Effectiveness, Efficiency and Equity of Tax Incentives for Private Hospital Investment in Developing Countries

Experience of the Sri Lanka BOI Investment Incentives Programme

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Outline

- Background motivation
- Sri Lanka background and scheme
- Methods, data
- Results
- Conclusions

Funding for study from

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Sri Lanka

Global currents

- Belated recognition of substantial role of private expenditures for health
- Desire to increase and optimize resource flows for MDGs
- Ideological presumption of greater efficiency of private provision and ability of private sector to reach the poor
- Globalization of health care use by affluent leading to pressures for enabling access to high technology services

Sri Lankan Context

- Population 20 million
- Low-income economy
  - Per capita GDP US$ 800-1,100
- Good health performer
  - IMR ~11, LEB ~73
  - Levels of basic access comparable to OECD
- Low health spender
  - Public expenditure <1.7% of GDP
  - Total expenditure <3.7% of GDP
  - Public spending less than US$ 5 per capita until 1990s

Sri Lankan Health System

- Dual system
  - Public sector
    - 50% of financing, tax financed
    - Pro-poor, hospital dominated, highly efficient
    - High levels of provision
      - ~20% admission rate, 2.5 physician visits per capita
  - Private sector
    - Laissez faire policy
    - 50% of financing, mostly out-of-pocket
    - Used more by rich, outpatient dominated
    - 40-60% of outpatient care, <5% of inpatient care

Board of Investment (BOI)

- Originally established in late 1970s to promote manufacturing exports through tax holidays
- 1990s: Expansion of incentives to other sectors
- 1992: Provision of tax incentives for hospital investors

BOI Program Incentives

- Qualifying criteria
  - Minimum new investment
    - US$ 2.5 million -> US$ 0.5 million
  - Beds
    - 100 -> 0 beds
- Incentives
  - Corporate income/VAT tax exemptions
    - 5 - 20 years
  - Import duty exemption for capital goods
  - Land concessions
    - Lease of government land at below market prices

