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Ministry of Public Health

General Directorate of Policy, Planning and International Relations

Health Economics and Financing Directorate

Revenue Generation Strategic Framework for the Health Sector

November 2014

Abbreviations

BPHS	Basic Package of Health Services
BRT	Business Receipts Tax
EPHS	Essential Package of Hospital Services
EU	European Union
GDP	Gross Domestic Product
GoIRA	Government of the Islamic Republic of Afghanistan
HEFD	Health Economics and Financing Directorate
HPP	Health Policy Project
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPD	Inpatient Department
LMIC	Low and Middle-Income Country
MoF	Ministry of Finance
MoPH	Ministry of Public Health
NHA	National Health Accounts
OOP	Out-of-Pocket
OPD	Outpatient Department
PPHD	Provincial Health Directorate
THE	Total Health Expenditure
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Acknowledgements

Increasing domestic fund for the health sector is a vital element of healthcare financing in low and middle-income countries for moving towards implementation of universal health coverage (WHO, 2001). To achieve the health Millennium Development Goals and to ensure access to critical interventions, a low-income country is in need of around US$60 per capita (WHO, 2010). Therefore, it is important for Afghanistan to ensure that funding increases consistently over the coming years through the support of the international community and domestic revenues to enable the necessary scale-up of healthcare services.

I would like to acknowledge the contribution of the following people in the process of developing and revising the revenue generation strategy for the health sector. First, let me thank Dr. Ahmad Shah Salehi for conceiving and initiating the idea of domestic revenue generation for Afghanistan health sector, analysis of data, and his leadership in the process of developing this document. I also thank Dr. Husnia Sadat and Dr. Faridoon Joyenda for carrying out data collection and helping the process of developing this strategy. Special thanks go to the Non-Tax Revenue Department at the Ministry of Finance (MoF), and the World Bank for their valuable comments and suggestions. I would also like to acknowledge the technical support of Dr. Wu Zeng and Ms. Christine Kim from the USAID-funded Health Policy Project (HPP).

This strategy has been updated in November 2014 based on new data provided by the MoF and feedback provided by MoPH stakeholders.

We look forward to close collaboration of all stakeholders, particularly the MoF, for the successful implementation of this strategy.

Sincerely,

Dr. Suraya Dalil

Minister of Public Health

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Executive Summary

Adequate, sustained, and equitable financing is the foundation of health care systems. The design and implementation of strategy for generating revenue, however, remains challenging for many countries. In Afghanistan, to finance the health system in a more sustainable way, health financing mechanisms need to shift from dependence on external assistance and private household expenditures to government budget and prepayment mechanisms.

There are three main sources of health financing in Afghanistan: central government revenue, external aid, and private household expenditure. The National Health Accounts (NHA) report (MOPH, 2013) shows that in 2011-2012, out-of-pocket (OOP) expenditures accounted for 73.6% of total health expenditure (THE) (US$1,500,975,945) while the central government financed only 5.6% (US$84,148,093) of THE and International donor funding accounted for the remaining 20.8% (US$312,468,367).

The goal of this document is to present a multi-year strategy to increase domestic revenue for health to reduce the dependency on external aid and increase government contribution to the health sector in Afghanistan, and reduce OOP expenditures of households.

The proposed revenue strategies are estimated to generate around US$196 million per year for health (Table1). The strategy include levying taxes on imported tobacco products, vehicle tax, fuel tax, introducing user fees for secondary and tertiary health care, and commencing health insurance scheme. The revenue generated by implementing these strategies would contribute to improving the quality of healthcare services and expanding health programs.

Table 1 Summary of revenue generation streams

Policy	Proposed strategy	Estimated revenue (Annual)	Next steps
Tobacco Tax	Excise tax of 50% levied on all imported tobacco products	$25million	Remove legal barriers, advocacy for earmarking to health
Vehicle Tax	Phase 1: Specific tax of 12,500 Afs ($223 USD) levied on imported vehicles Phase 2: Road Permit of 1,750 Afs ($31 USD)	Phase 1:$2.2million Phase 2:$25 million	Advocacy and implementation

