Feasibility and projections for earmarked VAT tax as a source of health financing

Skills workshop Report

February 14-15 2013. Harare

Training and Research Support Centre
With
Ministry of Health and Child Welfare
With
National Health Insurance Authority Ghana
and KIT Netherlands
Regional Network for Equity In Health in East and Southern Africa (EQUINET)

In the Programme on Advancing Equity in Universal Health Coverage in Zimbabwe

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Workshop delegates


Acknowledgement to the international Consultants, MoHCW, members of the Technical Working Group and the Atchison team for their support, contribution to the planning and roles in the workshop. Thanks to IDRC Canada for support to the Universal Health Coverage in Zimbabwe work and the workshop.
1. Background

In 2009, the Ministry of Health and Child Welfare (MOHCW) produced the ‘National Health Strategy 2009 – 2013: Equity and Quality in Health – A People’s Right’. The Strategy raises universality, equity and quality as central principles, ie that all have access to defined health interventions and services based on health need, including those that promote health and prevent ill health, and that sufficient resources for this are mobilised according to ability to pay and allocated according to health need.

Despite this stated policy goal, the public health financing for this is currently inadequate, the benefit package is not costed, and financing, including in private health insurance schemes is highly fragmented; with little cross-subsidies across funding pools. Out of pocket spending is high raising the risk of health spending increasing poverty in poor and vulnerable groups that depend to a large extent on public services. Efforts to mobilise resources need to address concerns about transparency and accountability in the management of resources.

From a practical, public finance perspective, it has been argued that taxes and other revenue sources should be judged by their

- Revenue adequacy and stability: the tax should raise a significant amount of revenue, be relatively stable, and be likely to grow over time.
- Efficiency: the tax should minimize economic distortions.
- Equity: the tax should treat different income groups fairly.
- Ease of collection: the tax should be simple to administer.
- Political acceptability: there should be transparency, broad diffusion, and clarity about the uses of the tax to promote acceptability (IMF and World Bank 2005):

Earmarking of Tax, or hypothecation, refers to the assigning of receipts either from a single tax base, or as a proportion from a wider pool of revenue, to a specific end use; it contrasts with general fund financing of expenditure from consolidated receipts.

Stakeholders identified in February 2012 that as the economy recovers, tax financing for health needs to be 1) progressive, 2) linked to sectors that are expected to grow substantially in the economy and 3) linked to population health and health behaviour. Mining (occupational health), tourism (sexual and reproductive health), agriculture (occupational and environmental health), transport/infrastructure (environmental health and accidents) and consumption (food & nutrition patterns, alcohol and tobacco use) were identified as potential sources of tax. In response to stakeholder proposals further work is being done to implement research on the feasibility of and revenue levels of different tax options. One of the areas being explored is an earmarked portion of value added tax (VAT). Research work was thus proposed to assess the feasibility, levels, projections and issues in pooling and allocating Value-Added Tax (VAT) as a source of health financing.

The work will provide evidence and analysis on

i. Assessment of the context for decisions on feasibility of VAT as a source of health financing: ie macroeconomic and political context including the fiscal space, whether the economy can accommodate an additional tax element; efficiencies in tax collection; opportunities and threats

ii. International experience of VAT as a source of health financing, in African countries and more widely, in terms of the context, levels and revenue collected, efficiency, equity, method and ease of collection, and measures for addressing political acceptability

iii. Projections of VAT as a source of financing, including initial levels / earmarked shares of of VAT based on the initial financing gap to be addressed; the projected additional revenue at selected proposed additional percentages of VAT (taking issues in (i) and (iii) into account); forecast modelling of different scenarios of the
implications of changes to the VAT rate, taking into account the elasticities in VAT. (The basic assumption will be that VAT revenue is relatively inelastic in order to avoid any distortions in the tax system).

iv. Public and policy maker perceptions of the implementation of an earmarked share of VAT for health financing.

v. Options for policy consideration on the optimal level/share of earmarked VAT, the conditions and issues to be addressed, including for the work on institutional and legal arrangements for collection, management and allocation of health financing.

Atchison Actuaries was commissioned to carry out the research work. In addition, National Health Insurance Authority of Ghana personnel were commissioned through the Royal Tropical Institute (KIT) Netherlands to provide resource input to the work. A skills workshop was held to review the experiences internationally of earmarking of Value Added Tax (VAT) and the methods for revenue simulations and projections, drawing on the expertise of Mr Francis-Xavier Andoh-Adjei and Mr Benjamin Markin Yankah and involving the local consultancy team from Atchison, Zimbabwe Economic Policy Analysis and Research Unit (ZEPARU) and delegates from the Training and Research Support Centre (TARSC), Ministry of Health and other institutions in the Technical Working Group (TWG).

