Resource Pool for a Single National Health Insurer in Tanzania

Mariam Ally
DPP/MOHSW

Arin Dutta, PhD
Health Policy Project

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On Behalf of DPP/Health Financing Unit, with support from P4H and Health Financing Strategy working group

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Objectives

1. Background
2. Methods for fiscal space analysis
3. Introduction to MBP
4. Innovative Financing Sources
5. Summary and Results
6. Implications

What is fiscal space analysis?

- ***Fiscal space*** (for health) can be defined as the combined potential annual resources that could be mobilized across government, development partners, philanthropy, and households.
- Comparison with resources needed can help determine if current sources will be sufficient or if new sources must be found
- Fiscal space analyses should anticipate changes to trend and the potential for innovation

Recent fiscal space analyses for health in Tanzania

- OPM October 2014. Scenarios based on:
  - GOT spending at Abuja target (15% of pub. exp.)
  - 50% population on health insurance by 2024/25
  - Innovative sources of financing
  - “Efficiency savings”
  - Borrowing
  - Resource needs for gap analysis based on per capita spending target, not sector strategy

Revised fiscal space analysis for HSSP IV

- Changes made:
  - Revise based on:
    - latest data (macroeconomics and PER/RBA)
    - trend in on- and off-budget external funding
  - Update based on draft Health Financing (HFS) design
    - Incorporate scenarios based on HFS options
  - Revise innovative financing ideas to latest options*
  - Compare to MBP costs

* Includes AIDS Trust Fund and options discussed by Inter-ministerial Steering Committee for the HFS

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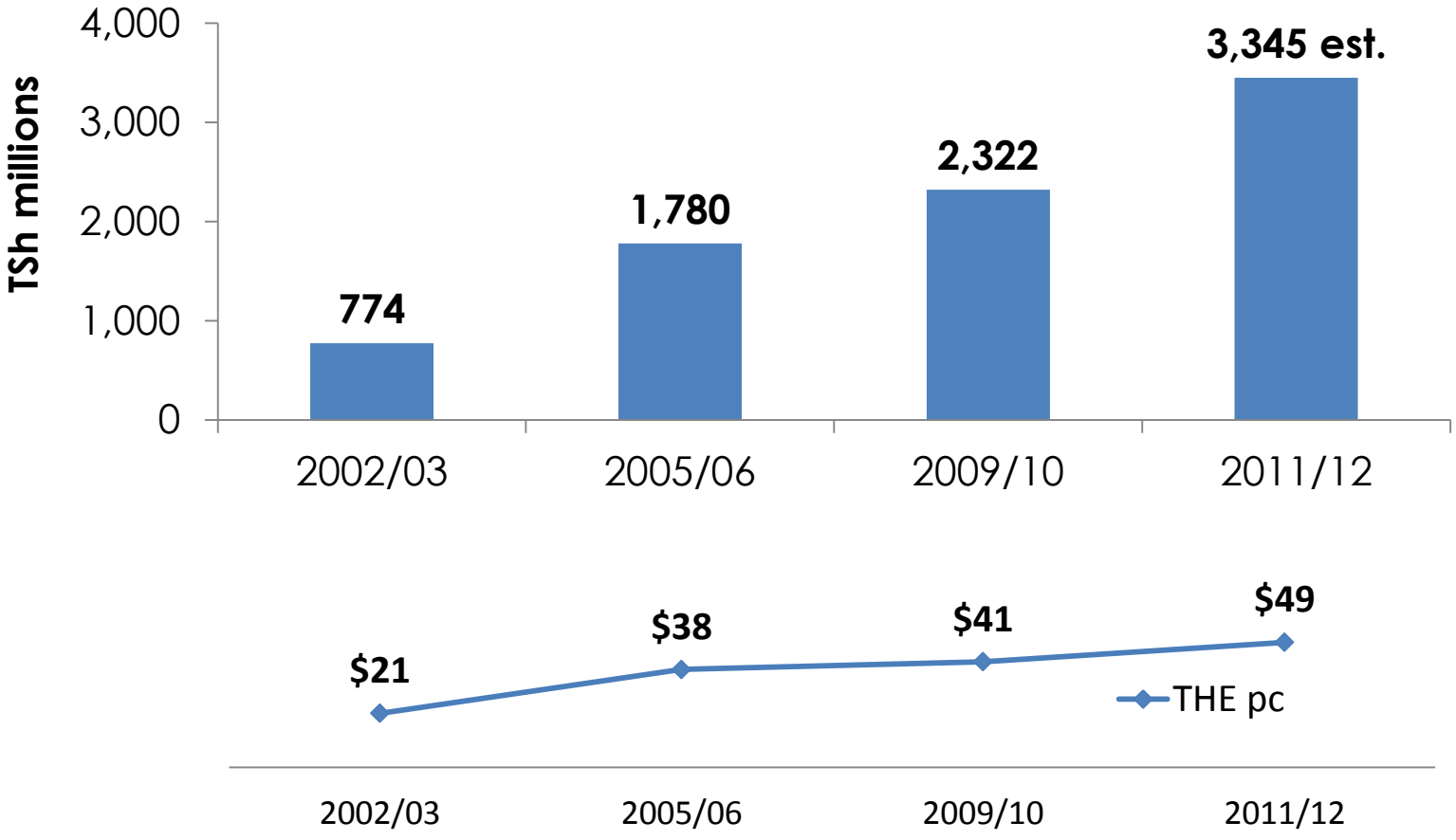
BACKGROUND

Total health expenditure



Source: National Health Accounts. 2011/12 values are draft estimates and should not be cited.

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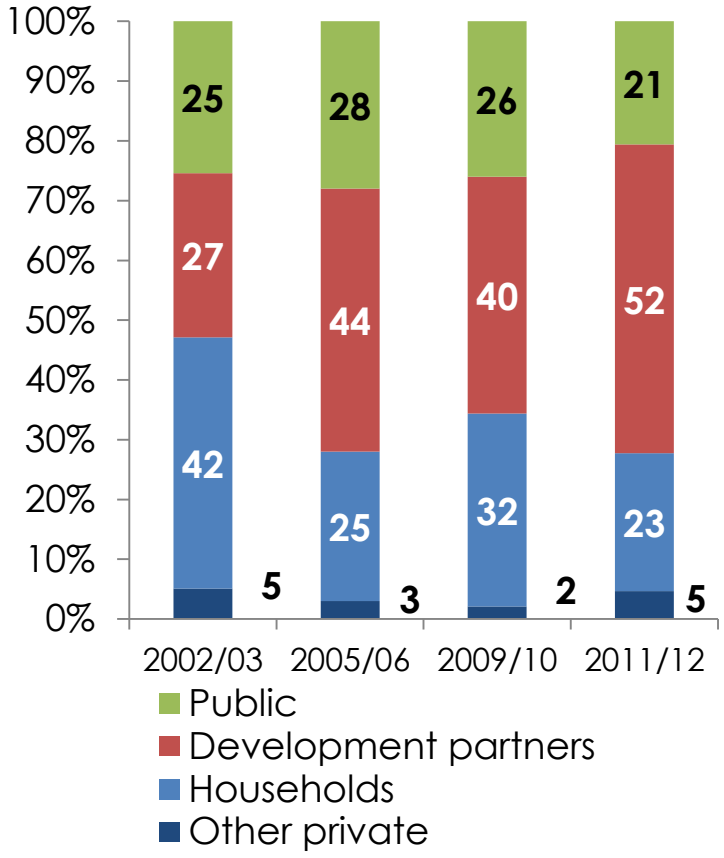
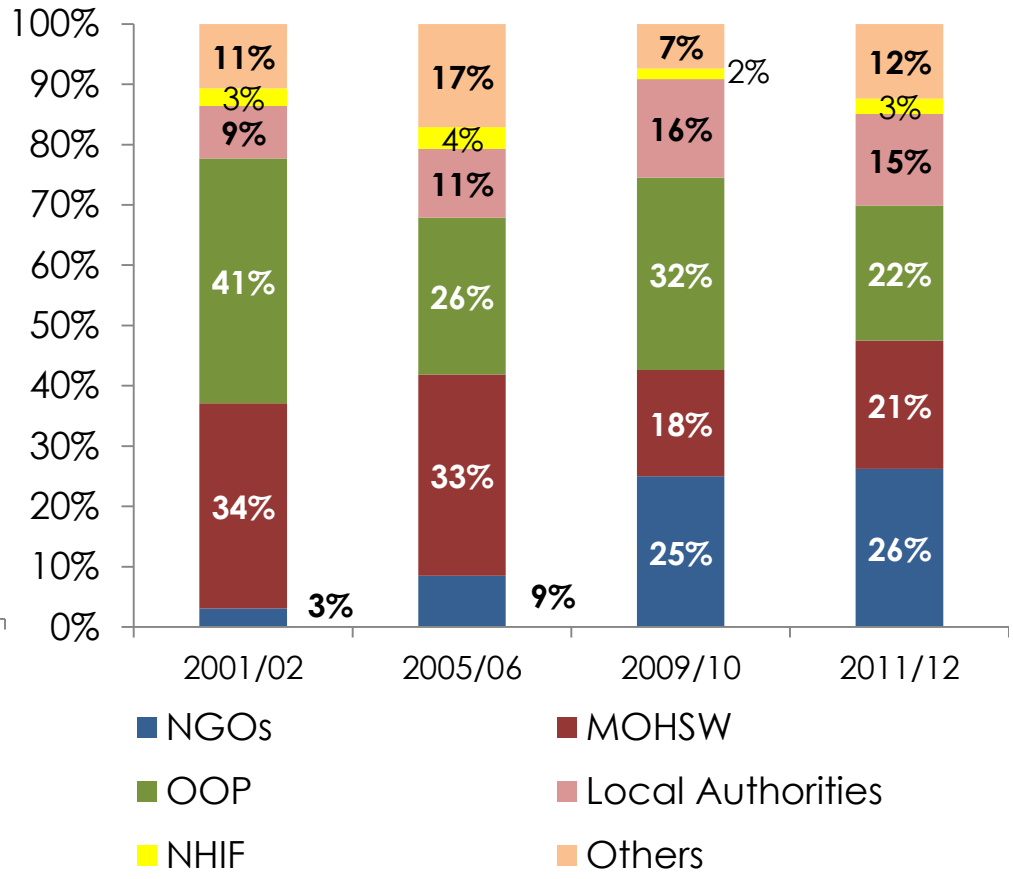
Health financing sources and agents

Total Health Expenditure by Financing Source and Financing Agent





Source: National Health Accounts. 2011/12 values are draft estimates and should not be cited.

