

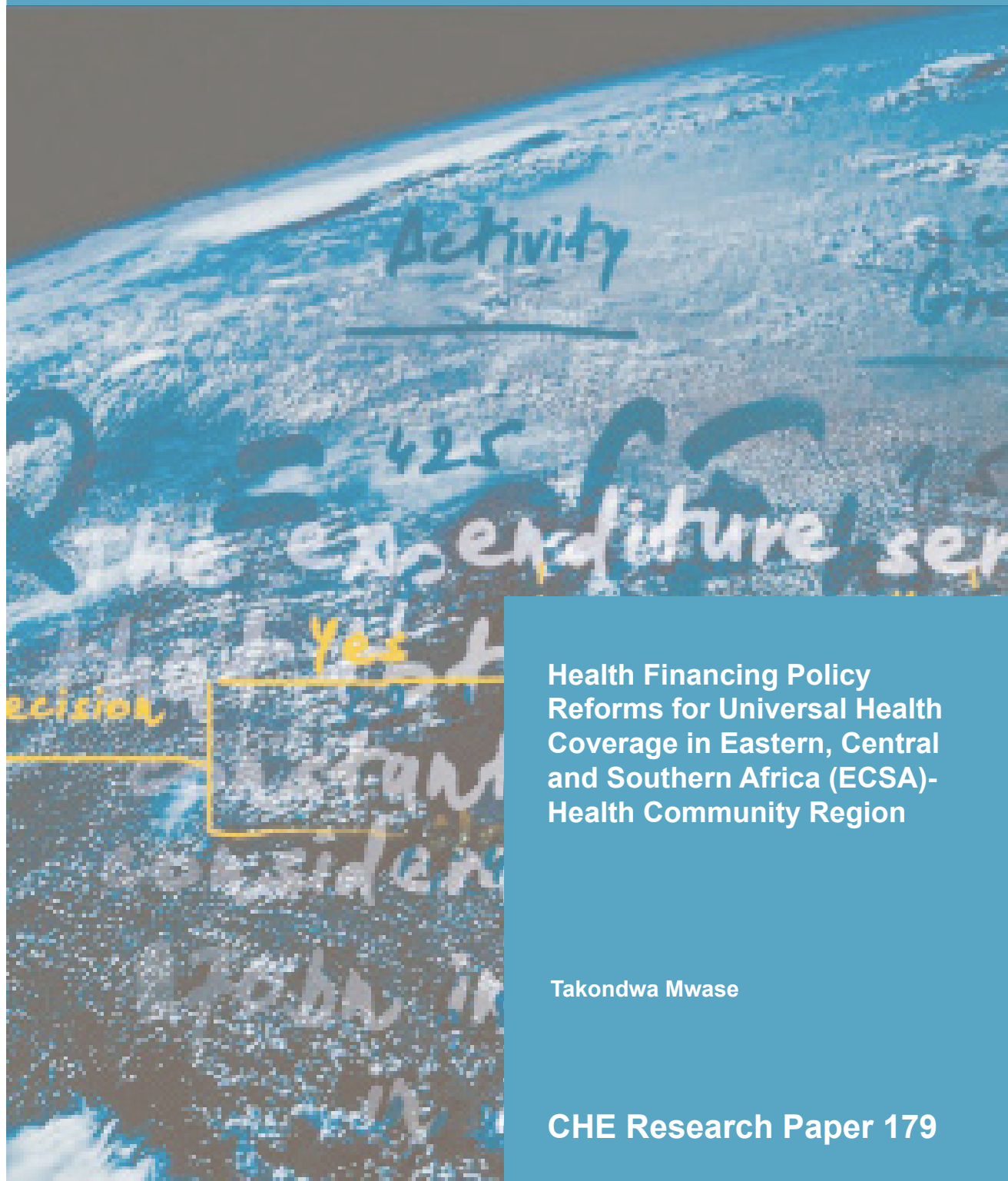


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**Health Financing Policy
Reforms for Universal Health
Coverage in Eastern, Central
and Southern Africa (ECSA)-
Health Community Region**

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Health financing policy reforms for universal health coverage in eastern, central and southern Africa (ECSA)-health community region

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1. Background

Providing access to health care services and goods to all citizens has long been a cornerstone of modern health financing systems in many countries (World Health Organization, 2000). In sub-Saharan Africa (SSA), this became evident soon after independence in the 1960s: in order to redress the significant levels of inequality and deprivation during the colonial era, most countries introduced free public health care services, as a way of increasing access to (and utilisation of) modern health services and, hence, achieving the equity goal (EQUINET, 1998). However, with the passage of time, countries in SSA have been faced with an increased disease burden and growing demand for quality health care services, amidst limited economic resources, low economic growth, a large informal sector with unregulated labour markets, and high population growth rates (World Bank, 1993a). In order to respond to this crisis, in the 1980s and 1990s, many governments with the influence/support of international organisations undertook health sector reforms, with regard to health financing, which saw the reversal of the policy of the provision of free public health care services (Akin, Birdsall, & De Ferranti, 1987; World Bank, 1993b). User fees for health services at the point of use in public health facilities were introduced in almost all countries in SSA—only a few countries, such as Malawi and Mauritius, resisted the temptation of introducing user fees for public health services at all levels nationally.

Despite user fees once being seen to promote a higher quality of health services, and provide an important source of revenue (especially at lower levels of the health system), nearly all global health actors now agree that user fees represent an inefficient funding mechanism that negatively affects the utilisation of essential health services, especially among the poor and the vulnerable population groups (Robert & Ridde, 2013). This poses a major financial barrier to achieving one of the Sustainable Development Goal 3 targets of Universal Health Coverage (UHC), including financial risk protection, access to quality health care services, and access to safe, effective, quality, affordable essential medicines for all (Ridde, 2015; United Nations, 2015). It is against this backdrop that countries in SSA and, in particular, the Eastern, Central and Southern Africa (ECSA)-Health Community (Eswatini, Kenya, Lesotho, Malawi, Mauritius, Tanzania, Uganda, Zambia and Zimbabwe) have intensified and prioritised health financing policy reforms in order to achieve the UHC goal of financial protection—reduce direct out-of-pocket payments, and increase equity in health services utilisation.

However, as ECSA-Health Community member states embark on these health financing policy reforms within their context, it is important to document and share experience across the region. This is because there is a need to avoid repeating common mistakes, and to also learn from the best practices across the ECSA-Health Community region. UHC encompasses several dimensions, requiring multiple interventions, and at times there could be both external and internal pressures to adopt such reforms that have not worked well when implemented elsewhere (as it was with the introduction of user fees in public facilities in the 1980s and 1990s). This Policy Brief aims to provide information to policymakers and advisors in the ECSA-Health Community Region that could inform and improve accountability for decision-making, and facilitate the sharing and dissemination of knowledge and experience. This Policy Brief will provide information on two main health financing policy reforms for revenue collection and pooling: 1) removal of user fees in public facilities, and 2) design/implementation of social health insurance (SHI)/community health insurance (CHI) schemes that have been implemented widely in SSA countries, including ECSA-Health Community member states. In addition, it will also examine the search for innovative domestic financing mechanisms for raising additional funds for health implemented in a few SSA countries and beyond.