Specifically the workshop sought to:
- explore ways of realising additional funding from earmarking VAT;
- draw input from National Health Insurance Ghana, on methodologies for estimating, simulating and projecting potential VAT revenues;
- draw lessons from international and local experiences on experiences of VAT as a source of financing; and
- answer questions on how to address challenges with data collection and analysis, review of tools, preliminary results and reporting.

The workshop was jointly organised by the Training and Research Support Centre and the Ministry of Health and Child Welfare. It was held at the Ministry of Health Board Room, 4th Floor Kaguvi Building. Significant logistical support was provided by personnel from the MOHCW. It was facilitated by TARSC and two international Consultants from the Ghana National Health Insurance. A CD Rom of background materials was prepared by TARSC. On the first day of the workshop there was an open session for the members of the Technical Working Group from 0830 hours- 1100 hours, where a presentation on international and regional experiences with VAT was made by Mr Francis-Xavier Andoh-Adjei with a subsequent discussion with the TWG. The remainder of the two days involved participants more directly involved in the follow-up research. The programme is shown in Appendix 1 and the delegate list in Appendix 2.

2. Opening

The workshop was opened by the Principal Director (Preventive services) and joint co-ordinator of the work in MoHCW, Dr Gibson Mhlanga. He welcomed the international consultants from Ghana, members of the TWG and the local consultants. He gave a brief background on the work on Universal Health Coverage in Zimbabwe; how it was conceived of, the discussions of the Advisory Board of Public Health (PHAB) and the subsequent stakeholder meetings in 2012 that gave impetus to further research in the area. He then gave a brief account of some of the key expectations from the workshop pointing out the need for the local consultants to meet the expectations of the MoHCW and the Minister of Health who is keenly awaiting the results of the study to present them before his Cabinet. Dr Mhlanga explained the nexus of relationships among all the participating institutions: The work on earmarked taxes is being done under the policy coordination of MoHCW and the
MoHCW Top Management Team (TMT) with the PHAB. Technical co-ordination and management is provided by Training and Research Support Centre, and technical guidance from a Technical Working Group. TARSC and Atchison nationally; and Francis-Xavier Andoh-Adjei and Benjamin Markin Yankah of the Ghana National Health Insurance Authority internationally are playing lead roles in support to the work on earmarking VAT and the International Development Research Centre (IDRC) Canada is providing support for the work. After these remarks, Dr Mhlango then officially declared the workshop open.

3. Ghana’s experience with earmarking of VAT

Mr Francis Andoh gave the first morning open session presentation that focused on Ghana’s Experience with the National Health Insurance. He pointed out that developing new institutions and policies is a complex exercise that takes a lot of time to come to fruition. In Ghana the discussion on a social health insurance started in 1969, but was only implemented in 2003 as a national health insurance (NHI) system. Ghana’s national health insurance system was established by an Act of Parliament that made provision for 3 schemes;
(i) District (Public) Mutual;
(ii) Private Mutual; and
(iii) Private Commercial.

The process of setting up an NHI began with the setting up of an Inter-Ministerial task team comprising the Ministry of Health as the lead ministry, the Ministry of Finance, the Ministry of Local government, Ministries of Information, Labour and Social Welfare. The Inter-Ministerial task team was mandated to harness ideas from various stakeholders such as labour, civic societies and professionals. The ideas from the stakeholders led to the development of a policy framework in 2002 that subsequently led to the drafting of a bill by the Attorney General’s office. The bill went through executive scrutiny, parliamentary processes and stakeholder processes for refinement, before it was finally accepted and passed into law in 2003. A legislative instrument that provided some details to the law was also passed in 2004. The Scheme was then officially launched by the President in 2004 to give it the importance that the Executive attached to it.

The NHI started as a pilot programme in 45 districts. Currently it is being implemented in all districts in Ghana. Ghana’s NHI had the objective of offering financial risk protection to the people of Ghana against the cost of basic health care services. It was based on the basic premise of offering access to basic services for all residents regardless of their status. It covered those in both the formal and informal sectors. The Ghana NHI programme is sustained from contributions from VAT; where 2.5% of the general VAT collections are earmarked for the NHI and complemented by 2.5% (which is 2.5% of the payroll) contribution from the Social Security (SSNIT) collections. The NHI covers about 95% of the disease conditions that affect the Ghana people. The benefit package includes:

- outpatients services;
- inpatients services;
- maternal services; and
- emergency services.

Apart from paying for claims submitted by health service providers, the NHI also invests its “surplus” funds in order to grow its reserves. other sources of funding include Parliamentary allocations, gifts, donations, grants and other voluntary contributions. The figure 1 below shows the NHI funding structure;
Over the years, the VAT contribution to the NHI has grown from 61.8% to about 72% of the total income as shown in the figure 2 below.

