Bank and other international organisations in the context of financing policy strategies such as social protection and health. Unlike personal income taxes, indirect taxes offer the possibility of taxing different components of consumption of goods at different rates. Taxation theory recommends that indirect taxation be relatively high on commodities with a relatively low price elasticity, in other words, on commodities whose demand hardly reacts to changes in its price, and lower on goods that are more sensitive to price changes in order to prevent relevant substitution effects and hence welfare losses (Belan & Gauthier 2006: 1202f). In practice, many countries apply reduced tax or even zero-rates for products that are considered necessary basic needs, such as food, but also newspapers or public transport services.

It is argued that wealthier people consume far more goods and services and hence pay far more indirect taxes in absolute terms compared to poorer people. However, the relative weight of indirect taxes for better-off households can still be lower than the indirect financial tax burden of poor households. Even if tax rates are adapted to price elasticity, or in more practical terms, to greater or lesser degrees of necessity – charging a low tax rate on basic food consumption and a very high rate on luxury goods – indirect taxation is unable to differentiate according to ability to pay or purchasing power and hence remains regressive (cf. OECD/ ECLAC 2013: 21).

Promoters of tax-based health financing often tend to either neglect or underestimate the fact that progressive taxation is only one source of overall tax revenue. A necessary and sufficient condition for a tax to be equalizing is to be globally progressive (Enami et al. 2016: 10). Besides personal and corporate income taxes and taxation of wealth and property, other sources of tax revenue exist and influence the level of overall progressivity of a tax system. Even in industrialised countries, which are supposed to have relatively effective and fair tax systems, the share of progressive tax revenue is just around half of overall tax money collected (BMF 2015; Eurostat 2013: 27; Eurostat 2015: 129f). In Latin American countries in transition like Brazil and Chile, the share of indirect taxes is around 70 % of tax revenue (OECD/ECLAC 2013: 84ff). India managed to reverse the relationship between direct and indirect taxation by increasing the share of direct tax revenue from 36 % in the fiscal year 2000/2001 to 58 % in 2009/2010 (MoSPI 2015).[17]

[17] At first glance, this development might appear promising for having improved the equity of the Indian tax system and enhanced pro-poor redistribution. However the assumption seems to be rather doubtful and rather reflects India's rapid economic growth during the 2000s. On the one hand, the significant increase of indirect tax revenue derives mainly from increasing corporation taxes whereas the relative weight of income tax revenue has undergone a relevant decrease by almost 10 percentage points. Moreover, the relative increase of indirect tax revenue relies to a certain extent on rising revenue from services taxes (MoSPI 2012: 75).

The usual assessment of the redistributive effect of mandatory public health financing such as taxation and social insurance contributions relies on comparing the difference between the pre- and post-payment incomes. The resulting value indicates whether the payment reduces or increases inequality (van Doorslaer et al. 1999: 293). The potential reduction of the respective Gini coefficient reflects the redistributive effect (O'Donnell et al. 2008b: 197). Estimations of the Kakwani index showed that the direct taxes that finance healthcare in 12 OECD countries are pro-poor in their redistributive effect.[18] This actual redistributive effect, however, is reduced below its maximum potential due to the differential treatment of various labour and socio-economic groups in direct taxation, such as the existence of tax exemptions, and tax deductions for the self-employed (van Doorslaer et al. 1999: 301, 303).

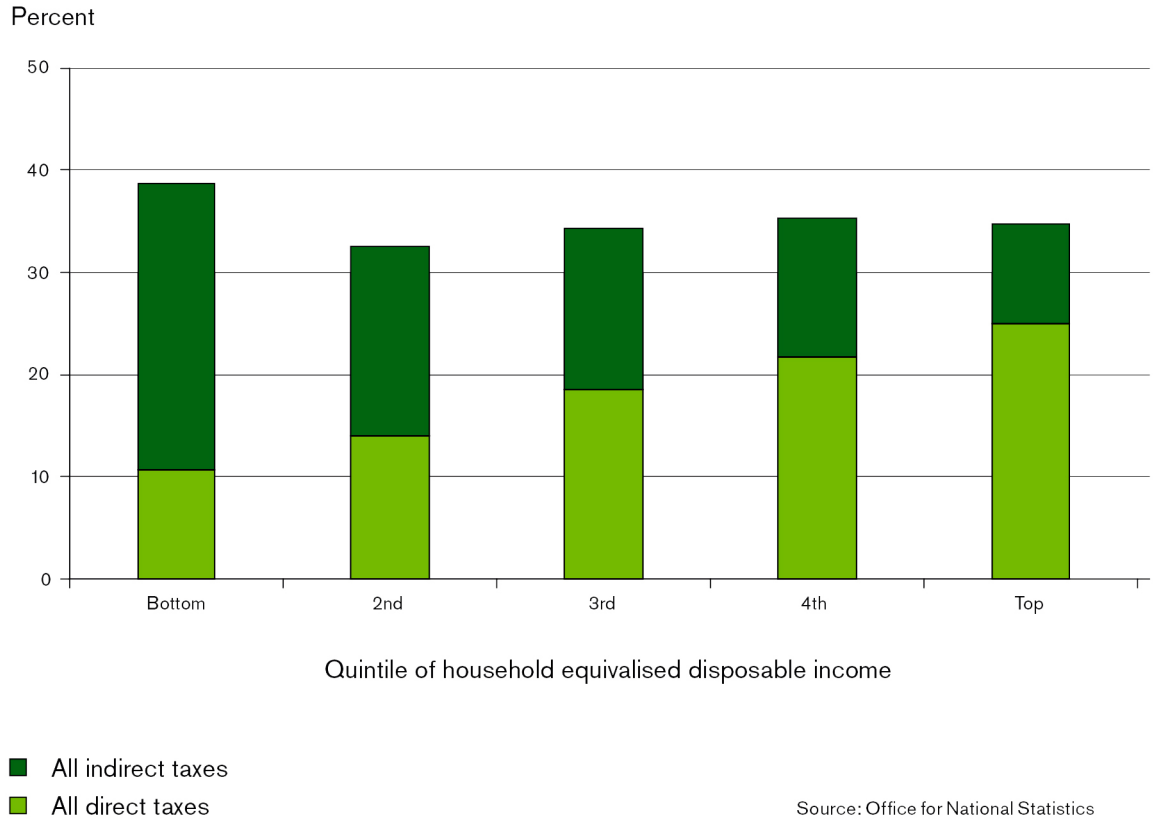
The overall progressivity of tax revenue used for financing healthcare depends on several factors that are intrinsically linked to the underlying tax system and hence closely related to relevant aspects of good financial governance. In this regard, the effectiveness and efficiency of revenue collection and fairness of taxation depend on a series of factors including the following:

- Political stability: the more unstable the situation is in a country, the more difficult it will be for the government to collect taxes and to implement an effective and sustainable tax system (cf. Ajaz & Ahmed n. y.: 2).
- Administrative capacities: institutional capacity and/or political willingness or ability to collect taxes tend to be weak in many developing countries.[19] The undesired effects of low capacity might be aggravated by corruption within the tax administration.
- Tax evasion: avoidance and bypassing of tax payment is another major challenge in many countries, which undermines the fiscal space, development, equity and social cohesion. Tax evasion can have different manifestations such as flight or exodus of capital, under declaration of income and profits, and creative accounting for hiding profits (applied e. g. by Ikea or Apple).
- Relation between direct and indirect tax revenue: the overall progressivity of general tax revenue as a whole depends on the mix of direct and indirect taxes and on the level of progressivity of each form of taxation (cf. McIntyre 2007: 13).

[18] The redistributive effect associated with direct taxes was especially high in Finland, but also the United States. The fact that the pro-poor redistributive impact of the taxes used to finance health care was larger in the US than it is in tax-financed health care systems (e. g. Finland and the United Kingdom) underpins the role of public financing for compensating inequities brought about by commercial private health markets.

[19] See statement on low compliance of tax administration in the Dominican Republic in footnote 21.

Figure 1 Taxes as a percentage of gross income, by quintile, 2007/8



Source: Marmot et al. 2010: 29

Unlike direct taxes, the financing of healthcare from indirect taxes caused pro-rich redistributive effects in all 12 OECD countries included in the above-mentioned comparative study (van Doorslaer et al. 1999: 301, 303). As shown in the Marmot report on social determinants of health, the impact of indirect taxes is highest in the poorest socio-economic groups, while they only represent a minor share of overall tax spending in the richest quintile.

While indirect taxes are practically always regressive and VAT (or general sales taxes – GST) tends to be very regressive in high-income countries (Wagstaff et al. 1999: 285), this is not necessarily the case in low-income and transition countries. One relevant reason for VAT or GST to be regressive is the fact that it is usually levied as a flat-rate tax (e. g. 15 or 19 % on all goods and services), so that poorer households pay a higher proportion of their income than richer households, which can save a higher share of their income (McIntyre 2007: 13). However, there are strategies to make indirect taxation more conducive to promoting proportionate universalism or becoming pro-poor by implementing progressive VAT or GST designs that take into consideration people's ability to pay. Two main strategies exist for reducing the regressivity of indirect taxation: exempting basic needs and other goods typically consumed by the lower socio-economic quintiles from VAT; and applying high tax rates to luxury or imported goods that are commonly consumed by the better-off and the wealthiest population groups (cf. McIntyre 2007: 13).

Beyond the design of taxes and levies, the potential of indirect taxation to become progressive depends also on the income distribution and the size and purchasing power of the richest group.[20]

Despite some observations that VAT can be progressive due to low compliance of tax collection or other reasons (Jenkins et al. 2006: 14),[21] and the theoretical option to design VAT with the objective to reduce its regressive character, indirect taxes tend to represent a higher financial burden for poor households (cf. Dameraux 2011: 45). Hence, implementing or increasing resource generation for social health protection by means of indirect taxation will usually make lower socio-economic groups pay relatively more for healthcare and has the potential to counteract poverty-reducing effects that are achievable by better access to affordable care.

Hence, the redistribution and pro-poor effect of tax-based health financing depends inalienably on the share of direct and indirect taxes in overall taxation. As mentioned above, even in industrialised countries with relatively efficient tax collection systems the share of indirect tax revenue tends to get ahead of direct tax revenue.[22] In contrast, in developing and transitional countries, tax collection often relies primarily on indirect and particularly on value-added tax revenue. Hence, due to the low effectiveness of progressive tax collection and particularly the high share of indirect tax revenue, most developing countries are far from achieving the redistributive potential of tax-based health financing and cannot derive relevant pro-poor effects from taxation in the sense implied by proportional universalism (Morrissey 2013: 13).

Moreover, the progressivity of taxation is further reduced by tax concessions to private health financing corporations as well as exemptions from taxable revenue of either PHI contributions or private expenditure on health. The potential of public subsidisation of the private insurance industry does not yet play a major role in most developing countries due to its low market share, but whenever PHI becomes strong and governments want to incentivise private health coverage, the respective redistributive effects have to be taken into account. For instance, from 1986 until 2002, the Chilean government subsidised PHI contributions for middle-high income groups that would otherwise not have been able to enrol into private plans paying just the mandatory 7-percent income share; in 1999, the last year of the full impact of the "legal additional 2 % contribution", the government spent almost EUR 22 million on subsidising the demand for private health plans (Superintendencia de ISAPREs 2001).[23] Tax exemptions for contributions paid to PHI corporations as well as for co-payments in health accomplished cross-subsidisation in

[20] Depending on the design of indirect taxation and the socio-economic distribution of consumption, VAT can become less regressive and even progressive. This is the case in Ghana (Akazili et al. 2012: i16) and according to some calculations also in Tanzania (Mtei et al. 2012: 129f) (for more details see country cases below).