2. Overview of the ECSA-health community member states

The socio-economic status of the ECSA-Health Community member states is presented in Table 1. The table shows that Mauritius is the richest country in the ECSA-Health Community region and also has the lowest infant and maternal mortality rates; 100% of births attended by skilled health personnel; highest number of doctors per population; and the highest expenditure per capita. However, the majority of the health expenditures in Mauritius are from private sources—mainly households through direct out-of-pocket expenditures or payments in the private-for-profit health sector. The rest of the member states (with the exception of Eswatini) are poor, with varying degrees of poor health indicators, and low expenditures on health—the majority of which are funded from external sources—ranging from a low of 15% in Zimbabwe to a high of 52% in Malawi, of total current health expenditures as of 2017.

Table 1.

Indicator	Eswatini	Kenya	Lesotho	Malawi	Mauritius	Tanzania	Uganda	Zambia	Zimbabwe
Population (in thousands 2017)	1367	49700	2233	18622	1265	57310	42863	17094	16530
GDP per capita (PPP int.\$, 2017)	8,659	3,293	3,030	1,190	22,348	2,861	1,958	4,033	3,030
Poverty rate (PPP\$/day, %) ¹	28.43	36.83	26.92	70.35	0.21	49.08	41.66	57.50	33.94
Infant mortality rate (per 1000 live births, 2017)	43	31	66	35	14	38	34	40	34
Maternal mortality ratio (2017)	437	342	544	349	61	524	375	213	458
Births attended by skilled health staff (%) ²	88	62	78	90	100	64	74	63	78
Doctor per 1,000 population ³	0.1	0.2	0.1	0.0	2	0.0	0.1	0.1	0.1
Nurses and midwives per 1,000 population ⁴	2	1.5	0.7	0.3	3.4	0.4	0.6	0.9	1.2
Current Health Expenditure as % of GDP (2017)	7	5	9	10	6	4	6	4	7
Domestic General government health expenditure as % General Government Expenditure (2017)	10	8	12	10	10	10	5	7	15
Current Health Expenditure per capita (in PPP in 2017)	600	158	266	115	1278	104	123	180	201
Out-Of-Pocket Spending as % of Current Health Expenditure (2017)	10	24	17	11	49	24	39	12	21
External health expenditure as % of Current Health Expenditure (2017)	24	18	20	52	1	32	43	43	15
Domestic health expenditure as % of Current Health Expenditure (2017)	76	82	80	48	99	68	57	57	85
Domestic general government health expenditure as % of Current Health Expenditure (2017)	51	43	63	31	43	43	16	39	52
Voluntary Health Insurance as % of Current Health Expenditure (2017)	11	10		3	6	1	2	1	13

Notes 1 Eswatini and Malawi=2016; Kenya and Zambia=2015; the rest=2017; 2 Malawi, Mauritius, Tanzania and Uganda=2016; Zimbabwe 2015; the rest=2014; 3 Eswatini, Malawi and Zambia =2016; Kenya, Tanzania and Zimbabwe=2014; Lesotho=2010; Mauritius and Uganda=2015; 4 Eswatini and Mauritius=2015; Kenya, Tanzania and Zimbabwe=2014; Malawi and Zambia=2016; Lesotho=2010.

Source: (World Health Organization, 2017); (World Bank, 2018)

3. Approach

This Policy Brief has been prepared using two main methods of data collection: 1) scoping review of studies published using PubMed and grey literature through an internet search, using Google search engine, using some key search words such as 'health financing reforms in low- middle-income countries/sub Saharan Africa', 'user fees', 'cost sharing/recovery' 'user fees exemption/removal', 'user fees removal in Kenya, Zambia etc.', 'social health insurance in Tanzania, Kenya etc.', 'community health insurance in Uganda, Kenya, etc.', 'health financing in Malawi', 'health financing in Kenya', 'health financing in Lesotho' etc.; and 2) key informant interviews with well-known health economists in the ECSA-Health Community region, via telephone.

4. Theoretical framework of health financing reforms

The preparation of this Policy Brief has been guided by one major theoretical/analytical framework: the health financing function (World Health Organization, 2000)—which stipulates that health financing has three functions: 1) revenue collection, 2) pooling, and 3) purchasing. To expound it further, the McIntyre (2007) framework, which proposes that health financing mechanisms should be assessed according to their feasibility, equity, efficiency and sustainability (McIntyre, 2007); and the Policy Analysis Triangle framework, which examines the process, actors and context within which policy is developed and implemented (Walt & Gilson, 1994), have been added wherever possible.

Collection of revenue involves the collection of funds from various sources via: prepaid funding or financing of insurance—voluntary insurance rated by income, voluntary insurance rated by risk, compulsory insurance, general taxes and earmarked taxes, community loan funds, health services accounts, external funding, and user fees/out-of-pocket payments (Wiysonge et al., 2017).

Using the McIntyre framework (McIntyre, 2007), in regard to feasibility of the revenue collection/pooling mechanism, this includes: actor/political support or opposition to the revenue collection/pooling mechanism, the feasibility of collecting funds, and availability of capacity—technical, administrative etc.

In regard to equity of revenue collection/pooling mechanism, the understanding is that the distribution of financing should be ‘fair’—by which contribution to health should reflect progressivity or regressivity—whether the burden falls disproportionately on the better-off or worse-off in society, relative to their capacity to contribute (Wagstaff & van Doorslaer, 1993). The general consensus is that individuals should contribute according to their ability to pay, and benefit according to their need for care (Wagstaff & van Doorslaer, 1993). To this end, an equitable health system will involve cross-subsidisation e.g. from the rich to the poor and from the healthy to the ill (McIntyre, 2007). For example, in direct tax revenues, taxes tend to be progressive; whereas payroll taxes for health insurance tend to be proportionate, as they are mostly set as a fixed percentage of salary. Indirect taxes and household direct out-of-pocket payments tend to be regressive.

In regard to the efficiency of the revenue collection/pooling mechanism, it is contended that the revenue collection/pooling mechanism could be described to be efficient, if it generates a relatively large amount of funds at low cost (Nicole & Manthaer, 2010). Furthermore, it is also contended that efficiency is assessed on how the health financing functions influence technical and allocative efficiency (McIntyre, 2007). This is to mean, the resource allocation mechanism of a health financing mechanism is technically efficient, if it provides resources to the maximum number of fundable services; and is allocatively efficient, if resources are allocated to services addressing the heaviest burden of ill health in the community for which effective interventions exist, while giving priority to the most cost-effective interventions (McIntyre, 2007).