Ghana’ national Health Accounts show some significant changes in contribution to health expenditure. For example, the contribution from the Social Security Fund as a percentage of general government expenditure on health has grown from 21.7% in 2005 to 33.6% in 2010, which is a significant change. Government Health expenditure and Private Health expenditure as percentages of the total health expenditure have somehow fluctuated over the 10 year period, although overall government expenditure has gone up while the private expenditure has gone down. It is also important to note that the real out-of-pocket expenditure has gone down from 33% in 2000 to 27.2% of, although as percentage of private health expenditures it has grown from 64.4% to 67.2% as shown in Table 1 below.
### Table 1: Health Expenditure Indicators, WHO NHA

<table>
<thead>
<tr>
<th>Description</th>
<th>2000</th>
<th>2005</th>
<th>2007</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE as % of GDP</strong></td>
<td>4.7</td>
<td>7.0</td>
<td>6.0</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Financing sources measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Resource as % of THE</td>
<td>14.5</td>
<td>25.8</td>
<td>14.1</td>
<td>16.9</td>
</tr>
<tr>
<td>GGHE as % of THE</td>
<td>48.7</td>
<td>66.4</td>
<td>62.4</td>
<td>59.5</td>
</tr>
<tr>
<td><strong>Pvte Exp. on Health as % of THE</strong></td>
<td>51.3</td>
<td>33.6</td>
<td>37.6</td>
<td>40.5</td>
</tr>
<tr>
<td>GGHE as % of GGE (Abuja?)</td>
<td>8.3</td>
<td>15.2</td>
<td>15.4</td>
<td>12.1</td>
</tr>
<tr>
<td>SSF as % of GGHE</td>
<td>21.7</td>
<td>25.2</td>
<td>25.2</td>
<td>33.6</td>
</tr>
<tr>
<td>Pvte Insurance as % of Pvte Exp.</td>
<td>10.6</td>
<td>11.0</td>
<td>6.2</td>
<td>6.3</td>
</tr>
<tr>
<td><strong>OOP as % of Pvte Health Exp.</strong></td>
<td>64.4</td>
<td>63.7</td>
<td>66.4</td>
<td>67.2</td>
</tr>
<tr>
<td><strong>Real OOP Expenditures</strong></td>
<td>33.0</td>
<td>21.4</td>
<td>24.9</td>
<td>27.2</td>
</tr>
</tbody>
</table>

Source: Francis Andoh, Ghana NHIS

The introduction of the earmarking of VAT in Ghana, although it took some time, was never a major problem as result of the existence of other similar funds. For example, when the VAT law was passed in 1998, 2.5% of the revenues had already been earmarked for education. The success of the education fund, referred to as the GETFund made it easier for the NHI advocates to convince the policymakers. The success of other funds such as the MP’s common Fund for developing their constituencies and the District Assembly common added to the acceptability of the earmarking of funds.

Instead of using the word VAT, the NHI coined the earmarking as a National Health Insurance Levy. This gave it a neutral and more appealing status. The levy was premised on exempting essential commodities from the earmarked VAT. These commodities and services which are commonly accessed by the poor majority of the people of Ghana enabled the NHI to sell their idea, which reflected in essence that the earmarked VAT was not generally regressive, but instead was more progressive and equitable. Evidence to support this assertion was presented from studies by James Akazilli, Bertha Gashong and Caroline Jehu-Appiah of the Ghana Health Services.

Some of the commodities and services that are exempted from VAT include the following;
- medical services and pharmaceuticals;
- educational services/items;
- transportation;
- water, electricity, printed matter (books and newspapers);
- agricultural and aquatic food product in its raw state produced in Ghana;
- animals, livestock, poultry and fish imported for breeding purpose;
- animal product in its raw state produced in Ghana; and
- goods for the disabled, etc.

There was also greater acceptability of the tax because the initiative was through a bipartisan approach, involved broader stakeholder participation, was legally institutionalised and parliament was actively involved in the annual allocation of the funds to the NHI.

In terms of the institutional arrangements, the collection and disbursement of the earmarked VAT remained with the existing tax collection structures; the VAT secretariat, the Internal
Revenue Service and the Customs, Excise and Preventive Service. In order to fully monitor the flow of funds, the Ghana NHI tracks the collections as captured by the Ministry of Finance. Coupled with the legal framework, the Ministry of Finance is obliged to release the funds collected to the NHI. This legal framework makes it easier for the NHI to demand what is due to them from the collecting agency. Accounting for the use of funds is done through quarterly reconciliations done jointly between the NHI and the Ministry of Finance. The provider/purchaser and client relationship is clearly structured and defined, making it easy to identify the flow of funds and services, identify the intermediary players and their roles as shown in the Figure 3 below.

**Figure 3: Organisation of Health Services in Ghana**

The Ghana NHI acts as a regulator, implementer and fund manager. Initially providers were paid on a fee for service basis. Payments were then progressed to Diagnostic Related Groups (DRGs) after experiencing some challenges identified with the fee-for-service payment methods. Currently the NHI is considering introducing Capitation payment method for services delivered at the primary out-patients department. This has been piloted in one region and is will be rolled out countrywide. NHI currently does not support the provision of ARVs since they are catered for under a vertical programme. However opportunistic conditions arising deom HIV infection are covered under the scheme. The success of the use of earmarked VAT for the Ghana NHI as best practice has attracted attention from a number of countries and organisations.