[21] Jenkins et al. (2006: 15) show that progressivity of VAT in the Dominican Republic is mainly due to the fact that the tax administration does not consider it cost-effective to enforce the collection of indirect taxes from small shops and open markets in suburban and rural areas where the cost of tax collection is likely to be greater than the VAT revenues actually collected. This strategy reduces the amount of VAT paid by the poor relative to their income to such an extent that it proves to be lower than the income share of VAT paid by the better-off.

[22] In 2012, direct tax revenue was 50.6 % of overall tax revenue in Germany while indirect tax revenue already accounted for 49.4 %. Throughout the European Union, the share of indirect taxes has increased in many countries, and overtook that of direct tax revenue in 1993 in several cases (Eurostat 2013: 176).

[23] Eight years after the termination of dictatorship, the Chilean government abolished the *Contribución adicional legal del 2 %* in 1999. In the last year of its full application, the public subsidisation of private health accounted for 0.4 of total expenditure on health plans (Superintendencia de ISAPREs 2001).

favour of the better-off sub-system and further reduced the overall progressivity of health financing (Mesa-Lago 2009: 443).

Even clearer evidence can be drawn from industrialised countries where PHI plays a more important role either as a full-scale/substitutive or complementary social health protection mechanism. It is worth mentioning that in Australia public assistance to the health-insurance industry, e. g. through tax concessions, has proven to significantly distort the progressive pattern of tax-based healthcare financing. About 50 % of the value of tax concessions for PHI goes to the best-off third of taxpayers; and less than a fifth of these concessions go to the one-third of individuals in the lowest taxable income group. Hence the overall distributional effect has an 'upside-down' outcome (Smith 2000: 20).

In the USA, tax exemptions for employer contributions to PHI and medical care for staff accounted for a total revenue loss of 160 billion US dollars (USD) in 2010 and 173 billion USD in 2011 (EBRI 2011: 16). Tax exemptions for PHI contributions by the self-employed and payments to medical savings accounts reduced government revenue by a further 7.5 billion and 8 billion USD in 2010 and 2011 respectively (ibid.).[24] In fiscal year 2012, tax exemptions for employer contributions to PHI and medical care for their staff accounted for a total revenue loss of up to USD 278 billion (Horpedahl & Harrison 2013: 1).[25] This is a significant public subsidy favouring the formally employed, who can be considered as better-off compared to those who are informally employed, sub-employed, unemployed or poor. If tax exemptions for company contributions to PHI are added to direct government spending for Medicaid, Medicare, Veterans Affairs and some other SHP schemes, the US public expenditure on health accounts for more than 50 % of total expenditure on health.[26] At the same time, it makes tax-based health financing even more regressive and inequitable.

Last but not least one should also take into account tax deductions for private expenditure on health offered by the tax systems of many industrialised countries. A preliminary assessment of data from Germany shows that savings of individual tax payers based on direct health spending such as over-the-counter (OTC) medicines, alternative therapies etc. accounts for a not insignificant amount of money.[27] Since wealthier persons tend to take out more private prescriptions and OTC products and to benefit more from tax exemptions, this mechanism reduces the overall distribution and progressivity of health financing in Germany. In Switzerland, tax allowances for private health expenditures will be even more relevant: due to the high share of deductibles and co-payments, overall OOP payments of many users are likely to exceed the minimum of five percent of annual income required for tax deductions in most cantons (cf. Kantonales Steueramt Zürich 2012).

Altogether, with regard to the above-mentioned international financing strategies, global currency-transaction levies probably have the largest potential to be progressive and to evolve the right kind of

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[24] It is noteworthy that adding the public subsidies to health via tax exemptions increases government spending on health to almost 53 % of total expenditure and makes public resources the most important share of health financing in the USA (WHO 2013b).

[25] $170 billion in income tax revenue and another $108 billion in payroll tax revenue (Horpedahl & Harrison 2013: 1).

[26] It is noteworthy that adding the public subsidies to health via tax exemptions increases government spending on health to almost 53 % of total expenditure and makes public resources the most important share of health financing in the USA (WHO 2013b).

[27] Oral communication from Dr. Bernard Braun, Zentrum für Sozialpolitik, University of Bremen.

dynamic to be pro-poor. Although other strategies to raise additional revenue such as solidarity taxes on airline tickets and product franchising are a kind of VAT, and hence regressive, they are likely to become progressive at global level since consumers living in the wealthier countries tend to make use of more taxed goods and services than the world's poor.

3.2.2 Social health insurance contributions

Contributions to social health insurance (SHI) schemes are typically proportional to wages and earnings but can exceptionally be progressive if contribution rates rise with increasing income.[28] SHI applies the principle of solidarity since everybody contributes according to ability to pay and, in return, receives services according to need and independently of the level of prepayment for health. Provided that health risks are equally spread among all beneficiaries, proportional contributions produce redistribution from the wealthier to the poorer households enrolled.[29] Health financing through SHI contributions thus has a redistributive effect that goes beyond the reallocation inherent in all types of health insurance, namely from the healthy to the ill. According to comparative international evidence, "social insurance entails more horizontal inequality than direct *and* indirect taxes *combined*" (van Doorslaer 1999: 305). This applies to industrialised countries, which rely on relatively effective tax collection systems, on progressive income taxation, and a higher or at least equal share of direct tax revenue compared to indirect taxes.[30] In developing countries and countries in transition however, tax collection is often inefficient and unfair due to the difficulties of effectively collecting tax revenue, tax evasion and the high share of indirect taxation.

Likewise, SHI has a huge potential to enhance equity and operationalise proportional universalism since it provides cross-subsidisation according to financial and health needs. However, the overall redistributive effect of SHI is essentially restricted by two conditions:

1. **Cross subsidies exist only within one risk pool**: If various SHI schemes coexist in one country and provide highly unequal conditions of social protection, redistribution is restricted to one single SHI fund unless adequate risk equalisation is in place. While SHI funds assure a high level of internal redistribution and proportional universalism within one risk pool, the overall redistributive capacity of SHI systems depends on the level of universality. The coexistence of various SHI schemes requires effective risk equalisation and corresponding cross-subsidisation from the better-off funds to those with a worse risk mix in order to contribute to proportionate universalism. If it is to ensure a high level of redistribution in health financing, SHI coverage has to be universal, either through a single-payer system with one national insurance fund covering all

[28] E. g. the Social Security Chaco scheme (Sozialversicherung Chaco) set up in the Mennonite colony in Western Paraguay (Holst 2003: 35ff).

[29] This redistributive potential of SHI is even higher since evidence shows that the risk of falling ill is inversely proportional to the socio-economic level: provided that SHI ensures equal access to health services covered by the scheme, the higher needs of lower socio-economic groups compared to better-off beneficiaries enhance the redistribution within an SHI fund.

[30] International comparisons of the redistributive effects of SHI underlie a series of limitations, such as the fact that contributions differ because earnings are taxed differently in different schemes; contribution schedules and thresholds or ceilings are defined on an individual earner's wage rather than on a household income basis; many social insurance schemes are not universal since eligibility for certain social insurance schemes is on an individual basis rather than a household basis; some social insurance schemes do not charge additional contributions for additional non-earning household members (van Doorslaer et al. 1999: 296f).

residents, or through effective risk equalisation between several SHI funds, which has to compensate different incomes and health conditions as well as the relevant social determinants of health for equity and social justice.

2. **Upper ceilings reduce fairness of financing**: Practically all SHI schemes set upper contribution-assessment ceilings so that enrolees earning more than the respective threshold income do not have to pay more than the maximum contribution. The widespread application of upper ceilings implies a major constraint for SHI schemes and systems to contribute to proportionate universalism and pro-poor redistribution. Whereas SHI health financing is progressive up to the ceiling, it becomes increasingly regressive for household incomes above the ceiling. Hence the redistributive potential of SHI is usually under-utilised since high-income groups are generally exempted from paying contributions on their total available income. A typical argument is that otherwise very high-income earners would not be able to understand the insurance character of SHI if the contribution increased proportionally with their income.[31] However, this is only one possible explanation. The development of today's well-established SHI systems in rich countries tells another history: upper contribution ceilings date from the period when SHI schemes were (mainly) providing cash benefits such as sickness or maternity-leave pay designed in the same way as pension or unemployment benefit schemes, namely according to the principle of equivalence. Meanwhile the benefit package of SHI has fundamentally changed since nowadays healthcare benefits represent by far the largest share of benefits. The transition from cash benefits to healthcare services implied the shift from equivalence to solidarity except for the taxable income above the upper ceiling.

A critical hurdle for SHI to safeguard the equity of access and financing derives from the fact that it was initially designed for, and still applies best to, formal sector employees and workers. Due to key design features such as mainly automatic wage deduction according to the contribution rate, and shared contributions between employer and employee, empirical evidence shows that expanding SHI schemes to the informal economy is a major challenge. In the SHI pioneer country of Germany, as in other European states with SHI systems, which nowadays have a relatively small informal sector, it took up to 80 years from the set-up of the social-security system until coverage included the most difficult-to-enrol population groups, namely farmers, students and artists. Costa Rica needed 20 years for the universalisation of SHI coverage, while in the Republic of Korea it took just 12 years. In most Latin American countries, SHI coverage remained low and never expanded beyond 50 % of the population, since enrolling the informal sector turned out to be cumbersome and ultimately unachievable. Developing countries with a large informal economy such as Kenya, the Philippines and Tanzania are still far from achieving universal coverage via their national SHI schemes.

In addition, SHI schemes operating in developing countries tend to charge very low contributions and even refuse or fail to adapt them in line with the inflation rate or the overall growth of salaries and

[31] It is worth mentioning that in Switzerland the implementers of the first pillar of the mandatory pension insurance system were obviously not that much worried about this problem: all Swiss citizens have to contribute 8 % of the income to the pension scheme that provides a standard old-age pension for all, regardless of the individual contribution during active life. The Swiss system gives an example of a pension scheme based on the principle of solidarity and shows that upper ceilings are not as irremediable as economics textbook usually claim.

purchasing power. This often results in chronic under-funding of SHI schemes and is likely to set in motion a vicious circle of low scope and/or quality of the benefit package and little incentive to enrol and contribute according to one's ability to pay. With regard to redistribution and particularly proportionate universalism in health financing, this downward spiral has detrimental effects on risk sharing, fairness of financing and equity.