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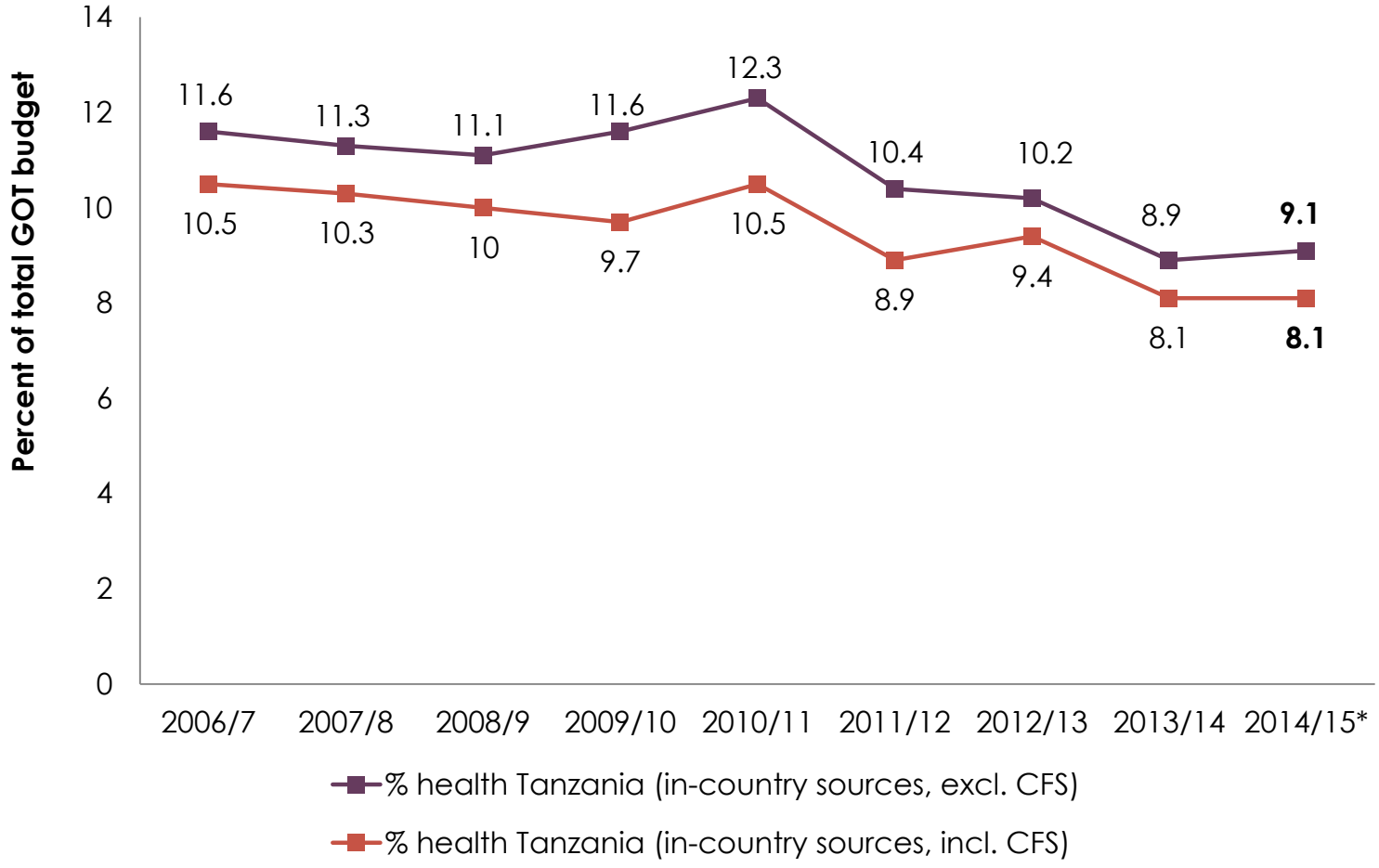
GOT allocation to health



Source: PER 2014. Final FY 2014/15 values may shift slightly.

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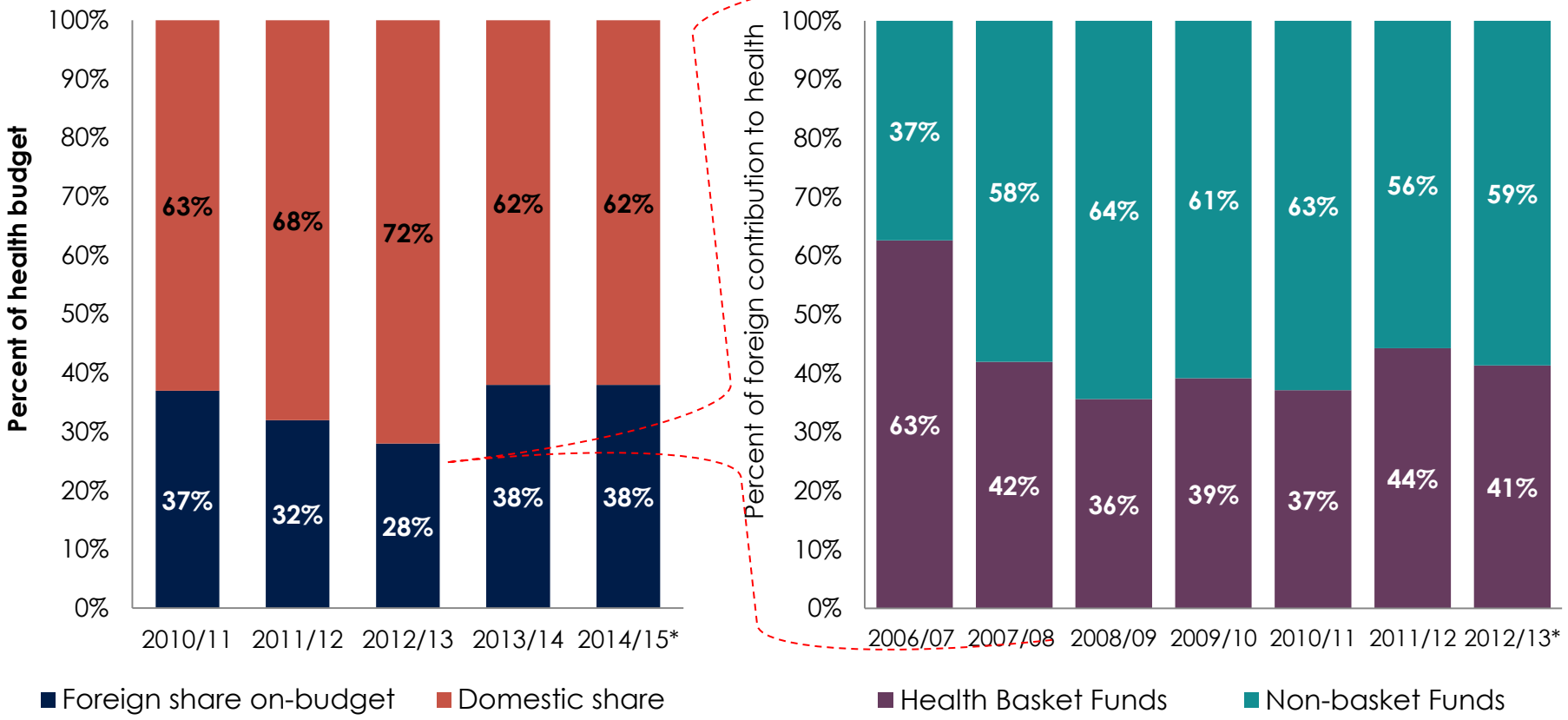
External resources on-budget, MOHSW



Source: PER, various. * Budget amounts. All other amounts based on actuals.

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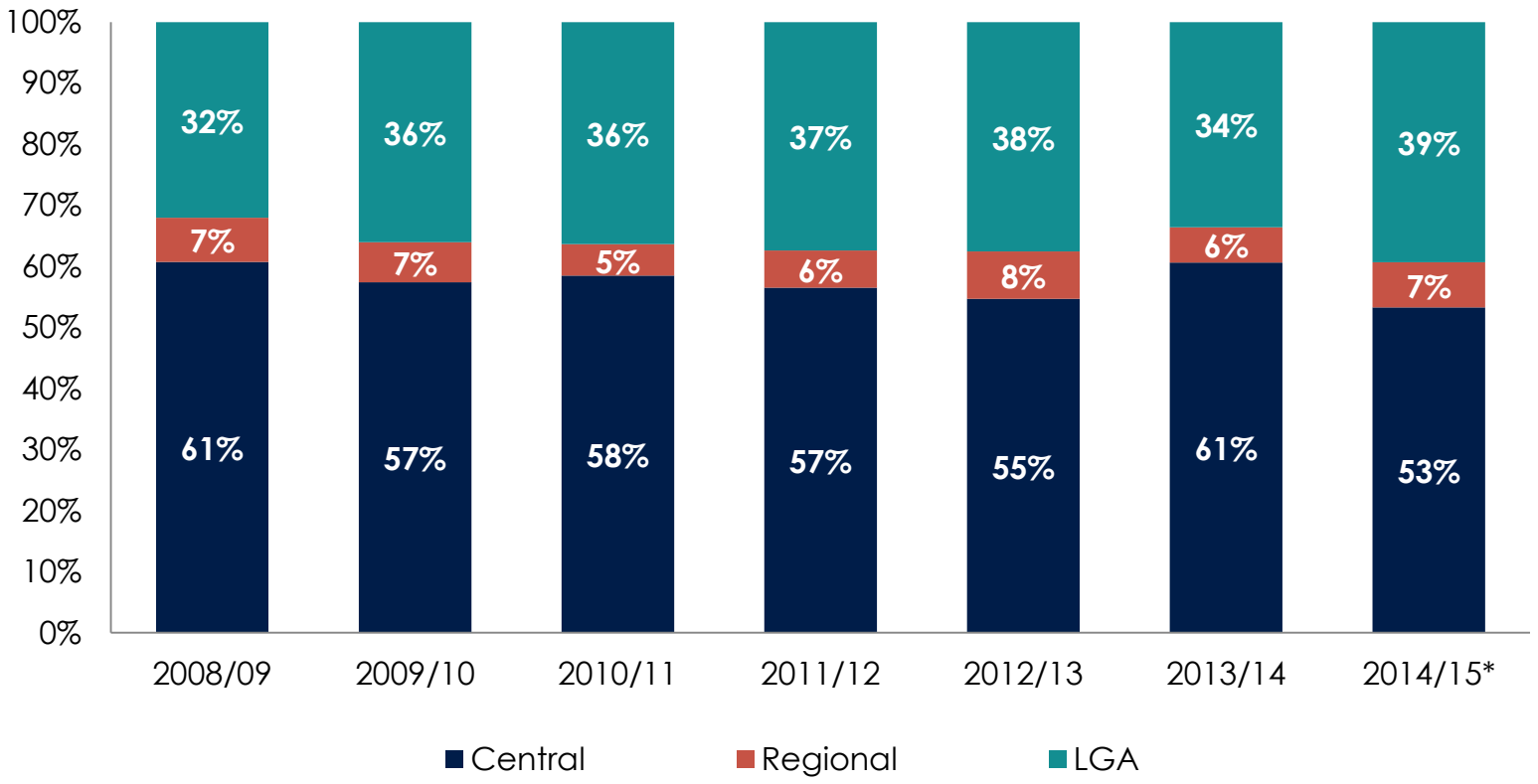
Where does GOT health spending occur?

Composition of GOT health sector actual expenditure, by level



Central level includes PMO-RALG spending but not TACAIDS. Further disaggregation is needed.