In regard to sustainability of the revenue collection/pooling mechanism, it is contended that a financing mechanism should be considered sustainable if it has long-term stability and the potential for generating revenue—a financing mechanism that is not subject to considerable and frequent fluctuations (McIntyre, 2007).

Pooling involves a process whereby contributions are put together so that the costs of health care are shared by all and not borne by individuals at the time of illness—risk sharing as the ultimate goal. The main theoretical issues are: adverse selection, cream skimming, subsidisation and compulsion, number of pools—multiple or single among others (Jowett & Kutzin, 2015; World Health Organization, 2005). Adverse selection and cream skimming are mainly associated with voluntary financing, such as in private health insurance. Generally, the issue is that population coverage will remain limited in any voluntary schemes e.g. community health insurance; and, to remedy such a situation to move towards UHC, there is a need for subsidisation using general tax revenues and compulsion of the members in the scheme (Jowett & Kutzin, 2015; World Health Organisation, 2005). In regard to the number of pools, the issue is that multiple pools need to be minimised so that there is equity: cross-subsidisation among members e.g. between the ill and the sick, between the young and the old, and between the rich and the poor (Jowett & Kutzin, 2015); and also single pools promote efficiency in management—lower administrative costs, compared to benefits to members.

Purchasing is the process whereby the contributions are used to buy or provide appropriate and effective health interventions. The issues surrounding purchasing are discussed in a separate Policy Brief.

In this Policy brief, we will only look at revenue collection and pooling, and we will analyse how different health financing reform policies (domestic innovative financing mechanisms, user fees removal, and SHI/CHI implementation) affect feasibility, equity, efficiency and sustainability, as proposed by McIntyre 2007 (McIntyre, 2007); and also see, wherever possible, how these health financing policy reforms have been viewed by different actors and experts among ECSA-Health Community member states and beyond, using the Policy Analysis Triangle (Walt & Gilson, 1994).

5. Empirical evidence of health financing policy reforms in low- and middle-income countries (LMICs)

5.1 Domestic innovative financing mechanisms for raising additional revenues

Evidence reveals that prepaid resources are key to achieving the UHC goals of effective coverage and financial protection, compared to other sources of financing e.g. out-of-pocket payments (Cashin et al., 2017). As such, there is a great need for LMICs to increase public funding for health services, in spite of the current low health spending levels by most LMICs, especially in SSA, which has been hugely augmented by external resources for some time and now also faces a major decline. To this end, several LMICs and donors have either explored or implemented “innovative domestic financing” mechanisms aimed at raising additional revenues through several mechanisms, among which are imposing taxes/levies on certain goods and services (World Health Organization, 2010).

At the international level, for instance, innovative financing mechanisms have included the airline ticket voluntary solidarity contributions, and the international financing facility for immunisation—where funds are raised from international capital markets, debt buy-downs, and advance market commitments, among others (World Bank, 2009). Some of the options for innovative financing at the domestic level have included levies on financial transactions, diaspora bonds, and public health taxes on tobacco, alcohol, and unhealthy foods (e.g. sugar, salt etc) (World Health Organization, 2010). While the majority of goods are already taxed (‘sin taxes’) as part of health promotion e.g. taxes on alcohol, tobacco, etc., there is little experience in taxing other goods and services, hence their potential contribution is not yet known, as most studies do not quantify the actual amount of revenue that could be raised (Barroy, Sparkes, & Dale, 2016). Using the McIntyre framework (McIntyre, 2007), in terms of efficiency, the few studies that have quantified the amount of revenue to be generated from other innovative taxes show that it is generally very low (Cashin et al., 2017). However, a few exceptions have been noted, for example in the Philippines, where a significant amount of revenue has been mobilised for the health sector from taxes on tobacco and alcohol (Kaiser, Bredenkamp, & Iglesias, 2016).

5.2 Removal of user fees in public health facilities

A major response to the devastating negative impact of user fees on the use of health services in SSA has been the removal of user fees in public health facilities. Using the Policy Analysis Triangle framework (Walt & Gilson, 1994), the evidence shows that the experience of user fee removals, in most SSA countries (outside the ECSA-Health Community), has at times been hasty, politically driven policy decisions with no prior preparation and with great potential for unintended effects, such as deteriorating quality of care as a result of inadequate funds, drug stock-outs, and a huge increase in demand for health services in some cases (Gilson & McIntyre, 2005). For example, in regard to the actors, policy decisions have mainly been made at the highest level of government—the presidency, as seen in Madagascar and South Africa. In most SSA countries, these decisions have often been made suddenly, in a highly politicised context. For example, in Madagascar, this was aimed at repairing the consequences of political and economic crises prior to the presidential election of 2001 (Fafchamps & Minten, 2007); while in South Africa, it was one of the first post-apartheid government decisions (Wilkinson, Sach, & Karim, 1997). The evidence further shows that the policy of user fee abolition has focused on several fronts: certain services for all users (Ghana, South Africa); population groups, such as children under a certain age, pregnant women or women during child birth (South Africa); and health facilities (Ghana) (Ridde & Morestin, 2011). However, the most widely implemented decision in SSA has been to remove user fees for certain services for all users (Ridde & Morestin, 2011).

Outside the ECSA-Health Community region, the duration of the removal of user fees has also varied from being temporary in Madagascar, to being permanent in Ghana (Fafchamps & Minten, 2007; Witter & Adjei, 2007). When it comes to funding the cost of providing free health care services, evidence shows that there have been serious delays between the announcement of free health care services and the provision of adequate funds; for example, drugs in Madagascar (Fafchamps & Minten, 2007) and activities in Ghana, as there was no costed plan developed or set period for the user fee removal (Witter & Adjei, 2007). In addition to the delays, there were also different systems set up for the management of funds. For example, while Madagascar centralised the funds for replacing the user fees, Ghana decentralised the funds management to the districts which then reimbursed the health facilities (Fafchamps & Minten, 2007; Witter & Adjei, 2007). Of paramount importance is the inadequate communication and consultation with health care workers and their managers in the process of user fees removal, leading to serious implementation infidelity which might have led to serious unintended effects, including ineffectiveness of the policy reform in some SSA countries.

Evidence of the impact of user fees removal in public health facilities in SSA is mixed. Some earlier studies have shown that user fees removal had led to an increase in the utilisation of general health services (Lagarde & Palmer, 2008) and the use of maternal health services in particular (Hatt, Makinen, Madhavan, & Conlon, 2013). However, it has been noted that the positive effects of user fees removal is very much dependent on the determinants of the demand for health care—in line with the economic theory which stipulates that removing user fees would increase utilisation of health services, if fees represent a significant financial barrier for households to access care (Lagarde & Palmer, 2008). Thus, if other factors, such as distance to health facilities or poor quality of care, are the main drivers behind low utilisation, then removing the financial barriers would more likely have a very limited effect (Lagarde & Palmer, 2008). This has been the case in some countries in SSA where user fees removal has not led to the desired impact (Lagarde & Palmer, 2008; Mwabu & Wang'ombe, 1997) but also led to some unintended effects, such as charging unofficial fees and increased workload among health workers, leading to further deterioration of quality of health care (Lagarde & Palmer, 2008; Witter, Arhinful, Kusi, & Zakariah Akoto, 2007).