It was noted in the discussion that while Zimbabwe is not thinking about introducing a National Health Insurance system, Mr Andoh’s presentation highlighted some good practice issues to be considered in the proposals for domestic health financing, including through earmarking a share of VAT, including:

1. Political acceptability - The success in introducing the NHI in Ghana was based on both political and technical support, largely the former, demanding advocacy and an effective communication strategy.
2. A legal framework was used to legalise the earmarking of funds. In Ghana the constitution stipulates that all funds should pass through the consolidated fund, but the NHI Act makes it mandatory for the monies to be transferred to NHIS fund by the Ministry of Finance. Any legal statutes need to be harmonised with the constitution.
3. A clearly defined institutional framework on who is purchaser, provider and how they relate to the client.
4. A clear exemption mechanism on any charges, such as in Ghana for those under 18 years, pregnant women, indigents, pensioners and all those contributing to the social security scheme.
5. The acceptability of the funding mechanism hinges on it being pro-poor and equitable; with more benefits realised by the poor people. The financing source should also exhibit progressivity.
6. The management and accounting of funds must be done jointly with the Ministry of Finance i.e. independently verifiable.
7. Parliament should strongly support the fund by actively participating in the allocation, disbursement and accounting of the funds.
8. The stakeholders should see value in the fund itself.
9. The private sector should participate.
10. There should be clear mechanisms and punitive measures to deal with perverse behaviour.
11. The Ministry of Health should not be over ambitious with the benefits that it promises to the people, rather, it should promise less and provide more rather promise more and prove less.

Mr Benjamin Yankah of the Ghana NHIA continued with information on the structure of the NHI and the VAT collections. According to the NHI statistics, the active membership of the national insurance rose from 1.35 million in 2005 to 8.23 million in 2011. This was attributed to the success of the NHI in addressing its objectives, specifically that of increasing access to health services in poor and vulnerable populations (distribution in 2011 was Under 18 years 49.7%, informal sector 36.4%, 70 years and above 4.9%, SSNIT contribution 4.5%, Indigents 4.2% and SSNIT pensions 0.3%). The out-patients utilisation also increased dramatically for the period 2005 to 2011 as shown in Figure 4 overleaf.

The NHI administration expenditure (including capital expenditure) is about 28% 30% of the total revenues, with the other 72% of the funds going to pay the insurance claims. However, Mr Yankah indicated that the Ghana NHI model leaned towards curative services more than preventive services. In the discussion, this was observed to be an expensive approach, contributing to escalating costs.

While the outpatient utilisation has increased over the years, the claims payments have also increased. This has created deficits that have eroded the income and reserves that NHI had built over the years through investments as shown in Figures 4 and 5 overleaf.
4. **Overview of the work in Zimbabwe on earmarked VAT**

Dr Rene Loewenson from TARSC discussed the scope of work and the expected activities and outputs from the consultants to explore this area of work in Zimbabwe. She noted that this was a policy option that had the potential to raise significant sums of money, but that needed assessment of its feasibility and equity. The terms of reference for the proposed technical work were circulated in advance and summary discussed in this session to ensure a common understanding of the scope of work.

The work seeks to look at the feasibility (including in terms of fiscal space and public perceptions), levels and projections, and issues in pooling and allocating Value-Added Tax (VAT) as a source of health financing for district health services

- context for decisions on feasibility;
- international experience;
• projections - initial levels / earmarked shares of VAT based on the financing gap to be addressed; projected additional revenue at selected proposed additional percentages of VAT, forecast modelling;
• public and policy perceptions;
• options for policy - optimal level/ share, conditions and issues to be addressed, including institutional and legal.

It was explained that the work would be done under the overall supervision of TARSC, MoHCW and the national TWG, with Atchison getting support from the international consultants from Ghana National Health Insurance Services. The work is being implemented by Mr James Olubayi from Atchison Actuaries working with Mr Tawanda Chituku, Mr ElphasTorevei and Ms Mercy Chifamba. Dr Rene Loewenson with Mr Z Mlambo and Mr S Shamu will be responsible for communications on the MoU from TARSC and Dr G Mhlanga MoHCW will be responsible for policy direction. Dr Loewenson discussed the ownership of the finished work and reports, and it was emphasized that the individual authorship and contributions and acknowledgement will be inside the report. Reports and data held by Atchison will be held confidentially until released in the public domain and subject to the ethical requirements of confidentiality of individual source and consent on any interviews held.

The expected outputs of the work are;
• report of the desk review of the national context and international experience;
• report of the assessment of stakeholder perceptions;
• draft report of the VAT tax feasibility, projections, options and follow up issues; and
• final report of VAT earmarked tax feasibility, projections, options and follow up issues.