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METHODS

Fiscal space methodology

- Created a macroeconomic model
  - GDP, tax collections (VAT, excise, direct taxes)
- Disaggregation of MOHSW allocation + external
  - External resources on- and off-budget
  - Domestic resources from GOT
  - Provision for LGA own sources: allocation to health
  - Provision for potential innovative sources
- Module for *Single National Health Insurer* contribution scenarios

Some assumptions

GOT

- Nominal GDP growth 2016/17 to 2020/21: 11.2 → 8.4% p.a.
- Tax revenue as % of GDP: at 17.2% from 2016/17 (grants: 1.9%)
- GOT expenditure with deficit target of 4% of GDP from 2015/16

Development partners on and off budget: summary

- Health Basket Fund FY 2015: $47 mil. Thereafter, 5% decline p.a.
- GF alloc. 2014-17: $633 mil. + $79 mil. incentive (HIV). Decline 5% p.a. from FY 2017/18
- USG (USAID, CDC, DOD): $349 mil. based on 2011/12 NHA. For FY 2013: $25.7 mil. FP/RH; $12.6 mil. MCH; $45.8 mil. malaria; $348 mil. HIV. *Removed $12.1 mil. for PEPFAR internal mgmt. & ops.*
  Total = $420 mil. or *TZS 735 billion* in 2014 shillings.

Other assumptions, contd.

- **World Bank**: FY 2016/17-20/21: $200 mil. IDA; $30 mil. GFF TF + $54 mil. USAID aligned*. Disaggregated over time. **USAID value for 2016/17 adjusted appropriately*
- **DFID**: $23.45 mil. for health (est.) in FY 2013. NHA 2011/12 value: $22.5 mil.
- Most bilateral partners: value derived from 2011/12 NHA and adjusted for inflation, flat till 2016/17, and then some decline from 2017/18:
  - USG - 5% p.a.; DFID – 10% p.a.; Canada: 20% p.a.

Overview of cost calculations

- Created a *new model to estimate the costs* of SNHI given choices on MBP inclusion, and:
  - utilization assumptions per capita
  - planned purchasing mechanism and cost recovery
  - expected SNHI coverage per year (x5 years)
  - analysis of cost to subsidize the poor
  - demographics, current public and FBO/NGO patterns of outpatient and inpatient care use by diagnoses
  - unit cost data from the NEPHI* study (2012)

* National Essential Package of Health Interventions

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Comparison to HSSP IV analyses

HSSP IV

Costing

- Costing using the OneHealth tool
- Costs based on strategy + disease program targets at population level
- Ingredients-based unit costs
- Not facility-based costing

Fiscal space

- Fiscal space for the entire system, not just SNHI
- With/without SNHI scenarios

SNHI analysis as of Apr. 1

Costing

- *Based on minimum benefit package*
  - MBP: 2 OPD scenarios, 2 IPD
  - MBP+: 2 OPD scenarios, 2 IPD
  - Capitation for OPD
- Uses data from NEPHI costing*
- At facility level, not population

Fiscal space

- Only from the perspective of the SNHI
- Analysis of expected subsidy cost

* NEPHI, MOHSW 2012

OVERVIEW: MBP ASSUMPTIONS

Review key SNHI assumptions

- **Standard MBP**
  - Intends to cover NEPHI services: PHC, and IPD at DH or RH
  - Yet to be defined exclusions
  - Intended for **all** except those who access MBP+
  - Currently planned providers are public and FBO facilities
  - The poor (subsidized population) can access MBP
- **MBP+**
  - Covers current formal sector scheme provisions under NHIF
  - Current formal sector members retain this coverage
  - Providers include public, FBO, and private* facilities
- Administrative costs of 15% of contributions (declines)

* Accredited facilities

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Standard MBP – OPD variants

Low Variant – Jan. 29 model

Services costed/included

- Pediatric/RCHS
  - Immunization, childhood diseases at PHC, ANC, BEmONC, CEmONC
- Communicable *(varies by level)*
  - Malaria, diarrheal diseases, acute respiratory infections
- NCD *(varies by level)*
  - Diabetes, hypertension, asthma
- General (injuries, etc.)
  - Head injuries, fractures, burns
- Not included
  - HIV treatment (incl. PMTCT), cancer treatment, mental health

vs. MBP Option Paper: Option 1

Interventions
Antenatal care
Safe delivery
PMTCT
Postnatal care
Routine immunization
Growth monitoring
Acute respiratory infection
Diarrhea
HIV/AIDS/STI
Tuberculosis (TB)
Malaria
Injuries / trauma

Standard MBP – OPD variants, Pt.2

High Variant – Jan. 29 model

Services costed/included

- Pediatric/RCHS
  - *Same as Low Variant*
- Communicable *(varies by level)*
  - Malaria, diarrheal diseases, acute respiratory infections, **ART 1st line**
- NCD *(varies by level)*
  - Diabetes, hypertension, asthma, **some cancer treatment**
- General (injuries, etc.)
  - Head injuries, fractures, burns
- Not included
  - ART 2nd line, certain types of cancer treatments, mental health (epilepsy)

vs. MBP Option Paper – Option 2

Interventions
Antenatal care
Safe delivery
PMTCT
Postnatal care
Routine immunization
Growth monitoring
Acute respiratory infection
Diarrhea
HIV/AIDS/STI
Tuberculosis (TB)
Malaria
Injuries / trauma
Anemia
Eye, ear, and skin infections
Nutritional deficiencies
Health education

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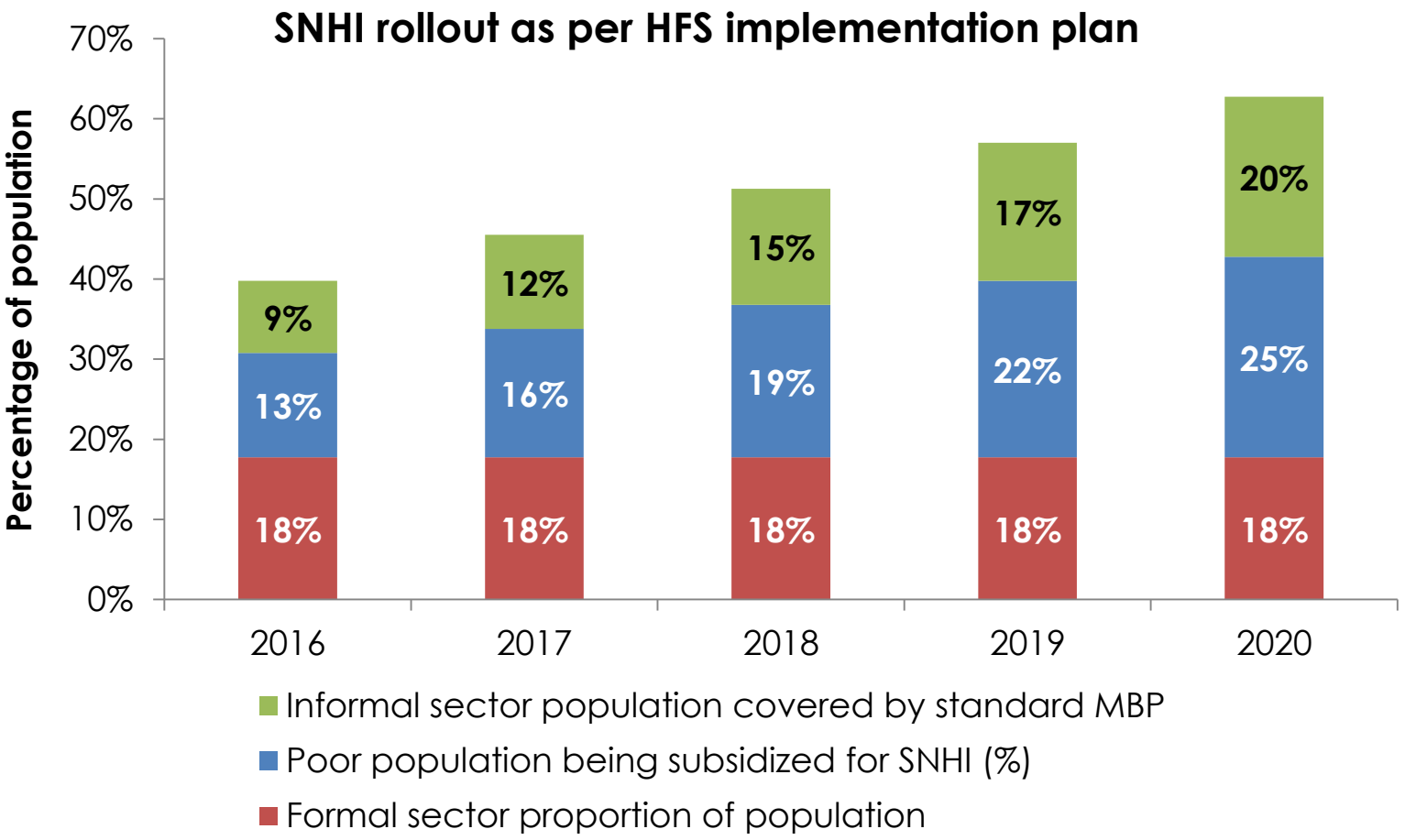
SNHI rollout assumptions



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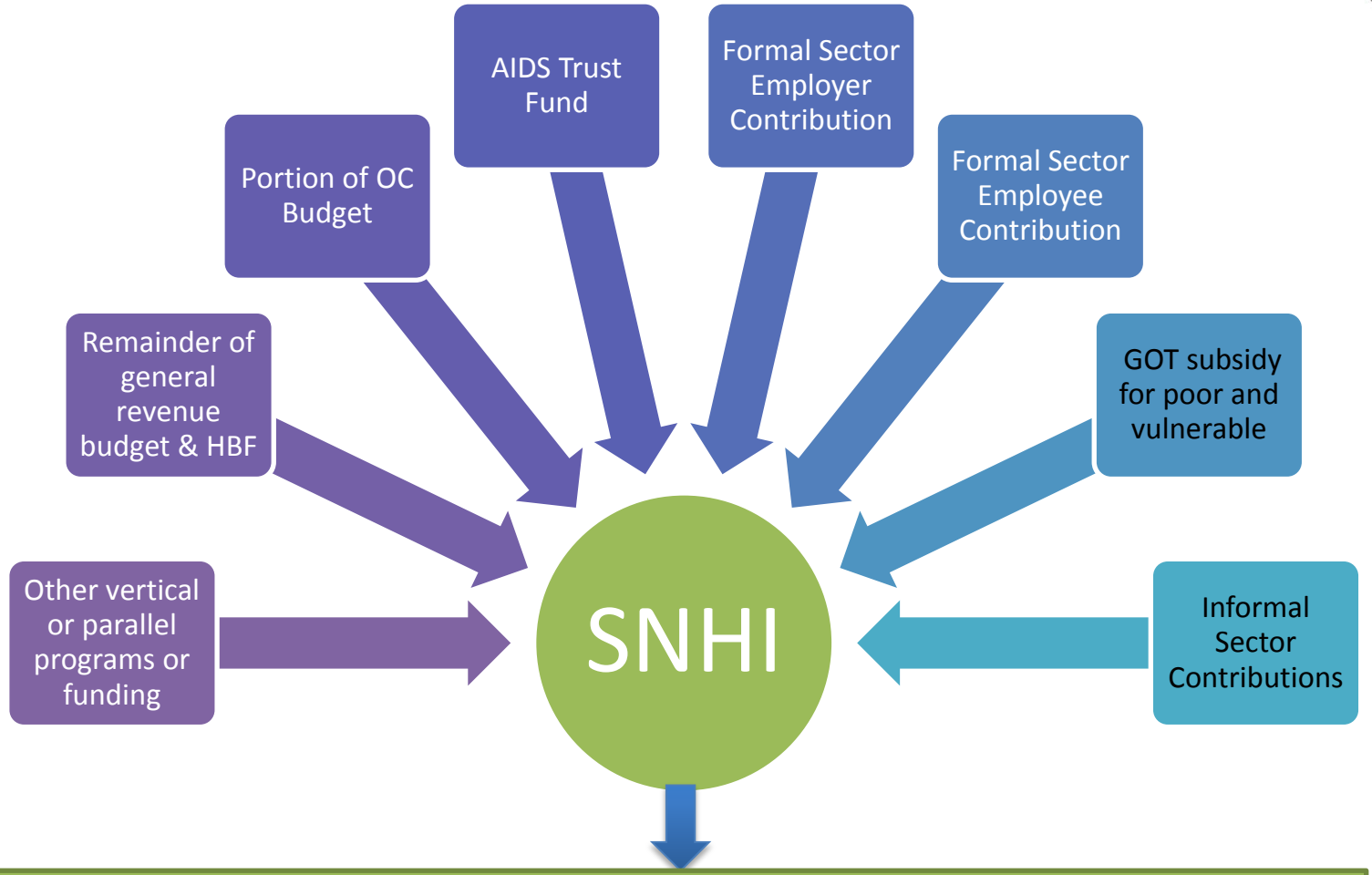
REVENUE GENERATION & POOLING