In predominantly Bismarck-style health-financing systems, the level and scope of redistribution and pro-poor effects as well as the potential of social health insurance to contribute to proportionate universalism depend ultimately on basic design features such as enrolment conditions, contribution arrangements, and the number and size of funds:

Enrolment: The more heterogeneous the socio-economic living and income conditions of the beneficiaries are, the larger is the redistribution potential within an SHI fund, and hence the closer SHI comes to proportional universalism. In order to be pro-poor, a health-insurance fund has to be open for low-income households and even for indigents. Due to the design of SHI, which is primarily made for the formally employed workforce, this requires specific efforts and additional funding. This has normally to be provided by public authorities from tax revenue because the other contributors' ability to pay is usually insufficient for the full cross-subsidisation of poor beneficiaries.

Contribution design: SHI contributions are historically set as a flat percentage share of (taxable) income. Some developing countries apply a simpler mechanism, charging flat contributions according to income brackets. While proportional contributions grow continuously with rising wage levels and the overall income situation, these sliding scales do not automatically adapt to the enrolees' purchasing power and require active political decisions for each increase. Insufficient contribution payments, which do not reflect everybody's ability to pay, reduce the redistribution and pro-poor effects of SHI. This is particularly true when payment according to income brackets represents a relatively higher burden on low than on high-income earners and make health financing regressive.

As mentioned above, practically all SHI schemes reduce the potential redistribution capacity of social insurance by implementing upper assessment ceilings. Social security contribution ceilings reduce the fairness of financing since they prevent high-income earners from contributing according to their ability to pay. Financing becomes increasingly regressive, the higher people's income is above the respective contribution assessment ceiling. Empirical evidence from OECD countries shows that specifically the ceilings in general use fundamentally reduce the pro-poor redistributive effect of SHI and invert the basically progressive resource generation for SHI into regressive financing (van Doorslaer 1999: 303). However, social health insurance has proven to be pro-poor in its redistributive effect in all SHI systems except in those countries that allow the exclusion or opting-out of high-income earners from statutory sickness funds in favour of PHI (ibid.).[32]

SHI fund size: According to the law of large numbers, the risk-pool size determines the financial viability and sustainability of an insurance fund: the larger a risk pool, the broader the distribution of the finan-

[32] This refers to Germany where the better-off can opt out of the public system, and the Netherlands where higher income groups are excluded from public SHI funds and have to enrol in private schemes. Nonetheless, the absolute value of redistribution for SHI was highest in these two countries and in France.

cial burden arising from losses or claims. Sharing risk is the core function of insurance and implies redistribution according to the insurance principle, namely from those pool members who are currently not affected to those who are currently suffering from insured losses.

In addition to the insurance principle, SHI operationalises the solidarity principle since everybody contributes according to ability to pay through wage- or income-related levies, and is entitled to a purely needs-based benefit package that is not dependent on what the individual has paid in. The principle of solidarity inherent to SHI ensures horizontal as well as vertical equity. However, redistribution and pro-poor effects are intrinsically restricted to a single health-insurance fund. Hence, proportional universalism is only achievable through a single-payer SHI system covering the whole population or effective financial risk adjustment between several SHI funds in a multiple-payer system.[33]

In summary, SHI has the potential to be equitable and operationalise proportional universalism provided that it covers practically the whole population. Due to its design features, SHI faces particular challenges to cover the informal sector and implies a certain risk to enhance inequity during the implementation phase and as long as coverage is restricted to selected population groups. Moreover, the typical implementation of upper income ceilings further reduces the redistributive potential of SHI.

3.2.3 Redistributive capacity of public health financing

In general terms, public mandatory health financing either through tax revenues or SHI contributions has the potential to redistribute resources from rich to poor households. This is basically due to the redistribution inherent in – at least partly - progressive tax systems and – at least within each risk pool – SHI contributions where lower income groups pay less in absolute terms than the better-off. This design feature makes a huge difference compared to private health insurance (PHI) as well as non-health branches of social security such as pension and unemployment benefit schemes. PHI operates according to the principle of equivalence; that is to say contributions depend either on the individual risk or the scope of benefits covered, or both. Likewise pension and unemployment schemes apply the principle of equivalence where contributions today are proportional to future benefits since old-age pensions and unemployment compensations depend on the level of income during active life and hence on the contributions paid as a certain percentage of the income.

In contrast to private health markets, public prepayment for health is related to income, wealth, property or purchasing power and not to individual risk or scope of benefits, and thus provides needs-based access to equal services.[34] Irrespective of the amount of taxes or contributions paid for healthcare, all beneficiaries are entitled to the same benefit package. If everybody pays for health coverage according

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[33] If several SHI funds exist for different population groups, redistribution and proportionate universalism are difficult to achieve because they require sufficient risk equalisation to balance potentially large differences between pools; this applies e. g. to the multiple-payer SHI system in Mexico (Laurell 2007: 523ff) and was one of the main reasons for the Republic of Korea to convert the multiple-payer into a single-payer system (Kwon 2003: 76f and 2008: 64). It has to be pointed out that even well-organised and regulated risk adjustment cannot prevent all inequities deriving from competition between health-insurance funds. Hence redistribution is partially reduced in competitive SHI markets, as shown in detail by Höppner et al. 2005.

[34] To make prepayment for health work in the informal sector, countries usually apply flat-rate payments, which tend to be regressive since they charge the same amount regardless of the income situation of the households. Exceptionally, differentiated flat rates are applied, as in the case of mutual health insurance in Rwanda, in order to align the financial burden with ability to pay. Cooperatives offer the opportunity to charge according the volume of sales or transactions instead of income or wages.

to his or her ability to pay and is entitled to the same scope of benefits whenever he or she needs them, the solidarity principle comes into operation. Redistributive effects in health protection beyond the mere insurance principle – namely from the better-off to the poorer members of society, from the economically active to the inactive, from younger people to the elderly and from singles and small families to larger families (if dependents are covered free of charge) – arise automatically from combining progressive resource generation with needs-driven allocation based on a unique benefit package (Holst 2012b: 87).

At least in theory, redistribution in health financing through progressive revenue generation is complemented by socio-economic health inequalities. Since the average health status is directly related to the socio-economic status, low-income households tend to have a higher need for health services compared to wealthier population groups. Provided that publicly financed health systems ensure equal access to healthcare according to need and regardless of ability to pay, the use of health services is inversely related to people's financial contribution. The fact that households contributing less in absolute terms tend to make use of more services than those who prepay higher amounts for healthcare has the potential to complement the redistribution of progressive resource generation and thereby reduce inequity in healthcare. In many low and middle-income countries, however, wealthy people tend to make use of more publicly financed health services than poor people (Castro-Leal et al. 1999: 55f; Makinen et al. 2000: 58ff; Filmer 2003: 1; Gwatkin et al. 2004: 1273ff); amongst other reasons this is attributable to the fact that the demand for healthcare by the poor is price-sensitive (Meessen et al. 2006: 2253).

However, in many developing and transition countries, publicly financed health services are scarce or even unavailable, of modest quality, or associated with long waiting times and bad behaviour. Quantitative and qualitative insufficiencies of public healthcare provision particularly in state-run systems are strong motivation even for poor people to use private facilities despite the high costs they entail. The inability of publicly financed healthcare providers to satisfy the demand of low-income households often reverses the redistribution due to the different needs of the different socio-economic groups.

According to economic theory, the possibility for wealthy people to opt out of the public system in favour of private health insurance and healthcare is expected to reduce the financial burden on public health financing (Pauly et al. 2006: 378) and the diversion of public revenue from the neediest to better-off socio-economic groups (Bennett & Gilson 2001: 10). Moreover, private health insurance is considered a mechanism that allows the demand of high-income groups on other forms of healthcare financing to be reduced, thereby freeing up more public resources for the poor. In practice, however, the second argument depends critically on whether any 'freed up' resources are actually used to support healthcare for the poor. And in order to make this happen, adequate regulations governing PHI and interactions with the rest of the healthcare system are indispensable (Bennett & Gilson 2001: 9f).

Instead, evidence shows that even in emerging countries such as Chile and South Africa where high-income citizens can enrol into PHI and access private providers (Castro-Leal et al. 1999: 51), higher socio-economic groups still benefit from public subsidies (e. g. Wang et al. 2010: 5ff), which reduces the pro-poor effect of public financing (cf. Dollar & Kraay 2002: 26). This applies particularly to tax-funded systems that tend to allocate a larger share of resources to more expensive specialised urban hospitals than to local primary healthcare (PHC) facilities (Castro-Leal et al.1999: 56; Chibuye 2010: 22).

If a tax-funded system for those working in the informal economy coexists with a social health insurance system for people employed in the formal sector, the equity effects depend largely on how well and fairly funded the tax-based system is, and whether it can deliver a similar package of benefits to the social health insurance system (cf. Bennett & Gilson 2001: 4). This has not been the case in Latin American countries, where formal-sector workers are often still covered under one or several SHI schemes whereas the Ministry of Health provides tax-funded services for people outside the formal sector and the poor (Londoño & Frenk 1997). In Thailand, a series of high-cost treatments are excluded from the Universal-Care-System (see 7.1), while they are covered by the SHI funds for public (CSMBS) and private sector (SSS) employees (Antos & Taylor 2007: 2f). The fact that tax-based benefit packages are usually more limited or of lower quality compared to SHI health services makes tiered health financing systems less equitable than those with a single risk pool, either a nationwide SHI scheme as in Costa Rica or a tax-based health system as in Brazil.

Altogether, public prepayment for health either through taxation or SHI contributions has the potential to implement overall progressivity, realise the principle of solidarity and ultimately achieve redistribution from better-off to poorer households. In a universal healthcare system with equal access to care, this redistributive effect is corroborated by socio-economic health inequalities since lower socio-economic status correlates with higher burdens of disease. In a series of countries in the Global South, however, the combination of scarce resources, low managerial capacity, planning and allocation deficits together with poor governance reduce efficiency and fairness.

3.2.4 Private health insurance

Private health markets are probably the most powerful globalising force promoting inequities in health, particularly if they are poorly regulated. Market-driven health-sector reforms and privatisation of health tend to convert health into a commodity and to induce commercialisation at the expense of universality, equity and social justice (cf. Chen & Berlinguer 2001: 40f). The core function of PHI as a means for protecting oneself against the costs of needed medical care is the spreading of health-related risks in order to prevent households from suffering health-related economic shocks and to share individual risks among several pool members. Societal objectives such as fairness of financing, social justice and ultimately universal coverage are beyond the scope of PHI.

Community-based health insurance (CBHI) has shown to be effective in mobilising resources for healthcare among the poor and spreading risks in order to ease the financial burden associated with the cost of illness. Community health financing indeed requires significant local capacity to implement, manage and monitor, and CBHI is usually not self-sustaining due to the small size of local pools and insufficient revenue to operate sustainable financing (Lundberg & Wang 2006: 63). Although micro health insurance schemes can cover even larger population groups, overall societal goals such as universality are not priorities in the design and implementation of CBHI.