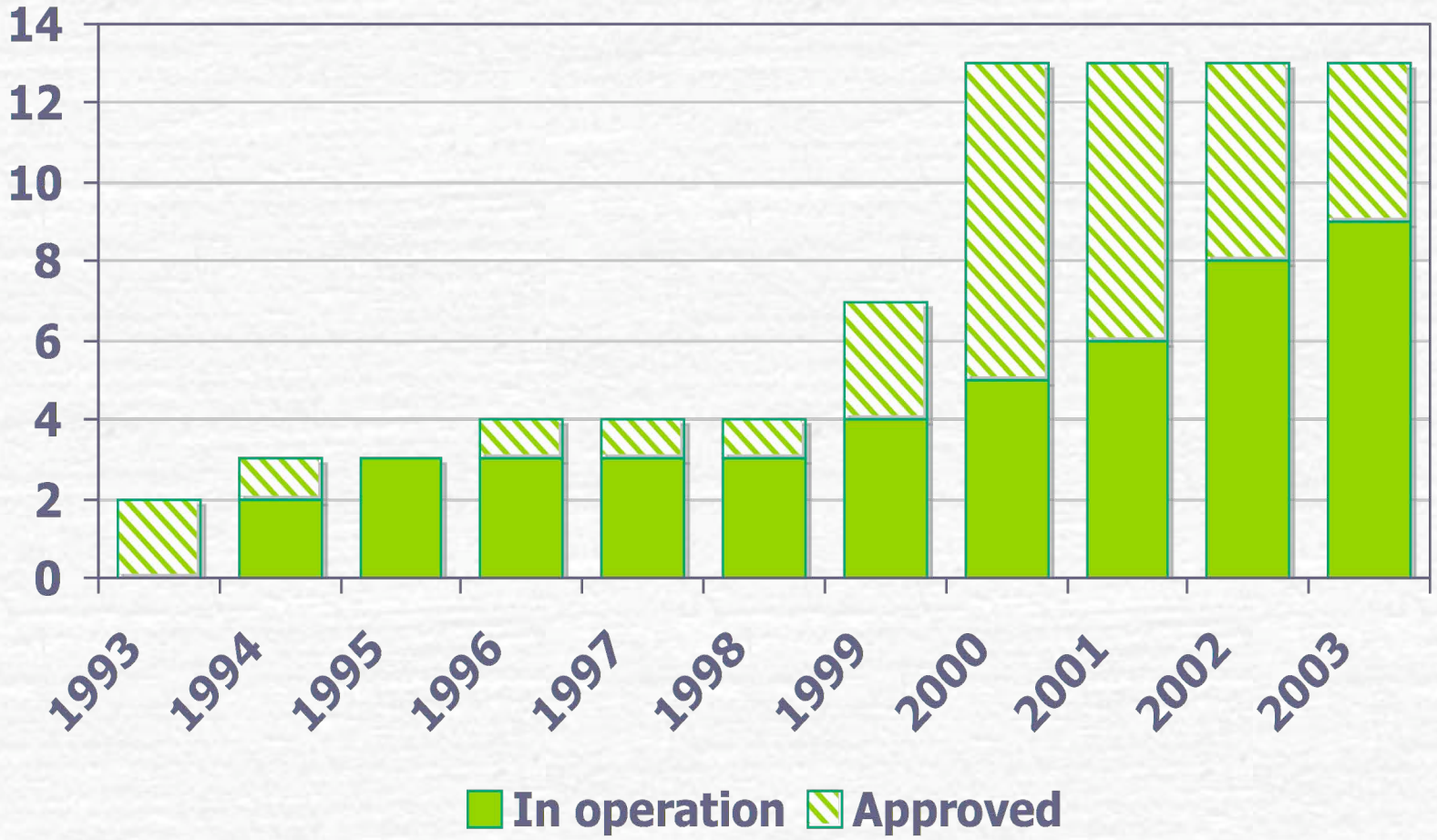
BOI Program Objectives

- Outcome of lobbying of political leaders by private investors - Not discussed with MoH
- Post-hoc objectives
  - Expand private hospital provision to reduce fiscal burden of government provision
  - Assist consumers by lowering prices for private inpatient care
  - Save foreign exchange by providing high-tech services in country