5.3 Social health insurance

Another major response to the devastating effects of user fees reducing access to (and utilisation of) health services in many LMICs, and SSA in particular, has been the design and implementation of SHI. This is a form of mandatory health insurance for the formal sector employees, including retirees and pensioners, and their financing is mainly by earmarked payroll and pension contribution—from employers and employees. Further, governments often contribute on behalf of the population that cannot afford to pay for themselves. Benefit entitlement is directly linked to a contribution made by or on behalf of, specific individuals in the population. Few examples exist of middle-income countries, such as Costa Rica and Thailand, that have made great progress to UHC using the Universalist approach through SHI in combination with general tax revenues, as opposed to the targeted approach used in some LMICs (McIntyre, Ranson, Aulakh, & Honda, 2013). The majority of LMICs, especially in SSA, have faced serious challenges in implementing SHI due to large informal sectors/unregulated labour markets that make it difficult to devise cost-effective measures to collect regular contributions from members (McIntyre et al., 2013; Yazbeck et al., 2020). Compounding the situation is the lengthy administrative bureaucracy and inadequate capacity (e.g. poor data management equipment/software systems, technical skills, independent verification mechanisms etc.) in claims processing of health service providers, leading to frustration of service providers and eventually denying provision of health services to the insured clients (Acharya et al., 2012). Related to this is the inadequately equipped and staffed

health facilities, leading to poor quality of health services, especially in rural and peri-urban areas where the insured have to travel long distances to access care (McIntyre et al., 2013; Yazbeck et al., 2020). In such situations, health insurance coverage may be of little value to households living in rural areas, where road networks to health facilities are poor and transport options are almost non-existent, and with limited provider choice (Wagstaff, Lindelow, Jun, Ling, & Juncheng, 2009).

Thus, it is not very surprising that the existing empirical evidence from an earlier systematic review (Acharya et al., 2012) of the impact of SHI, to reduce direct out-of-pocket expenditures and improve utilisation of health services in LMICs, was found to be uncertain. Of the 15 studies reviewed, 11 reported higher utilisation of health services, while four studies reported no increased utilisation among the insured (Acharya et al., 2012). Furthermore, it was also found that, of the 10 studies reviewed, seven reported to have found SHI to have reduced out-of-pocket spending, while three studies found the opposite effects (Acharya et al., 2012). As regards impact on health outcomes, it was found that of the five studies reviewed, three studies found little or no improvement in health outcomes for the insured, and two studies found improvements in health outcomes (Acharya et al., 2012). In regard to the impact of SHI on equity, it was found that four studies reported increased utilisation of health services by poor individuals, while two studies found no effect on the poor (Acharya et al., 2012).

A more recent review of systematic reviews also found similar results. The review found that the impact of social health insurance on utilisation of health services in low-income countries was uncertain and the evidence grade certainty was very low (Wiysonge et al., 2017). Further, in the most recent commentary, Yazbeck et al (2020), conclude that they find very little evidence to justify the pursuit of SHI for health care in LMICs, due to its limited revenue generation potential—resulting from large informal sectors and persistent evidence that such financing policies could lead to increased inequity and fragmentation of the health system.

5.4 Community health insurance

Community health insurance (CHI) is another response that most LMICs, especially in SSA and Central and West Africa in particular (known as *Mutuelle de la sante*), have championed to mitigate the devastating impacts of user fees of reduced utilisation of health services and catastrophic and impoverishing health expenditures, especially among the rural population (Dror & Preker, 2002). In SSA countries outside the ECSA-Health Community region, Rwanda offers a best practice example in designing and implementing CHI. It was established in 1999, as a response to user fees introduction some three years earlier, and with the President's encouragement that all citizens had to join CHI schemes. The number of schemes increased from 100 to 400 between 2003 and 2007, with the number of beneficiaries increasing from 500,000 to 6.5 million (MoH, 2010). With donor support paying for the contributions of the indigents and people living with HIV/AIDS, by 2008, membership of CHI schemes reached about 86% of the population, with the rest of the population covered by other schemes (MoH, 2010). The evidence from Rwanda shows that CHI significantly reduced annual per capita out-of-pocket spending; however, the benefits are in favour of the rich and not the poor (Woldemichael, Gurura, & Shimeles, 2019). Furthermore, the scheme also reduces the incidence of catastrophic healthcare spending significantly but much more so among the non-poor (Woldemichael et al., 2019).

The evidence, from across LMICs, from a systematic review (Acharya et al., 2012) of the impact of CHI on out-of-pocket spending in LMICs was found to be uncertain. Of the two studies reviewed, a decrease in out-of-pocket spending was found in one study, while the results of the other study were noted to be invalid due to the small sample size (Acharya et al., 2012). In regard to the impact of the CHI on

utilisation of health services among the insured members in LMICs, it was found that it could lead to an increase in utilisation of health services among the insured members (Acharya et al., 2012). Of the three studies included in the systematic review, all of them reported increased utilisation of health services among the insured members (Acharya et al., 2012). In regard to health outcomes, it was found that only one study reported improvements in health outcomes (Acharya et al., 2012). With regard to impact of CHI on equity, in the two studies included in the systematic review, it was found that one study reported an increase in health outcomes among the poor, while another study reported the opposite result (Acharya et al., 2012).

In a recent review of systematic reviews, it was also found that CHI may increase health service utilisation in low-income countries, however its impact on health outcomes is uncertain- with a very low certainty evidence grade (Wiysonge et al., 2017).

6. Experience of ECSA-health community region with health financing policy reforms for UHC

With regard to the two health financing functions of revenue collection and pooling examined in this Policy Brief, ECSA member states are at various levels of implementing health financing policies to achieve the UHC goal of improving financial protection, through the reduction of direct out-of-pocket spending at the point of use of health services, and improving equity in service utilisation. This has mainly focused on three financing policy reforms: 1) raising revenues through pre-paid ‘innovative financing mechanisms’ (e.g. Zimbabwe), including feasibility assessment of various innovative mechanisms for raising additional revenues (e.g. Malawi, Tanzania); 2) removal of user fees in public facilities or in mission facilities (e.g. Kenya, Uganda, Zambia and Malawi); and 3) implementation/expansion of prepaid schemes, i.e. national health insurance fund/national hospital insurance fund (e.g. Tanzania, Kenya), including assessment of the feasibility of establishing social health insurance in all ECSA-Health Community member states except Mauritius; and implementation of CHI (e.g. Tanzania).

