



Resource Pool for a Single National Health Insurer in Tanzania

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March 2015

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Objectives

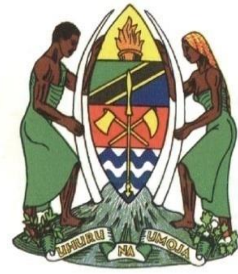
1. Background
2. Methods for fiscal space analysis
3. Introduction to MBP
4. Innovative Financing Sources
5. Summary and Results
6. Implications



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



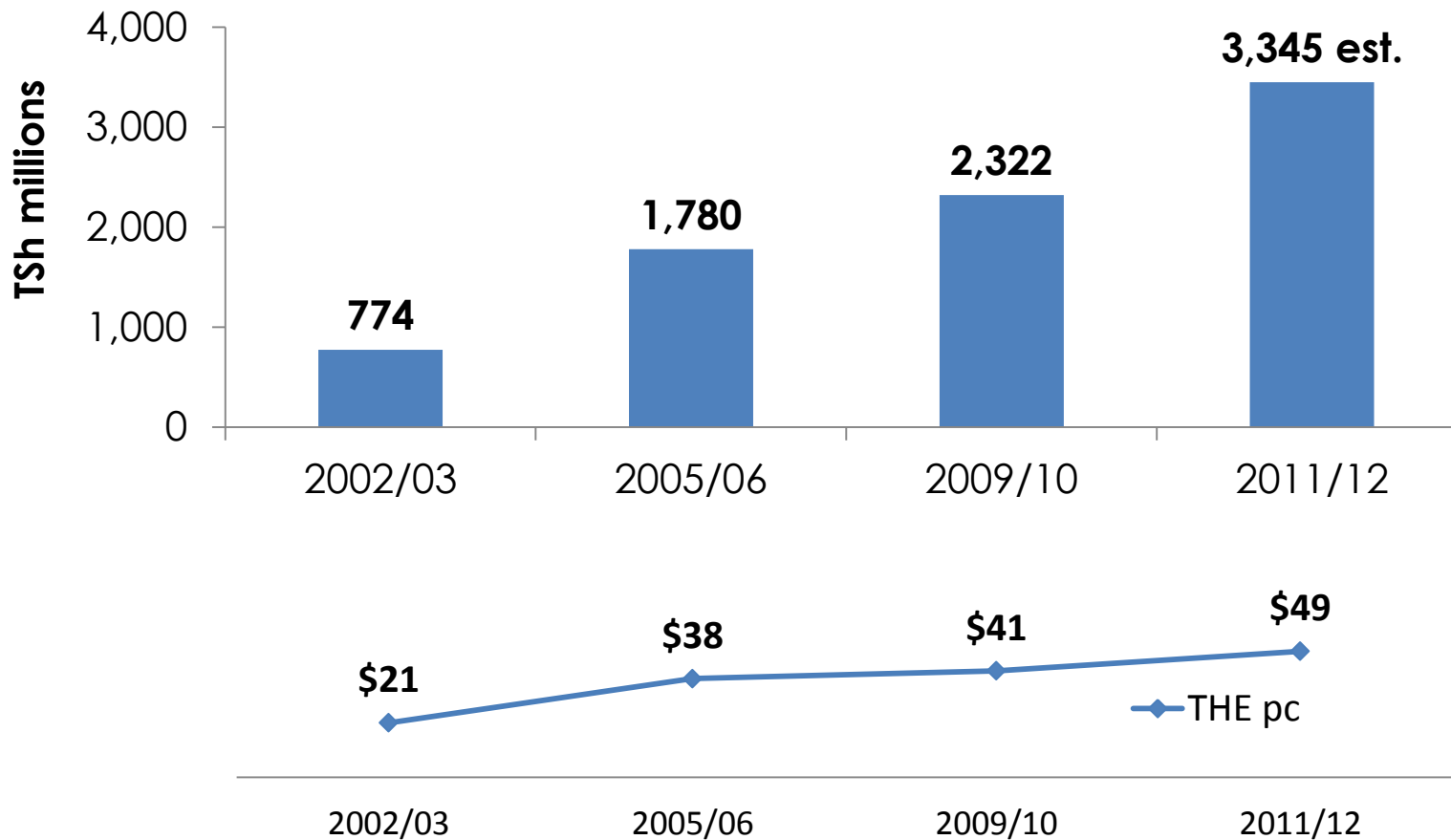
- Changes made:
 - Revise based on:
 - latest data (macroeconomics and PER/RBA)
 - trend in on- and off-budget external funding
 - Update based on draft Health Financing (HFS) design
 - Incorporate scenarios based on HFS options
 - Revise innovative financing ideas to latest options*
 - Compare to MBP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

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



BACKGROUND

Total health expenditure



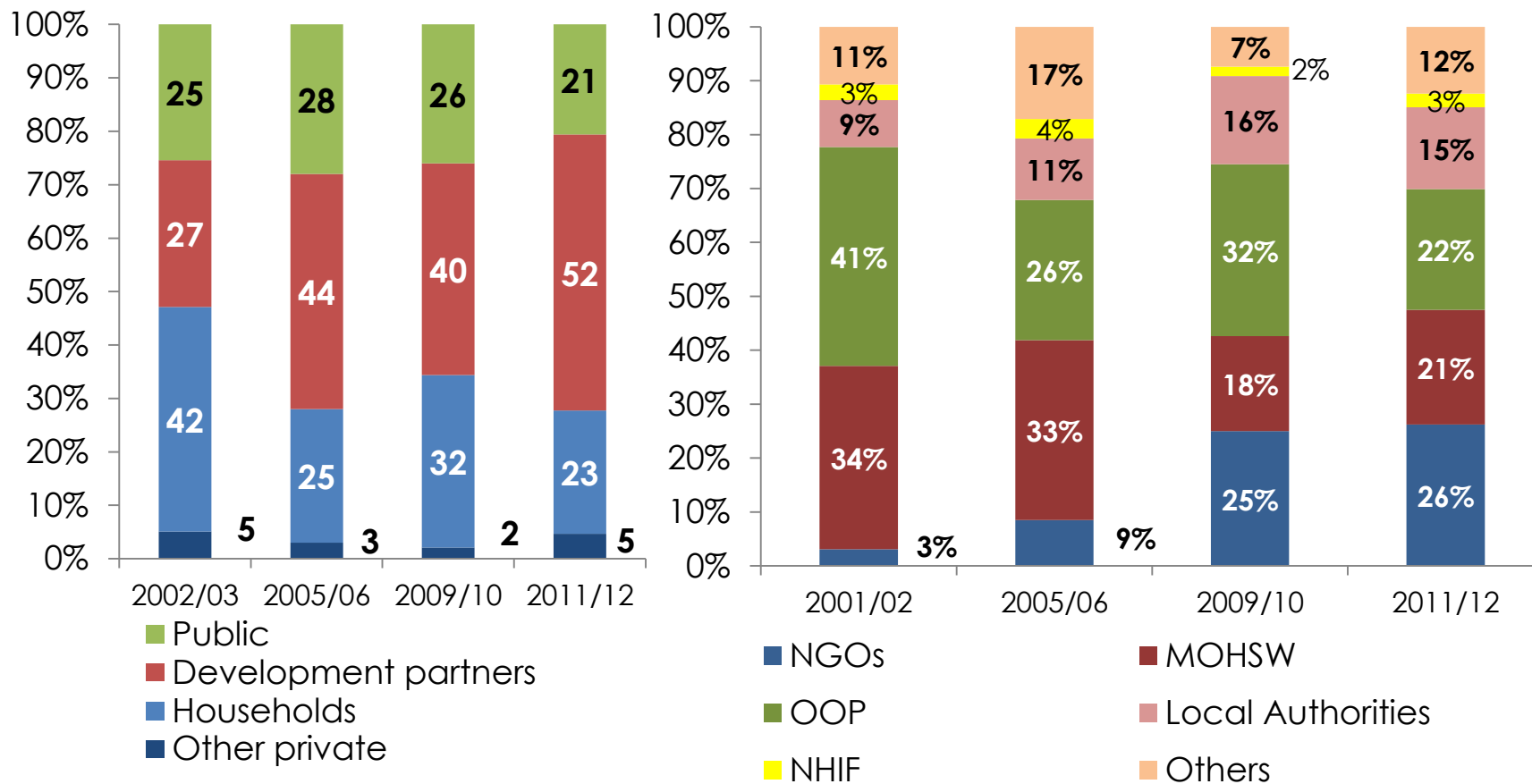
Source: National Health Accounts. 2011/12 values are draft estimates and should not be cited.