Regarding horizontal inequalities, a comparative study of 12 industrialised countries shows that the redistributive effect of private insurance tends to vary across countries, but was negligible in most of them. In Switzerland and the United States of America, two countries with widely privatised and market-driven health-financing systems, the redistributive effects of PHI contributions was significantly pro-

rich, while in the two countries where higher-income groups can or must opt out of the public system – Germany and the Netherlands – the authors detected a measurable pro-poor effect, mostly due to horizontal equity effects (van Doorslaer et al. 1999: 303).[35] This result coincides with the general finding that commercial private health insurance is regressive when it plays a dominant or compulsory role. On the other hand, PHI can be progressive when it is supplementary to public systems (Odeyemi & Nixon 2013: 3). However, it has to be stressed that core design features of both commercial PHI – with risk-based contribution payment – and CBHI – based on flat-rate contributions – reduce the potential of private prepayment for health to operationalise vertical redistribution. Due to the regressive nature of risk-rated or "actuarially fair" contributions, commercial PHI rather adversely affects equity; frequently applied flat-rate co-payments and deductibles further enhance the level of inequity of PHI (ibid.: 6).

In developing countries, PHI is generally confined to high-income and politically influential groups, and it commonly captures significant government subsidies. In practice, political economy tends to prevent the regulations governing the private insurance market from ensuring that SHI is a 'pro-poor' financing mechanism. Given the substantial threats to equity posed by private insurance systems and the practical difficulty of establishing an effective regulatory framework for this industry, particularly in developing countries, commercial private insurance does not offer the potential to promote universal coverage and fair redistribution, does not provide an effective mechanism for developing pro-poor effects, and should thus not be encouraged as a means for equitable and sustainable health financing systems (Bennett & Gilson 2001: 20).

In a nutshell, private health insurance has low capacity to contribute both to universal coverage and fairness of financing or redistribution. Due to basic design features, PHI is intrinsically regressive and lacks the potential to develop redistribution effects.

[35] This is probably due to the fact that the level of contributions depends on the age of affiliation and is not directly linked to the individual health risk after enrolment; this design feature diminishes the effect of operationalising the principle of equivalence, commonly applied by PHI.

4 Financial governance in health

4.1 Good governance in health financing

4.1.1 Definition of good financial governance

Governance in health financing is closely related to the right to health, and to the entitlement to socially agreed health services.[36] It should be pointed out that good financial governance (GFG) is a means to an end and not an end in itself. Essentially three policy goals are connected to GFG:

1. Effective and efficient use of financial resources at the three levels of health financing, namely resource collection, risk pooling and allocation
2. Inclusion and equity or fairness of financing
3. Sustainability of resource generation, pooling and allocation.

Bad financial governance in the health sector has increasingly become the focus of attention in many countries, primarily as a means for preventing financial losses and reducing healthcare costs. Among a series of other specific areas such as fraudulent provision of sickness certificates, corruption and error by employees of healthcare organisations, by opticians concerning the provision of sight tests, fraud concerning services and supplies, long-term care, community based services, and others, foster and child care, losses due to bad financial governance have been particularly measured with regards to fraud (and error) concerning capitation payments to general practitioners; payments made to doctors to manage a patient's medical care; for in-patient hospital services; dental charges by patients; and prescription fraud by pharmacists and patients (cf. Gee & Button 2015: 5).

The effective, efficient and development-oriented use of public funds is vital for a functioning healthcare system. Yet, all too often health ministries and national insurance providers face key challenges in the management of public resources, which leads to suboptimal outcomes in service provision. These include, amongst others, poor planning and budgeting practices, weak procurement systems and limited over-sight mechanisms (cf. UNDP 2011: 37; Gee &Button 2015: 9f). As a result, loopholes for corruption are created and funds are not used in line with national policy.

Moreover, the GFG approach is systemic in nature. It includes all subsystems of public finance (e.g. revenue and expenditure management, audit and control institutions, fiscal decentralisation) and spans across all government entities. That is to say while Ministries of Finance are often in the driving seat when it comes to GFG reforms, other government institutions, including sector ministries and parastatal entities should not be disregarded. It is especially these spending agencies that need to be accountable and transparent in the use of public funds and allocate often-scarce resources in a development-oriented and sustainable manner, in line with national policy goals. Accountability towards the public is particularly underdeveloped where state actors are seriously underfunded (van Belle & Mayhew 2016: 12).

[36] Cf. Footnote 1.

Good Financial Governance (GFG)

Past experiences in public finance reform have shown that a mere technical approach to improving government finance does often not lead to sustainable changes. Instead, the normative and political-economy dimensions of public finance reform cannot be neglected.

- According to the German Development Cooperation's GFG approach, the normative dimension incorporates development-orientation in all public finance reforms and aims to reinforce good governance principles. These include poverty-orientation and sustainability, human rights, democracy and rule of law, results-orientation and transparency, as well as cooperative behaviour in a global system.
- The political-economy dimension addresses the often highly political nature of public finance reforms. Government finance is at the heart of policy implementation and the decisions to allocate more or less resources to certain sectors or programmes are often a contentious process, which produces winners and losers. Power struggles, institutional capacities and incentive mecha-nisms are important factors for any change management process and should be carefully considered especially in public finance reforms.

Source: GIZ 2013

The concept of health-financing governance refers to the way in which political actors and stakeholders within the health financing system and the civil society, by means of explicit processes and rules, interact to generate, pool and allocate resources for healthcare according to health demand and needs. All health-financing systems reflect a particular set of social and political agreements between the various actors such as government and civil service, providers, financial institutions, and users, but particularly between the state and society. Designing and carrying out strategies for health financing policies in a successful manner requires a broad consensus between all actors involved.

4.1.2 Public responsibility and the rule of law

Given that all reforms in the public finance area are already highly political and intervene in relevant power structures and the allocation of the resources within a society, health-financing reforms are extremely sensitive since they affect powerful stakeholders with very different and partly contrary interests. A development-oriented public finance system is characterised by an orientation towards essential governance principles, such as pro-poor and sustainable policy design, human rights, democracy and rule of law, state effectiveness and transparency (Klemp & Wagner 2009: 6).

The following section will briefly present relevant aspects of public finance management in the health sector and shed light on the role of various actors, in particular the sector ministries, their interests, incentives and powers in the budget process, as well as normative aspects shaping budgetary decisions. This part provides a general framework that allows for classification of the selected country experiences used to demonstrate relevant challenges for the sectors involved in the health financing system.

Due to the intrinsic difference of functions and interests, the communication and coordination between public-sector actors and, in particular, between the Ministry of Finance (MoF) and/or Planning (MoP) and the sector ministries are often poor. This is partly attributable to the perceived dominant role of the MoF in the budget process, and of the MoP in general political priority setting. Sector ministries might assert different priorities and argue that overarching political institutions are ignoring the sector strategies and needs. On the other hand, sector ministries and particularly the Ministry of Health (MoH) are often unable to present convincing arguments underpinning their budget and/or investment needs.[37]

Conflicts may also arise between different departments of public institutions and because of dual budgeting. Dual budgeting implies that there are two separate processes for preparing the capital (or development) budget and the recurrent expenditures. In countries with both a Ministry of Finance and a Planning Ministry, it may even be the case that the ministries issue their own budget circulars; the MoF being responsible for recurrent spending and the Planning Ministry for the capital budget. While capital and recurrent expenditures need to be clearly identified in the budget and thus presented separately, the budgeting process, for the sake of a better analysis of the overall government expenditures, should be integrated. Moreover, weak communication within the ministries, in particular between the administrative entities responsible for the budget preparation and execution and the technical divisions working on national policies, can hamper the provision of public services. Administrative tasks are indispensable at all levels of the healthcare sector, and spending on administration is not necessarily a bad thing; but simplifying administrative projects, strategies and burdens and a stronger focus on governance-induced instead of governance-related management might be promising to reduce administrative waste (OECD 2017: 260f).

As adequate resources are a core prerequisite for social health protection to be effective, good financial governance requires setting adequate conditions for collecting sufficient revenue; defining, implementing and controlling the rules of pooling; and allocating resources earmarked for health according to effective and transparent mechanisms setting the right incentives. Therefore, reliable and transparent sources of information on health financing governance are indispensable.

Evidence of the capacity of a health system to effectively mobilise and allocate resources, implement pooling and social health protection schemes, and distribute the financial burden of care equitably can be drawn from national health financing data and indicators (e. g. National Health Accounts (NHA), WHO, World Bank, and OECD databases, special studies and surveys). Public expenditure tracking surveys provide a comprehensive overview of public-sector spending and outcomes and help observe and control the flow of public funds from central government to lower-level authority units, and hence the reliability of financial de-centralisation. All these diagnostic studies are important governance tools in the health sector since they provide information on the public-private mix of goods and service provision, public expenditure priorities, the link between expenditure inputs and outcomes, and public sector institutional arrangements (WHO 2008: 3, 9).

[37] In many countries the Minister of Health is usually a physician who might be an excellent clinician but inexperienced in health policy, health economics and strategic planning.

Ultimately, the rule of law plays a crucial role in the strive for good financial governance in the healthcare system. Pro-poor health-financing systems require sustainable policy designs, human rights, democracy, rule of law and effective public policies (BMZ 2013: 10). Clear institutional standards and enforcement, accountability and responsibility based on checks and balances, as well as transparency through open and understandable rules, procedures, and information are essential conditions for good financial governance. Good governance and the rule of law, together with accountability and transparency, imply stable partnerships between state and society, converging incentives and strong institutions. Well-functioning political systems have established legal institutions,[38] which are capable to promote accountability by imposing horizontal checks on authorities and providing platforms for citizens' claims. The extent to which these institutions are accessible and effective fora for citizens to challenge the more powerful in society varies considerably from country to country, as a function of historical circumstances as well as the political calculus of elites (World Bank 2017: 93).

4.1.3 Transparency and responsiveness

As a precondition for good governance in health financing, the three essential branches of government - executive, legislative, and judicial - must provide regulatory tools and mechanisms that allow all institutions involved in health financing to understand their rights and obligations, protect their expenditures, and determine the rules (Bitrán & Urcullo 2008: 130f). Altogether good governance in the health-financing system requires a set of core conditions to be in place:[39]

1. Transparency of decisions made in the health (financing) sector;
2. Responsiveness of all stakeholders involved in healthcare financing;
3. Accountability in the generation, utilisation and evaluation of financial resources for health;
4. Responsibility of stakeholders for each and every decision they have a say in;
5. Broad consensus between all stakeholders involved (cf. Arredondo & Orozco 2008: 39).

In low-income countries with primarily tax-based health-financing systems, raising sufficient financial resources for healthcare usually implies increasing revenues through tax reforms. Reforming taxation is very much related to the political economy in a society and requires political commitment as well as administrative will (Wagstaff & Claeson 2004: 148). From the perspective of good financial governance, it is crucial to what extent the characteristics of a good tax system are fulfilled, i.e. one which mandatorily consists of a combination of the following principles (Waris 2007: 276):

1. Economic efficiency: the tax should allow for efficient allocation of resources;
2. Administrative simplicity: the tax should be easy and inexpensive to administer;

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[38] Including courts and associated agencies such as prosecutors and police, special-purpose oversight bodies, e. g. ombudsmen, auditors, anticorruption or human rights commissions, etc.) safeguarding the public administrative law functions of executive agencies such as those involved in property allocation and registration, the issuance of identity documents, or the provision of health, education, and sanitation services (World Bank 2017: 93).