6.1 Domestic ‘innovative mechanisms’ for raising additional revenues (Zimbabwe) and assessment of fiscal space (Malawi and Tanzania)

Few countries in the ECSA-Health Community region have experience with the design and implementation of ‘innovative health financing mechanisms’ for raising additional revenues, as advocated by the international community in light of the declining external resources to achieve UHC. Zimbabwe stands out, not only in the ECSA-Health Community but also in SSA, as a best practice example in domestic health financing, with its design and implementation of a Health Trust or Endowment Fund—the Zimbabwe AIDS levy and Zimbabwe National AIDS ‘Trust Fund’. This is a domestic policy response to the HIV/AIDS pandemic dwindling resources—3% is levied on the income of individuals, companies and trusts, and that is paid into the National AIDS Trust Fund (ZNAFT) monthly. Using the McIntyre framework (McIntyre, 2007), in terms of efficiency and sustainability, the levy is held as a success (African Union, 2016). This is despite challenges in implementation—such as the directive that 55% of the funds should be used for Antiretroviral Therapy (ART) (since 2014), which has resulted in having limited resources allocated to preventive, and other HIV/AIDS, activities, and being only 15 % of the national funding requirements for HIV/AIDS. It sustained the HIV/AIDS activities between the 2007 and 2008 economic crises—a good indication that it is sustainable, even under the worst economic situations. Further, even in the face of hyper-inflation, the levy managed to reach and retain about 59% of those eligible for ART by the end of 2010. Since the levy is mainly levied on formal employees, and about 70% of Zimbabweans are in the informal sector, this means that its growth will continue to be limited in the medium term (African Union, 2016).

Malawi and Tanzania provide best practice examples in undertaking detailed assessments of the feasibility and potential of various ‘innovative financing mechanisms’ for raising additional domestic revenues in the ECSA-Health Community region and SSA (African Union, 2016; Chansa et al., 2018). The assessments involved a long process: starting with setting up local technical teams chaired by the Ministries of Health; identifying international organisations to provide financial/technical support; undertaking a health financing situation analysis; followed by a detailed technical evaluation of the financing options; to development of a health financing policy. Malawi technically evaluated 12 levy/tax options: fuel; tobacco products; alcohol; mobile phone talk time; corporate businesses; value-added tax; extractive industries; monies received from loans applied through parliament; donations received from developing partners, foundations, etc.; annual earnings paid by employees and employers to private

health insurance schemes; monies earned by investments made by, or on behalf of, the proposed Malawi Health Fund; and motor vehicle insurance (Chansa et al., 2018). Tanzania technically evaluated five options: remittances levy; airtime levy; alcohol levy; mainstreaming; and private sector mainstreaming (African Union, 2016). In both countries, in terms of efficiency, the revenue generation potential of 'innovative financing mechanisms' for health through taxes/levies was found to be very limited, and it amplified calls for intensifying efforts to expand fiscal space for health to be directed at efficiency-improvement measures, including the strengthening of governance and public financial management (African Union, 2016; Chansa et al., 2018).

6.2 Removal of user fees in public/mission facilities (Kenya, Uganda, Zambia, Malawi, Mauritius)

Kenya, Uganda and Zambia removed user fees in public and mission health facilities, with the goal of eliminating financial barriers to access to care, and increasing utilisation of health services (Masiye, Chitah, & McIntyre, 2010; Nabyonga Orem, Mugisha, Kirunga, Macq, & Criel, 2011). Malawi has maintained a free public health care system since independence in the 1960s, but in the mid-2000s implemented a financing reform aimed at protecting the poor and the vulnerable from direct household out-of-pocket payments at mission facilities — mainly located in rural areas, where poverty is rampant (Chirwa, Kazanga, Faedo, & Thomas, 2013). Mauritius has continued with the provision of free public health care services since its independence in the early 1960s, as it has no mission health facilities but a fast growing private-for-profit sector.

Using the Policy Analysis Triangle framework (Walt & Gilson, 1994), the context, process and actors in the implementation of user fees in the late 1980s and early 1990s are somehow similar in these ECSA Health-Community countries, like in the rest of SSA. As a result of debt and macroeconomic stagnation, and under the recommendation of the World Bank, these countries were mainly influenced to introduce user fees (Akin et al., 1987; Lancet, 1988). This was based on the theoretical understanding in regard to the price inelasticity of demand for health care, whereby it was envisaged that the health sector would be able to raise its own revenue, and improve the deteriorating quality of health services in a sustainable manner (Akin et al., 1987; Gilson & Mills, 1995). However, from an equity perspective, as earlier noted, the implementation of a user fee policy - although accompanied by exemption mechanisms in some countries - did not only fail to achieve this objective, but it also led to decreased utilisation of health care services, especially among the poor which resulted in increased morbidity and mortality (Yates, 2009). Compounding the situation is the fact that the exemption mechanisms, that were expected to cushion the poor from user fees, were rarely implemented and generally found not to be effective in identifying the poor to benefit from free health services (Ridde, 2008).

As a response to this situation, the majority of ECSA-Health Community countries, like other SSA countries, decided to remove user fees in public health facilities, though the process differed from country to country. For instance, in Kenya, this was characterised by inconsistency in the policy implementation: starting with withdrawal (due to concerns for inequities in utilisation and health outcomes), then re-introduction (due to inadequate fiscal space), then reduction in the 1990s; and in the early 2000s the Ministry of Health removed user fees for all citizens, except for a minimal registration fee in government dispensaries and health centres; and finally, in 2013, abolished all user fees in public dispensaries and health centres, and provided nearly US\$7 million for compensation to lower-level facilities (Barasa, Rogo, Mwaura, & Chuma, 2018; Mwabu & Wang'ombe, 1997). This is unlike in Uganda, where all user fees were removed simultaneously in the early 2000s, following a presidential directive—similar to other SSA countries at the height of a presidential election (Nabyonga

et al., 2005). However, Zambia followed the same path as Uganda—during the peak of the campaign, a presidential directive was made whereby user fees were removed in all public health facilities in rural areas in 2006, with the exception of foreigners and those coming outside the catchment areas, but in phases, like Kenya—peri-urban in 2007 and all primary health care facilities in 2012 (Kaonga, Banda, & Masiye, 2019; Masiye et al., 2010).

Malawi and Mauritius are unique amongst ECSA- Health Community member states, as they have maintained the provision of free public health care services. However, due to rising maternal and neonatal deaths- which are partly blamed on inequitable access to health services, arising from the existence of mission facilities which charge user fees - in the mid-2000s, Malawi decided to cover the cost of free maternal and neonatal health services for the mission health facilities (Chirwa et al., 2013).