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Health financing sources and agents



Total Health Expenditure by Financing Source and Financing Agent

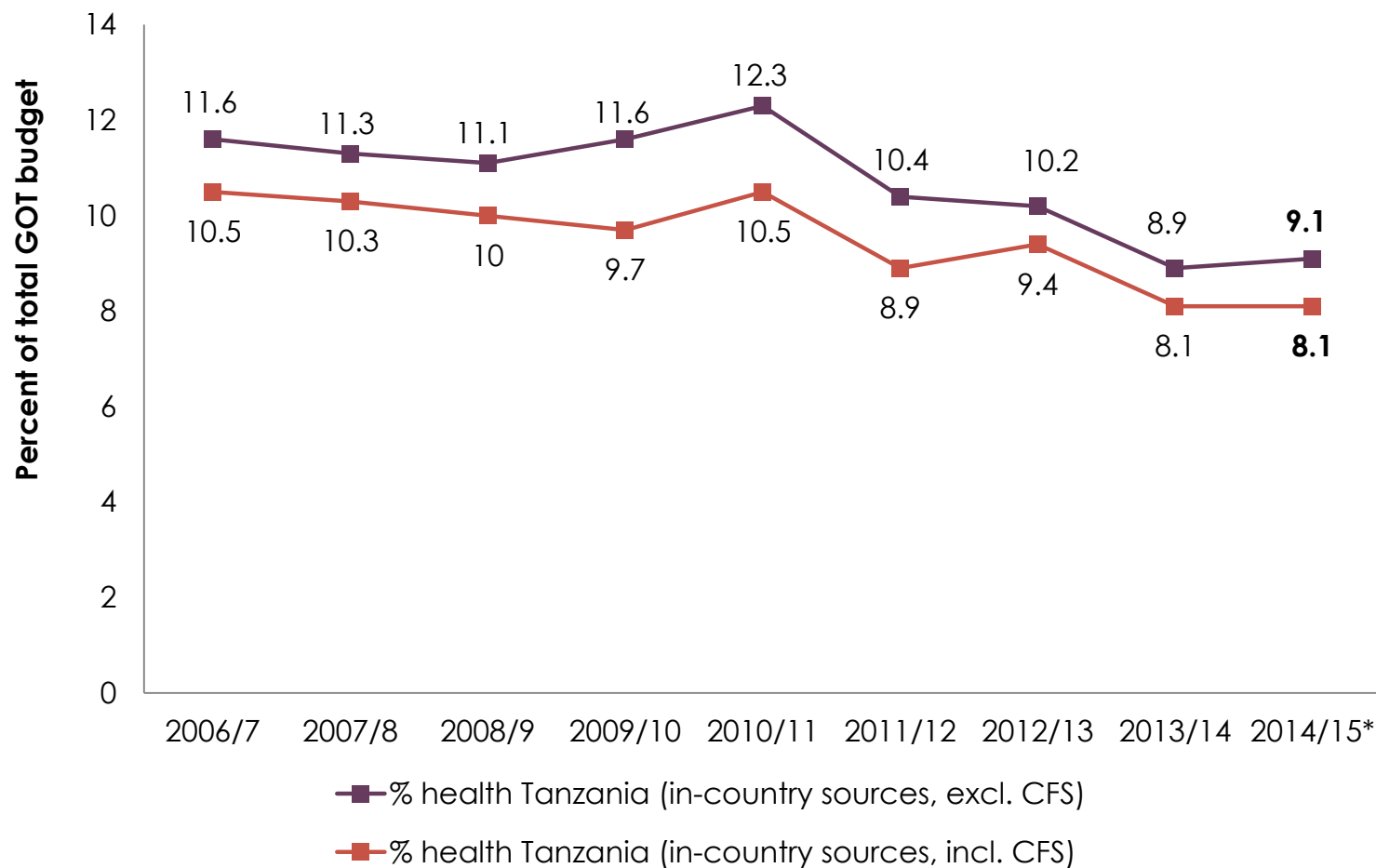


Source: National Health Accounts. 2011/12 values are draft estimates and should not be cited.

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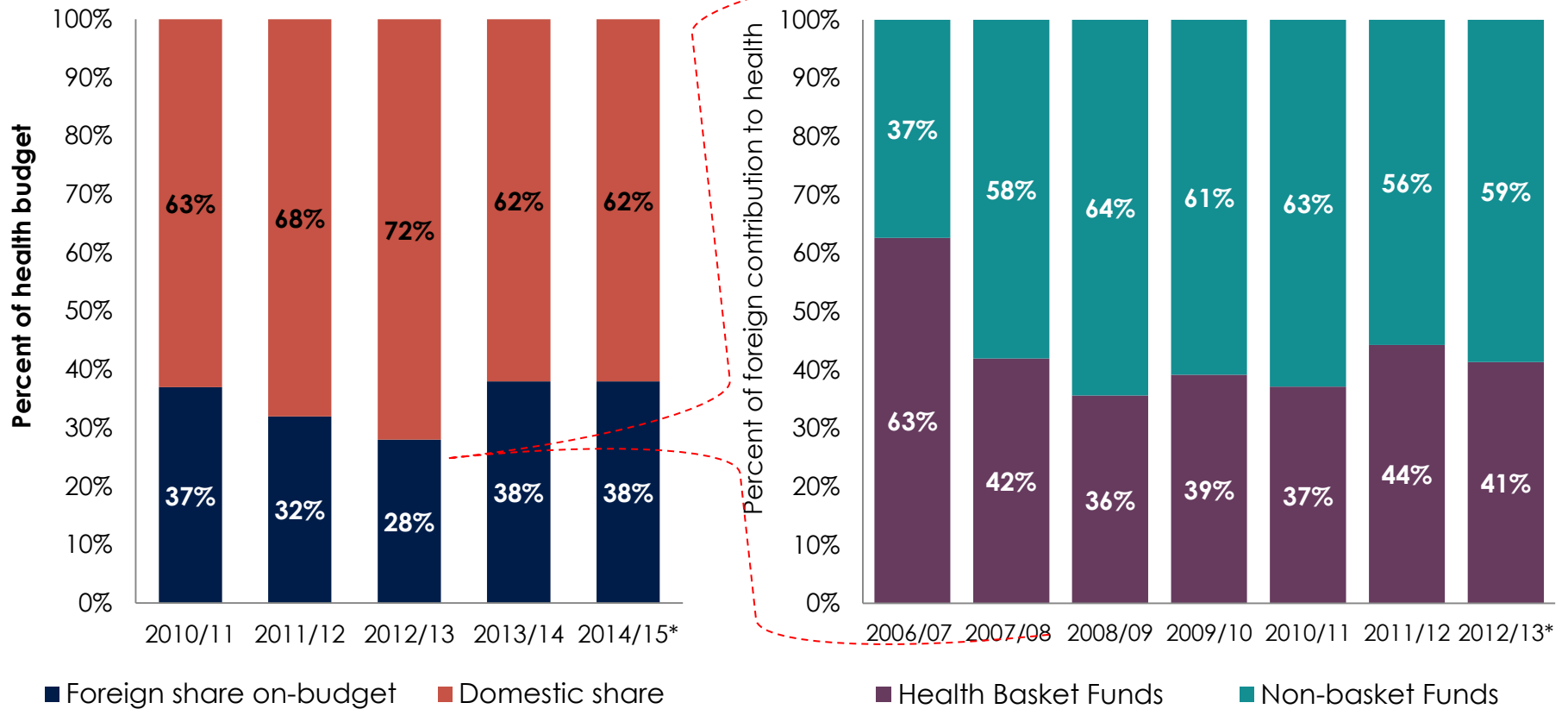
GOT allocation to health



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

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External resources on-budget, MOHSW

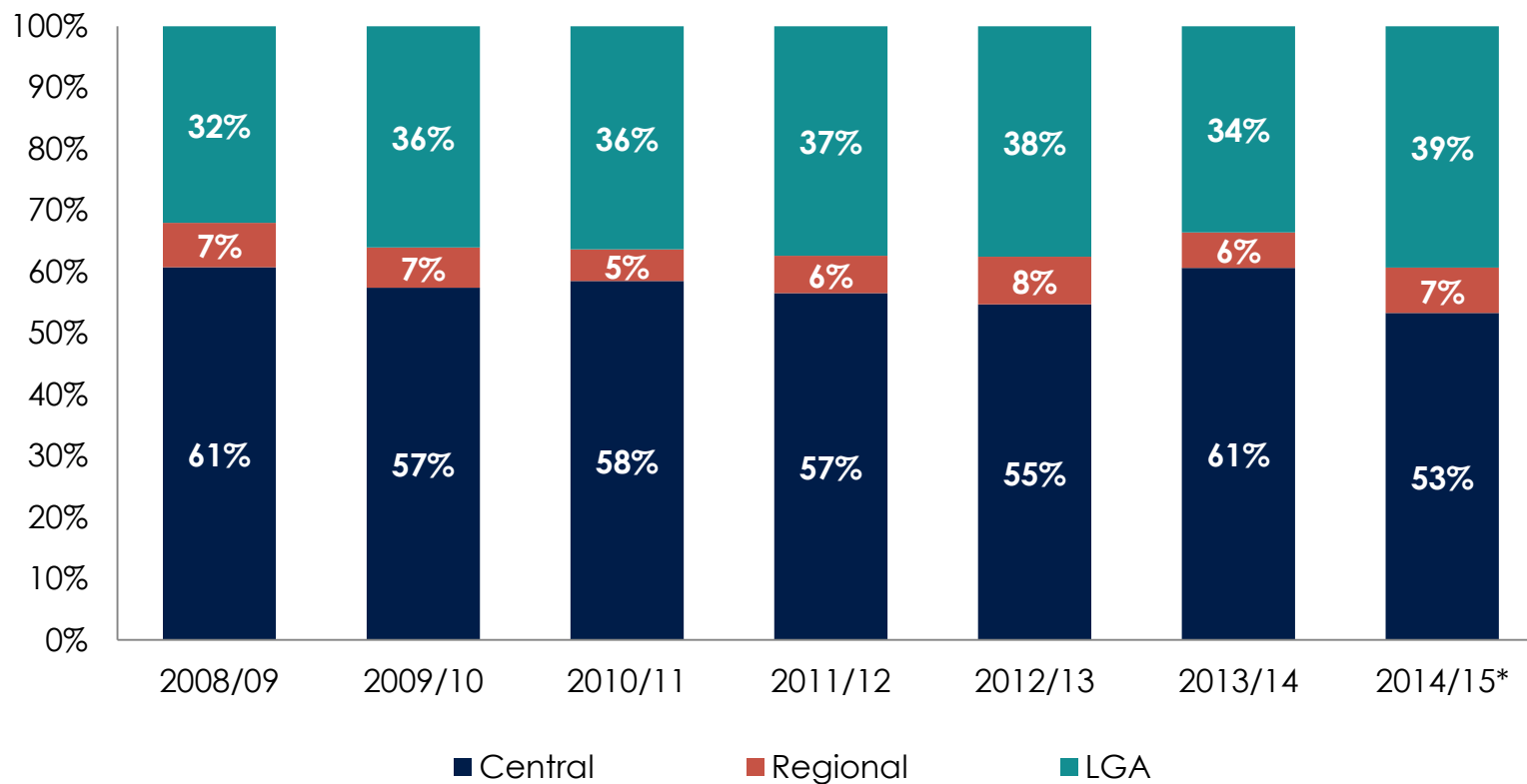


Source: PER, various. * Budget amounts. All other amounts based on actuals.