[39] The British National Health Service (NHS) provides a useful example of how to operationalise good financial governance in the healthcare by sector defining the roles and responsibilities of the chief executive, controlling assurance statements, internal audit standards, accountability according to annual reports and accounts and in-year (see DoH 1998/2013).

3. Flexibility: the tax system should respond easily to changes in economic conditions;
4. Transparency: the tax burden should be easily ascertainable and politically tailored to what society considers desirable;
5. Fairness: the tax system should be fair in its treatment of different individuals.

For health financing systems based on SHI contributions the challenges are similar to those for taxation: designing and enforcing the suitable regulatory framework, implementing the right institutions as well as achieving transparency, accountability and financial governance. GFG requires SHI funds at first to attain their essential objectives, which are often prominently declared together with the vision and mission of a health-insurance scheme.[40] Fiduciary problems deriving from mismanagement, waste, fraud and corruption tend to expose all health financing mechanisms based on prepayment and pooling to (almost) the same level of risk, which depends much more on the general governance situation in a country than on theoretical and practical technical aspects. Management and financial control of both tax-based and contribution-based health-financing systems require adequate administrative, technical and human-resources capacities (cf. Musango et al. 2012: 4).

Beyond capacity building with regard to processes related to revenue collection, pooling and allocation, good financial governance requires well-regulated, capable and effective regulatory institutions and frameworks that allow them to develop, perform and cooperate according to their specific roles and tasks. Overall governance in a country can be broadly defined as the set of rules and institutions by which authority is exercised. In this regard, it is worth mentioning that African legislatures have, on average, less institutional capacity for financial scrutiny than their counterparts in high-income countries (CABRI & AfDB 2008: 14). As a matter of example, the case of the Central American country of Costa Rica depicts that separating the three core functions of health system – regulation, financing, and provision – and more specifically implementing a clear purchaser-provider split has become an essential recommendation for health system designs and reforms. However, for being effective the division of functions has to be accomplished by clearly defined and direct linkages between regulation, financing, and healthcare provision. If e. g. health service purchasing is assigned to an administrative division without any clear, direct link to the financial division, planning and purchasing processes lack an appropriate interrelationship to facilitate financial and budget scheduling, resource allocation, and adequate service provision (Cercone & Pacheco-Jiménez 2008: 213).

Last but not least it has to be stressed that (financial) governance must engage and particularly regulate both the public and private health sector if it is to be effective and achieve good standards. Financial governance in the health sector concerns the rules and institutions that shape policies, programmes, and activities related to providing funding in the equitable, transparent and sustainable manner that is required to achieve health and health-sector objectives. Evidence shows a positive relationship between governance indices and measures of health performance and outcomes (Lewis 2006: 9f).

[40] One can cite the Annual Report 2009 of the Philippine Health Insurance Corporation as an example since the report tends to be first and foremost statements of accounts, with 20 out of a total number of 37 net pages dedicated to merely financial data on cash flow, investments, returns etc. At the same time, data on membership enrolment, the characteristics of enrolees and beneficiaries, services delivery and benefits delivered to insurees are lacking.

4.1.4 Conclusions

The concept of good financial governance requires efficient use of resources, fairness and sustainability of health financing particularly in the public sector. Corruption and other fraudulent behaviour as well as other forms of avoidable waste of resources are challenging healthcare systems all over the world and lead to suboptimal outcomes in service provision. Good governance in health-financing refers to the effective application of explicit processes and rules in the health-financing system in order ensure that resource generation, pooling and allocation merely follow to health needs.

4.2 Reasons for low standards of financial governance[41]

4.2.1 Societal versus individual

Evidence from a number of countries suggests that vague and poorly understood policies, uneven record keeping due to poor capacity and failures to produce acceptable reports, and minimal use of such information contribute to poor management: GFG requires adequate management of resources, and management requires sufficient information and evidence. Therefore, data collection and documentation are indispensable. However, in many countries reporting and record keeping of medical, financial and other relevant data is particularly poor in the public service sector. Moreover, available data are often not fully explored and used for financial (and other) planning and decision-making; the lack of evidence-based strategies and policies negativly affects financial governance.

GFG is a systemic and structural rather than an individual behavioural problem of users and particularly of providers in the healthcare and health financing system: despite the above-mentioned potentially negative effect of selected players in key functions, the part played by individual behaviour is certainly much less important than general system features and overall societal conditions. Providers all over the world tend to maximise income or other benefits according to the rules of the game in place, but this is much more a systemic challenge than a question of individual misuse of funds or unethical behaviour. However, provider governance has not received sufficient attention in health-system research that it deserves (Saltman & Duran 2016: 733). There is certainly no perfect provider-payment system in place, but political decision makers are responsible for setting the regulatory framework and supervision right in order to achieve GFG.

In some countries, national centralism might entail an explicit weakening of good financial governance (GFG), since it can be limited by the low level of local capacity in setting and supervising legal frameworks as well as by the inability of the decentralised levels to play a part in national health-sector reforms (Arredondo & Orozco 2008: 45). Resource allocation to the different decentralised levels has to occur according to well-defined, clear and transparent criteria based on population data, regional and local conditions. It has to aim at a fair distribution of health financing, which might imply targeted investments in the public health provider infrastructure in the least attended regions in order to reduce existing inequities. In doing so, health expenditure has to follow empirically proven needs and clinical

[41] Cf. Lewis 2006: 34f and Gatti et al. 2002: 1080f.

protocols in accordance with technical evidence of how to optimise healthcare delivery (Ugá et al. 2012: 422).

4.2.2 Human resources

Governance in the health sector as a whole is often undermined by (perceived) low or irregular staff payment: in many developing and transition countries, civil servants and public-sector employees such as teachers, administration staff and health professionals are used to receiving rather low wages. Besides the high risk of brain drain towards the private sector and abroad, offering better income opportunities particularly for medical and nursery staff, poor and often irregular payment of the personnel has the potential to promote corruption and unethical behaviour.[42] Factors like unchecked decision-making power, lust of power, greed, susceptible financial arrangements within the health system, and definitely the general state of governance in a country tend to contribute to the level of corruption in a society, including "survival corruption" where salaries of health workers are insufficient for covering basic needs (Gaitonde et al. 2016: 6). From the perspective of GFG, the level of corruption in a country's healthcare system matters a lot. Moreover, it is extremely important to assess the extent to which corruptive behaviour is socially accepted, which legal restrictions are in place for preventing or fighting corruption, and last but not least which positive incentives have the potential to reduce corruption.

Health professionals should be accountable to regulatory bodies, but the enforcement of standards as well as sanctions for deviation from standards are sometimes limited or non-existent due to limited financial and human resources. Furthermore, regulatory agencies might be based and influenced by those they are charged with regulating. Finally, in the health sector the distinction between corruption and inefficiency is often difficult to discern due to poor management and administration (UNDP 2011: 12f). Recent research estimates waste in the healthcare sector of industrialised countries and some countries in transition at approximately 20 % of overall expenditure on health (OECD 2017: 19ff).[43]

Typically, the overall management of health systems, hospitals and clinics too often falls to physicians, few of whom have the training or experience necessary to effectively carry out their jobs (Lewis 2006: 34): physicians might be good and even excellent clinicians, but except for some naturally talented cases or after special training they are usually not sufficiently prepared for administrative and management tasks. Moreover, clinicians usually prioritise treatment of individual patients rather than the broad

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42 The following key dimensions can be identified as relevant definitions of corruption.

- The person who abuses power may directly commit the abuse or may be complicit in its abuse.
- It can be by people who are either in private or public positions of power.
- A position of power or authority may be either entrusted by the formal systems of governance or by social/cultural systems.
- The abuse may be for the benefit of oneself, a group, an organisation, a party, or others close to those who abuse their power.
- Benefits can be financial, material or non-material (such as furtherance of political or professional ambition).
- The abuse violates the rights of other individuals or groups (Gaitonde et al. 2016: 6).

43 A considerable array of different factors contribute to wasteful health spending, such as ineffective and inappropriate delivery of care, oversupply of health services, excessive prices, inadequate supply causing avoidable adverse events, and ineffective administration among others (OECD 2017: 21ff).

public-health picture. Professional socialisation and experience of clinical staff might put at risk rational allocation of funds and efficiency, and hence hamper GFG in health.

A lack of bottom-up accountability along with weak community oversight tend to negatively affect governance and support corruptive behaviour in playing a larger role in health financing and overall health systems management: omnipresent conducive factors for corruption and misuse of resources earmarked for health cannot be neutralised by regulation, supervision and penalisation alone. It is at least as important to promote and strengthen inhibitive factors at system level and beyond to effectively reduce corruptive practices. That is why the participation of users and civil society is key for implementing accountability in the health-financing system (cf. Gatti et al. 2002: 1080f). Strengthening community participation and oversight has the potential to make corruption and misuse more difficult to engage in and more risky for the reputation of stakeholders in the healthcare system.

4.2.3 The relevance of transparency

Moreover, there is evidence of pressure being brought to bear on public officials by an active and open media – particularly radio and print media, but also television and increasingly new social media – and a citizenry who are actively engaged with the media (Betley et al. 2012: 22, 57). Independent media, together with civil society organisations, can play an important role when powerful industries or other vested interests attempt to weaken legislation, to subvert the will of parliament, or to bribe public officials who are in charge for enforcing legislation and rules (WHO 2017: 74). GFG will ultimately be very difficult to achieve without transparency and informed participation; however, participation requires adequate power balances in order to be effective.[44] A promising key driver of change is the strengthening of bottom-up initiatives and promotion of political pressure from below, through organised demands for reforms and improvements from citizens. Informing people about their rights and assisting them in learning how to organise and articulate their demand for change, transparency and participation is an inalienable approach towards GFG (cf. Sundet & Moen 2009: 25f).

A core condition for good financial governance in the healthcare sector is accountability in revenue collection, pooling and resource allocation. Relevant measures for achieving accountability include (i) management, oversight, and evaluation of performance and impact, (ii) the capacity to audit, (iii) the authority to discipline, transfer and terminate employees who engage in abuses as well as to reward performance; and (iv) transparency on the performance of public services (Lewis 2006: 35).

[44] It should be mentioned, however, that community participation is subject to some risks of being smartly utilised or even misused by powerful stakeholders. This can be often observed in the strategy of pharmaceutical companies to set up alliances with patient organisations in order to promote the demand for new drugs (see e. g. Herxheimer 2003: 1209f). In Latin American countries, manufacturers tend to support civil-society organisations in their claim for the right to health, which is often interpreted as the right to all available medical treatments (see e. g. Reveiz et al. 2013).

Table 2 Weaknesses in governance

Weakness	Regions		
	A	B	C
Limited knowledge of legal framework and its scopes	++	++	+
Limeted scopes of the reform	++	+	–
Federal centralism	+++	+++	+
Efficiency problems for producing health services	++	++	+
Lack of mechanisms to monitor the use of resources	++	++	+
Lack of intergovernmental coordination	++	++	+
Political electoral corporatism	+++	+++	+
Social participation limited to official programmes	+	+	+
Limited planning	+	+	–
Lack of opportunities for participation in programmes design and decision-making	++	++	+

High = +++, Medium = ++, Low = +, Nil = –.

Source: Arredondo & Orozco 2008: 46
Regions according to socio-economic development: A low, B medium and C high.