Using the McIntyre framework (McIntyre, 2007), the evidence of the impact of fees removal on use of health services, and on the poor in particular, is mixed. For example, in Zambia, in regard to equity, the removal of user fees provided financial relief to users (Masiye & Kaonga, 2016); however, this relief from free healthcare was in favour of the least poor and not the poorest households (Lépine, Lagarde, & Le Nestour, 2018). In regard to sustainability, the fees removal delivered neither a sustained and significant impact on financial protection nor access to maternal health services (Lépine et al., 2018). Furthermore, between 2010 and 2015, the poor still experienced a higher incidence of catastrophic health spending than the rich: between 2010 and 2015, the intensity of catastrophic health spending increased for almost all the quintiles, but was significantly higher for the poor (Masiye, Kaonga, & Kirigia, 2016). In addition, evidence shows that households in rural areas are more likely to experience catastrophic payments, and the main cause of such inequities in access to care could be attributed to long distances to health facilities and the poor quality of services provided at health facilities (Masiye & Kaonga, 2016). For example, the lack of medicines at health facilities forces patients to buy drugs from private pharmacies and drug stores (Masiye et al., 2016).

The evidence from Kenya also mirrors the same: both public and mission facilities experienced a modest increase in the utilisation of outpatient services after the removal of user fees (Maina & Kirigia, 2015). In regard to equity, the incidence of catastrophic health expenditures is high—ranging between 9.8-14.8% (Chuma & Maina, 2012; Kimani, Mugo, & Kioko, 2016). Like in Zambia, the incidence of these catastrophic health expenditures is more severe among the poorest households and in rural areas (Salari, Giorgio, Ilinca, & Chuma, 2018), and about 2.6 million Kenyans face the risk of impoverishment, as a result of health care depleting household savings (Salari et al., 2018).

In regard to the feasibility of policy implementation, Kenya stands out to demonstrate one issue which has been a problem in implementing user fees removal policies in most SSA countries—implementation fidelity among front line health workers. Evidence shows that there was a high level of adherence to the removal of user fee policy in Kenya—85% of all facilities (Maina & Kirigia, 2015). This is unlike in Uganda, where the majority of health facilities continued to charge unofficial user fees (Nabyonga et al., 2005). However, like in other ECSA member states (such as Zambia and Malawi) and other SSA countries, the policy implementation in Kenya encountered some challenges during the implementation process, due to: limited consultation with stakeholders during policy design and planning; unclear communication of the policy reform to frontline health workers and other key stakeholders; delayed reimbursement of funds for providing free health services to patients; and drug shortages, among others (Chirwa et al., 2013; Maina & Kirigia, 2015; Masiye et al., 2016).

Unlike in Kenya and Zambia, in regard to equity, the evidence from Uganda shows that the removal of user fees led to an increase in utilisation of health services among the poor (Burnham, Pariyo, Galiwango, & Wabwire-Mange, 2004; Nabyonga et al., 2005). However, utilisation of health services among the least poor in public health facilities decreased to a rate lower than before the removal of user fees, as the least poor switched to private health facilities; but, paradoxically, health services utilisation in private health facilities by the poor also increased (Xu et al., 2006). This is mainly explained by perceived differences in quality between public and private health sectors (Xu et al., 2006). Evidence shows that, in Uganda, the private health sector is the preferred provider for both the rich and the poor, due to the perception of poor quality of care in public health facilities (Orem & Zikusooka, 2010). Thus, despite the removal of user fees in public health facilities, overall direct out-of-pocket payments have remained high in Uganda (Nabyonga Orem et al., 2011). In addition, Uganda faces high direct out-of-pocket payments due to the presence of informal payments in the public health facilities (Xu et al., 2006). Similar to Zambia and Kenya, as a consequence of high direct out-of-pocket payments, there is a high level and intensity of both financial catastrophe and impoverishment in Uganda (Kwesiga, Zikusooka, & Ataguba, 2015). About 23% of Ugandan households face financial ruin, using a 10% cut-off point of household income and using the international US\$1.25/day poverty line; about four percent of the population are further impoverished by direct out-of-pocket payments (Kwesiga et al., 2015).

As Malawi only partially removed user fees for maternal and neonatal services in mission facilities and covered its cost, but provides free public health services, overall the Malawi health system faces serious inequities in access to and utilisation of health services (Mchenga, Chirwa, & Chiwaula, 2017; World Bank, 2012; Zere, Moeti, Kirigia, Mwase, & Kataika, 2007), catastrophic health expenditures especially among rural and middle income households due to unofficial fees (Mchenga et al., 2017) and poor health outcomes e.g. high maternal mortality among others (World Bank, 2012). As regards the evidence of the effect of fee removal on the use of maternal health services in mission facilities in Malawi, it shows that it led to a 15% increase in the mean proportion of women who made at least one antenatal care (ANC) visit during pregnancy, a 12% increase in average ANC visits, and an 11% increase in the average proportion of pregnant women who delivered at the facilities (Manthalu, Yi, Farrar, & Nkhoma, 2016). However, no impact was found on other maternal health services, such as ANC in the first trimester and postpartum care visits (Manthalu et al., 2016).

Like other ECSA-Health Community member states that implemented a user fee removal policy across public and mission facilities, in terms of feasibility of policy implementation, Malawi also faced similar challenges with its partial financing policy reform of covering the costs of maternal health and neonatal health in mission facilities: 1) inadequate resources, with the absence of any revenue for raising additional resources through taxes or external resources (McIntyre et al., 2013); 2) the policy was implemented in haste, without developing the required capacity at district level to manage the contracts, or establishing mechanisms for monitoring and evaluation and for resolving the conflicts (McIntyre et al., 2013); 3) a lack of routine adjustment of the payment rates, whereby the fee schedules were not updated for up to five years (Chirwa et al., 2013); and 4) a lack of clarity on whether fees can be charged and, as such, some of the contracted hospitals charged whatever they felt was appropriate, thus driving up the costs (Chirwa et al., 2013).

6.3 National health insurance/national hospital insurance fund (Tanzania, Kenya)

An increasing number of SSA countries have either established, or are in the process of designing and establishing, public health insurance/national health insurance. Outside the ECSA-Health Community this includes: Ghana, Nigeria, Rwanda, Sierra Leone, Liberia, and Burkina Faso (Lagomarsino, Garabrant,

Adyas, Muga, & Otoo, 2012). Among ECSA Member States, only Tanzania has already established the National Health Insurance Fund (NHIF), with Kenya having commenced the expansion of the National Hospital Insurance Fund (NHIF) to act as its national health insurance scheme; and Zambia, Swaziland, Lesotho, Malawi and Uganda are at different stages of preparation.

The goals that led to the establishment of national health insurance/hospital health insurance schemes in Kenya and Tanzania appear to be different. Kenya established the NHIF in 1966, with the aim of providing mandatory coverage of the formal sector employees only and their dependents—with the mandate extended in 1998 to cover the informal sector (IFC, 2011). Tanzania started with voluntary community-based health financing schemes in 1997-98, with the goal of reducing catastrophic direct out-of-pocket payments incurred by informal, mostly rural households in primary health facilities, and rolled it out nationally in 2000—including the scheme for the informal sector in urban areas, known as TIKA. Tanzania only established the NHIF in 1999, with the aim of covering the public sector employees, whereby contributions were split between the civil servant (3 percent salary) and the government (paying the other 3 percent). However, this was done without legislation, as it was with the Kenya NHIF, but - in both cases - without the goal of universal coverage at inception (Barasa et al., 2018; McIntyre et al., 2013).