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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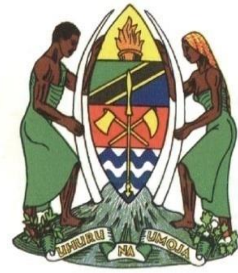
METHODS

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: MBP ASSUMPTIONS

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

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



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)



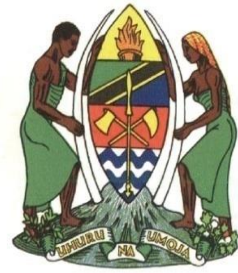
Standard MBP – OPD variants

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

Standard MBP – OPD variants, Pt.2

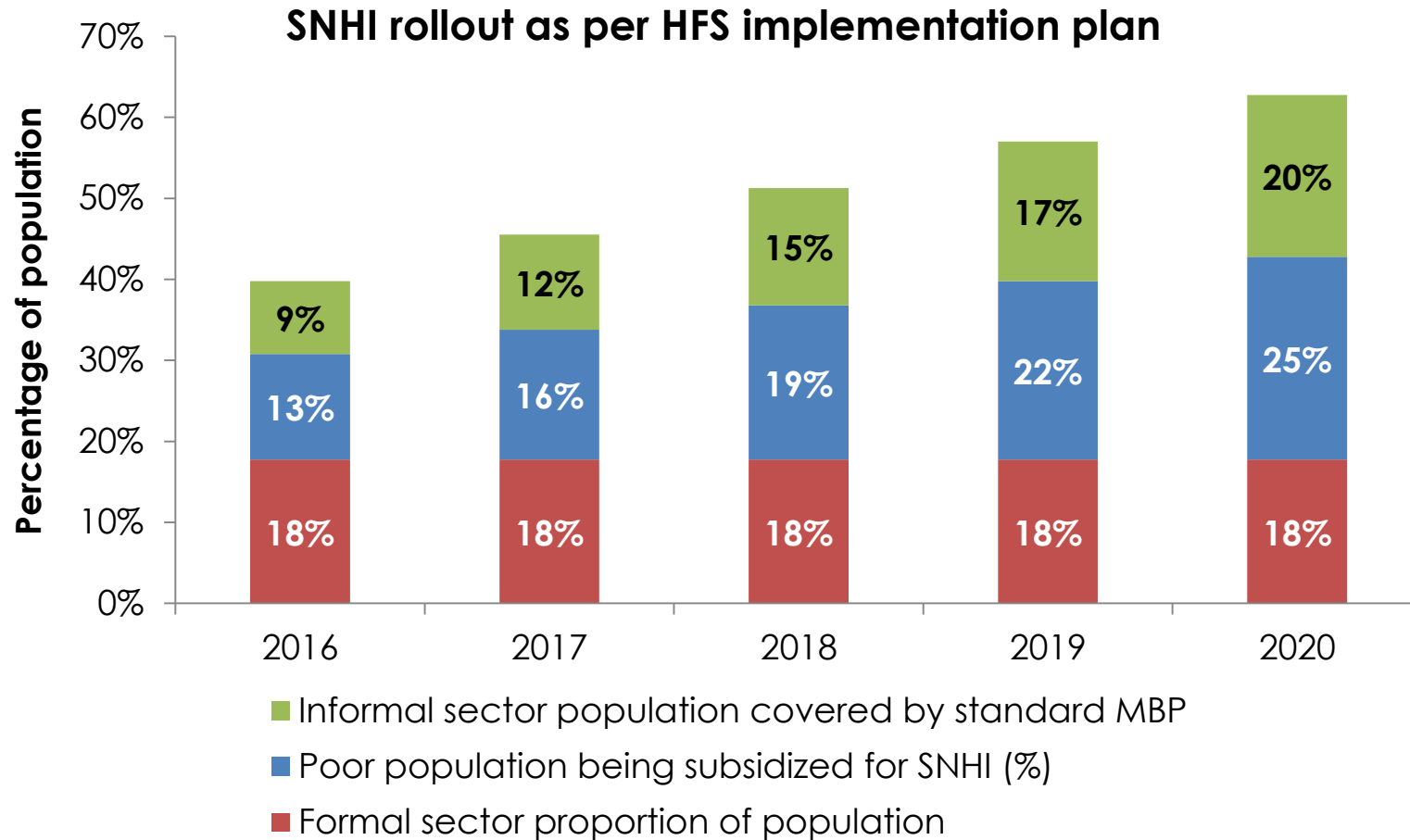
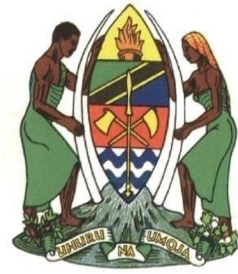


High Variant – Jan. 29 model

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)

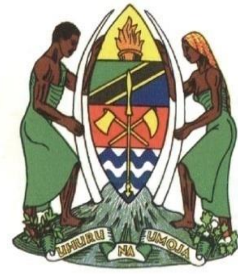
SNHI rollout assumptions





REVENUE GENERATION & POOLING

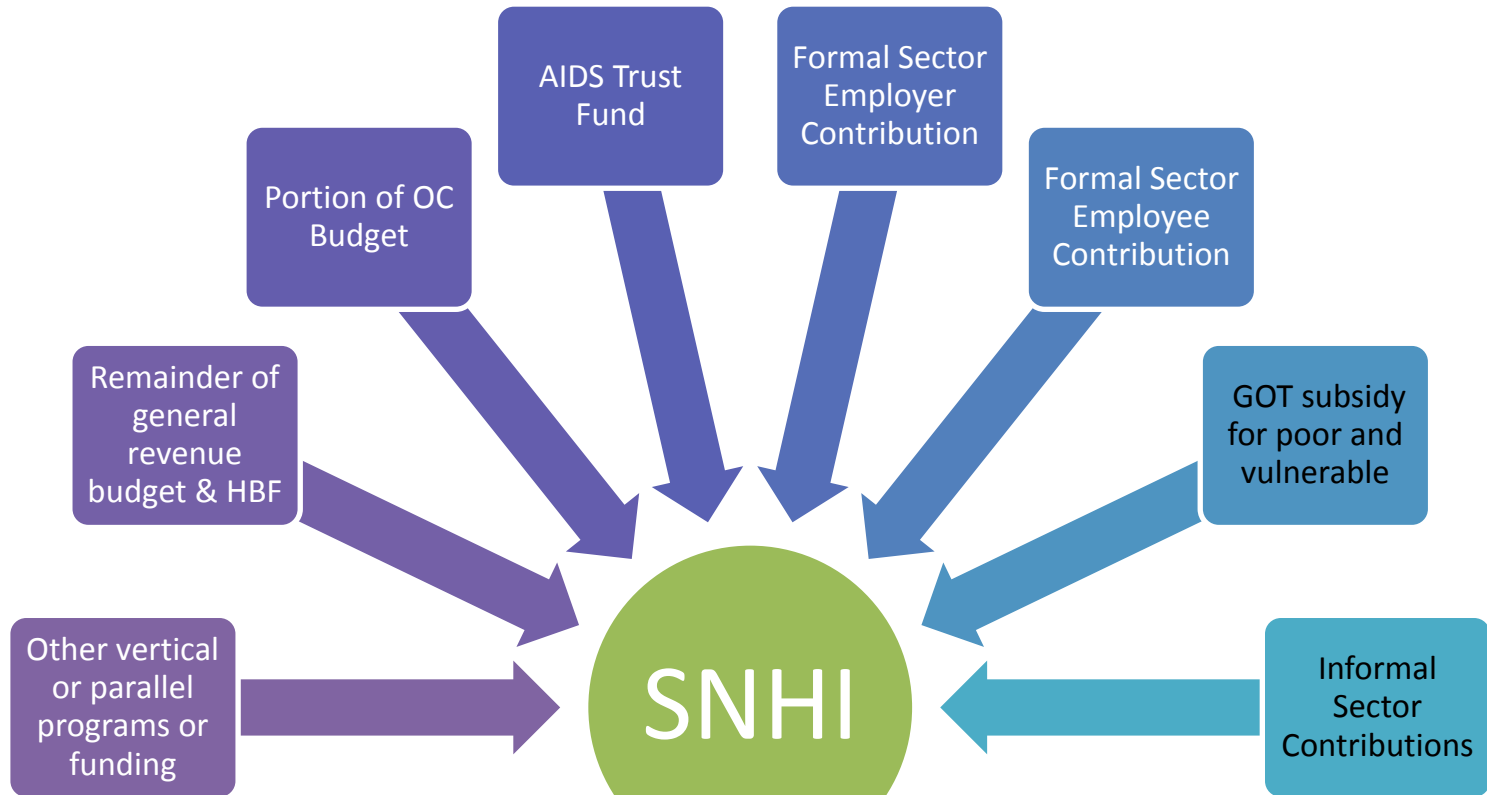
Pooled fund sources for SNHI



- 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?