5. Methods and data sources for revenue projections

Mr Benjamin Yankah presented the potential model that can be used for the analysis and projections of the VAT earmarked taxes. Key areas covered included
• evaluation of Tax and tax buoyancy;
• evaluation of Changes in Economic Conditions;
• evaluation of the Effect of Inflation on simulated revenues;
• Additional Factors
  o macroeconomic Environment;
  o changes in Different Tax Bases;
  o trade Flows;
  o business Income;
  o domestic Transactions of Goods and Services;
  o growth in Demand for Goods Subject to Excise Tax; and
  o mapping of the VAT exemptions in Zimbabwe.

Mr Yankah provided some examples of income and expenditure simulations that were done for the NHI using different levy rates and coverage rates as shown in figures 6 - 9 below.
On the last day of the workshop, the international consultants, the local consultants from Atchison, MoHCW and TARSC went through the specific methods in the TORs assessing to emphasise the actual methods, data and data sources to be used for the analysis;

1. For Assessment of the context *(macroeconomic and political context; fiscal space, whether the economy can accommodate an additional tax element; tax revenue data and trends; efficiencies in tax collection; opportunities and threats for VAT as a revenue source)*  
   Desk review and analysis of secondary data will be used for this. Sources include Zimbabwe Statistics Agency, Zimbabwe Revenue Authority, Ministry of Finance, MoHCW, Health Services Board, Local Authorities, National Aids Council (NAC), National Social Security Authority (NSSA), Parliament, Parliamentary Portfolio committees on Health and Finance, IMF reviews, World Bank. It will also include Zimbabwe’s experience with earmarked income taxes in the form of HIV & AIDS levy.

2. On International experience of VAT as a source of health financing, *in African countries and more widely, in terms of the context, levels and revenue collected, efficiency, equity, method and ease of collection, and measures for addressing political acceptability*  
   This will draw on two sources of evidence: 
   i. The Ghana experience in terms of the context, assumptions, levels and revenue collected, efficiency, equity, method and ease of collection, measures for addressing political acceptability; institutional arrangements, as well as relevant experiences that Ghana drew on.  
   ii. A brief desk review of literature on experiences is use of VAT, structured in terms of the categories above, especially drawing from African / low and middle income countries.
3. For Projections of VAT as a source of financing, including initial levels / earmarked shares of VAT based on the initial financing gap to be addressed; the projected additional revenue at selected proposed additional percentages of VAT (taking issues in (i) and (iii) into account); forecast modelling of different scenarios of the implications of changes to the VAT rate, taking into account the elasticities in VAT.

It is assumed that a dedicated VAT related tax for health will be combined with general tax allocation to health for pooled health funding of the Essential Health Benefits (EHB). The first part of this element would examine what level of dedicated VAT funding the health sector should be calling for. The initial financing gap to be covered by the VAT will be determined by the estimate of the total cost of services to be covered, compared against the sum total of all other sources of revenue other than the VAT. The total cost of services to be covered may be estimated through different cost estimates, providing projections for each viz

i. use of the 2010 Investment Case costing of community, primary care, district and referral services to obtain the per capita costing and applying these to population covered; (this will give the costs to deliver on the MDGs)

ii. calculating the expected number of persons to be covered, the cost of the EHB per person (e.g. using the WHO per capita cost of $60/capita), to get the total cost of services to be covered;

iii. The value of a defined percent of GDP (using levels of countries that have prioritised publicly funded health services - Costa Rica 6.1%; Cuba 6.5%; Namibia 4.7%).

The data required for an actuarial estimation of VAT levels (using Ghana’s social health insurance model) include data for the past 5 years and official projections for the next 20 years, if available, modified or expanded to suit the scheme or program being considered, on

i. scheme-specific demographic and financial data – initial coverage and future uptake;

ii. general demographic and economic data; General population by Age and Gender

iii. economic data: Inflation and Interest rates; GDP; Labour force; Employment (formal and informal sector); Unemployment etc;

iv. general Government Revenues and Expenditure, Government expenditure on Health;

v. legal Provisions (in terms of extent of coverage, eligibility conditions);

vi. health systems data – Benefit package; coverage; eligibility; utilisation of services by age and gender; outpatient cases and prescriptions; inpatient cases and prescriptions;

vii. current sources of health financing;

viii. average cost of health care services (both service and medicines) for both OPD and IPD;

The work will explore whether this requires an additional percentage loaded on existing VAT of 15% or allocating a given percentage on the current rate. VAT projections will be made considering:

i. the existing VAT rate and what percentage needs to be earmarked;

ii. the state of the economy: whether the economy at its current state can accommodate an additional tax element;

iii. efficiency in the collection of the taxes.