Pooled fund sources for SNHI

- Sources we anticipate going to the SNHI pool
  1. Formal sector employees contribution
  2. Ability-to-pay informal sector contributions
  3. Portion of GOT domestic allocations for health
     - Transfers to LGAs (PE/OC), development funds
     - Portion of external on-budget resources, incl. Global Fund, GFF, RBF resources
- SNHI pooling is 'weighted' to SNHI coverage
- Assume GOT and partners still fund health for non-SNHI population

What is pooled for SNHI?



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Pooling considerations

Pooled Area	Option 1	Option 2	Option 3
1. GOT domestic funds: PE/OC to LGAs, central medicines, funds for regions; LGA own source	Pool proportion = % of population in SNHI being subsidized (poor)	Pool a greater proportion, e.g., poor + informal % in SNHI	Pool for the entire % of population in SNHI
2. Health basket fund	Pool proportion = % of population in SNHI being subsidized (poor)	Pool a greater proportion, e.g., poor + informal % in SNHI	Pool proportion = % of population in SNHI
3. On-budget vertical disease programs + on-budget donors	Pool proportion = % of population in SNHI being subsidized (poor)	Pool proportion based on other considerations, e.g., % of disease needs covered in SNHI	Pool proportion = % of population in SNHI
4. Off-budget vertical disease program funders + other bilateral donors	Do not pool into SNHI	Pool proportion based on other considerations, e.g., % of disease needs covered in SNHI	Pool proportion = % of population in SNHI or % of population being subsidized (poor)

Greater fiscal space for SNHI

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Contribution scenarios	1. Lower informal sector household contributions	2. Higher informal sector household contributions
A. SNHI contributions: *formal sector contributions shared 50% with employer*		
Urban areas: per year		
Formal sector	400,000 per household (current avg.)	
Informal sector	94,000 per household	152,000 per household
Rural areas: per year		
Formal sector	As urban areas	
Informal sector	53,000 per household	91,200 per household
B. GOT domestic sources including LGA own sources: *increases taken from FY 2016*		
GOT domestic	2% increase p.a.	
LGA own source	5% increase p.a., 5% to health	
C. External on-budget sources: *increases or decreases taken from FY 2016*		
HBF	5% decline p.a.	
GFATM, etc.	Actual allocation till 2017, then modest decrease	
D. Innovative financing sources: *added from FY 2016 except AIDS Trust Fund*		
Taxes	Airtime/SIM levies, net surplus of parastatals, sin taxes	
Other funds	Add AIDS Trust Fund (from FY 2015): ? TSH	

DISCUSSION ON INNOVATIVE FINANCING

Options and Choices

Antecedents of options

- Interministerial Steering Committee (ISC) meeting, Feb. 9, 2015 review of health financing strategy
- Need to develop fiscal space scenarios for consideration by ISC as well as GOT leadership
- Request for additional analysis of potential pooling possibilities into SNHI* from:
  - Sin taxes, particularly tobacco taxes
  - Mobile communication (airtime) levy
  - Public corporations' surplus revenue levy
- AIDS Trust Fund

* Single National Health Insurer (proposed)

ALCOHOL AND TOBACCO TAXES

Current Tanzanian tax policy

- Three major sources from tobacco and alcohol:
  1. TRA *Domestic Revenue* division
     - Excise tax: small/medium producers (primarily alcohol)
     - 18% VAT from local retailers (primarily alcohol*)
  2. TRA *Large Taxpayers* division
     - Excise tax on large producers (alcohol and tobacco)
     - 18% VAT from large retailers (alcohol and tobacco)
  3. TRA *Customs & Excise*
     - Customs duty on alcohol imports

TRA: Tanzania Revenue Authority * Alcohol includes beer, wine, spirits, and *konyagi*

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Excise taxes on alcohol and tobacco have been raised several times

Item TZS	2012 rates	2013/14 rate	% increase	2014/15 rate	% increase
1. Beer: un-malted	310/liter	341/liter	**10%**	375/liter	**10%**
2. Beer: other	525/liter	578/liter	**10%**	694/liter	**20%**
3. Wine: domestic grapes >75%	145/liter	160/liter	**10%**	192/liter	**20%**
4. Wine: foreign grapes >25%	1,614/liter	1,775/liter	**10%**	2,130/liter	**20%**
5. Spirits	2,392/liter	2,631/liter	**10%**	3,157/liter	**20%**
6. Cigarettes : no filter (per 1,000)	8,210	9,031	**10%**	11,289	**25%**
7. Cigarettes: with filter (per 1,000)	19,410	21,351	**10%**	26,689	**25%**
8. Other cigarettes (per 1,000)	35,117	38,628	**10%**	48,285	**25%**
9. Cut rag or cut filter (per 1,000)	17,736	19,510	**10%**	24,388	**25%**

Sources: MOF, TRA, author analysis

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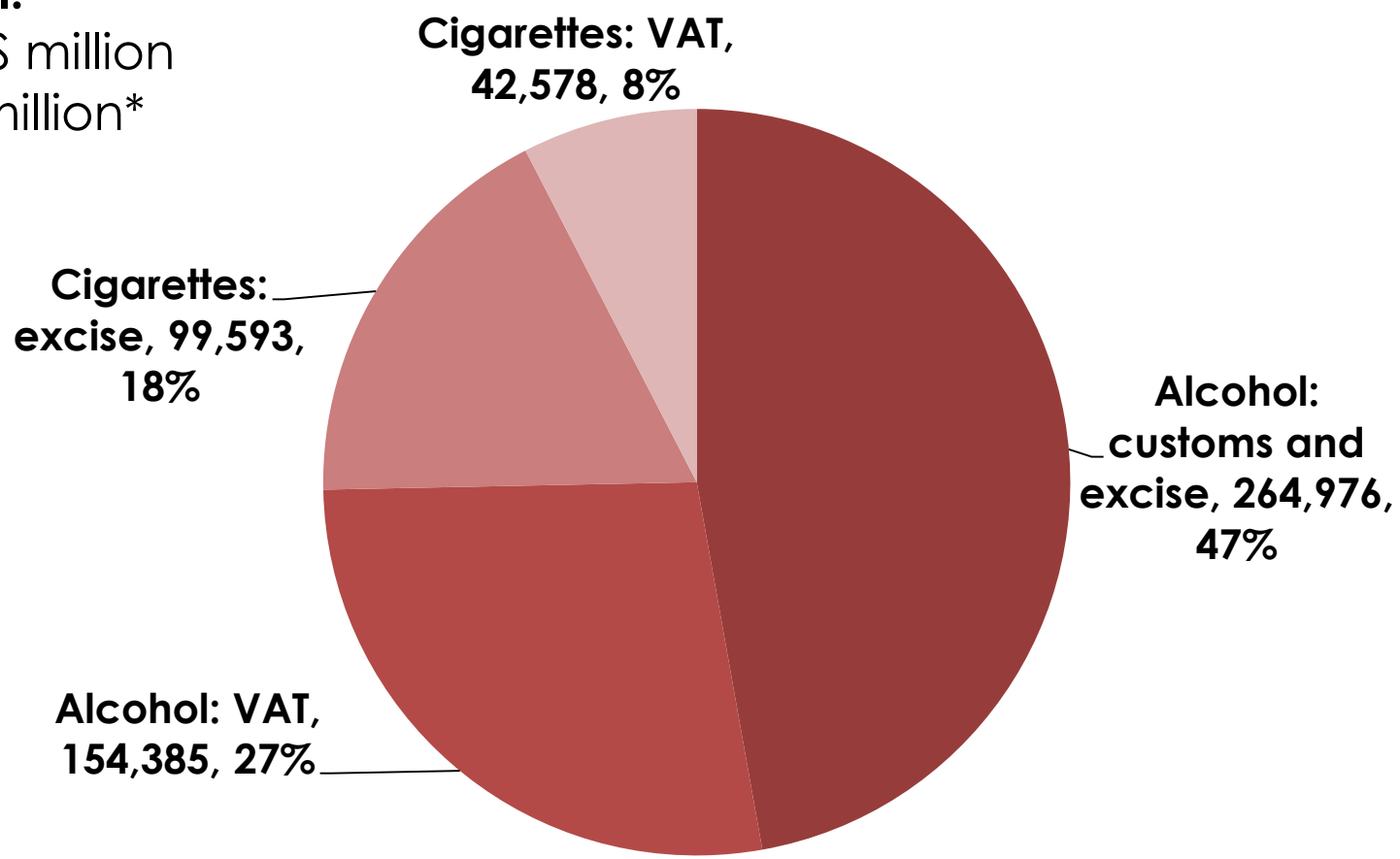
Total tax revenue from alcohol and tobacco: FY 2013/14