Reimbursement to Facilities Matching Payment to MBP Based on Core Output-Based Payment Systems

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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: <i>formal sector contributions shared 50% with employer</i>				
<i>Urban areas: <u>per year</u></i>				
Formal sector	400,000 per household (current avg.)			
Informal sector	94,000 per household	152,000 per household		
<i>Rural areas: <u>per year</u></i>				
Formal sector	As urban areas			
Informal sector	53,000 per household	91,200 per household		
B. GOT domestic sources including LGA own sources: <i>increases taken from FY 2016</i>				
GOT domestic	2% increase p.a.			
LGA own source	5% increase p.a., 5% to health			
C. External on-budget sources: <i>increases or decreases taken from FY 2016</i>				
HBF	5% decline p.a.			
GFATM, etc.	Actual allocation till 2017, then modest decrease			
D. Innovative financing sources: <i>added from FY 2016 except AIDS Trust Fund</i>				
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



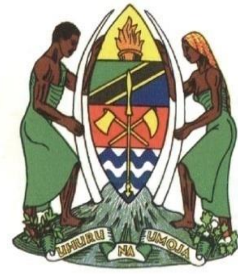
Antecedents of options

- 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

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%

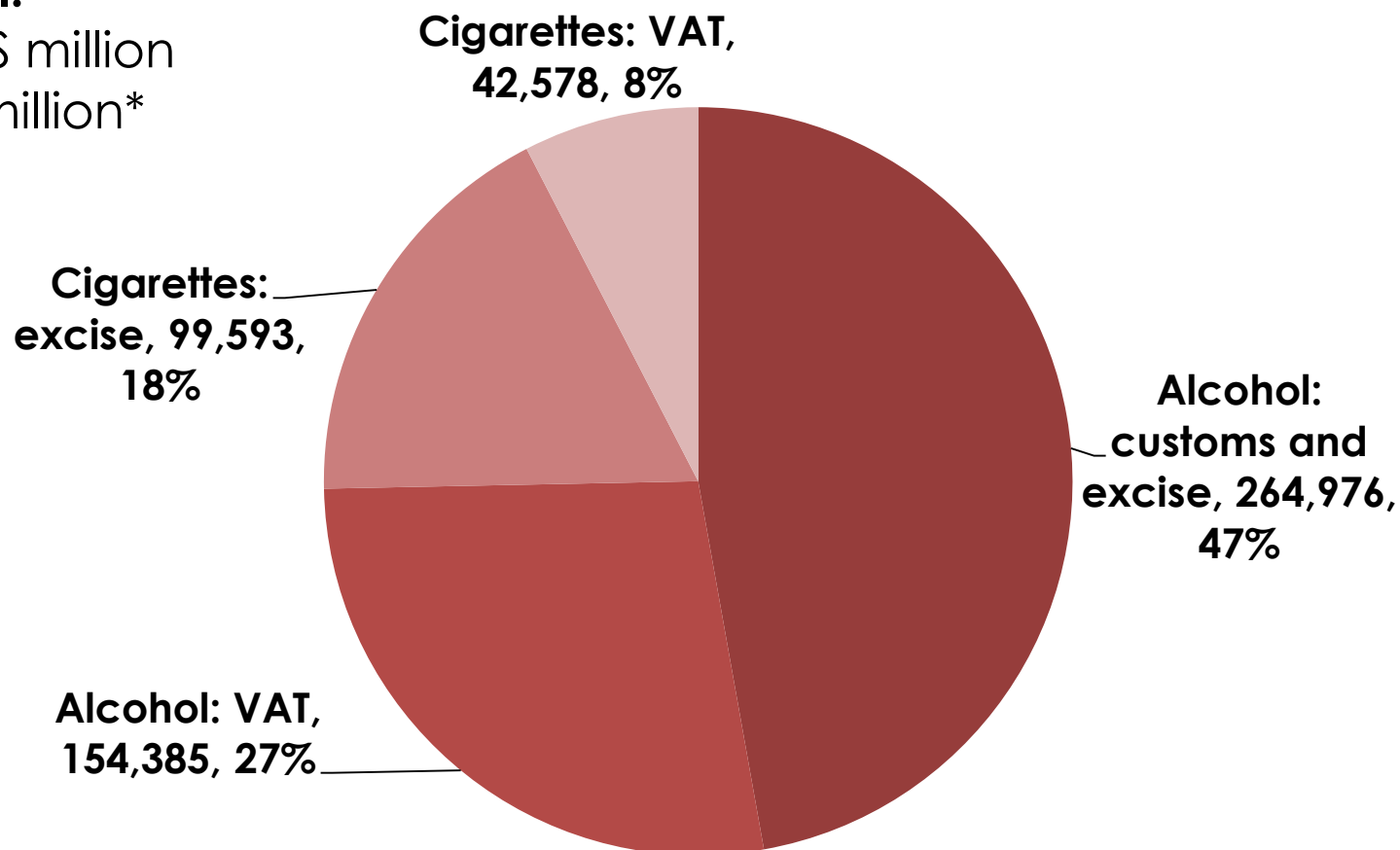
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Sources:
MOF, TRA,
author
analysis

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



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

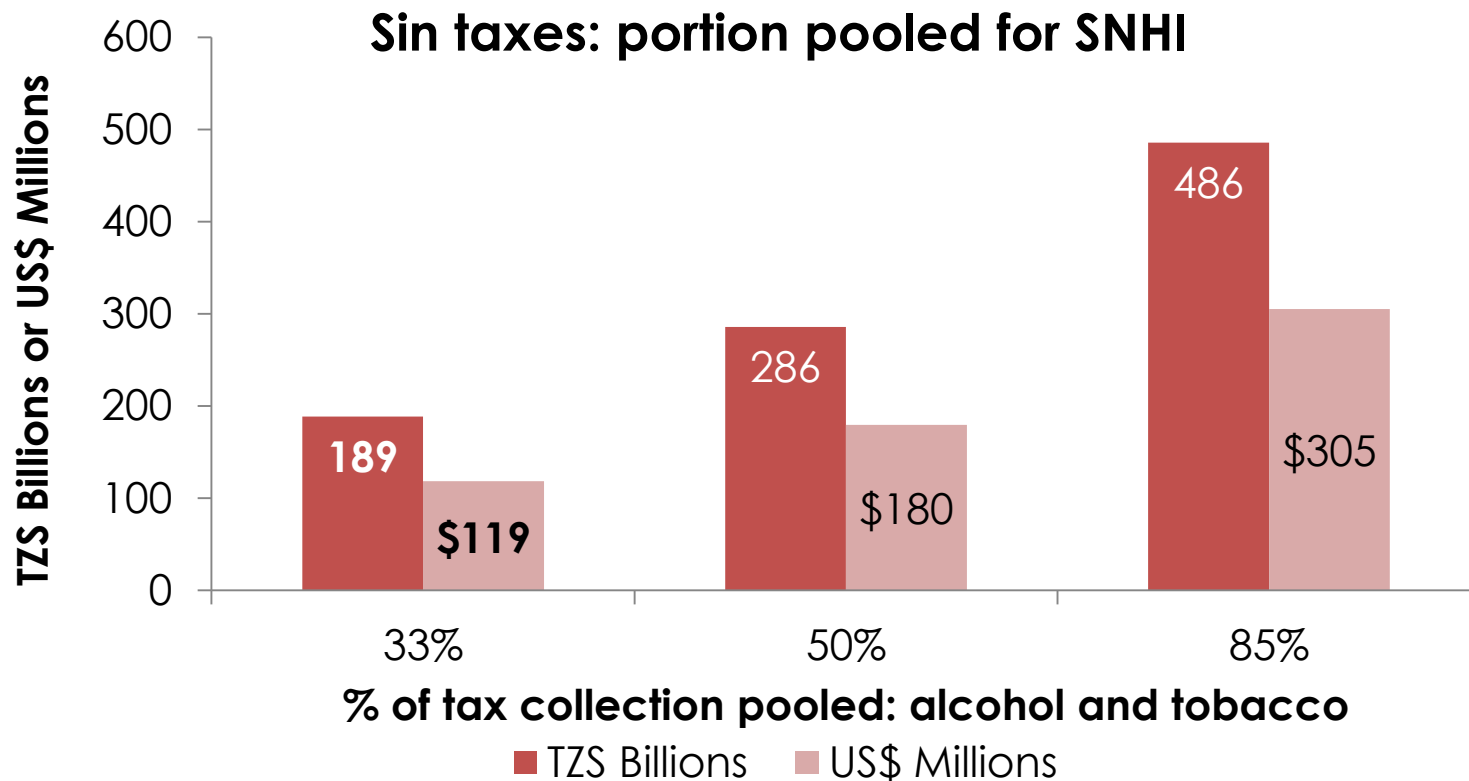


Discussion



- 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

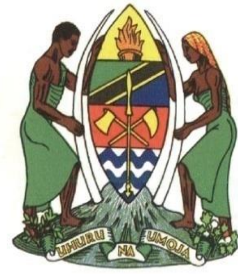


Portion pooled for health in current scenario: **33%** (S. Korea);
Other: 50% (Indonesia) 85%: Philippines (tobacco)