Fuel Tax	1 Afs levied per liter of gasoline with 100% of tax allocated to health	$32 million	Advocacy and implementation
User Fees	Introducing user fee of Afs 50 per outpatient visit and Afs 1000 per inpatient admission on secondary and tertiary health care services.	$62million	Address legal barriers, establish health equity fund, improve quality of care, advocate to use it at the facility level
Health Insurance	A feasibility study is being conducted to identify the best practical model and develop a road map.	Over $50 million	Road map, address legal barriers, improve quality of care

The implementation of this strategy requires careful planning, considerable advocacy effort, step-wise implementation, and close monitoring. The design should ensure equity with a particular attention paid towards the impact of fees on service utilization among the poor and disadvantaged groups. Furthermore, the collection process should not overburden the already stretched tax system and the secured funds should be earmarked for health programs. Finally, the programs need to be closely monitored and adjusted when needed to reflect on-going changes of the political, economic, and administrative realities.

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1. Background

A well-functioning healthcare system relies on sustainable and reliable financing mechanisms. However, this is a particular challenge for low and middle-income countries where administrative structures are at an ascent stage. Despite the many challenges, a number of innovative schemes have been implemented in developing countries to increase domestic funding for health. The health financing strategy in Afghanistan draws on lessons learned from other countries and is informed by data gathered and analyzed to set forth policy recommendations according to the context of Afghanistan.

2. Fiscal space and overall budget allocation

International Monetary Fund (IMF) defines fiscal space as "the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position" (Heller, 2005). While this strategy paper focuses on health, it is important to recognize that budgetary resources made available to the health sector is a function of macroeconomic growth of the country, government's overall fiscal policies, demands of competing ministries, and the structure of budgetary allocation.

To this end, the Government of the Islamic Republic of Afghanistan (GIRoA) has made notable progress towards improving revenue collection. Companies are now mandated to prepay 2% business receipts tax (BRT) on imported goods at border crossings. Improved monitoring and tracking systems have reduced the likelihood for corruption and delays in payment. Additionally, the government plans to introduce a value-added tax in the near future.

Nevertheless, domestic revenue generated through taxation remains low and fiscal sustainability is a continuing concern. While progress has been made to improve tax collection, the percentage of gross domestic product (GDP) collected through general taxation in Afghanistan is well below the average among low-income countries. According to the IMF, in 2010/2011, only11% of total GDP revenue was collected through taxation and fees in Afghanistan. This is incomparable to 18%in low-income countries, 23% in middle-income countries, and 32% in high income countries (Gottret & Schieber, 2006).

In Afghanistan the percentage of the government budget allocation to the health sector has not changed significantly since 2010. According to the 2014 Budget Decree of MoF, the government allocates 44% of the total government budget to the security sector, 12.9% to the education sector, 7.7% to the agriculture and rural development sectors and only 4.3% to the

health sector (MOPH, 2013). It indicates that the share of the government allocation to the health sector is far lower than the 15% recommended by the Abuja Declaration.

3. Health Financing in Afghanistan

Total health expenditure per capita was US$56 in 2011-2012 in Afghanistan. Of this amount, domestic revenue accounted for 5.6% of THE, external assistance accounted for 20.8 percent, and the remaining 73.6%was financed through private out of pocket (OOP) payments. Table 2presents an overview of health expenditure in Afghanistan from the 2011-2012 NHA report. (MOPH, 2013)

Table 2. Summary of health financing indicators

Indicators	**2011-2012**
Per capita income (USD)	$715
Total government health expenditure (USD)	$84 million
Total health expenditure (USD)	$1.5billion
Total Health expenditure per capita (USD)	$56
Government health expenditure as % total government expenditure	4.2%
Source of Public Health Expenditure	
Central government	5.6%
External Financing	20.8%
Private Expenditure	73.6%
Distribution of providers as percentage of total health expenditure	
Hospitals	24%
Outpatient care centers (clinics, district hospitals)	25%
Pharmaceuticals and medical equipment	26%
Other	25%

* Source: National Health Accounts, 2011-2012

From 2004 to 2012, external funding has increased from US$32 million to US$340 million to the health sector of Afghanistan. Overall support from major donors – namely the European Union (EU), United States Agency for International Development (USAID), and the World Bank (WB) – has had a catalytic impact on the development of the health system, including the restructuring of the health delivery system, the design and provision of the basic package

of health services (BPHS), the initiation and expansion of midwifery programs, etc. These essential reforms have led to considerable improvement of health status among populations, particularly maternal and under-five child health. However, to sustain gains in health, domestic sources of revenue should be increased in the long-run.