The impact of under-the-table payments is relevant for assessing the level of (financial) governance in the healthcare sector. Informal payments disproportionately affect the poorest and prevent them from having access to health services. Moreover, under-the-table payments run the risk of undermining official payment mechanisms and promoting unethical behaviour amongst health workers (cf. Holst et al. 2016: 222). Health systems with a high level of informal payments are characterised by low salaries, a marked absence of accountability and government oversight, and limited transparency (WHO 2008: 9).

A common approach for improving financial governance focuses on strengthening the demand side under the lemma that money has to follow patients in order to tie health professionals' time to specific patients. In fact, abundant evidence shows that paying public providers whether they see (or are assigned) patients or not, and compensating under and over-performance equally is both unfair and unlikely to build the trust needed in a health system (Lewis 2006: 36). Against this background, strengthening the demand side derived from economic theory, is assumed to improve healthcare provision according to people's expressed needs and priorities and is increasingly being applied in healthcare financing all over the world. However, it has to be stressed that this is but one approach for making healthcare services more effective and patient-oriented; and it is certainly unable to overcome general conditions such as information asymmetries, provider-driven steering effects and limited consumer capacities of ill persons. Also, policies aimed at strengthening the demand-side by means of the respective financial incentives definitely require the capacity to effectively supervise along with a functioning public financial management system in order to prevent undesired effects from happening (cf. Gaitonde et al. 2016: 17).

4.2.4 Provider payment matters

In more general terms, there is a mutual interdependency between financial governance and provider payment. On the one hand, a certain level of governance is indispensable for implementing the "right" payment system, and on the other hand, the way in which providers are remunerated determines to a large extent the possibilities of achieving good financial governance indicators. It has to be pointed out that health-sector performance, financial fairness and equity depend to a much larger extent on supply-side incentives or disincentives than on financial or other measures targeting the demand side (e. g. Rice & Labelle 1989). Providers use to respond to the incentives that the various types of healthcare funding may generate, and clearly the respective financial incentives influence the overall governance framework for these provider organisations (Saltman & Duran 2015: 34).

Governance weaknesses in state-run health systems are often related to the lack of coordination between different government levels and particularly between central, regional and local levels. In this area, channels to promote participation in financing and decisions related to budgetary resources tend to be limited. Politicising mainly public health resources and expenditures threatens good financial governance. Political corporatism, patronage or favouritism for political parties' interests in the use of social programmes are among the most relevant causes for weak financial governance. This weakness is commonly linked to limited opportunities for promoting a greater social participation in health-policy and strategic decision-making (Arredondo & Orozco 2008: 45).

With regard to the purely technical level, the participation of civil-society representatives in decision-making procedures on key health-financing issues such as targeting and allocation of resources, the scope of the benefit package or the introduction of additional services, and provider-payment mechanisms, might be of limited use (e. g. Evans et al. 2012: 68). However, active involvement of consumer organisations and independent individuals or communities has the potential to enhance transparency by voicing through the mass media their concerns about inappropriate decisions, as well as to reduce the risk of unofficial agreements between official stakeholders (ibid.).[45]

4.2.5 Conclusions

A variety of conditions at different levels interfere with good financial governance in the healthcare sector. Different from the predominant perception, governance in health financing is much more a systemic and structural challenge than an individual behavioural problem of users or providers. Beyond transparency, accountability, informed participation and strengthening the demand side, provider payment is crucial for good financial governance.

[45] Finding corroborated by the oral communication of a regular representative of patient organisations at the Shared Joint Commission (gBA) in Germany, where essential decisions on the SHI benefit package are taken by a mixed committee of purchasers and providers chaired by one independent person and shared with representatives of consumer organisations without vote.

4.3 Pro-poor effects in healthcare financing and provision

As already discussed in Chapter 3 on the distributive effects of health financing, budget allocations have an often-undervalued impact on redistribution and particularly on proportional universalism and pro-poor effects of health financing. Public health-financing systems tend to allocate a relevant share of resources to inpatient or specialised care provided at more expensive urban healthcare facilities, while local health centres and practices providing PHC are commonly under-financed, under-staffed and under-equipped. Despite long-lasting efforts to strengthen primary healthcare (PHC) and the respective health expenditure, most countries all over the world tend to spend disproportionately on secondary and even tertiary care facilities at the expense of less expensive, but also less profitable primary care. Although quantitative and qualitative limitations in public PHC provision force even the poor to use higher-level facilities, better-off population groups tend to benefit more from urban and better-equipped public hospitals. In contrast, strong prioritisation and more substantial financing of PHC would in themselves improve the targeting of spending to the poor, since the poorest quintiles use primary facilities in good measure and low-income patients commonly use more local than distant healthcare providers. Hence, implementing PHC strategies according to international policies that have been officially pursued since the adoption of the Declaration of Alma Ata as early as in 1978 but are mostly underrated in practical policy, is ultimately also a strategy for achieving good financial governance in health.

Most developing and transition countries have since long aspired to implement high-standard health services as defined by leading medical experts and to spread them to the whole population. Even in very poor countries the health-policy debate was often dominated by the eagerness of national elites to copy "modern" medicine from the Western world (cf. Gush 1979: 205f). International organisations have often supported medical schools in Africa, Asia and to a lesser extent Latin America to adopt the teaching and research approach of the industrialised world (ibid. 207). Likewise, WHO imposed a number of vertical programmes to defeat selected health problems, and bilateral donors often acted not only as development organisations in the interest of recipient countries but at the same time as brokers or promoters of export industries in their home countries. Finally, the increasing marketisation of the healthcare sector further boosted the global trend towards medicalisation and under-utilisation of PHC. Revoking this international drift in order to ensure good financial governance in the allocation of health resources is a major challenge since the political economy commonly runs counter to efforts to strengthen PHC. Resistance of healthcare and particularly medical professionals and – to a lesser extent – sections of the administration hamper and often impede a major redistribution of resources and staffing towards PHC facilities in rural areas (cf. e. g. Hughes & Leethongdee 2007: 1006). PHC-relevant earmarked donor funding for vaccination programmes and reproductive health have the potential to overcome the preferential treatment of specialised and even tertiary care in national health policies; however, developing countries do not always allocate resources towards programmes that yield the greatest health benefits. At the same time, a multiplicity of earmarked funds is another challenge for national decision-makers. Earmarking can distort local resource allocation and lead governments to accept interventions, which they cannot afford in a sustainable manner (Waddington 2004: 704f). When donors withdraw their support of PHC, many countries will be unable to reduce resources committed to the hospital sector in order to compensate for the missing donor funding (Farag et al. 2009: 1052).

Available research suggests that in selected Latin American countries inequity could be reduced by increasing the available national funding allocated to reduce the gap between rich and poor rather than through a redistribution of resources from the rich to the poor. Therefore, certain conditions and specific policy mechanisms are required so as to improve the equity of resource allocation through decentralisation. Colombia transferred funds and responsibilities to the decentralised levels according to an adjustment mechanism applying population-based formulae to assign resources from several central sources to each department and municipality. Fiscal decentralisation of the Chilean healthcare sector started in the early 1980s when municipalities became responsible for PHC facilities. Therefore, the country implemented intergovernmental transfers specifically assigned to PHC, and directly allocated to the municipalities based on a per-capita formula adjusted for rurality and the municipal poverty level. In addition, municipalities could assign their own local municipal revenues to social and civic services including health. A horizontal equity fund for municipalities complemented the fiscal decentralisation mechanisms by redistributing local funds from wealthier to poorer municipalities according to a per-capita formula (Bossert et al. 2003: 96). It is particularly worth mentioning that additional financial contributions from richer municipalities allocated to poorer communities are helpful for achieving more equitable financing (ibid.: 98f). Moreover, weighed resource allocation and adequate equalisation mechanisms are indispensable to the achievement of pro-poor redistribution and equity (e. g. Holst 2012b: 91ff).

Health Equity Funds: Demand-side financing mechanism to promote access to priority public health services for the poor in an environment where access to healthcare depends on user charges. Identification of beneficiaries occurs according to predefined eligibility criteria and can be done either in the community before healthcare demand (pre-identification) or at the health facilities by means of interviews (post-identification). At the health facility, the eligible poor patients get full or partial support from equity funds for the cost of user fees, transport and other expenses during hospitalisation. The fund management is usually entrusted to a third party, often a local NGO (Ir et al. 2010: Add. file 1).

Health equity funds are intrinsically implemented to be pro-poor; hence, they are geared up to improve the access of low-income groups to quality health services. They are a means for transferring public (or ODA) resources to healthcare delivery for the eligible poor. Hence they imply redistribution in favour of the income poor but do not necessarily contribute to achieving proportionate universalism. Moreover, as they are funded from fiscal resources, they tend to be rather regressive in many low-income countries and reduce the overall fairness of financing.

Vouchers: Demand-side instrument expected to improve the quality of health-care services by addressing the under-utilisation of essential services, improving the targeting of public subsidies to the needy, empowering consumers by offering a choice of providers, and promoting provider competition and responsiveness (Schmidt et al. 2009: 100). Some evidence exists that vouchers increase utilisation, improve quality and effectively target specific populations; however, there is insufficient evidence to determine whether vouchers deliver healthcare efficiently; and evidence of a positive impact of vouchers on health outcomes is lacking (Meyer-Brody et al. 2013: 370ff). Hence, it is still a preliminary requirement to determine the extent to which vouchers fulfil the expectations associated with the implementation of demand-side financing.

With regard to progressivity and redistribution, vouchers have only limited potential. They seem to be an effective means of demand-side financing to target the poorest and to enhance their demand for health services. As long as higher relative financial contributions of the better-off are ensured to raise revenue for vouchers, they fulfil the criteria of progressivity; if they are funded from fiscal resources they tend to make health financing rather regressive, except for those countries where the tax system is sufficiently progressive. Redistribution depends mainly on allocation according to financial and health needs, and occurs either from rich to poor countries if vouchers are paid for from ODA money, or from the better- off to the lowest socio-economic population groups if they are financed from domestic resources.

5 Country cases

5.1 Thailand

Thailand has considerable experience in financing healthcare for the poor. The first pro-poor health-financing scheme covered approximately one-fifth of the total population and had since expanded to one-third of the Thai population. The Asian economic crisis in 1997 triggered reforms to make the pro-poor health-financing scheme more efficient. Out of those efforts came new provider payment methods and a new way of managing public hospitals on a pilot basis. When a new government was elected in 2001, one of its major public policy initiatives was universal health coverage. The following year, a comprehensive universal healthcare plan was implemented nationwide, based on experience gained from the pilot project. At that time, the Universal Coverage Scheme (UCS) replaced all previous pro-poor health financing schemes.