TAXES ON MOBILE COMMUNICATION

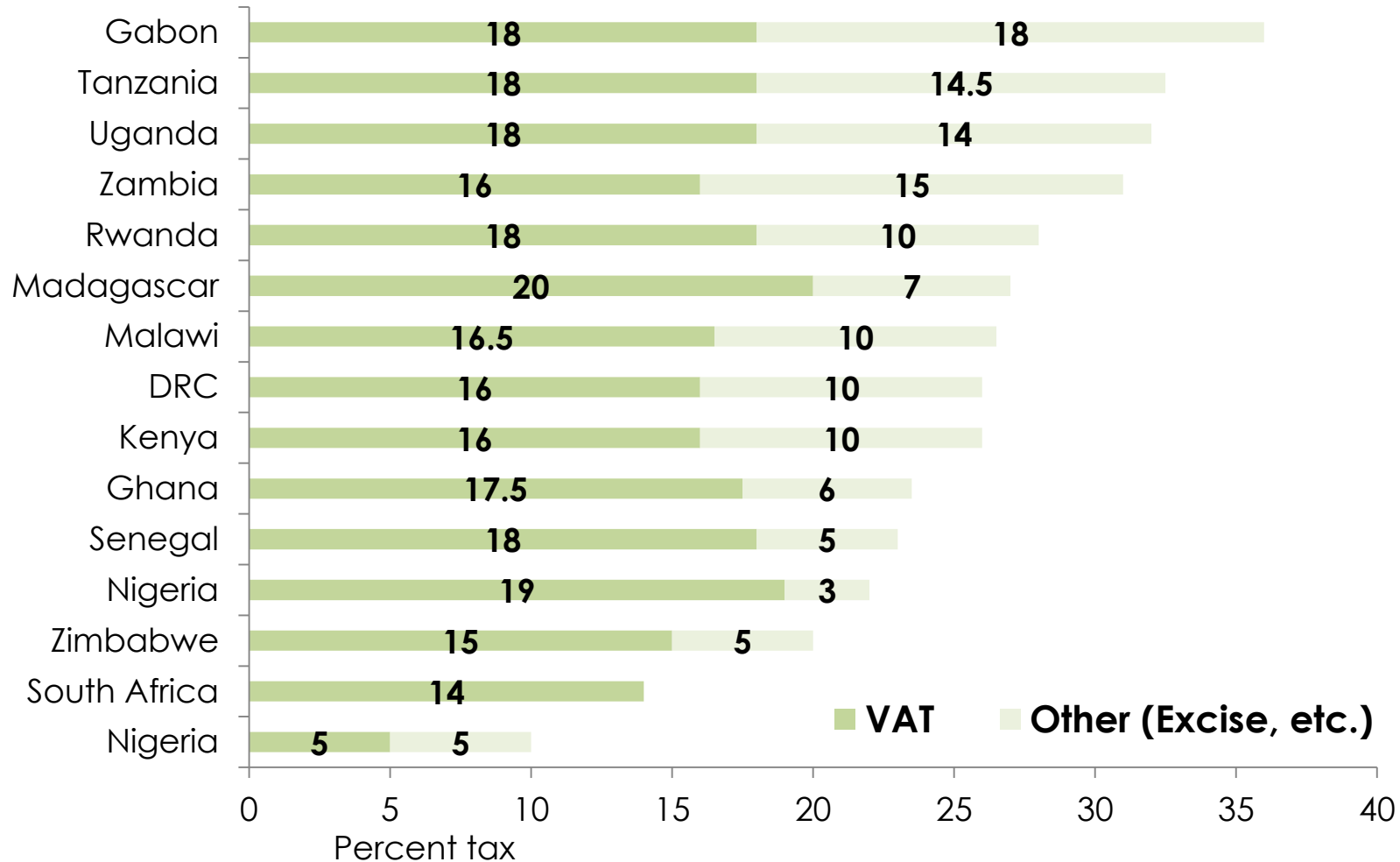
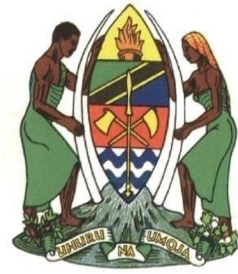
Current Tanzanian tax policy



- 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)

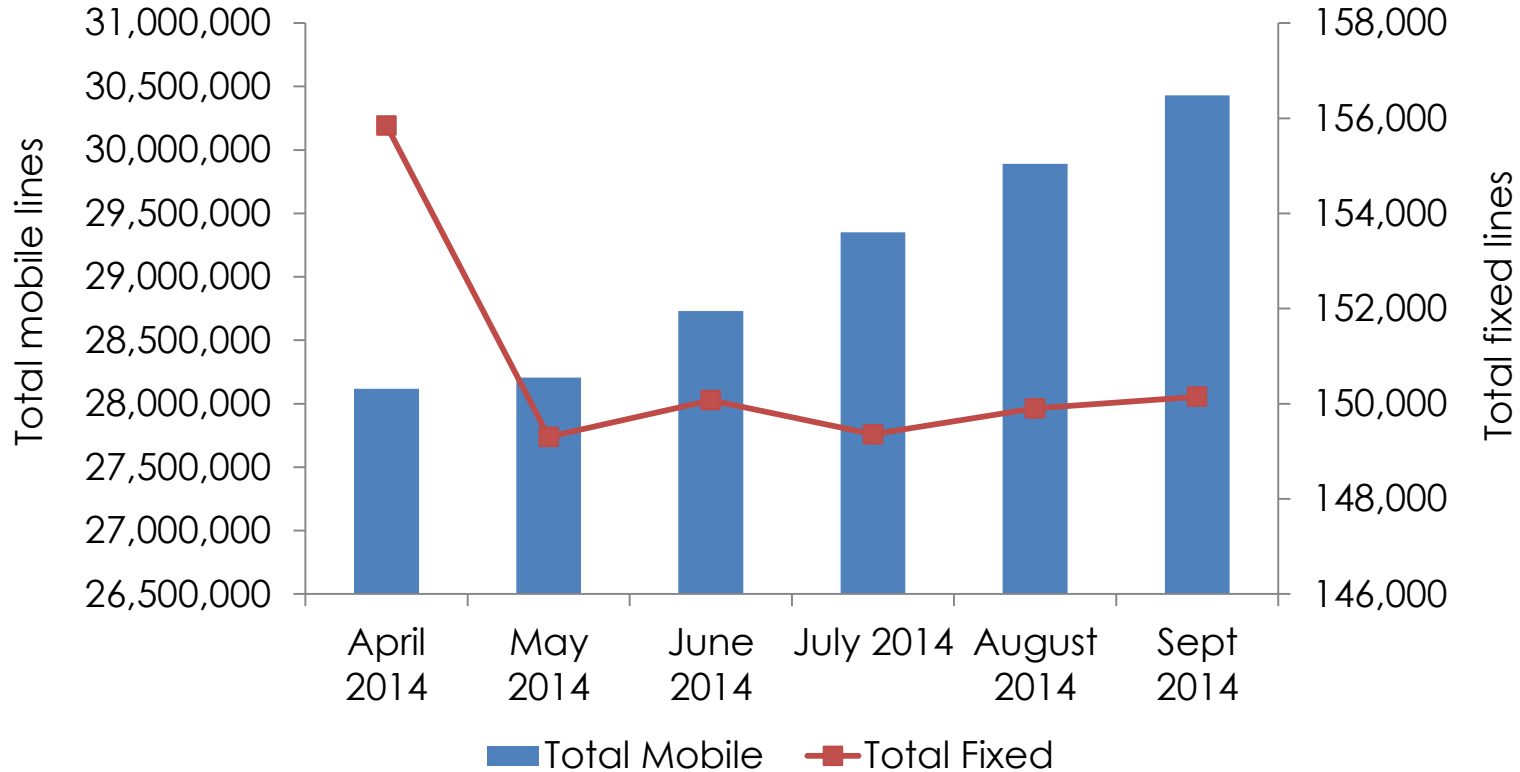
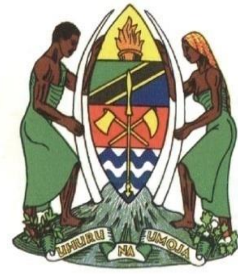
* Formalized in Finance Act, 2013. Replacement of ‘airtime’ with this new language clarifies tax application for a broader compass of communication activity. This discussion excludes taxes on handsets.

Taxes on mobile communication in Tanzania in relation to Africa



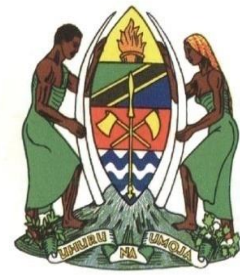
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Tax data hard to disaggregate: mobile vs. fixed telecom