4. Demographic Transition and Health Needs

Afghanistan has made impressive health gains over the past decade. According to recent government estimates, the infant mortality rate (IMR) has fallen from 129 to 77per 1000 live births and under-five child mortality rate has dropped from 257 to 97 per 1000 live births between 2006 and 2010 (AHS, 2006). Likewise, significant improvements have been noted in access to care: one in three women now gives birth under the care of a skilled health professional.

Despite the progress, the country faces a number of health challenges. Rapid urbanization has contributed to an increased incidence of non-communicable diseases. According to the Afghan Mortality Survey, over half (52%) of all deaths among women aged between 15 to 59 years old are due to non-communicable diseases, including cardiovascular diseases and cancer. Among men, nearly one fifth of mortality is due to road-traffic. Yet, the majority of the population remains rural and poor, suffering from preventable childhood infectious diseases, and poor health due to the unresponsiveness of the health system. Additionally, quality of care is generally low and access to available health services is an ongoing challenge.

5. Revenue Generation Strategic Objectives

Since 2003, the MoPH, with the financial support from developing partners, has embarked on implementing essential health programs such as the BPHS and Essential Package of Hospital Services (EPHS). As donor funding is reduced in the near future, these programs will not be sustainable without alternative sources of funding for the health sector to fill the financial gap.

The overall objectives of the Revenue Generation Strategy are:

- To introduce feasible strategies to increase domestic revenue for health;
- To reduce dependency on external aid from 75% of total public expenditure on health in 2012 to 50% by 2020;
- To increase allocation of government contribution - from 4.2% in 2012 to 10% of total budget by 2020; and
- To reduce out-of-pocket expenditures by households from 73%in 2012 to 50% by 2020.

5.1 Health revenue priorities

The specific MoPH priorities for collected revenues are for the following purposes:

- Improve overall quality of secondary and tertiary public health care;
- Establish a treatment and research center for ‘cancer’ and a control treatment centers for non-communicable diseases and injuries;
- Train highly qualified clinical staff to meet the needs of the country; and
- Equip and modernize hospital sector according to international standards.

6. Revenue Generation Plan

This revenue generation strategy takes various approaches, which include imposing excise tax on tobacco, vehicle, and introducing user fees at secondary and tertiary health services and introduction of social health insurance schemes which will generate around US$196 million for the health sector, if fully implemented. .

6.1 Excise Tax on Tobacco

6.1.1 Strategic Direction

Excise tax of 50% levied on imported cigarettes

6.1.2 Rationale

Empirical studies show that excise tax on tobacco is one of the most cost-effective policies to raise revenue and reduce prevalence of smoking. In Afghanistan, use of tobacco is on the rise. According to a 2010 study, the prevalence of tobacco use has become more than doubled with one in three men (35%) in Kabul over the age of 15 smoke at least one pack of cigarettes per week.

6.1.3 Tobacco Market

Afghanistan is a net importer of tobacco leaves and products. Annually a total value of US$ 98 million (580 million packs) of cigarette is imported into the country (Ministry of Finance, 2014). At present, all imported tobacco products are subject to a 10% customs fee and 4%BRT, which is collected at the custom office.

According to the survey conducting by MoPH in Kabul city in April 2014, the average price of one cigarette pack was estimated 36.4 Afs (HEFD, 2014).

6.1.4 Design and Implementation

In designing the tobacco tax policy, the tobacco market, smoking behavior, and capacity of the customs department to collect the revenue are taken into consideration.

On the demand side, consumption is driven largely by price, income and smoking behavior. Estimates from various Asian countries suggest that the short-run price elasticity for tobacco products, which measures the change in consumption as a result of price, ranges from −0.17 to −0.78, while long-run estimates range from −0.4 to −0.9 (WHO, 2009). Demand for cigarettes in the short run is more inelastic than that in the long run, which means that fewer cigarettes will be consumed with increases in price in the long run. Market factors such as availability of substitutes, social context of smoking, and demographics all affect price elasticity, and in turn, forecasted revenue. Similarly, on the supply side, the current administrative capacity within the customs department, the diversity of tobacco products (branding and types), the size and types of producers, and taxes in neighboring countries need to be considered.