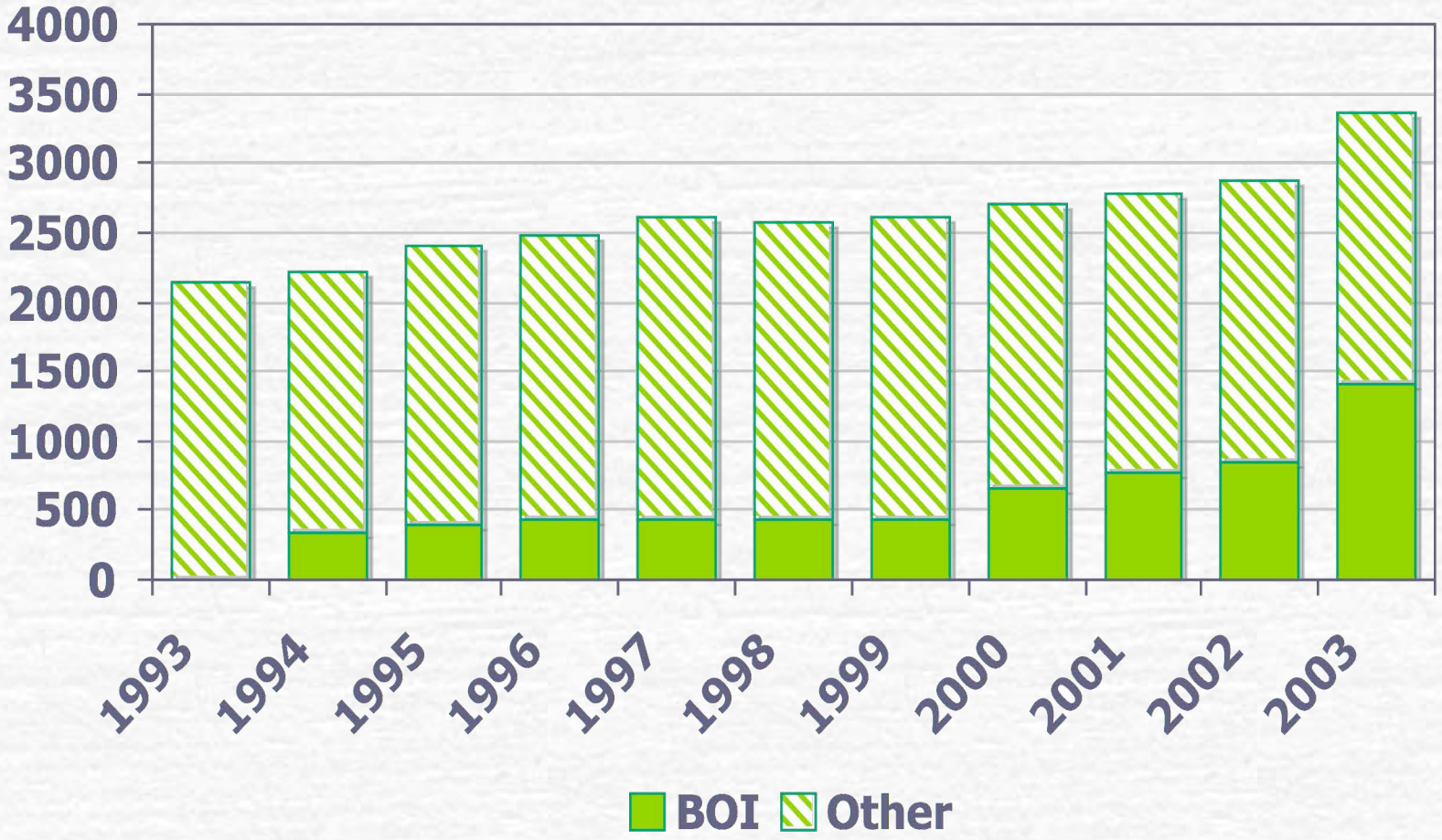
Methods and data

- Analysis of survey data to determine net impact of scheme on private hospital supply
- Analysis of BOI and imports data to cost value of concessions
  - Income tax/VAT/duty exemptions
  - Land concessions
- Comparison with public provision to determine impact on fiscal costs
- Analysis of household survey data to assess impact on equity