Although the Kenya NHIF was mandated to cover all formal sector workers at its inception, and later informal sector employees, slow progress was made, as membership remained low—below 10% by 2007 (Barasa et al., 2018). Among the factors behind this low membership growth was that civil servants were not mandatorily included in the NHIF, and there were very high attrition rates of informal sector employees that had joined the NHIF (IFC, 2011). Between 2012 and 2014, two main reforms of the Kenya NHIF, in regard to revenue collection and pooling, have been implemented and include: the introduction of the Civil Servants Scheme for formal sector government workers and their dependents (previously paid directly to civil servants as a medical allowance, now paid as premium contributions to the NHIF), and the introduction of the Health Insurance Subsidy for the poor (Barasa et al., 2018). Before Kenya took an expansional drive of its NHIF, Tanzania had already done so in 2005, by establishing the Social Health Insurance Benefit of the National Social Security Fund, covering mainly private sector employees; and, by 2013, it covered about 1% of the population (McIntyre et al., 2013).

Using the McIntyre framework (McIntyre, 2007), both Tanzania and Kenya face a major feasibility concern in expanding coverage of their national health insurance schemes through the use of a voluntary approach to informal sector employees, similar to experiences of other LMICs (Barasa et al., 2018; Lee, Tarimo, & Dutta, 2018; McIntyre et al., 2013; Yazbeck et al., 2020). For example, in Kenya, much as the number of members and their dependents in the NHIF had grown from 2.7 million in 2010 to 6.6 million in 2017, the number of NHIF principal members from formal and informal sector only marginally increased between 2010 and 2017. As such, health insurance coverage in Kenya continues to remain low—estimated at 14% of the population by 2018 (of which only 1 % is from the informal sector) (Barasa et al., 2018). This is also the same for Tanzania, where coverage by the NHIF was estimated at 7% of the total population by 2017 (Lee et al., 2018). Compounding the situation is the huge number of informal sector individuals not renewing their NHIF membership. For instance, in the Kenya NHIF, this was 73% in 2017 (NHIF, 2017). Like in other LMICs, the factors that are responsible for low informal voluntary enrolment are many, including: low ability to pay monthly premiums; and administrative challenges to enrol and collect regular premiums in the most cost-effective way (Lagomarsino et al., 2012; Okech & Lelegwe, 2015).

In regard to equity, in Kenya's NHIF, within the same pool, inequities arise in both the financing of, and access to, the benefit package, in that the government pays for the contributions of the civil servants and their dependents—(Barasa et al., 2018). In Tanzania, however, there appears to be equity in financing in the scheme, as civil servants make an equal contribution to that of government; but, as in Kenya, civil servants have a wider benefit package than informal sector workers (Barasa et al., 2018; McIntyre et al., 2013). In addition, while Kenya decided to use public funds to cover the selected poor in the NHIF, evidence shows this program is faced with several unintended effects: 1) serious leakages due to inadequate capacity to carry out poverty targeting to identify the poor—about 65% of the program beneficiaries were in the richest two quintiles; 2) weak communication, leading to low awareness among beneficiaries about their entitlements; and 3) long delays in contracting service providers (IFC, 2018). It is therefore not very surprising that this program neither increased utilisation of health services nor reduced direct out-of-pocket spending among the enrolled poor (World Bank, 2017).

Related to the above, in both the Kenya NHIF and Tanzania NHIF, separate pools have emerged within one scheme, similar to what is happening in other developing countries such as Thailand and Costa Rica (Barasa et al., 2018; Lee et al., 2018; McIntyre et al., 2013). The NHIF in Kenya has about three pools: for civil servants, the poor, and for the rest of the members- including the informal sector (Barasa et al., 2018). In Tanzania, the NHIF has three pools: civil servants, the private sector and recently included the CHF members—CHF contracted NHIF due to inadequate administrative and claims processing capacity, among other factors (Lee et al., 2018). These multiple pools have created special problems of a lack of cross-subsidisation within the same scheme (NHIF, 2014). This is not all, Tanzania brings a unique unintended effect in that the CHF consists of a scheme in each district; however, the country has now moved to having individual health facility bank accounts and this includes a separate CHF bank account, thus further fragmenting the pool (Lee et al., 2018; McIntyre et al., 2013).

In regard to efficiency, both the Tanzania NHIF and Kenya NHIF have been found to be inefficient (IFC, 2011; Lee et al., 2018). For example, the Kenya NHIF had a benefit pay-out rate of 55%, and a proportion of administrative costs of 45% by 2010 (IFC, 2011). Although there has been a decline of about 50% in administrative costs, and a rise to 75% of benefit pay out rate in the Kenya NHIF, between 2010 and 2017, this shows inefficiency (IFC, 2018). In the Tanzania NHIF, the administrative expense ratio rose from 17% in the 2012/13 financial year to 22% in 2016/17 (Lee et al., 2018). The expansion strategy of using voluntary enrolment of the informal sector in both Kenya and Tanzania, much as it is a feasibility challenge, is also a great efficiency challenge in finding the most cost effective ways of collecting regular monthly premiums; as such, revenues remain low with high attrition rates (Lee et al., 2018; NHIF, 2016). The management of separate pools in both the Kenya NHIF and Tanzania NHIF is also a serious inefficiency issue due to high administrative and management costs (Lee et al., 2018; NHIF, 2016).

The sustainability of these schemes in both Kenya and Tanzania also remains a great challenge. For example, the increase of premiums in the Kenya NHIF, although after 27 years (in 2015), has been reported to be unaffordable (Barasa et al., 2018). In Tanzania, although the NHIF has accumulated a surplus for years, there are indications that in the long-run (by 2025), it could be unsustainable if the trend of rising expenditures and claims ratios keep worsening (Lee et al., 2018).

7. Key lessons learned from health financing reforms in the ECSA-health community region and other LMICs

The key lessons learned from health financing reforms, in regard to revenue collection and pooling functions in the ECSA-Health community region and other LMICs, are many and include:

First, it is feasible to successfully raise domestic revenues through some earmarked levies in low income countries of the ECSA-Health Community and other LMICs, as experienced in Zimbabwe and the Philippines. However, the amount of revenues raised, for instance in Zimbabwe, is insufficient and the allocation of funds is subject to political directives.