Table 3. Overview of Tobacco Tax Design

Tax: Excise tax of 50% will be applied to all tobacco products (excluding raw tobacco materials).
Valuation: Value of imported tobacco products is determined by the customs office. MoPH will work collaboratively with MoF to monitor valuation of imported tobacco products.
Revenue: Revenue will be collected through the non-tax department within MoF, and will be earmarked to health on annual basis. This activity needs further discussion with MoF.
Monitoring: MoPH will routinely monitor retail pricing of tobacco to gauge the implementation process. In addition, on an annual basis, the MoPH will conduct studies to estimate the effect of excise tax on the prevalence of smoking and health gains as a result of reduced tobacco consumption.

6.1.5 Revenue Forecast

With an assumption of price elasticity of -0.5, we estimated that levying a 50%excise tax on imported tobacco products will generate an additionalUS$25million per year, the excise tax will be collected by the MoF custom department and it will be earmarked fully for the health sector.

At the beginning of implementing the strategy, it is anticipated that the revenue generated from the tax of imported tobacco will remain substantial given that the market dynamics are affected by price change and income increase, as well as resistance to smoking behavior change. Therefore, collected revenue as such, if used for health, could provide substantial support towards government's obligation to provide quality health services for Afghans.

6.2 Vehicle Tax

6.2.1 Strategic Direction:

Levy specific tax of 12500 Afs (~ $223) on imported vehicles and flat fee of 1750 Afs ($31) per vehicle during vehicle road permit renewal.

6.2.2 Rational

Afghanistan is undergoing rapid urbanization. Road construction, coupled with limited legislation on road safety and vehicle standards, has contributed to a sharp rise in motor-vehicle accidents, particularly among young people between the ages of 15 to 49. In 2007, an estimated 1,835 deaths and 3,212 non-fatal injuries were attributed to road accidents (WHO, 2011). While a formal assessment has not been conducted since 2007, it is estimated that more than 2500 lives are lost annually due to fatal crashes.

Accordingly, admission to the emergency room as a result of traffic injuries has increased by 30% between 2009 and 2011 (MOPH, 2012) Based on a recent MoPH study, on average, public hospitals in Kabul receive 15 - 25 cases traffic injury cases per day, and MoPH shoulders the majority of the associated treatment cost.

6.2.3 Design and Implementation

To reduce the growth rate of vehicles on the road and to offset health spending as a result of traffic injuries, the introduction of one-time specific tax of $223 per vehicle on all imported vehicles is proposed. In addition, MoPH, in collaboration with local transportation department, will collect an additional $31 per vehicle during 'road permit' (*Jawaz-e sair*) renewal. The fees are intended to offset costs incurred by district and provincial hospitals for ambulance and emergency transfers, and for treatment of injuries due to road accidents.

6.2.4 Revenue Forecast

Based on data provided by traffic department, there are currently 820,000 registered vehicles in Afghanistan. Furthermore, 10177 cars imported annually (Ministry of Finance, 2014).On average, costs range from $3,000 to $120,000, depending on model and year of the vehicle. A more aggressive tax scheme may be considered in the future, should the government consider using taxation as an instrument to adjust the number of vehicles on the road.

It is estimated that the proposed revenue stream will generate $ 27,689,471 per year and the tax collected will help defray healthcare costs associated with increase traffic related injuries, and provide MoPH with a source of sizable and predictable revenue.

Table 4. Overview of vehicle tax design

Tax: Specific tax of $223 will be applied to all imported vehicles; $31 will be applied to all road permit renewal.
Valuation: Value of imported cars will be determined by the customs office.
Revenue: Import fees will be collected by the non-tax department within the Ministry of Finance, and allocated to health on a quarterly basis. Licensure fees will be collected by the provincial office and verified by the provincial health officers.