Total:
561,532 TZS million
US$ 353 million*



Sources: TRA, author analysis

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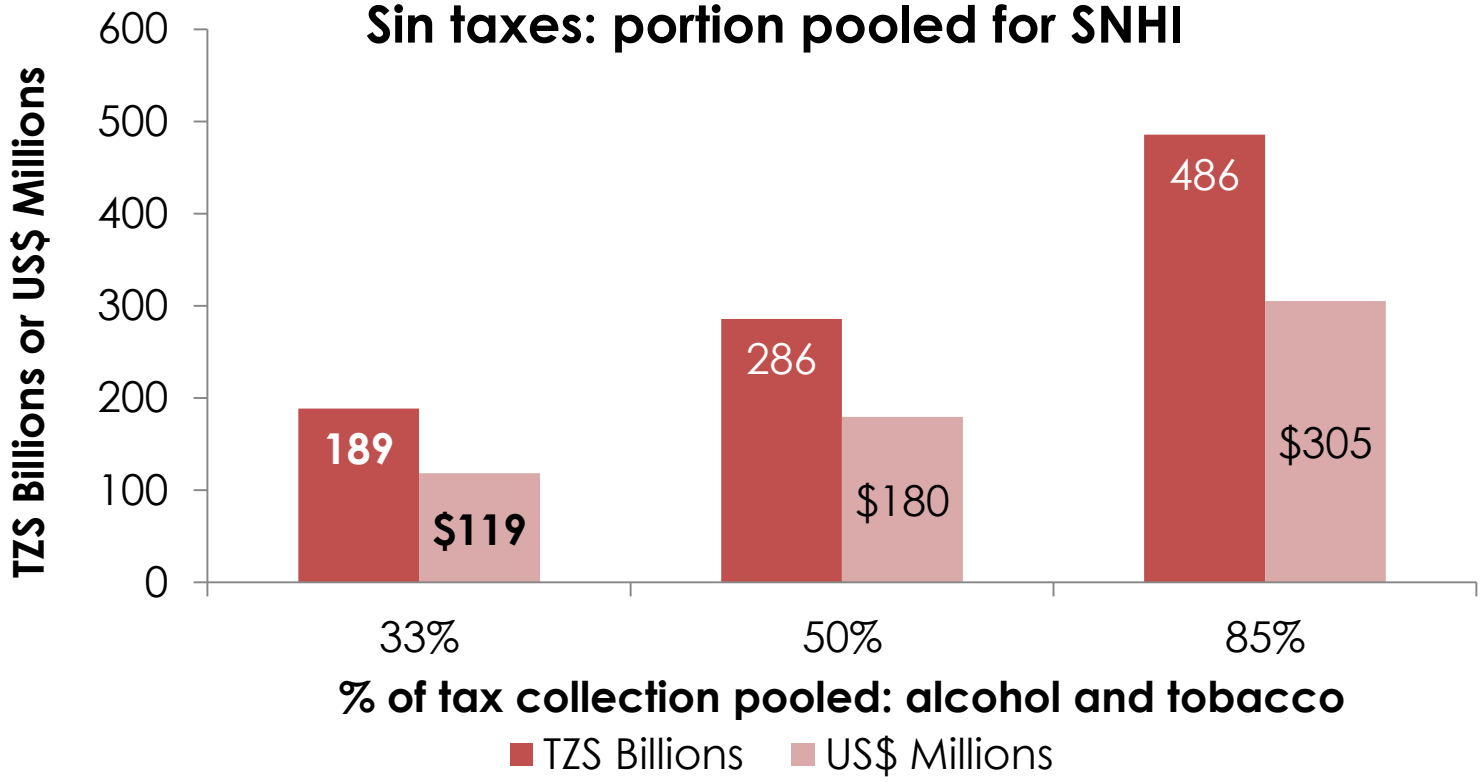
* All conversions using period average exchange rates.

Discussion

- Total collection (562 TZS bn.) is *higher* than reported in prior fiscal space analysis (James et al. 2014, 294 TZS bn.)
- Successive years of increases in alcohol and tobacco excise suggests limited space for further increase
- In discussion with MOHSW, considered 10% further increase in tobacco excise rates only
- VAT is fixed across the board (18%): no change
- Conclusion: Small increase in rates. A *portion* of sin taxes revenue can be pooled for health sector

Scenarios: sin taxes pooled for SNHI based on FY 2013



Portion pooled for health in current scenario: **33%** (S. Korea);
Other: 50% (Indonesia) 85%: Philippines (tobacco)

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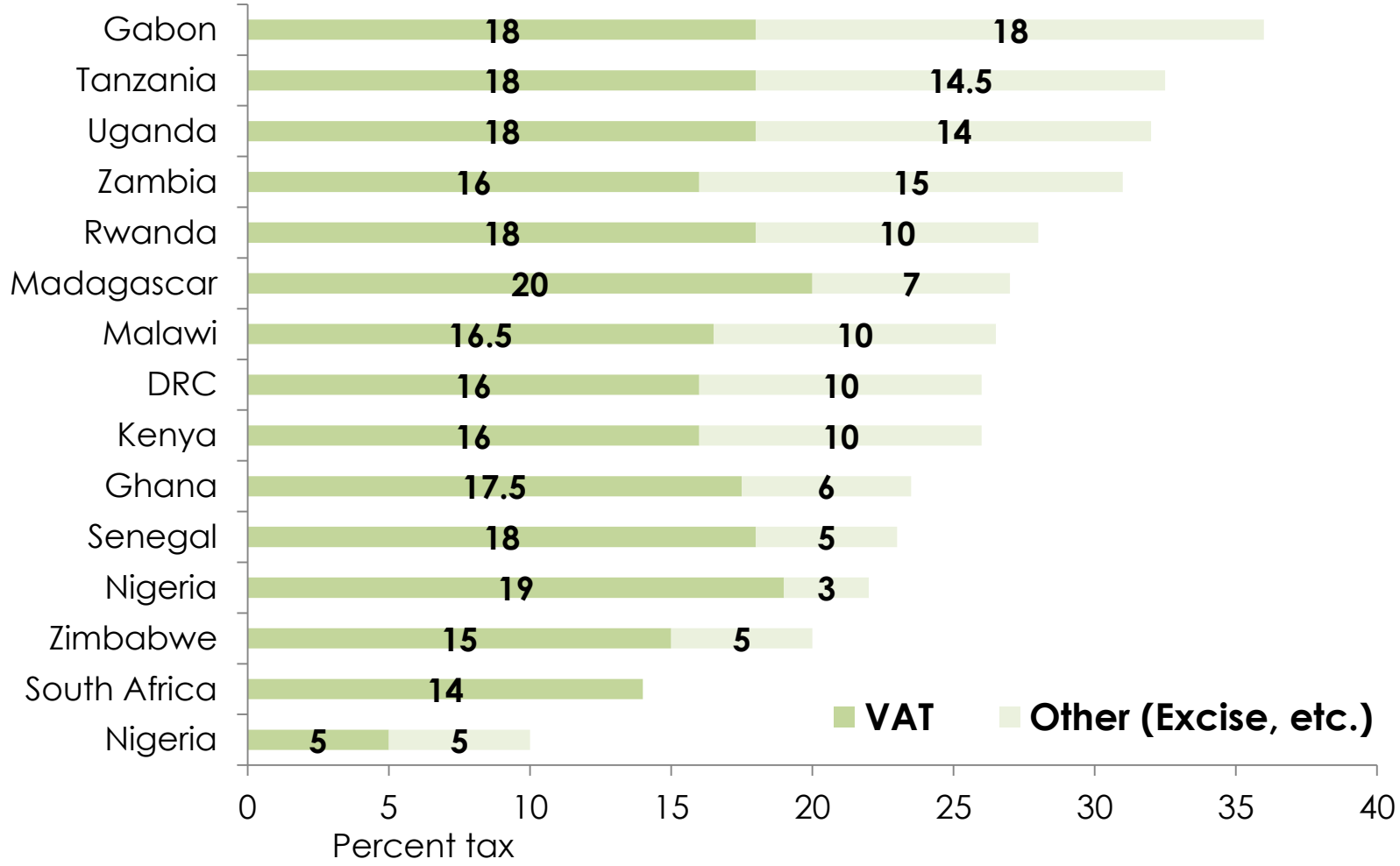
TAXES ON MOBILE COMMUNICATION

Current Tanzanian tax policy

- Two major sources from telecom services:
  1. Excise: as of Budget 2013/14*
     - **14.5% excise tax** collected on "electronic communication services" (incl. packaged airtime scratch cards, data)
       - **2.5 percentage points for education sector (17% of total)**
     - **TZS 1,000 per month** levy on each SIM card
     - Other: 0.15% of any amount > 30,000 TZS transferred via mobile phone (or other means)← *amended Budget 2014/15*
  2. VAT: **18%** on sale of electronic communication services (incl. airtime and mobile data)

* Formalized in Finance Act, 2013. Replacement of 'airtime' with this new language clarifies tax application for a broader compass of communication activity. This discussion excludes taxes on handsets.

Taxes on mobile communication in Tanzania in relation to Africa



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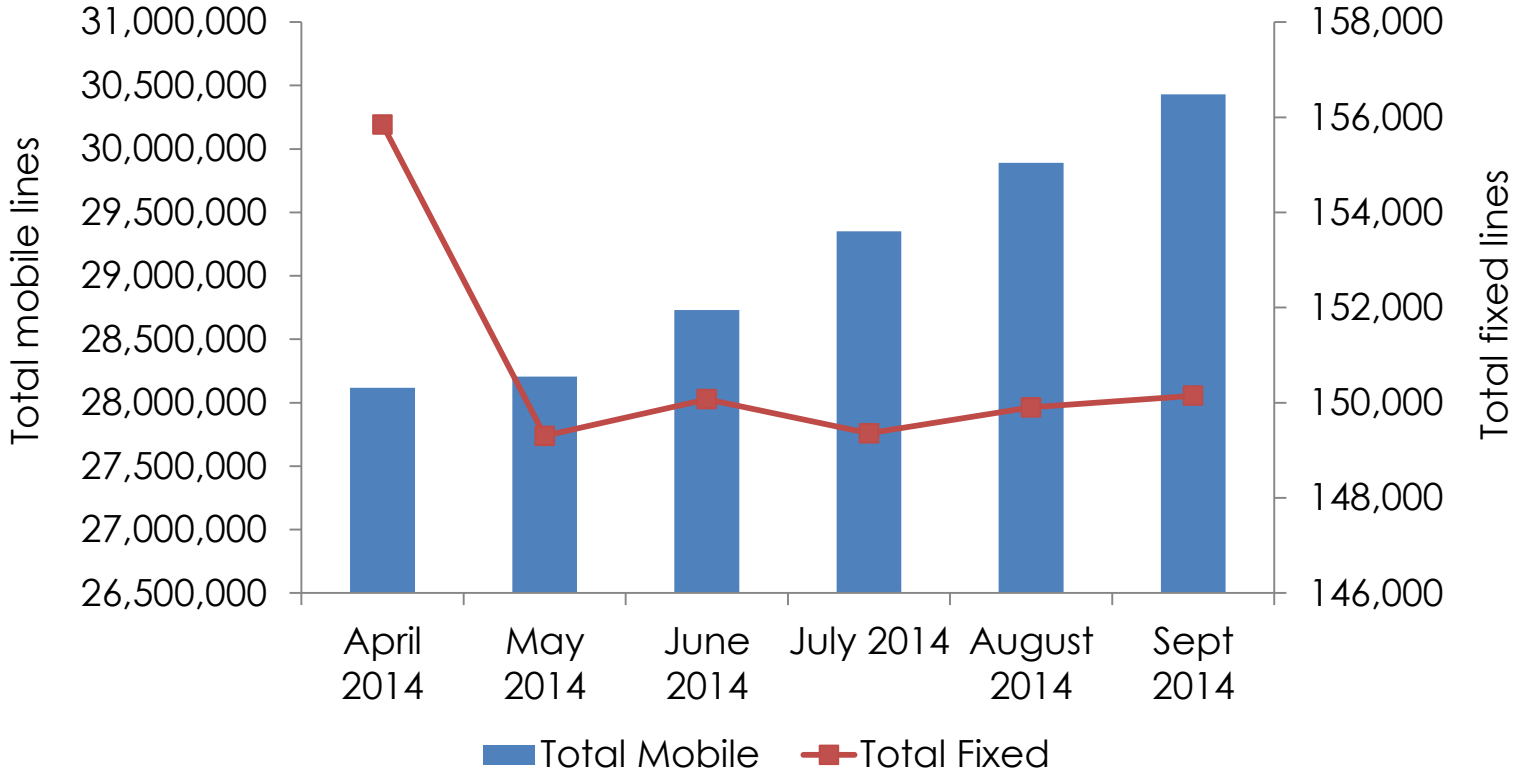
Sources: GSMA, PwC, etc., (2012-2014). Tanzania values do not reflect SIM levy or mobile cash transfer levy.