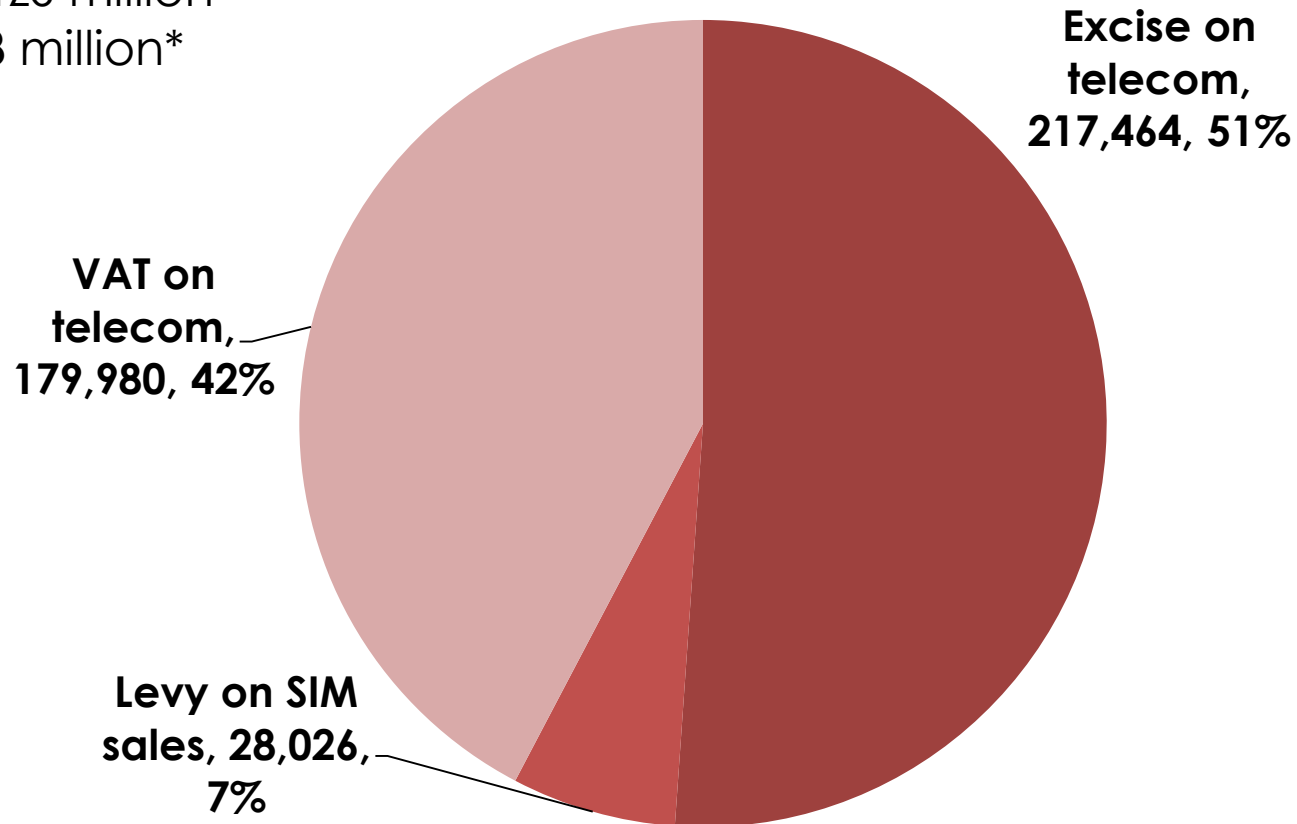


But safe to say that most activity is mobile and growing..

Total tax revenue from telecom services: FY 2013/14



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



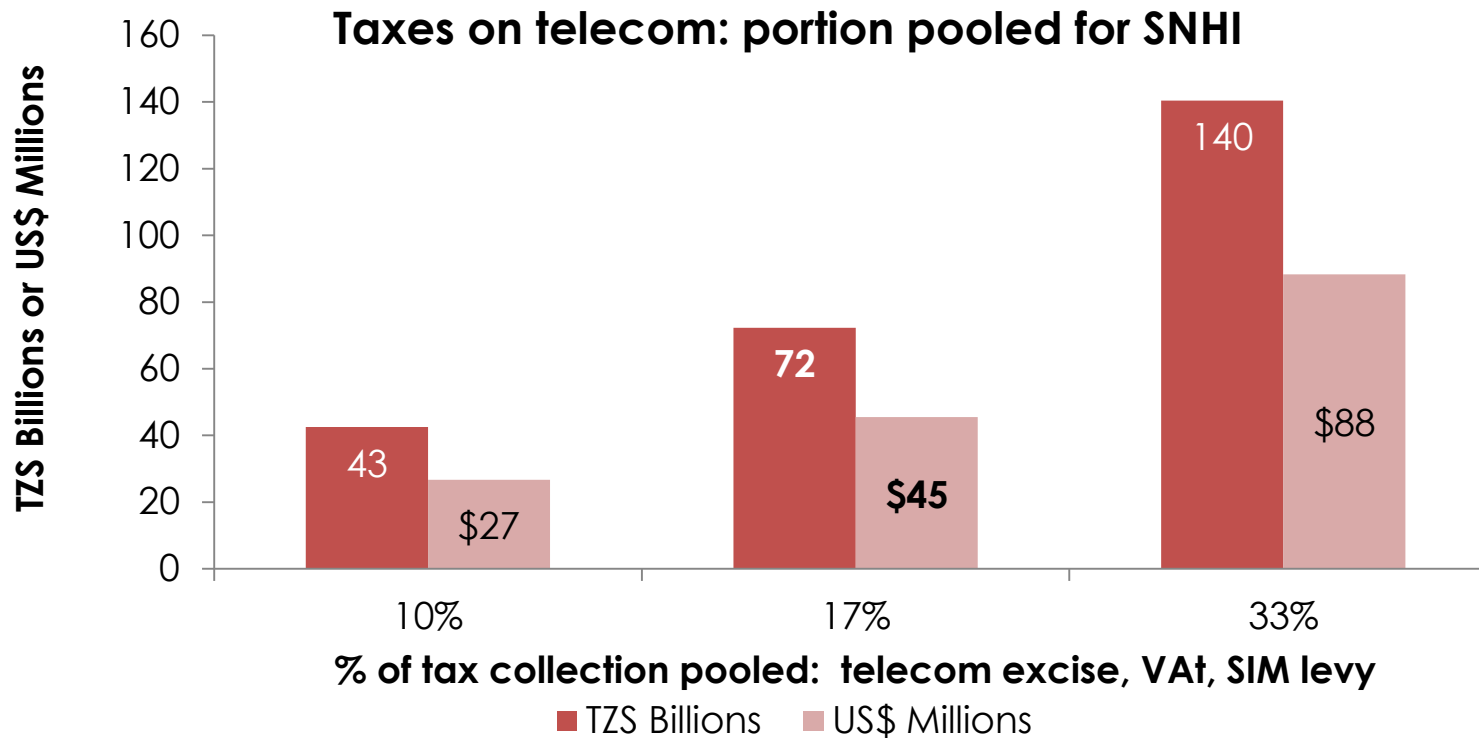
* All conversions using period average exchange rates. 40

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*

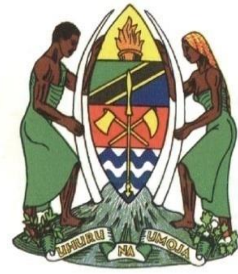
Excise collected on money transfers (remittances): ~TZS 26 billion (FY 2013) have been excluded due to lack of clarity on whether these are mobile or bank transfers

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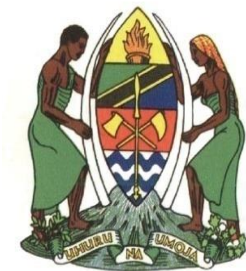
AIDS TRUST FUND

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



SUMMARY AND RESULTS

Innovative financing sources



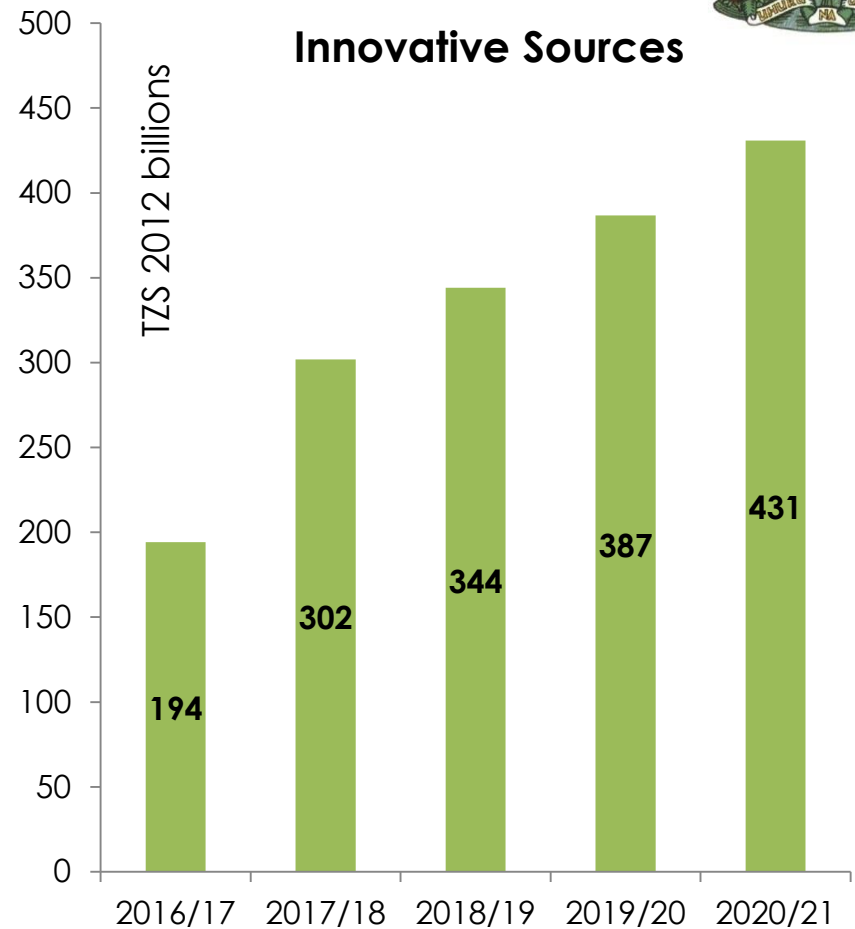
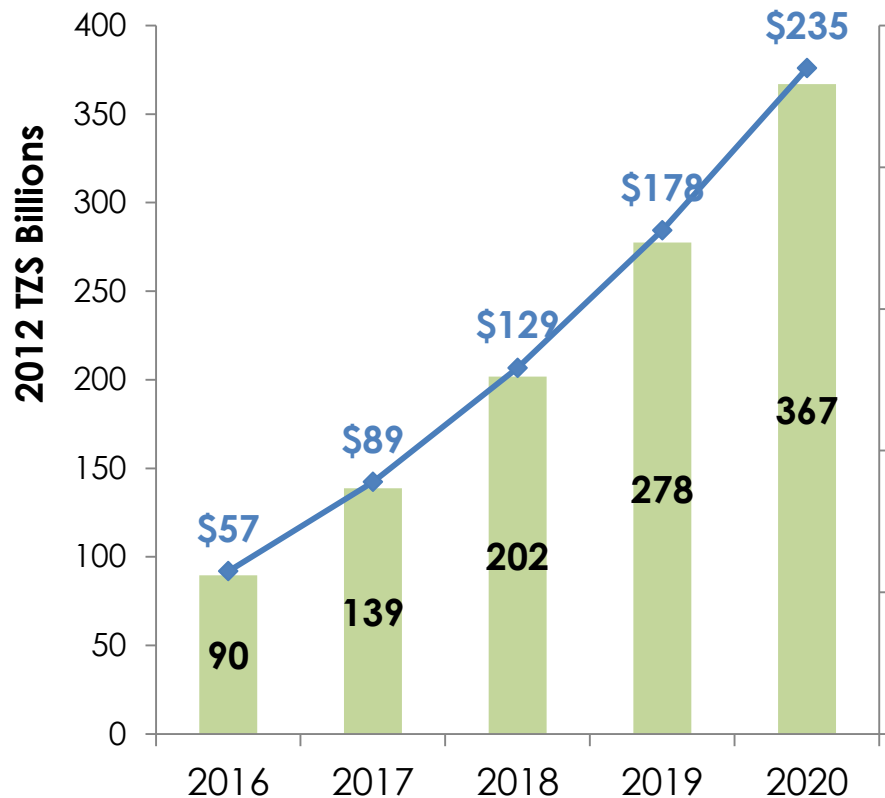
Source	Notes	Feasibility*	Size of potential revenue (FY 2013)
Tax on surplus of public corp.	<ul style="list-style-type: none"> Unknown equity Not common for health 	Unknown, value not reliable	TZS 94 bn. ~ 0.169% of GDP
Airtime levy	<ul style="list-style-type: none"> Possibly regressive Not common for health 	Positive	TZS 72 bn. ~ 0.13% of GDP
“Sin taxes”: - <i>Alcohol</i> - <i>Tobacco</i>	<ul style="list-style-type: none"> Unclear equity Known instances, also positive effects on health 	Positive outlook	TZS 286 bn. ~ 0.514% of GDP
AIDS Trust Fund; HIV commodities	<ul style="list-style-type: none"> 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