The UCS scheme has substantially improved the progressivity and equity of health financing in Thailand, providing more resources to low-income persons and promoting their access to health services, thus providing even coverage for a number of costly health problems. Hence, the expansion of insurance coverage brought about by the implementation of the UCS scheme has made government subsidies for healthcare more pro-poor within an overall context of proportionate universalism. About half of the UCS beneficiaries are in the lowest two income quintiles living primarily in rural areas and relying on district health services. About half of the beneficiaries in the formal-sector Civil Service Medical Benefit Scheme (CSMBS) and Social Security Scheme (SSS) are in the highest income quintile, concentrated in urban areas and more likely to use higher-level health facilities. The share of lowest-income quintile households facing health expenditures above 10 per cent of their income dropped from 4 % to 0.9 % in 2006. The decrease in catastrophic health expenditures since the implementation of UCS scheme can be seen as a proxy for improved redistribution (Antos & Taylor 2007: 6).

Apart from the official bodies, the National Health Security Office (NHSO) also supports and strengthens the participation of networks of civil society, professional groups and local governments in health-policy decisions. It has introduced local governments into the decision-making process by setting up Provincial Health Security Boards in 2004. It was expected that these third-party representatives would influence the provision of information, the targeting of resources and the introduction of services that respond to local health problems. The provincial boards injected more transparency into decision-making and resource allocation, following the rules and being responsive to health needs. Limited knowledge of and experience in UCS management of the third-party representatives meant that decision-making was often left to the representatives of the providers, who were mostly ministry staff (Evans et al. 2012: 68f). However, stakeholder participation under the UCS was assessed to be structurally and procedurally sound. Decision-making of the central as well as the regional and provincial governing bodies in the Thai healthcare system tends to be consensus-oriented and follows the rule of law (ibid.).

Strategic purchasing and scheme harmonisation were used as tracers to assess the power structures and interactions among policy actors, conflicts of interest and influences over policy decisions (ibid.: 67). With regard to resource allocation for healthcare provision, Thailand started to introduce capitation

payment in order to reduce the historical geographic inequalities in spending patterns between mainly urban and rural areas. Additional income resulting from "money following the patients" empowered primary care units and rural hospitals to recruit more staff in proportion with local populations while forcing "capitation-losing" urban hospitals to reduce staff (Hughes & Leethongdee 2007: 1004).

5.2 Brazil

The post-dictatorship Constitution from 1988 marked a significant change in the provision of social policy by making the state responsible for poverty reduction and the creation of a fairer and more equitable society. It is particularly worth mentioning that the largest country in South America adopted a new Constitution that laid a legal foundation for the state to provide health services (as well as education and social assistance services) as a basic right of all citizens (Senado do Brasil 2010: Cap. II Art. 6), while practically all other countries in the region and elsewhere followed the neoclassical shift towards marketisation and privatisation of social services (Laurell 2000: 312ff).

The Constitution of 1988 changed the role of the state, the structure of its political organisation and instituted the civil, political and social citizenship rights of a welfare state. Since then the state has implemented the basic principles of the Brazilian health movement, which are highly relevant for sector governance: establishing a healthcare network infrastructure; decentralisation of competencies, skills, programme management, and particularly of resources; setting up participative boards with decision-making power; and encouragement and establishment of social participation in healthcare services (Giovanella et al. 2012: 344f).

For adequately managing policy issues related to decentralisation, Brazil broadened the framework conditions for government decision-making, strengthened social participation and alliance-building between stakeholders, and institutionalised the participation of civil society organisations in decision taking on social policy (Moreira & Escorel 2009: 235ff). In addition to the existing national health conferences, health councils and committees were set up at both the state and federal levels (Miranda 2007: 189ff). This institutional structure allows for bipartite (federal states and municipalities) and tripartite (federal, state and municipal levels) decisions to be taken by consensus – a major step towards improving governance in the Brazilian healthcare system by defining areas of institutional responsibility and enabling stakeholders to participate in decision-making (Labra 2002: 51ff; Paim et al. 2011: 1768). The municipal *Comitês de Saúde* provide further evidence of Brazil's ongoing drive towards improving transparency and participatory governance for health (cf. Gómez & Atun 2012: 9).

SUS resource management starts with a planning process in which municipal and state health secretariats and units assess the main epidemiological challenges, analyse the effectiveness of previous government interventions, and prioritise future actions in order to improve the health situation. Informational and analytical bases of the existing planning tools in SUS, however, are precarious and conducted primarily in order to comply with the legal requirement rather than as a policy implementation tool (World Bank 2007: 13). Departing from the basic principles of SUS, health councils in most municipalities have limited influence on the definition of priorities and allocation of resources (ibid.: 15). Likewise, budget execution is also inconsistent and varies significantly between different health secretariats and even more between municipalities. Brazil's public health sector exhibits a certain level of arbitrariness in

budget preparation, inadequacy of allocated budgets to really meet planned activities, and inefficiencies in the budget execution process (ibid.: 22). Despite all success stories regarding universal coverage and integrality, the SUS still offers much room for strengthening accountability through management commitments or contracts geared towards better synchronising and aligning the processes of planning, budgeting and management in order to improve performance (ibid.: 71f).

These conditions aggravate the overarching GFG challenge of allocating sufficient public revenue to the health sector. The general lack of satisfaction with the SUS that recently erupted in countrywide protests is partly due to inadequate public funding of the healthcare system. In 2011, general government expenditure on health represented not more than 45.7 % of total health expenditure. Hence, public expenditure on health accounts just for 3.7 % of GDP, positioning Brazil last in the ranking of countries that have achieved universal population coverage, including Chile and Mexico (WHO 2013b).[46]

5.3 Mexico

The Mexican strategy for achieving universal coverage by setting up an additional SHI fund for informal workers and marginalised groups follows the tiered-system approach and maintains basic equity problems. The combination of income-related contributions with relevant subsidies shared between the federal government and the states does not provide the newly created *Seguro Popular* (SP - People's Insurance) with sufficient financial resources to make the same benefit package available for SP beneficiaries as exists for beneficiaries in the different formal-sector SHI schemes (Laurell 2007: 523f).

With regard to financial governance, the shared financial responsibility of the central government and the federal states is important to analyse. Although the law defines in theory the respective responsibilities, different incentives for the public stakeholders involved might hamper the effectiveness and transparency of revenue collection. Empirical evidence showed that it is a major challenge to reduce the dependence of political actors. Decentralisation might generate difficulties by causing a lack of continuity in the new financing policies due to changes that exert pressure on the government at central level (Arredondo & Orozco 2006: 156). The Mexican health system reform has not modified dependence on the central level; there is still uncertainty about reform strategies and a lack of participation in the search for financial resources to finance health systems.

Moreover, decentralisation can pull the best financial and human resources invested locally towards the central level, and thereby generate confusion at the different government levels (Arredondo & Orozco 2006: 156). As long as the federal level defines goals and priorities in the healthcare sector, operative personnel perceives that, in spite of decentralisation, there is still dependence on the national central level, and there is confusion regarding the flow of authority and power in decision-making (Arredondo & Orozco 2006: 156).

There was also evidence suggesting some training in the management of financial resources after decentralisation, as well as mobilisation of new financial resources that were not being collected before, enabling a greater flow of resources with a more locally oriented management of decisions on resource

[46] Countries with well-established social-protection systems in place spend a minimum of 65 % (Switzerland) and up to about 90 % of THE out of general government or public revenue (WHO 2013b).

allocation for local health programmes. Also, a greater participation of users, suppliers, and municipal and state governments has been promoted to establish priority health needs (Arredondo & Orozco 2006: 156). The application of specific norms for the management of resources led to a greater acceptance of direct contributions in the community (Arredondo & Orozco 2006: 155).

5.4 Ghana

The West-African country initially had a National Health Service and started to set up voluntary mutual health insurance (MHO) in the early 1990s in order to bridge the gap in social protection between people covered by formal schemes and those lacking any protection from healthcare expenditures and suffering from impoverishment due to bad health. The MHO expanded slowly in the 1990s and spread across the whole country in the early 2000s. The 2003 health-sector reform implemented nationwide mandatory health insurance in Ghana.

General tax revenue is generated from personal income tax (11 %), company tax (15.4 %), VAT (25.4 %), petroleum tax (18.3 %), import tax (16.5 %), earmarked tax for national health insurance (5.1 %) and a range of other taxes accounting for 8 %. Personal income tax is structured progressively with low-income earners being exempt and the marginal tax rate ranging from 5 % for the lowest income taxpayers to 28 % for the highest income taxpayers. Together with company tax, and despite the relatively low level of the top income tax rate, personal income tax, national health insurance tax and most excises are highly progressive (Younger et al. 2017: 18) and thus promising to be pro-poor; however their share is only slightly higher than the VAT share. VAT is charged at 15 % (10 % for general government revenue, 2.5 % as an earmarked tax for education and 2.5 % as an earmarked tax for health insurance). General government revenue collection from VAT is generally regressive but was found to be progressive in Ghana in relation to the financial burden of households and taking into account the share earmarked for social services (Akazili et al. 2012: i16). More specifically, the VAT and import duties as main indirect taxes are distributionally neutral, while the cocoa duty is regressive (Younger et al. 2017: 18).

Another important tax found to be progressive is import duty (approx. 17 % of total tax revenue in the 2005/2006 fiscal year). Not surprisingly, personal income tax is clearly progressive whereas the burden of corporate tax falls mainly on the rich. Fuel levy, however, is regressive (ibid.). Despite the relatively high level of progressivity of health financing in Ghana, the distribution of total benefits from using healthcare is ultimately pro-rich in both the public and private sectors, but particularly in the private sector. The richest quintile gained almost double (24 %) the benefits gained by the poorest (13 %); and the two richest quintiles accounted for almost half of total health benefits, whilst the two poorest quintiles gained less than 30 % of total public and private healthcare benefits (Akazili et al. 2012: i16). While inpatient care received at public sector district-level hospitals tends to be pro-poor, benefits of primary-level healthcare services are relatively evenly distributed (ibid. i16f). Outpatient care in Ghana is not more progressive than inpatient care; alongside with spending on education, health expenditures are the main budgetary means for reducing poverty, simply as it has a large budget and not due to good targeting (Younger et al. 2017: 9). It is worth mentioning that in-kind benefits from health (and education) services are essential in Ghana's strive for poverty reduction; otherwise the net effect of the fiscal budget would be to increase poverty (ibid.: 18).

With regard to good (public) financial governance, Ghana has experienced significantly improved external oversight particularly by resolving the backlog of audits, introducing open Public Accounts Committee hearings on audit reports, and achieving the timely submission of central government audit reports to Parliament (Hsiao & Shaw 2007: 10). Furthermore, Ghana provides evidence of the important role that the media can play in public financial management. A variety of processes such as public forums, open parliamentary debates, independent media assuming their scrutinizing responsibility, and public reporting of government actions can hereby help ensure transparency in the healthcare sector and improve governance in health financing (WHO 2017: 75). An active and open media together with an actively engaged citizenry have the potential and often the power to put pressure on public-sector officials so that they in turn feel a stronger sense of accountability. Although this pressure is necessary in many cases, it still might not be sufficient to ensure that actions such as investigation or further consequences are taken. One example is the greater attention placed on the Public Accounts Committee with regard to the reviews of external audit reports by broadcasting and televising its hearings. However, the Ghanaian experience also shows that the capacity of the public to hold officials to account is undermined by the lack of timely financial information available to the public, the poor comprehensibility of key budget documents, and limited expertise on budgetary and financial matters on the part of some officials, civil society, and the general public (Betley et al. 2012: 69).