Tax data hard to disaggregate: mobile vs. fixed telecom



But safe to say that most activity is mobile and growing..

Sources: TCRA

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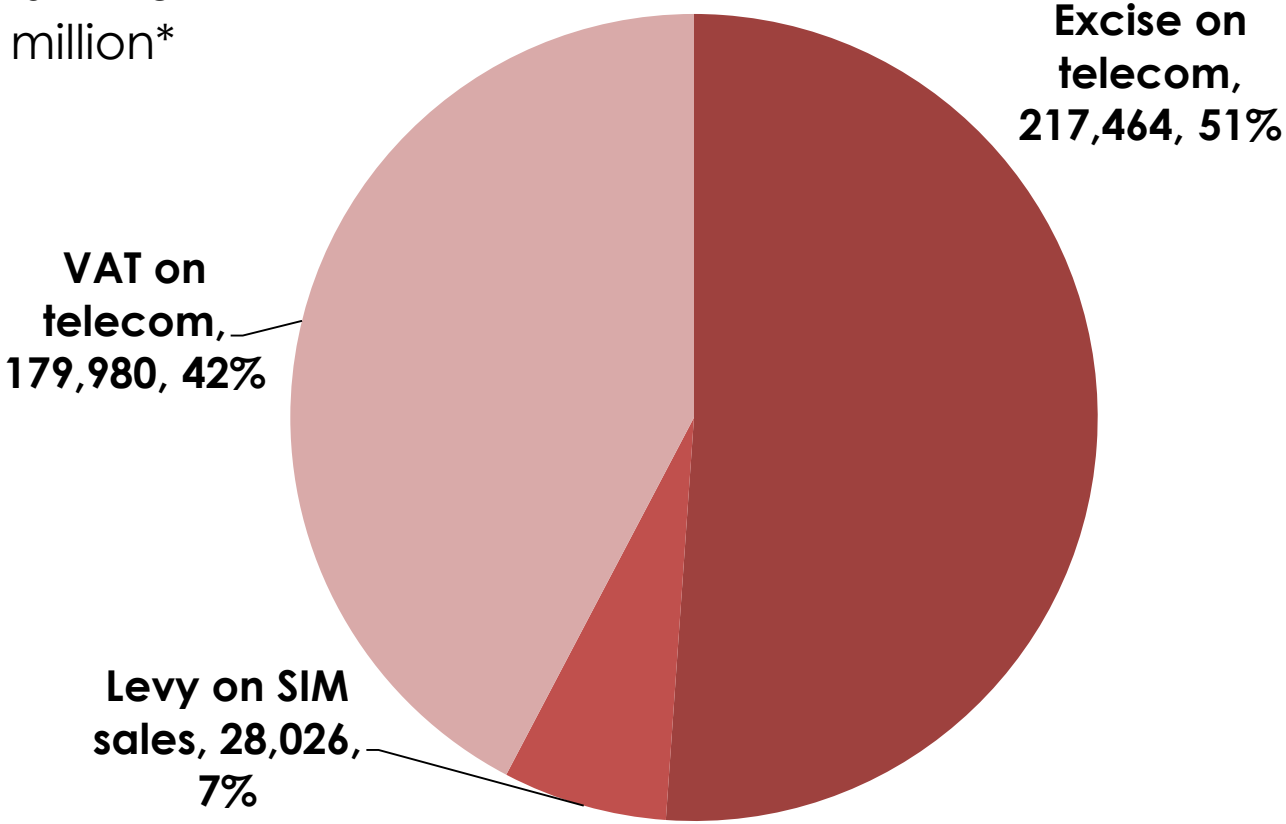
Total tax revenue from telecom services: FY 2013/14

Total:
425,470 TZS million
US$ 268 million*



Sources: TRA, author analysis

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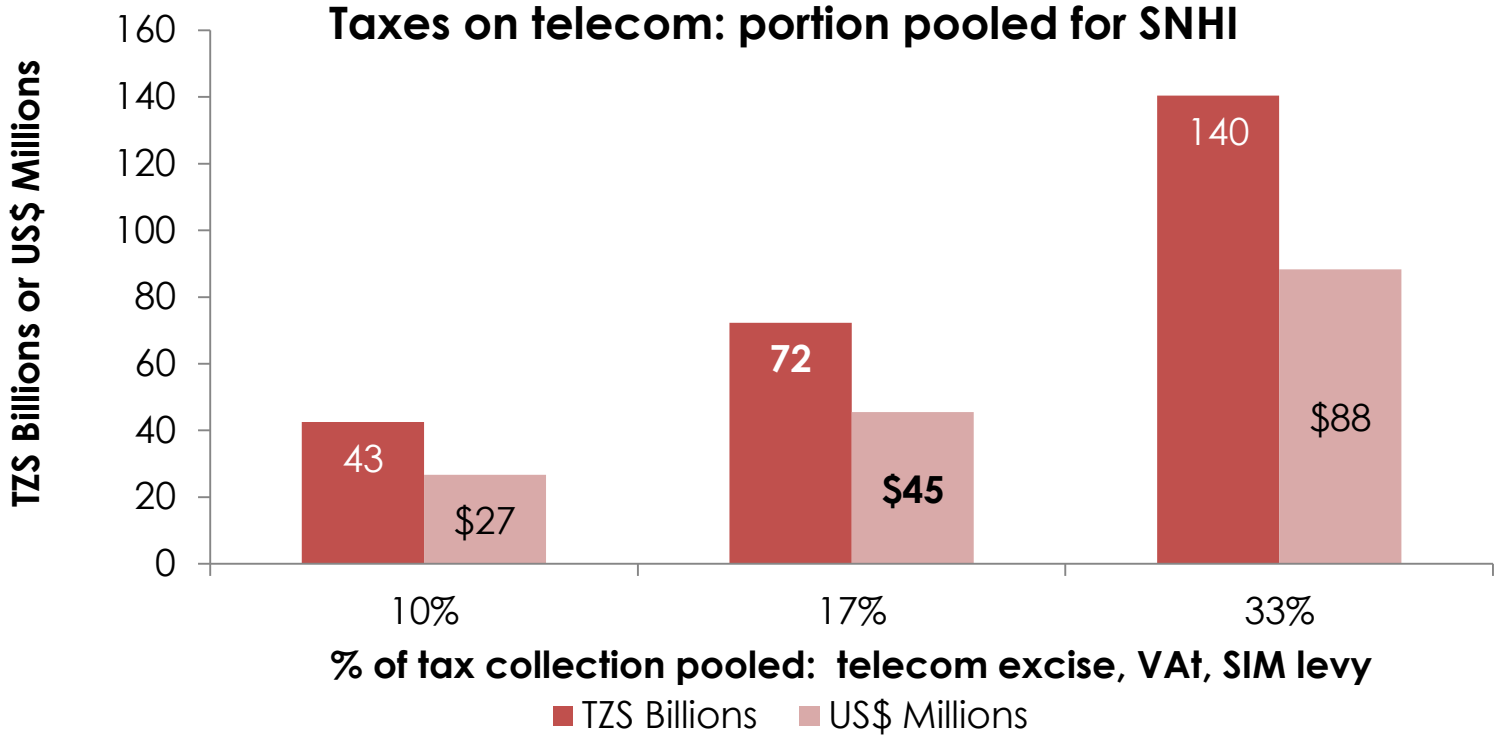
* All conversions using period average exchange rates.

Discussion

- Total collection (425 TZS bn.) is *much higher* than reported in a prior analysis (James et al. 2014, 69 TZS bn.)
- Indirect taxation of mobile communication is popular for revenue generation in less formalized economies
- Tanzania has relatively high total taxes in this category
- Tax on transfers removed in 2014, now 10% on fee charged only
- Conclusion: Not much scope for increase in rates. Rate increases would be passed on to consumers. This would likely be *regressive* and also affect consumption
- A *portion* of related revenue can be pooled for health
  - Note education already receives 17% of excise on mobile services

Scenarios: taxes on telecom pooled for SNHI, based on FY 2013



Portion pooled for health: **17%** to match the education sector.
Other: *20%: Ghana*

Excise collected on money transfers (remittances): ~TZS 26 billion (FY 2013) have been excluded due to lack of clarity on whether these are mobile or bank transfers

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AIDS TRUST FUND

Status of the AIDS Trust Fund

- Tanzania Commission for AIDS (Amendment) Act, 2014
  - Approved by Parliament, week of March 23rd, 2015
- Establishes a 'Trust Fund' administered by TACAIDS ED
- Funds and resources consisting of*:
  - Parliamentary appropriations
  - Other revenues raised by TACAIDS, or via loans, donations, grants, investment, and other acquired funds
- 2% used for co-ordination, entirety ring-fenced for HIV
- Proposed FY 2015/16 allocation unknown.
- Also effort to get an allocation for HIV commodities, cabinet paper

* Source: Language of the TACAIDS (Amendment) Act, 2014

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SUMMARY AND RESULTS

Innovative financing sources

Source	Notes	Feasibility*	Size of potential revenue (FY 2013)
Tax on surplus of public corp.	• Unknown equity • Not common for health	Unknown, value not reliable	TZS 94 bn. ~ **0.169**% of GDP
Airtime levy	• Possibly regressive • Not common for health	Positive	TZS 72 bn. ~ **0.13**% of GDP
"Sin taxes": - *Alcohol* - *Tobacco*	• Unclear equity • Known instances, also positive effects on health	Positive outlook	TZS 286 bn. ~ **0.514**% of GDP
AIDS Trust Fund; HIV commodities	• Unclear sources • Specifically for health	ATF is approved; Cabinet paper on ARVs gap	Unclear, assumed US**$158** mn. per year from FY 2017/18 (TZS 300 billion), TZS 3 billion in FY 2015/16, 100 billion in 2016/17