Expected subsidies vs. new sources



SNHI subsidies for MBP - OPD capitation & IPD payments

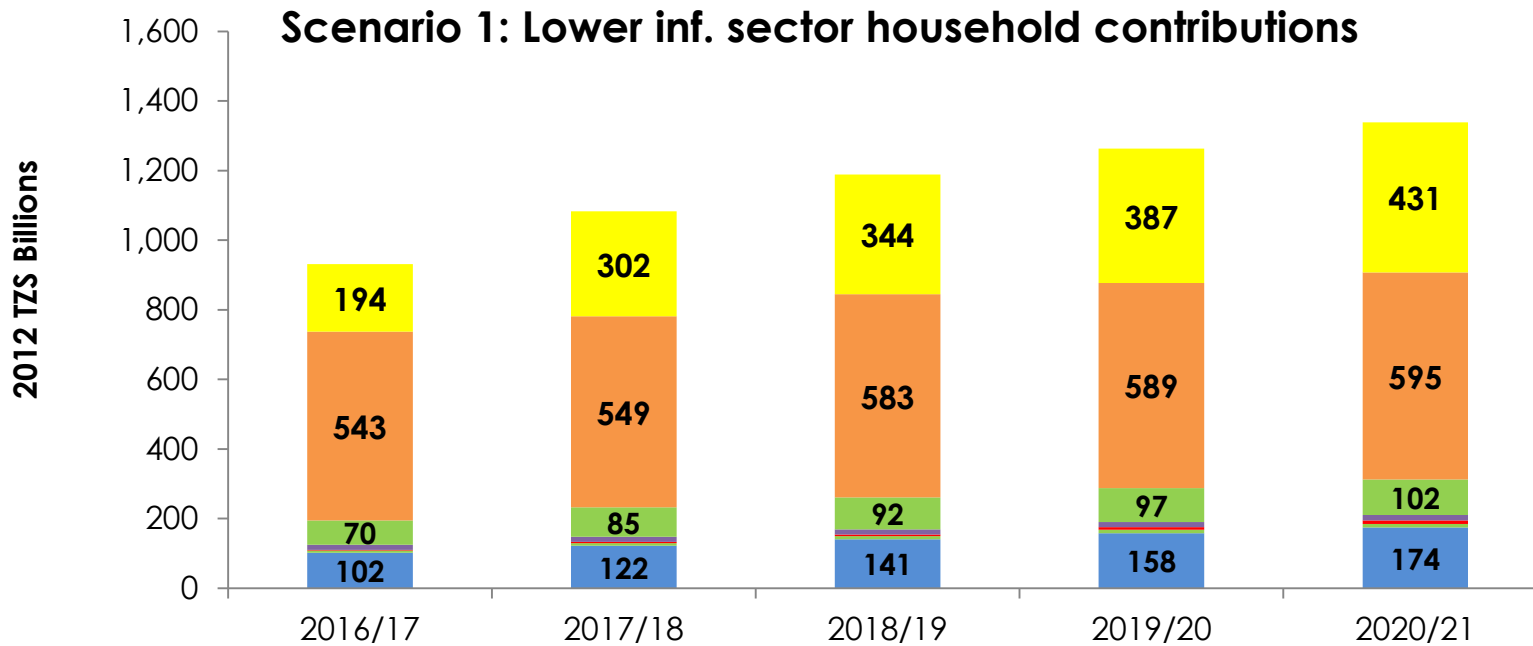
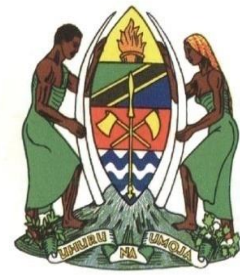


■ 8. Expected subsidies, MBP (low), TZS billions

◆ Expected subsidies, Std. MBP (low), 2012 US\$ millions

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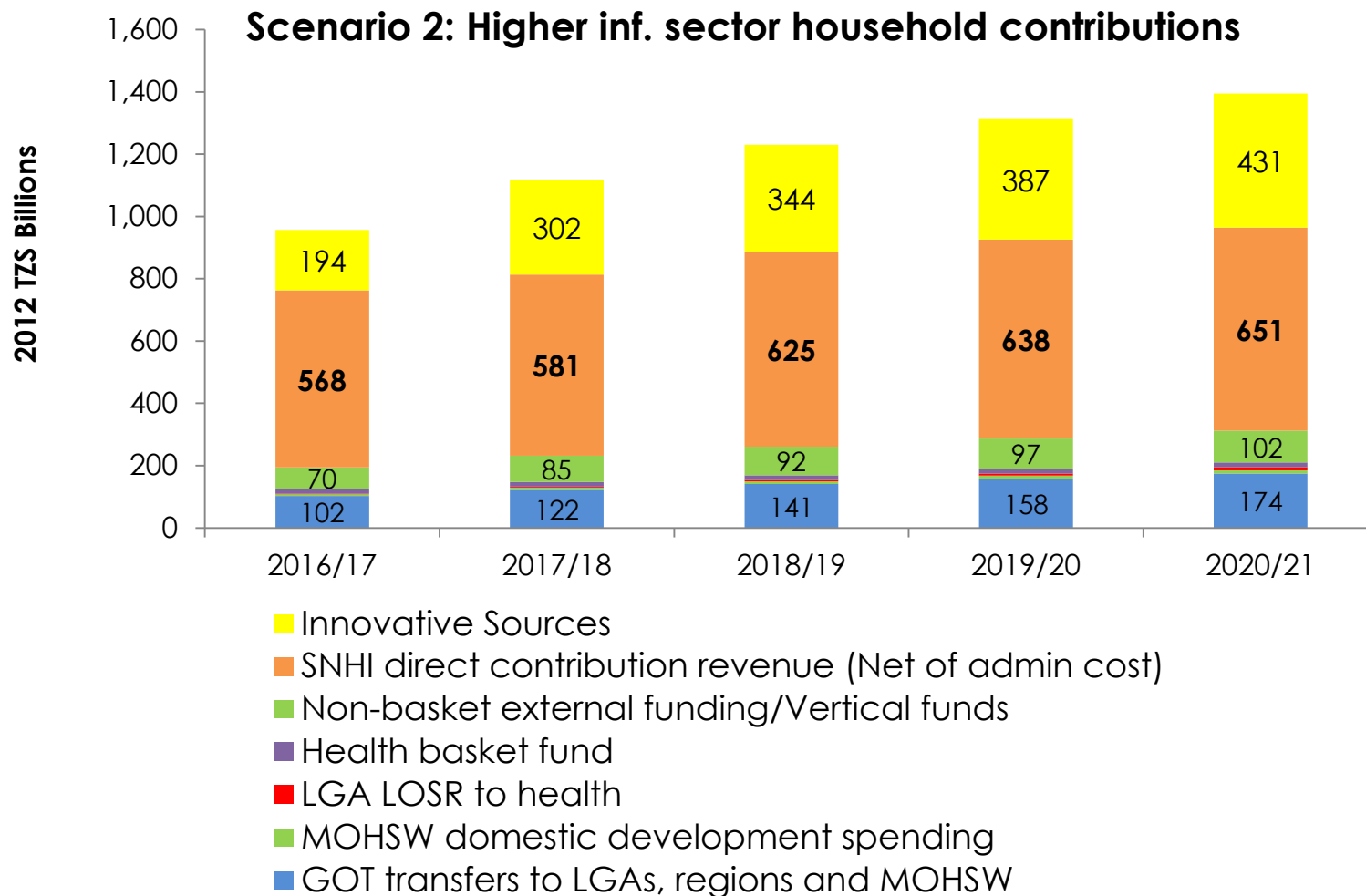
Scenario 1: fiscal space, *constant TZS billions*



- Innovative Sources
- SNHI direct contribution revenue (Net of admin cost)
- Non-basket external funding/Vertical funds
- Health basket fund
- LGA LOSR to health
- MOHSW domestic development spending
- GOT transfers to LGAs, regions and MOHSW