5.5 Tanzania

Revenue collection is relatively effective in Tanzania, although there are general concerns about tax fraud, and failure to prevent this is likely to have negative equity effects. General tax revenue is generated from international trade/import and export duties (45 % of total tax revenue); VAT (16 %); personal income tax (14 %); company tax (10 %); and a range of other taxes and levies (excise duties, other domestic taxes and charges, other income tax – combined accounting for 15 %). Personal income tax is structured progressively, with zero tax payable by low-income earners earning less than 960,000 Tanzanian shillings (almost EUR400) per year. The marginal tax rate ranges from 18.5 % for the lowest-income taxpayers to 30 % for the highest-income tax payers. Company tax is charged at a flat rate of 30 % of company profits (McIntyre et al. 2008, Annex: C).

Progressive direct taxation alone certainly has a pro-poor redistributive effect since households with higher taxable incomes pay more taxes as a share of their income than poorer households. However, most of Tanzania's tax revenue comes from VAT, which accounts for 43 %, followed by personal income tax and excise duties. VAT is charged at 20 %, but a number of items are exempt from VAT so that the overall effect of VAT is close to proportional. Among the consumption taxes for health-relevant goods, taxes on alcohol are very progressive, while taxes on cigarettes are regressive. Taxation of soft drinks is more progressive than average for consumption (Straehler-Pohl 2013: 23).

Governance is of specific relevance, as the decision on how to allocate funds is a governance decision. However, financial governance in the health sector is but one approach for improving responsiveness, often related to planning and budgeting processes. Attention to various other governance issues is required since the influence of health financing alone is rather limited, although provider payment offers some options for creating financial incentives for better governance.

Many African countries, including Tanzania, are facing relevant challenges in achieving good financial governance due to crippling debt burdens, low credibility of enacted budgets, poor links between policy priorities and inputs actually funded from public resources, and the high costs of wastage and corruption (cf. CABRI & ABfD 2008: 19f).

As in many other developing countries, the Tanzanian health sector depends to a relevant extent on external funding.[47] Significant donor involvement and funding endanger national ownership and political responsibility. Likewise, relevant off-budget funds in the health sector compromise effective planning and tend to further obscure funding needs (cf. GIZ 2013: 35f; see also CABRI & ABfD 2008: 23f). Moreover, managing external and particularly off-budget funds challenges the capacity of governments to provide adequate leadership and to ensure GFG. Effective management of foreign aid flows requires recipient governments to be capable of maintaining government institutions and putting in place policies to actively coordinate and manage donor activities; in addition, adequate information flows have to exist that allow governments to integrate external resources at different stages of the budget process and to ensure fundamental budgeting principles such as comprehensiveness, transparency and accountability (ibid.: 26).

5.6 Philippines

The Philippines started to set up health insurance in the late 1960s with the implementation of Medicare, modelled according to the U.S. health financing system. The shift towards universal coverage was made by implementing the Philippine Health Insurance Corporation (PhilHealth) in 1995 as a social health protection scheme for public and private sector employees. Contributions are shared between employer and employee, and defined as a fixed amount with reference to income brackets. Hence, PhilHealth contributions are in principle progressive but regressive within the brackets. Moreover, the amounts are lagging behind the development of wages and purchasing power and even inflation.

This is one of the reasons why PhilHealth contribution-revenue accounts for less than one-third of overall assets (PhilHealth 2012: 15f) and the fund has been extremely cautious about expanding to uncovered informal sector workers and extending the benefit package. The largest share of the considerable financial resources and assets accumulated by PhilHealth – in 2011 total assets added up to slightly more than 2 billion euros – referred to real estate, capital and other investment returns, while PhilHealth spent about 630 million euros on health benefits (ibid.). For many years PhilHealth maintained the corporate philosophy of its precursor, Medicare, and operated ultimately as a public financial corporation and only to a lesser extent as public-sector health-insurance provider.

Despite the financial success of PhilHealth the strategies for expanding SHP to informal-sector workers have shown little impact. Political and corporate decision-makers were reluctant to put institutional profitability at risk by including uncovered population groups or covering additional health services. Negative effects of the prevailing profit approach were aggravated by the omnipresence of patronage and the trend for political leaders to utilise PhilHealth during election campaigns.

[47] In 2011, 41, % of the total expenditure on health in Tanzania came from external resources (WHO 2013b).

The Philippine experience depicts that good governance in health financing has to go beyond assessing design features, transparency and accountability. Even if management and accounting might be correct and transparent, GFG has to analyse whether resources generated and earmarked for healthcare are really used for the purpose they are collected for. Self-evaluation and priority-setting have to reflect the core tasks of health-financing institutions such as social health insurance funds and others.

5.7 Kenya

Just three years after independence, Kenya started to set up a national health-insurance fund for the purpose of overcoming the constraints of the inherited national health system. The National Hospital Insurance Fund (NHIF) was implemented to cover inpatient care only, and today it still mainly benefits formal-sector workers. Contributions are shared between employers and employees and defined as flat-rates according to graduated income brackets (see NHIF 2013, 2017). The contribution brackets turned out to be extremely difficult to increase and lag behind general income development and even the inflation rate. All attempts to raise NHIF contributions tend to cause strong resistance from trade unions and other social groups and require repeated political negotiations. The NHIF, a para-statal organisation governed by an administrative board, has long been suffering from poor management and corruption: only 22 % of NHIF funds are actually used to pay for benefits; 25 % go to administrative costs and 53 % to capital and real-estate investment projects (Hsiao & Shaw 2007: 46).

Despite long-standing health-financing policies, the Kenyan health system depicts relevant backlogs in healthcare infrastructure, human resource development and administrative capacity, which are indispensable for effectively addressing the real service-delivery needs. This might derive from inconsistencies in the cooperation and coordination among the various departments and divisions involved in policy planning and budgeting at the ministries. The situation was temporarily aggravated by the splitting up of the MoH into two sector ministries[48] after the outbreak of severe violence after the 2007 presidential elections.

Shortcomings in linking policy objectives, strategic planning, budgeting and evaluation may be the single most important factor contributing to poor budgeting outcomes at a macro, strategic and operational level in developing countries. A major challenge in budget allocation derives from the difficulty faced by the health sector and the MoF in following a dynamic process that adequately matches needs and short-, medium- and long-term resource availability. From a GFG perspective it is important to note that the planning process in the Kenyan health sector does not properly inform the resource bidding process, which can lead to lower budget ceilings for the sector. While Kenya has employed good practice by implementing the sector-based budget mechanism, there seems to be limited attention to properly costing the full needs for adequate health service provision to the nation, so that progressive attainment of full provision can become a realistic possibility over time (cf. GIZ 2013: 35ff).

As in many other developing countries, the Kenyan health sector depends to a certain extent on external funding. Significant donor involvement and funding endanger national ownership and political responsibility. Likewise, relevant off-budget funds in the health sector compromise effective planning and tend

[48] The Ministry of Public Health and Sanitation (MOPHS) and the Ministry of Medical Services (MOMS).

to further obscure funding needs (ibid.: 35f). Moreover, managing external and particularly off-budget funds challenges the capacity of governments to provide adequate leadership and to ensure GFG.

5.8 Conclusions, Implications and Recommendations

Health-financing governance is critical for achieving universal health coverage. It refers to transparent and accountable decision-making and is closely related to leadership, management, efficiency and transparency in the framework and execution of financial flows within the health sector. Governance in health financing also applies to equitable and sustainable health-financing policies where the role of the government is critical in collecting, pooling and allocating resources in social health protection systems, regardless whether they are mainly tax-borne or collected via social health insurance. Governance in resource collection and pooling is closely related to issues of fair, pro-poor financing and redistribution; governance in purchasing of services decides upon equitable and needs-based access to care. Regardless of the health system design and the funding resources, the role of public authorities is crucial in health financing governance. For transparency and accountability reasons, however, governments also have to strengthen bottom-up mechanisms and support the establishment of civil society organisations provided with the means and the power to claim transparency, accountability and good financial governance.

- The government and/or parliament have to take a leading role in setting general guidelines on budget, coverage, benefits packages, provider payment, cost sharing, regulations and other basic issues. Moreover, public authorities set the rules of the game, make decisions on the major issues in the health financing system, and play a pivotal role in monitoring the system performance.
- Despite their crucial role, it is not recommendable to involve governments or parliaments into practical day-to-day decisions but rather apply the principle of subsidiarity, meaning that governments should transfer responsibility to the lowest possible level instead of doing, what could be done better at other levels: Specialised agencies are often better prepared for deciding on concrete implementation features.
- Each country has its own and specific organisational structure for the various functions of health financing with their own governance mechanisms, which are indispensable for making systems work well. Governance in the various sub-functions of health financing is essential for delegating decision-making and assigning responsibility to related agencies.
- For achieving good governance in the health-financing system, both the institutional design or organisational structure of health financing systems and the respective schemes in place have to be actively shaped and developed by modifying legal and regulatory provisions and by strengthening organisational capacity and enforcement practices.
- Good health-financing governance is a precondition for achieving universal coverage and requires both government commitment and relevant public expenditure on health. For universalising social health protection and access to care, resource generation, pooling and allocation have to be socially balanced, equitable, fair and sustainable.

- Establishing a single health information system for all purchasers and providers including data of patients regardless of their social health protection status can be a critically important technical step on the way to implement transparent information management, improving future planning of priorities and investments, and ultimately transiting towards a universal healthcare system (cf. Kutzin et al. 2009: 550).
- Besides decentralised programming and targeted policies for achieving fair financing and needs-based access to care, implementing bottom-up social accountability mechanisms and strengthening the role of civil society will become increasingly important for ensuring good health-financing governance.

Figures

Tables

List of abbreviations

CBHI	Community-based health insurance
CCM	Country Coordinating Mechanism
CSMBS	Civil Service Medical Benefit Scheme (Thailand)
DoH	Department of Health
EU	European Union
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross domestic product
GFG	Good financial governance
GST	General Sales Tax
gBA	Gemeinsamer Bundesausschuss (Federal Joint Commission) (Germany)
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GST	General sales tax
HIPC	Highly Indebted Poor Countries
HSA	Health Savings Accounts
ILO	International Labour Office
IMF	International Monetary Fund
LMIC	Low-middle Income Countries
MDG	Millennium Development Goals
MoF	Ministry of Finance
MoH	Ministry of Health
NGO	Non-government Organisation
NHSO	National Health Security Office (Thailand)
ODA	Overseas development aid
OECD	Orginsation for Economic Co-operation and Development
OOP	Out-of-pocket
OTC	Over the counter

PBF	Performance-based financing
PHC	Primary healthcare
PHI	Private health insurance
RSBY	Rashtriya Swasthya Bima Yojana (National Health Insurance)
SDG	Sustainable Development Goals
SHI	Social health insurance
SHP	Social health protection
SSS	Social Security Scheme (Thailand)
SUS	Sistema Único de Saúde (Unified Health System - Brazil)
THE	Total health expenditure
UCS	Universal Coverage Scheme (Thailand)
UN	United Nations
UNDP	United Nations Development Programme
USD	United States Dollars
VAT	Value-added tax
WHO	World Health Organization

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