* From HFS workshop

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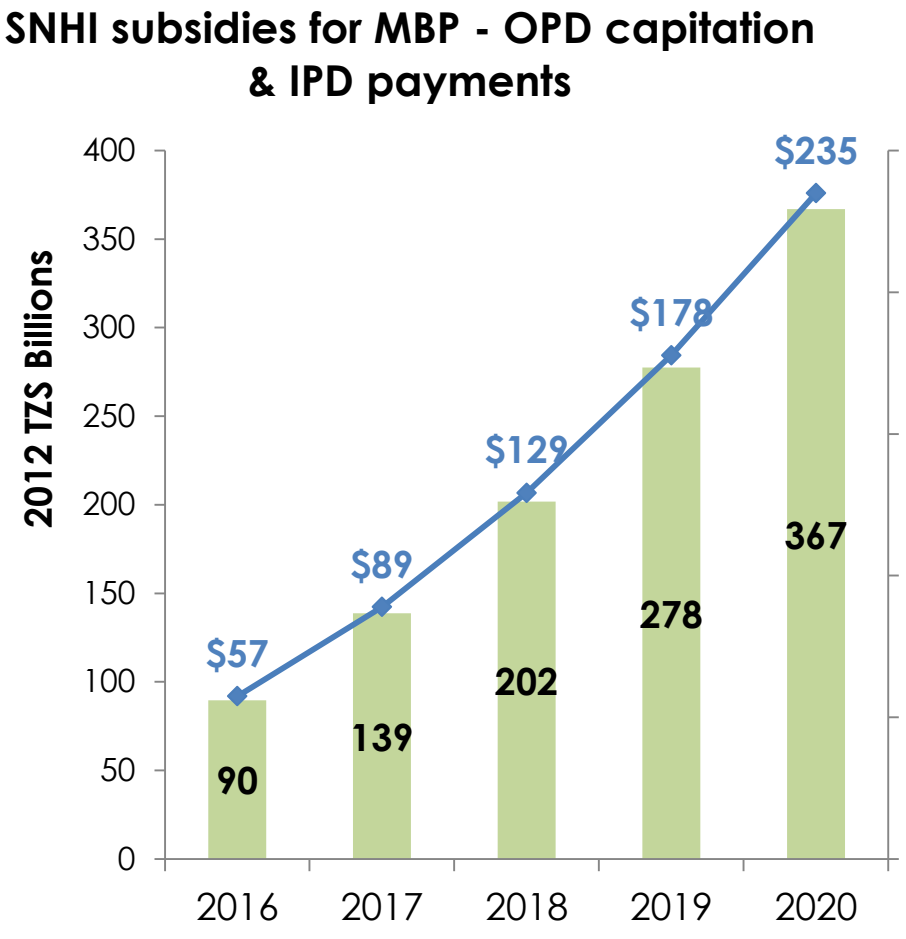
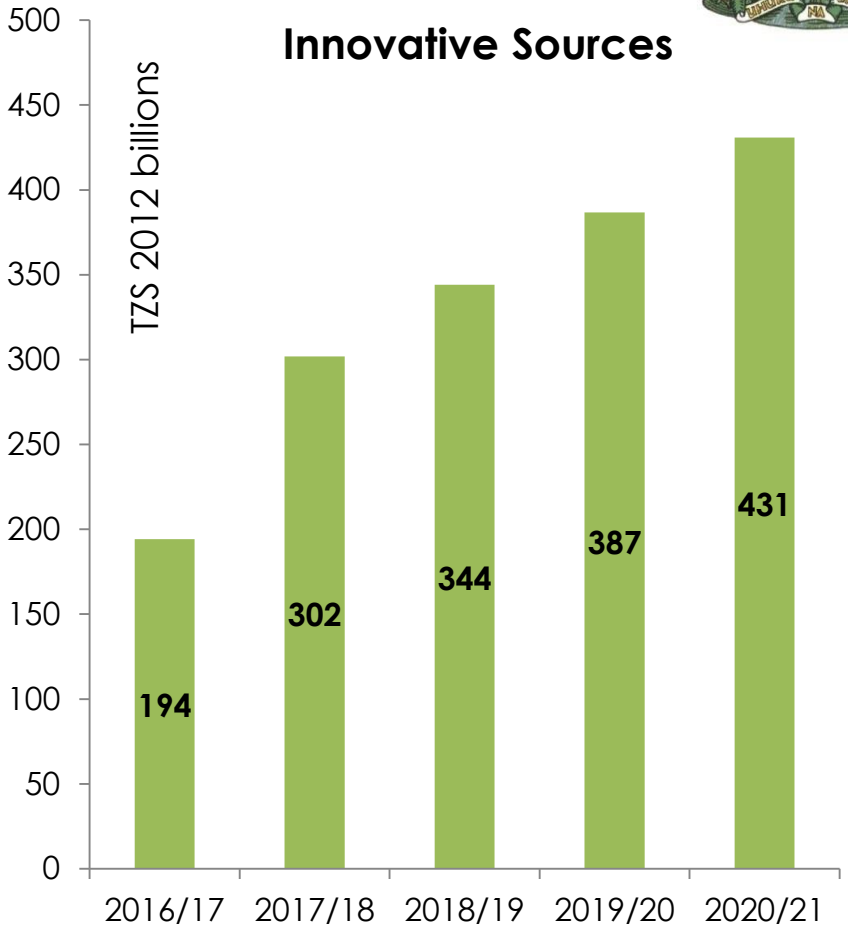
Expected subsidies vs. new sources





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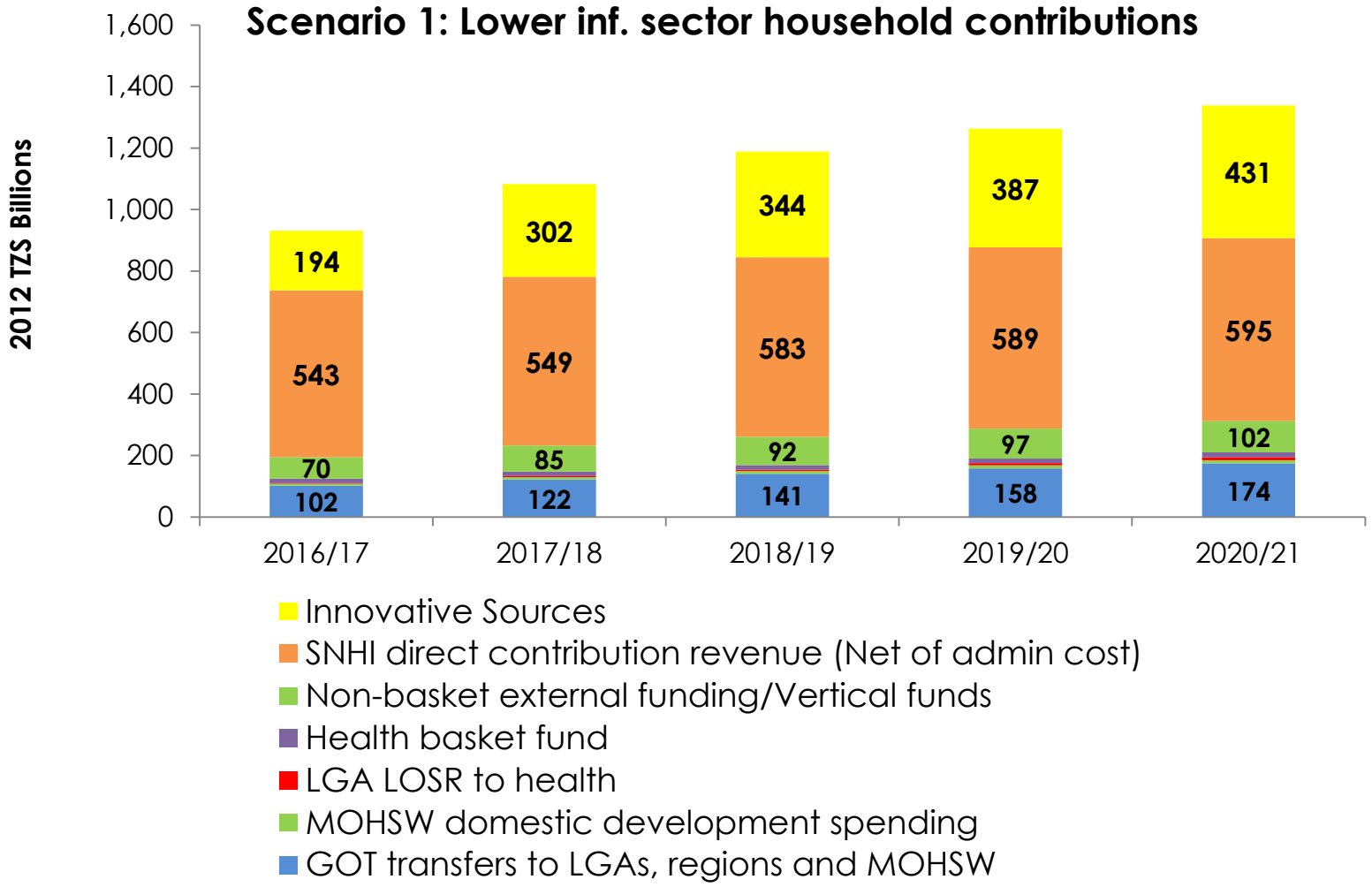
Scenario 1: fiscal space, *constant TZS billions*



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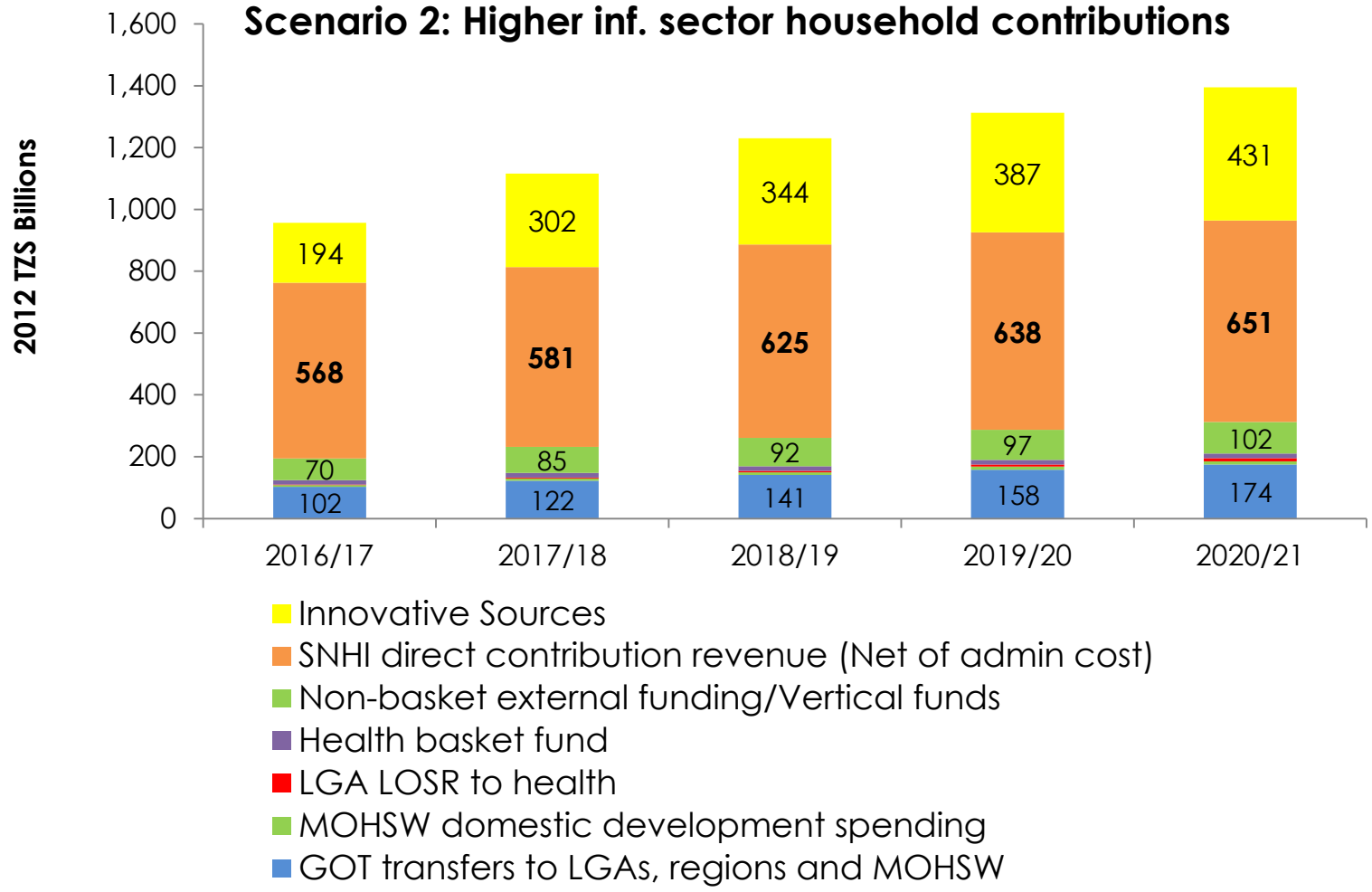
Scenario 2: fiscal space, *constant TZS billions*