The study will project the revenue raised from different changes to the VAT rate, taking into account the elasticities in VAT. The basic assumption will be that VAT revenue is relatively inelastic in order to avoid any distortions in the tax system. The potential revenue can be calculated by multiplying the tax base by the tax rate and the tax compliance rate.

Scenarios/simulation analysis will be used to model economic and revenue trends to inform discussion on options for the optimal level of earmarked VAT for health financing. The
simulation model can include analysis of tax changes if assumptions of inelasticity are not correct (i.e. modeling a dynamic model where demand changes); analysis of various tax rates and various elasticities; and revenue forecasts of differentiated VAT rates instead of the flat rate/single rate currently in place in Zimbabwe. The data sources for VAT projections include Zimbabwe Statistics Agency, Zimbabwe Revenue Authority and the Ministry of Finance. Given that these are mostly government Ministries and departments, there are not likely to be challenges in gathering the data.

4. Public and policy maker perceptions of the implementation of an earmarked share of VAT for health financing. This will be done through some interviews and mapping of opinions with relevant government, community/public/ civil society; parliament; funder; private, technical stakeholders (drawing on the stakeholder analysis implemented earlier on the work in line with the protocol provided by TARSC.

In the discussion it was noted that
- The data should not include the local government revenues,
- The cost per capita can also be generated from dividing the current MoHCW budget and the current population.
- The VAT projections should be done for the next 20 years so that they are harmonized with the country's economic development plans for economic recovery.
- The projections should be divided into the period to the MDGs (2015) with the investment case cost per capita assumed to be to cover the MDGs and then for a 20 year period to cover the full benefit package (i.e. the full cost of services at community, public health, primary care and district level)
- The scenario analysis of the VAT could be done for a 1%, 1.5% and 2% level. Whether this is earmarked or additional would be a matter of policy dialogue between Ministry of Health and Ministry of Finance.

6. Assessment of public and policy maker perceptions

Dr Loewenson, TARSC outlined the methods for stakeholder analysis on domestic health financing, to complement the analysis and projections of the earmarked taxes. The studies aim to assess public and policy maker perceptions of the implementation of the four areas of earmarked taxes for health financing, given the role of these views in both shaping and implementing policies for UHC.

The presentation focused on the methods for identifying, categorizing and analyzing stakeholders based on their perceptions, position, power and influence on different financing options. The work identifies the stakeholders, particularly primary stakeholders that are directly affected by the issue. The presentation then looked at how further analysis and interviews could be done to provide more information on the political feasibility in the implementation of any financing options. She explored the key questions to be addressed, ie
- What context issues are critical for earmarking VAT- essential facilitators, critical blocks?
- Who are the key primary and secondary stakeholders for the earmarking of VAT?
- What are the roles, positions, interests and influence of the primary stakeholders in the area of VAT?
- What implications does this have for the content (benefits to make clear, concerns to address, burdens to justify) of the policy options for earmarked VAT?
- What implications does it have for the process for policy development and implementation and for the institutional and legal arrangements for collection, management and allocation of the earmarked VAT?
Dr Loewenson outlined the methods for assessing and presenting the positions, interest and influence of primary stakeholders and gave an example of the analysis. Stakeholder analysis (and interviews) is used to identify stakeholders, particularly primary and secondary stakeholders, their positions, roles and interests, and the perceived concerns and benefits to consider in policy design. She highlighted that the analysis provides information on:

- The issues to take into account in policy content – e.g. equity, use of funds
- The issues to communicate to whom on the policy to avoid misapprehension
- The interactions to ensure in the policy development
- The challenges may arise in policy implementation and what institutional issues to address.

This is used to assist in identifying policy feasibility and issues to consider for the process of policy development, institutional design and implementation.

7. Next steps and closing

Following the presentations, Dr Loewenson facilitated a discussion on the next steps. The initial Gantt chart was slightly modified and the following points of exchange were then discussed and agreed:

- **Report of the desk review on international literature and national context**
  - DRAFT – Atchison - February 28
  - REVIEW FEEDBACK- - TARSC, KIT – March 9
  - FINAL – Atchison – March 16

- **Report of the workshop**
  - DRAFT – TARSC (SS) and TC – February 28
  - Edit and input- RL – March 8
  - Confirm draft – KIT, MoHCW – March 12.

- **Report of the stakeholder analysis**
  - DRAFT + suggested interviews – Atchison – March 15
  - REVIEW FEEDBACK- - TARSC – March 22
  - FINAL – Atchison – April 10

- **Final protocol, tools**
  - DRAFT – Atchison– February 20
  - Review feedback – TARSC. KIT– February 25
  - Final protocol and tools– Atchison– February 28

Queries on data, analysis between Atchison, TARSC and KIT – March to May

- **Report of VAT feasibility, projections, options and follow up issues**
  - DRAFT – Atchison – April 15
  - REVIEW FEEDBACK- - TARSC, KIT, MOHCW – April 22
  - FINAL – Atchison – May 12
  - PRESENTATION TO TMT, and revision – Atchison, MoHCW, TARSC - May
  - EDIT and Final scientific report – Atchison, TARSC, MoHCW - June

Dissemination to the MoHCW top management team, PHAB and stakeholder forum will be done through the meetings scheduled within the wider programme.