6.3 Fuel Tax

6.3.1 Strategic Direction:

Levy 1 Afs per liter of fuel, with 100% of funds allocated to MoPH

6.3.2 Rational

Air pollution due to emission of hazardous gases is a raising health concern in Afghanistan. Incidence of non-communicable diseases in Afghanistan is on the rise. In 2009, there were 11,340 cases of pulmonary diseases; the number increased to 12,350 in 2010. While there are a number of factors that contribute to cardiovascular and respiratory illnesses, studies show that pollution emitted from fuel have an adverse effect on health. According to a recent study published by the United States Institute of Medicine, an increase of air particles from 2.5 to 10 micrograms per cubic meter is associated with a 6% increase of the rate of cardiovascular diseases and 8% increase of respiratory illnesses.

In Afghanistan, rapid urbanization has led to a notable increase in the emission of traffic air pollutants and road congestions. To offset the health cost of treating illness associated with pollution, the MoPH is advocating for 1 Afs per liter of fuel to be implemented.

6.3.3 Design and Implementation

In collaboration with the non-tax revenue department within MoF, MoPH proposes the introduction of 1Af per liter of fuel. The fees will be collected by the customs department and earmarked for MoPH.

6.3.4 Revenue Forecast

In 2012, Afghanistan imported 1.8 million liters of fuel. It is estimated that imports will increase by 8 to 10% each year. During the first year of implementation, $32 million dollars will be collected per year and earmarked for health.

6.4 User Fees

6.4.1 Strategic direction

Introduction of a flat fee of 50 Afs on outpatient services and 1000 Afs on inpatient services at the secondary and tertiary levels.

6.4.2 Rationale

While there is an ongoing debate on introducing user fee as a mechanism to finance health in low-income countries, experience from China, Indonesia, Sub-Sahara Africa, and Cambodia

suggests that user fees are able to address the shortage of funds at the facility level and improve quality and efficiency of health services. For instance, one study shows that hospitals were able to raise their revenues through user charges by 15-45% of their non-salary expenditure, and effectively reduce the over-utilization of health services (Shaw & Ainsworth, 1995)

In Afghanistan, secondary and tertiary levels of health care are facing significant financial challenges. Quality of services is poor and only a limited budget is allocated to hospitals from MoF. Donors provide limited support to hospitals, particularly for tertiary healthcare services. Introduction of user fee can address financial constrains which significantly affect the quality of care and the utilization of care in public hospitals; it could be an effective mechanism to rationalize the use of care if it is implemented with care. The introduction of user fees allows population to pay more attention to the primary care, and improve the efficiency of hospital care. In combination with other mechanisms (i.e., exemption of user fees for the poor), it is possible that user fees will not discourage the utilization of necessary hospital care.

6.4.3 Design and Implementation

After removing the legal barriers, given the limited funding for hospitals, it is sensible to pilot a user fee scheme at Kabul hospitals aiming for scaling up to provincial and district hospitals gradually. The user fee policy will not only supplement the government budget and improve quality of care through augmenting hospital's discretionary funds but also discourage irrational use of hospital services.

Some international experience demonstrates that the effective use of judicious user fees influenced public behavior to achieve public health goals by discouraging patients from seeking basic care at higher level (and more expensive) and encouraging use of more appropriate and less expensive primary care health facilities (Akashi, Yamada, Huot, Kanal, & Sugimoto, 2004).

In Afghanistan a similar concept will be applied. The primary health care services will remain free, but patients who seek primary care at National Hospitals will be charged a flat fee of 50 Afs, which is almost20%of the average cost of outpatient department (OPD) services at this level. These approaches will discourage patients from seeking care at the national hospital level and will reduce the unnecessary consultations. In addition, it is required that the collected revenue will be used for the quality improvement for the hospital.

A flat fee of 1000 Afs represents almost 50% of the average cost of inpatient department (IPD) services at national hospitals (MOPH, 2012).By sharing the cost of services, revenues can go to improve quality and non-salary expenditures, such as maintenance costs (Thomas, 2006). The collected fees at the national hospitals from people who can afford to pay will be used to subsidize services for the poor through establishing equity fund (Akashi, Yamada, Huot, Kanal, & Sugimoto, 2004).

Table 4. Overview of User fees for secondary and tertiary care services

Pilot Sites: user fee will be introduce at Kabul hospitals and will be expanded to provincial and district hospitals
Pre-Implementation: Develop exemption system (health equity fund), oversight committee, communication plan, and fee schedule
Implementation: A flat fee of Afs 50 per OPD visit and 1000 Afs per IPD admission at the hospital level will be introduced. Revenue will be collected by hospitals and will be used for creating equity fund
Monitoring: Hospitals will have discretion in utilizing the funds. A committee comprising of members from MoF, central MoPH, Provincial Health Director and community will provide oversight.