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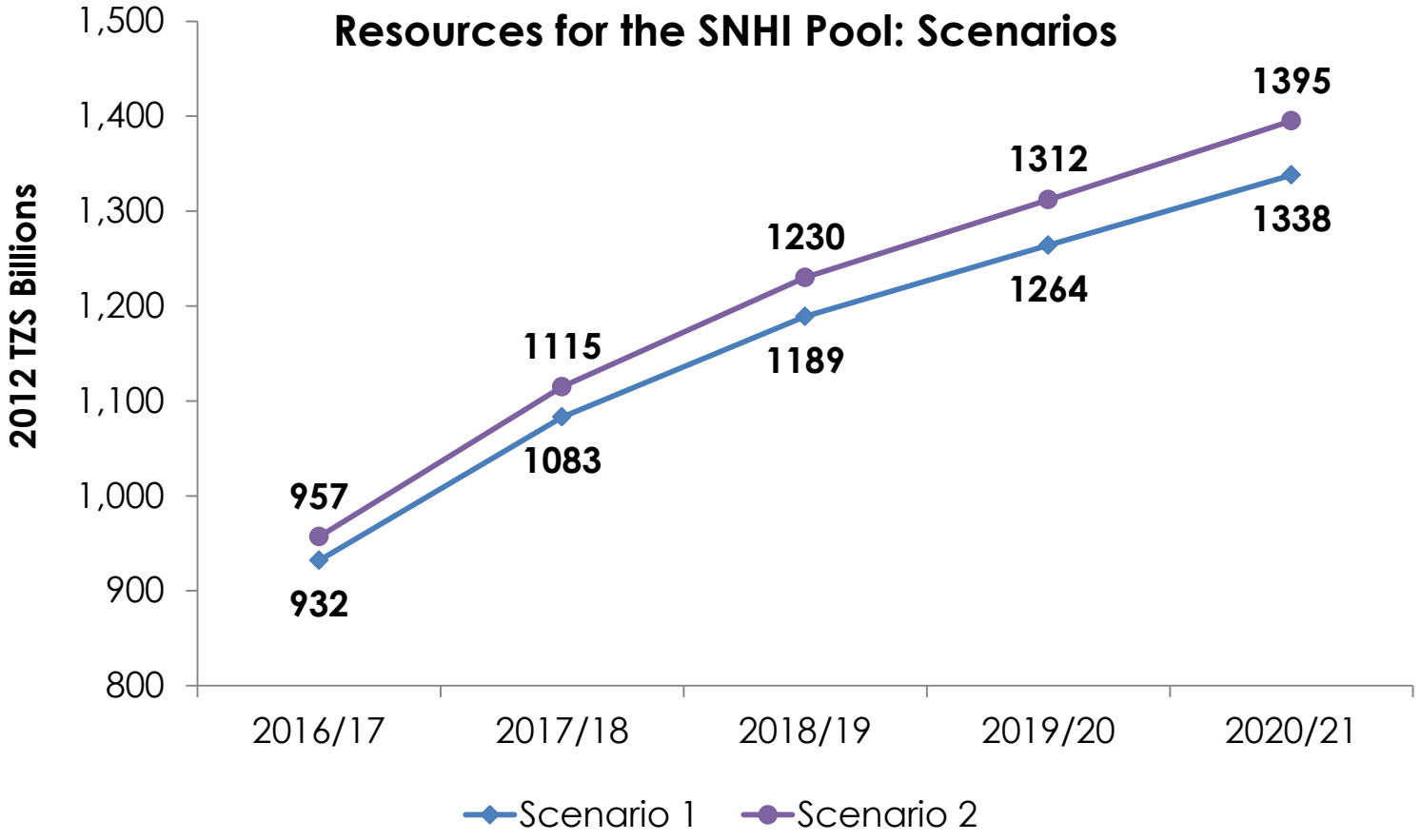
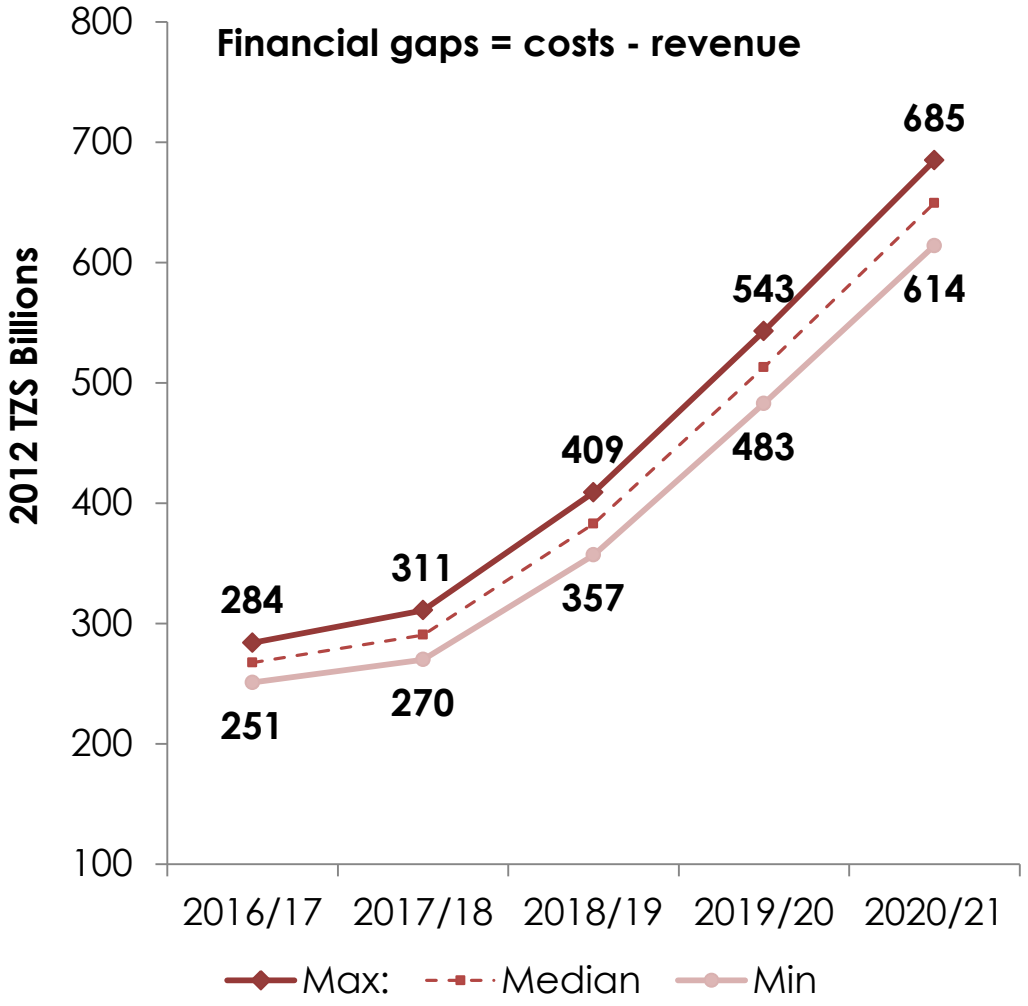
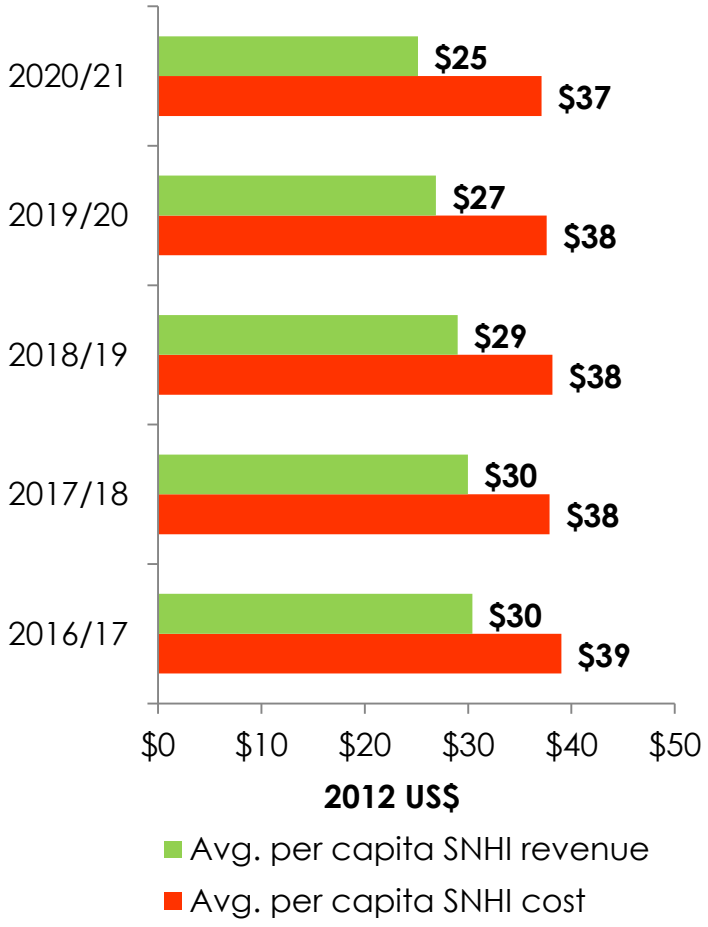
Comparison of scenarios: total pooled resources



SNHI Financial Gaps





The population considered here is only the SNHI population covered per year.

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IMPLICATIONS AND NEXT STEPS

Some implications

- OPD: Across standard and MBP+, cost recovery varies for notional capitation rates
  - ~72% against high variant cost and ~86% against low
- Resource gaps with pooled options are significant ($160-390 mn. p.a. in the minimum of the range)
- Resource gaps will decline if other pooling options are considered across existing sources
- Costs can decline if efficiencies and referral system enforcement increases over time
- Further refinement of MBP may be needed, with exclusions

ASANTENI SANA