The workshop was then closed with thanks from Dr Loewenson for TARSC/EQUINET to delegates, to MoHCW, to the colleagues from Ghana and the hosting by MoHCW. Final closing remarks and wishes for productive work were made by Mr Gwati, Ministry of Health and Child Welfare.
## Appendix 1: Programme

**Advancing Equity in Universal Health Coverage in Zimbabwe**

### Research on earmarked VAT for health financing
**TARSC/ EQUINET and MoHCW with KIT/NHIA Ghana**
**Inception workshop, 14-15 February 2013,**
**4th Floor Board room, Kagvi Building, Harare**

### Programme

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
<th>FACILITATOR</th>
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<tbody>
<tr>
<td>0830-0900</td>
<td>Registration and Administration</td>
<td>Mr S Shamu TARSC</td>
</tr>
<tr>
<td>0900-0920</td>
<td>Welcome, opening, Objectives of the workshop introductions</td>
<td>Dr G Mhlanga MoHCW, Dr R Loewenson TARSC Delegates</td>
</tr>
<tr>
<td>0920-10.00</td>
<td>Session 2: Presentation on International and Ghana experience with VAT as a source of financing for health</td>
<td>Mr F Francis-Xavier Andoh-Adjei, National Health Insurance Authority Ghana and KIT</td>
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<tr>
<td>1000-1030</td>
<td>Discussion</td>
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<tr>
<td>1030-1100</td>
<td>TEA BREAK</td>
<td>MoHCW chairing</td>
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<tr>
<td>1100-1300</td>
<td>Session 4: Discussion with the team on issues in and experiences with VAT as a source of financing for health insurance, including: i. Macroeconomic and other context issues; opportunities and threats; ii. International experience on levels and revenue collected, efficiency, equity, collection issues, and measures for addressing political acceptability</td>
<td>Mr F Andoh and delegates</td>
</tr>
<tr>
<td>1300-1400</td>
<td>LUNCH BREAK</td>
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<tr>
<td>1400-1600</td>
<td>Session 5: Presentation on the methodologies for projections of VAT as a source of financing, (levels/earmarked shares; projected additional revenue; forecast modelling etc), Group work/exercise using the methodological approach and the data for a hands-on trial</td>
<td>Mr F Andoh, Mr B Yankah and delegates</td>
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<tr>
<td>1600-1630</td>
<td>TEA BREAK AND CLOSING</td>
<td>Delegates</td>
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<td></td>
<td><strong>Evening</strong>: Own work, reading</td>
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<td></td>
<td><strong>Friday 15th February 2013</strong></td>
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<tr>
<td>0900-1100</td>
<td>Session 6: Presentation, review and feedback on team work</td>
<td>Delegates, Mr F Andoh, Mr B Yankah and Mr T Chituku</td>
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<tr>
<td>1100-1300</td>
<td>TEA BREAK</td>
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<tr>
<td>1130-1300</td>
<td>Session 7: Data sources; ensuring data and results quality, validity. Questions and discussions on the presentations, data, methods, analysis</td>
<td>Mr F Andoh, Mr B Yankah, Mr S Shamu TARSC and Delegates</td>
</tr>
<tr>
<td>1300-1400</td>
<td>LUNCH BREAK</td>
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<tr>
<td>1400-1430</td>
<td>Session 8: Methods, tools and targets for assessment of public and policy maker perceptions</td>
<td>Dr R Loewenson TARSC</td>
</tr>
<tr>
<td>1430-1530</td>
<td>Session 9: Planned protocol for the VAT work next steps; Points of interaction with NHIA/KIT</td>
<td>Dr R Loewenson, Mr S Shamu, TARSC with Mr F Andoh, Mr B Yankah and Delegates</td>
</tr>
<tr>
<td>1530-1600</td>
<td>Session 10: Concluding feedback, discussions, closing</td>
<td>Mr F Andoh, Mr B Yankah MoHCW and TARSC</td>
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<tr>
<td></td>
<td><strong>TEA BREAK AND CLOSING</strong></td>
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<tr>
<td></td>
<td><strong>END OF WORKSHOP</strong></td>
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</tbody>
</table>
### Appendix 2: Delegate list