Second, prior to implementing an innovative domestic health financing policy—such as levies on tobacco, alcohol etc.— it is better to undertake a detailed assessment of the potential revenues that could be raised, so as to avoid a wastage of resources in implementing policies that would have little added value, as was done in Malawi and Tanzania. This implies that, in situations where the assessment reveals little potential for raising additional revenues from alternative domestic innovative financing sources, ECSA-Health Community member states could be immediately directing their efforts to the search for policies that would improve efficiency and equity in resource allocation and management.

Third, when it comes to the removal of user fees in public health facilities, it is important to align political directives with financial and technical capacity (concrete plan and budget), and with the clear involvement of all key stakeholders, in particular ministries of health and finance, so as to smoothly mitigate the expected increased demand for health services. This is in light of the findings that the process of user fees removal in the ECSA-Health Community region, like in other SSA countries and beyond, has largely been implemented in haste and ‘politicised’—usually during an election campaign period and characterised by policy reversals in some cases. This has led to many unintended effects, including no corresponding or delayed replacement of funds for providing free health services—leading to poor quality of health services. Eventually, this leads to little or no impact on the poor, as catastrophic payments and impoverishing health expenditures still remain high among the poor and in rural areas—the poor continuing to pay unofficial fees for poor quality health services in public/mission health facilities.

Fourth, developing a waiver fee policy for user fees is a serious challenge in the ECSA-Health Community region, as it is in other SSA countries and beyond, as the criteria used to identify the poor is difficult to develop and implement. This raises the issue of whether a Universalist approach—no user fees in all public facilities at all levels, such as that of Malawi and Mauritius—could be considered by other ECSA-Health Community member states. However, as noted, even Malawi (with its free public health service provision) also faces serious inequities in health services utilisation and catastrophic payments, due to unofficial fees among the poor and rural households.

Fifth, it is important to develop a clear information, education and communication strategy for all stakeholders, in particular the frontline health workers, to ensure implementation fidelity—this is in order to avoid unofficial fees, and the poor not demanding services due to lack of information on the existence of free health services. This is based on the understanding that a declaration of user fee removal or provision of free health services alone does not automatically translate into services being available in health facilities—more effort is needed to make such a policy work.

Sixth, SHI in situations characterised by a small formal sector/unregulated labour markets, like those in the ECSA-Health Community, face a huge challenge—that of low revenues and coverage (Yazbeck et al., 2020). This challenge is much worse when the joining of the scheme, by the informal sector and the poor, is on a voluntary basis. This creates huge challenges in the collection of regular premiums, and high dropout rates—due to poverty, among others, as seen in the Kenya NHIF and Tanzania NHIF. These two schemes have failed to mobilise sufficient funds and expand coverage, using the voluntary basis, and appear to be inefficient, with high administrative costs compared with other similar schemes globally. Similar schemes globally have administration costs of around 4.7% of the total costs (Nicole & Manthaer, 2010).

Seventh, expanding population coverage of SHI, in situations of a small formal sector/unregulated labour markets, to the informal sector and the poor requires a Universalist approach—using government general tax revenues and, where feasible, donor funds right at inception, as opposed to a targeting approach. The experience of the Kenya NHIF in the ECSA-Health Community region, with the targeting of the poor, faced serious challenges of leakages, as it benefited the majority of the non-poor and required a huge capacity to develop a good mechanism for identifying the poor. Thus, although universal coverage in SHI of the informal sector and the poor requires a huge amount of general tax revenues (which are currently inadequate), this appears to be the most appropriate route to take—similar to what was done in Costa Rica and Thailand (McIntyre et al., 2013). Within SSA, Rwanda provides a best practice example of how to mobilise resources for coverage of the informal sector and the poor, in a CHI scheme using government taxes and external aid (Woldemichael et al., 2019).

Eighth, having multiple pools within one pool is both inefficient and inequitable, especially where one group is using general tax revenues to pay for premiums, and is also entitled to a more comprehensive benefit package than the rest of the members in the same pool, with little cross-subsidisation between the pools. The experience of the Kenya NHIF is a good example in the ECSA-Health Community. Civil servants could be deemed to be better off and more privileged in countries where there is rampant poverty (Barasa et al., 2018; McIntyre et al., 2013). As such, they need to pay for their premiums, as is the case in the Tanzania NHIF. With multiple pools within the same pool, as in the Tanzania NHIF and Kenya NHIF, there is limited cross-subsidisation, i.e., inequity arises and also high costs are incurred for processing claims—this partly explains the high administrative costs of the Kenya NHIF and Tanzania NHIF.

Ninth, CHI schemes are challenged by small infrastructure and a lack of capacity for administration and claims processing. As such, it is beneficial to outsource claims processing, card issuing, and funds management to a larger entity with comparative advantage in these functions, as has been done between CHF and NHIF in Tanzania (Lee et al., 2018; McIntyre et al., 2013).

In summary, the major lesson learned is that removing user fees in public and mission facilities, and introducing SHI, appear not to be achieving the goal of UHC in the ECSA-Health Community and other countries in SSA, as the poor/rural communities continue to face huge catastrophic payments and impoverishing health expenditures, and inadequate access to (and utilisation of) quality health services. Thus, further searches for appropriate and complimentary health financing policies need to be pursued.

8. Future Research

Future research in the ECSA-Health Community region should, among others, look into the following: 1) evaluation of the potential and feasibility of other innovative domestic resource collection mechanisms not previously assessed; 2) technical and allocative efficiency investigations; 3) understanding what works, for whom, and in what context, in terms of user fees removal and SHI/CHI design/implementation: e.g. the long-term equity/fairness in financing and service use among the poor — does user fees removal reflect the inverse equity hypothesis or not? (Victora, Vaughan, Barros, Silva, & Tomasi, 2000); and 4) User perception of fee abolition and the quality of health services, including: the effects of user fees removal on workload of health workers/quality of health services, existence and magnitude of unofficial fees after user fees abolition, the effects of user fees abolition on community health financing schemes, willingness of informal sector/poor/rural population to join a SHI scheme/CHI scheme when user fees are abolished in public/mission health facilities or desirability and feasibility of SHI when user fees are abolished in situations with large informal sectors, and the feasibility of SHI in achieving UHC in situations with large rural sparse populations with poor health infrastructure and long distances to health facilities. In addition, as also identified by McIntyre et al (2013): 1) appropriateness of using general government tax revenues for paying for contributions of civil servants in SHI schemes; 2) feasibility of coverage of those in the informal sector and the poor using a voluntary approach— contributory schemes, as opposed to using general government tax revenues; and 3) the challenges of targeting, as compared to a universalist approach in health financing policies.

Conclusion

The experiences from other countries across SSA and beyond clearly demonstrate that health financing policy reforms have been taking place for decades. While each of the reforms reviewed in this Policy Brief have also taken place in the ECSA-Health Community region, each country provides valuable unique lessons that should be considered in developing health financing policy reforms for UHC across the ECSA-Health Community region. As such, lessons learned can consist of successes as well as missteps, and can aid ECSA-Health Community member states in navigating the potential complications in implementing health financing policy reforms for UHC.

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