6.5 Health Insurance

6.5.1 Strategic direction

Introduction of Health Insurance at the national level

6.5.2 Rationale

In low allow income countries, out-of-pocket health expenditures constitute the highest proportion of total health expenditures. High levels of out-of-pocket expenditures discourage individuals, particularly the poor and vulnerable from seeking timely care (MOPH, 2013). This leads to increased incidence of diseases and other adverse health conditions. It delays treatment, leaving conditions to worsen over time, and driving costs up further. Risk pooling through health insurance can alleviate some financial barriers and increase access to services by ensuring that all members of the pool— individuals of varying degrees of health status— pool financial resources to cover the costs of health services. In Afghanistan there is a pressing need to introduce financial risk protection mechanisms to control surging out-of-pocket expenditures. With no current health insurance or risk pooling system in place, private

expenditure on health is almost entirely from out-of-pocket payments made at the time of service use, estimated at 73.6% of total health expenditures. Recent studies suggest that BPHS is being offered in districts in which roughly 75% of the population resides. Despite this, approximately 60% of the population live more than one-hour away from the nearest BPHS facilities, making access to healthcare a challenge for a large proportion of the population. Patients in the lowest income quintile incur higher costs than those in the wealthiest quintile ($10.00 vs. $8.40) when obtaining health care; as do those living in more remote areas. In addition to the costs of treatment, an individual living in an inaccessible area would incur not only higher transportation costs to travel to a clinic, but also loss of income. In addition, informal payments are also prevalent practice at both central and peripheral health facilities, which adds to the costs of services.

6.5.3 Design and Implementation

At the beginning a feasibility study will be conducted at the level of different categories of potential beneficiaries, such as government employees, non-government formal sector employees, informal sector employees, and the poor. Based on the findings and recommendations of the feasibility study the scheme will be designed.

6.5.4 Revenue Forecast

It will be forecasted after the result of feasibility study. However, a rough estimation shows that over 50 million dollars will be generated by a premium paid by the formal sector.

7. Next Steps

Establishing adequate, stable and diversified sources of financing is critical in the development of a health care system. The design of each revenue stream takes into account a number of factors including market structure and administrative feasibility. Furthermore, implementation requires careful consideration; each strategy requires a detailed work plan which encompasses stakeholder analysis, advocacy plan, capacity building activities, implementation, and monitoring and evaluation.

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Annex

Table 1: Estimated Revenue to be generated through Excise Tax on Tobacco

Year	Current Tax	Import duty inAfs (14%)	Proposed Tax	Price elasticity	Change of price	Change of quantity	Import duty inAfs (50%)	Revenue for MOF in Afs 14%	Current revenue USD 14%	Revenue in Afs 50%	Revenue in USD 50%	Additional Revenue for MOF in USD
2014	14%	5,000,000,000	50%	-0.5	0.316	-0.158	4,210,526,316	700,000,000	$ 12,500,000	2,105,263,158	$ 37,593,985	$25,093,985

Table 2: Tax on Motor Vehicle:

Quantity	Proposed Fee in US$	Total (USD)
10,177	$223	$2,269,471

Table 3: Fees on road permit re-registration

Quantity	Fees (at 25% of existing licensing fees)	Total (USD)
820,000	$31	$25,420,000

Table 4: Tax on Imported fuels

Fuel imported in ton	Fuel in liters	1 Afs tax on fuel	Total in Afs	Total in US$
1,566,297	1,842,701,432	1,842,701,432	1,842,701,432	$32,905,383

Table 5: User fee

OPD Hospital				**IPD Hospital**					
Number of OPD	Unit cost	Total in Afs	Total in USD	Number of Bed	Occupancy rate in day	Occupancy rate in year	Cost per bed per day	Cost per bed per year in Afs	Cost per bed per year in USD
12,864,799	AFA 50	AFA 643,239,950	$ 11,486,428	10,576	7932	2,895,180	AFA 1,000	AFA 2,895,180,000	$ 50,792,632

[1]Exchange rate for the calculation is 1USD equals to 56 AFA