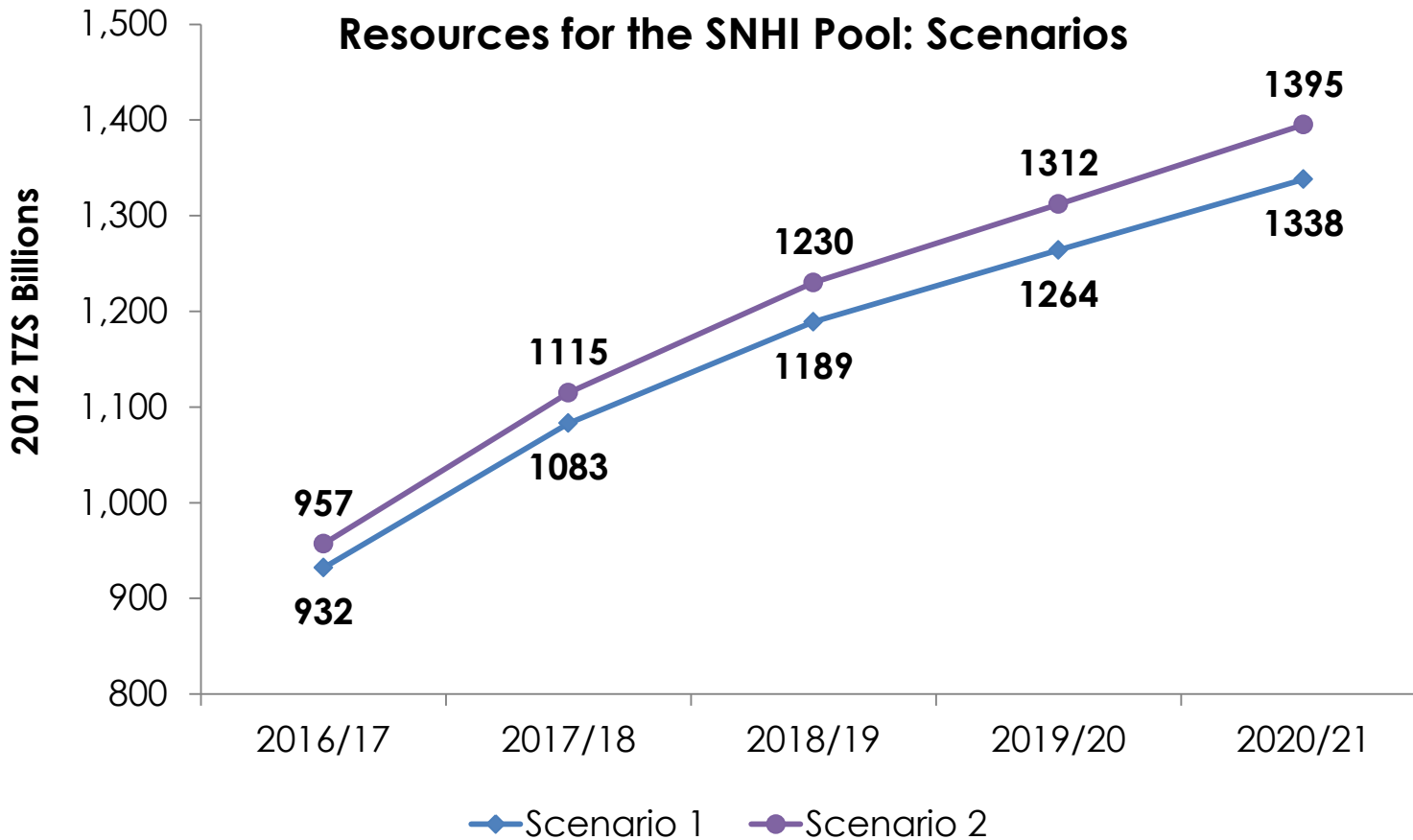
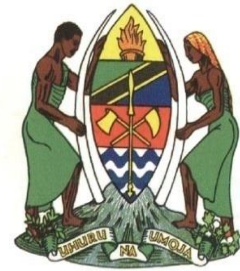
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Scenario 2: fiscal space, *constant TZS billions*

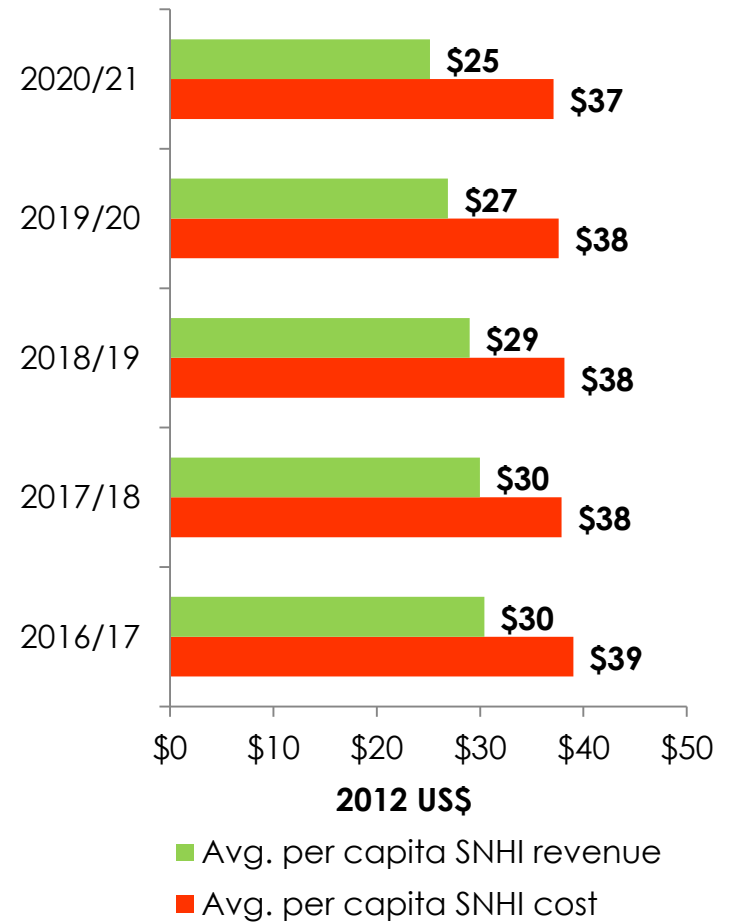
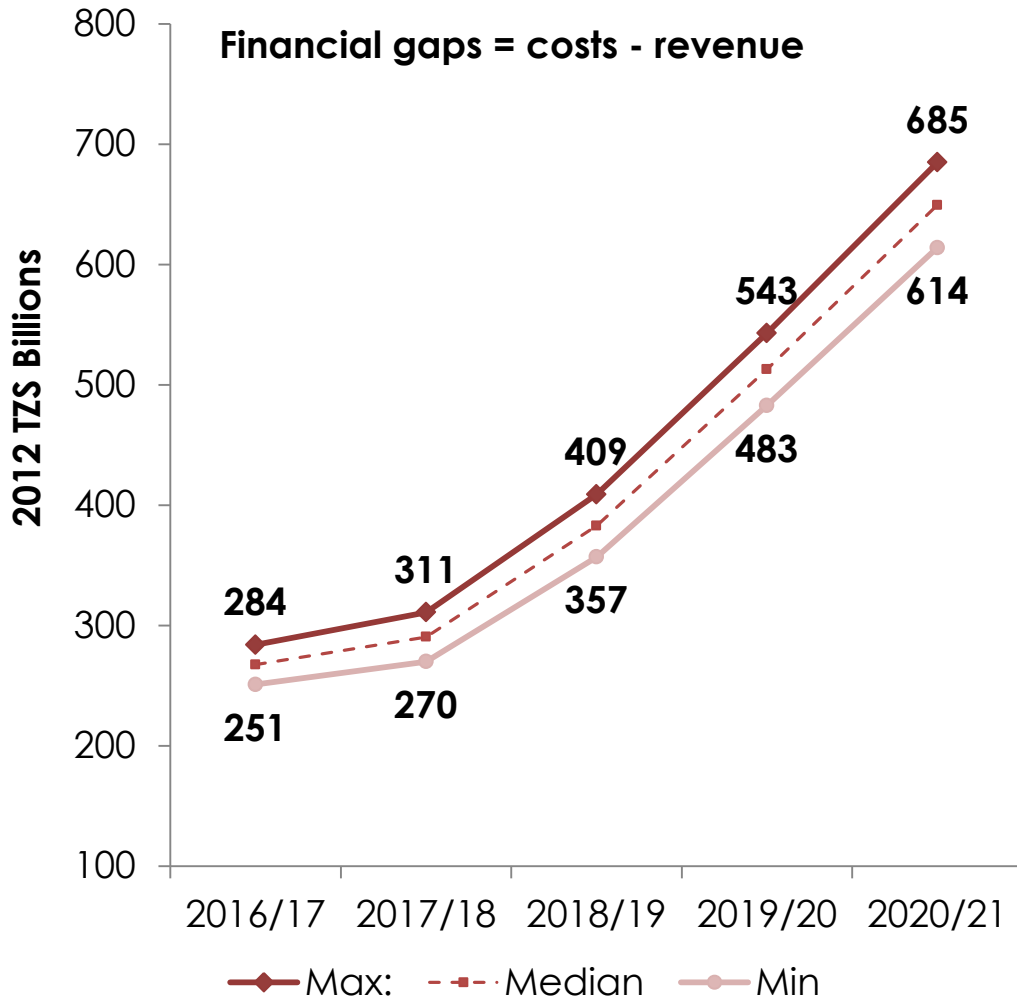
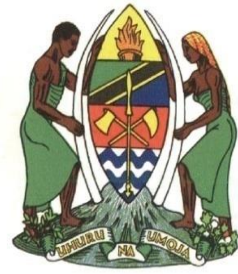


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Comparison of scenarios: total pooled resources



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