<table>
<thead>
<tr>
<th>Names</th>
<th>Organisation</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hon Minister Dr H Madzorera</td>
<td>Ministry of Health and Child Welfare</td>
<td><a href="mailto:sbmakuni@gmail.com">sbmakuni@gmail.com</a></td>
</tr>
<tr>
<td>Dr Gibson Mhlanga</td>
<td>Ministry of Health and Child Welfare</td>
<td><a href="mailto:mhlanga.gibson@gmail.com">mhlanga.gibson@gmail.com</a></td>
</tr>
<tr>
<td>MrL Mabhandi</td>
<td>Ministry of Health and Child Welfare</td>
<td><a href="mailto:Leonardmabandi@gmail.com">Leonardmabandi@gmail.com</a></td>
</tr>
<tr>
<td>Mr Gwati Gwati</td>
<td>Ministry of Health and Child Welfare</td>
<td><a href="mailto:gwatigwati@gmail.com">gwatigwati@gmail.com</a></td>
</tr>
<tr>
<td>Mr Tonderai I Kadzere</td>
<td>Ministry of Health and Child Welfare</td>
<td><a href="mailto:Kadzeret@gmail.com">Kadzeret@gmail.com</a></td>
</tr>
<tr>
<td>Ms Mavis Bhara</td>
<td>Ministry of Health and Child Welfare</td>
<td><a href="mailto:mavisbhara@yahoo.com">mavisbhara@yahoo.com</a></td>
</tr>
<tr>
<td>Mr Francis Andoh</td>
<td>NHIA- Ghana 36-6th Avenue Ridge Pub Ministries Accra</td>
<td><a href="mailto:faxandoh@yahoo.com">faxandoh@yahoo.com</a></td>
</tr>
<tr>
<td>Mr Benjamin Yankah</td>
<td>NHIA- Ghana 36-6th Avenue Ridge Pub Ministries Accra</td>
<td><a href="mailto:bamyankak@yahoo.co.uk">bamyankak@yahoo.co.uk</a></td>
</tr>
<tr>
<td>Mr Tawanda Chituku</td>
<td>Atchison Actuaries</td>
<td><a href="mailto:tchituku@atchison.co.zw">tchituku@atchison.co.zw</a></td>
</tr>
<tr>
<td>Ms Mercy Chifamba</td>
<td>Atchison Actuaries</td>
<td><a href="mailto:actuaries@atchison.co.zw">actuaries@atchison.co.zw</a></td>
</tr>
<tr>
<td>Mr Elphas Torevei</td>
<td>Atchison Actuaries</td>
<td><a href="mailto:actuaries@atchison.co.zw">actuaries@atchison.co.zw</a></td>
</tr>
<tr>
<td>Mr R Samanga</td>
<td>Atchison Actuaries</td>
<td><a href="mailto:rsamanga@comarton.co.zw">rsamanga@comarton.co.zw</a></td>
</tr>
<tr>
<td>Mr James Olubayi</td>
<td>Atchison Actuaries</td>
<td><a href="mailto:jolubayi@aforbes.co.ke">jolubayi@aforbes.co.ke</a></td>
</tr>
<tr>
<td>Mr Shepherd Shamu</td>
<td>TARSC) 47 Van Praagh Ave Milton Park</td>
<td><a href="mailto:shepherd@tarsc.org">shepherd@tarsc.org</a></td>
</tr>
<tr>
<td>Dr Rene Loewenson</td>
<td>TARSC) 47 Van Praagh Ave Milton Park</td>
<td><a href="mailto:rene@tarsc.org">rene@tarsc.org</a></td>
</tr>
<tr>
<td>Mr N Muza</td>
<td>TWG Advisory Board of Public Health (PHAB), MoHCW</td>
<td><a href="mailto:nmuza@cimas.co.zw">nmuza@cimas.co.zw</a></td>
</tr>
<tr>
<td>Dr Gibson Chigumira</td>
<td>Zimbabwe Economic Policy Research Unit (ZEPARU) No. 55 Mull Rd Belvedere Harare</td>
<td><a href="mailto:chigumirag@zeparu.co.zw">chigumirag@zeparu.co.zw</a></td>
</tr>
<tr>
<td>Mr T Mabugu</td>
<td>HEPRI 0777280301/ 0772907254</td>
<td><a href="mailto:travamabugu@yahoo.com">travamabugu@yahoo.com</a></td>
</tr>
<tr>
<td>Dr J Chirenda</td>
<td>UZ DCM 0734016944</td>
<td><a href="mailto:chirenda1@yahoo.co.uk">chirenda1@yahoo.co.uk</a>; <a href="mailto:joconiah@gmail.com">joconiah@gmail.com</a></td>
</tr>
<tr>
<td><strong>Apologies</strong></td>
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<tr>
<td>Dr Annah Miller</td>
<td>Ministry of Health and Child Welfare</td>
<td><a href="mailto:Amillerdoc@gmail.com">Amillerdoc@gmail.com</a></td>
</tr>
<tr>
<td>Dr Charimari</td>
<td>WHO country office 82 – 86 Enterprise Cnr Glenara, Highlands, Harare 4-253724-30</td>
<td><a href="mailto:charimari@zw.afro.who.int">charimari@zw.afro.who.int</a></td>
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