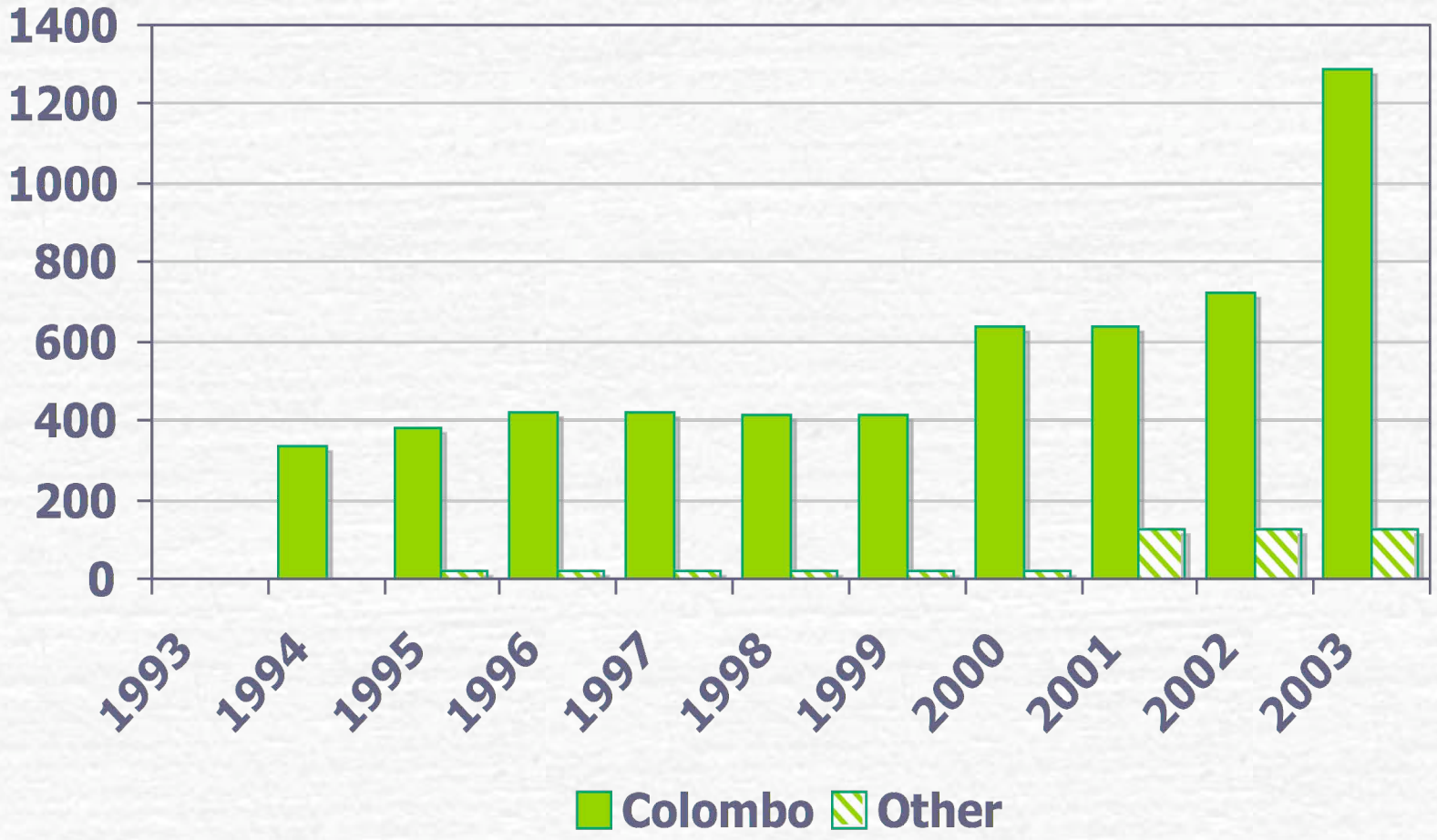
Impact on Supply: Hospitals



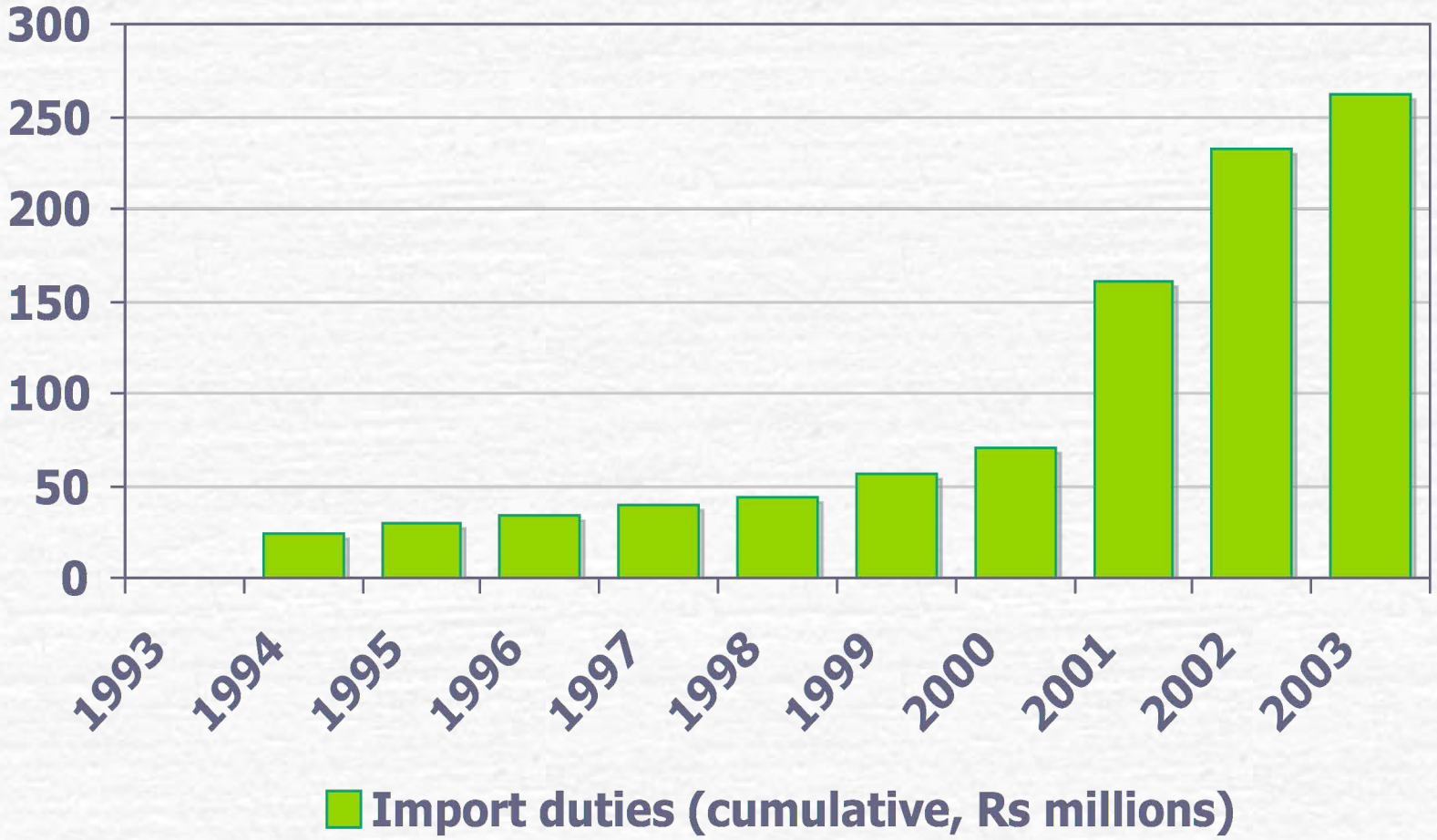
Impact on Supply: Beds



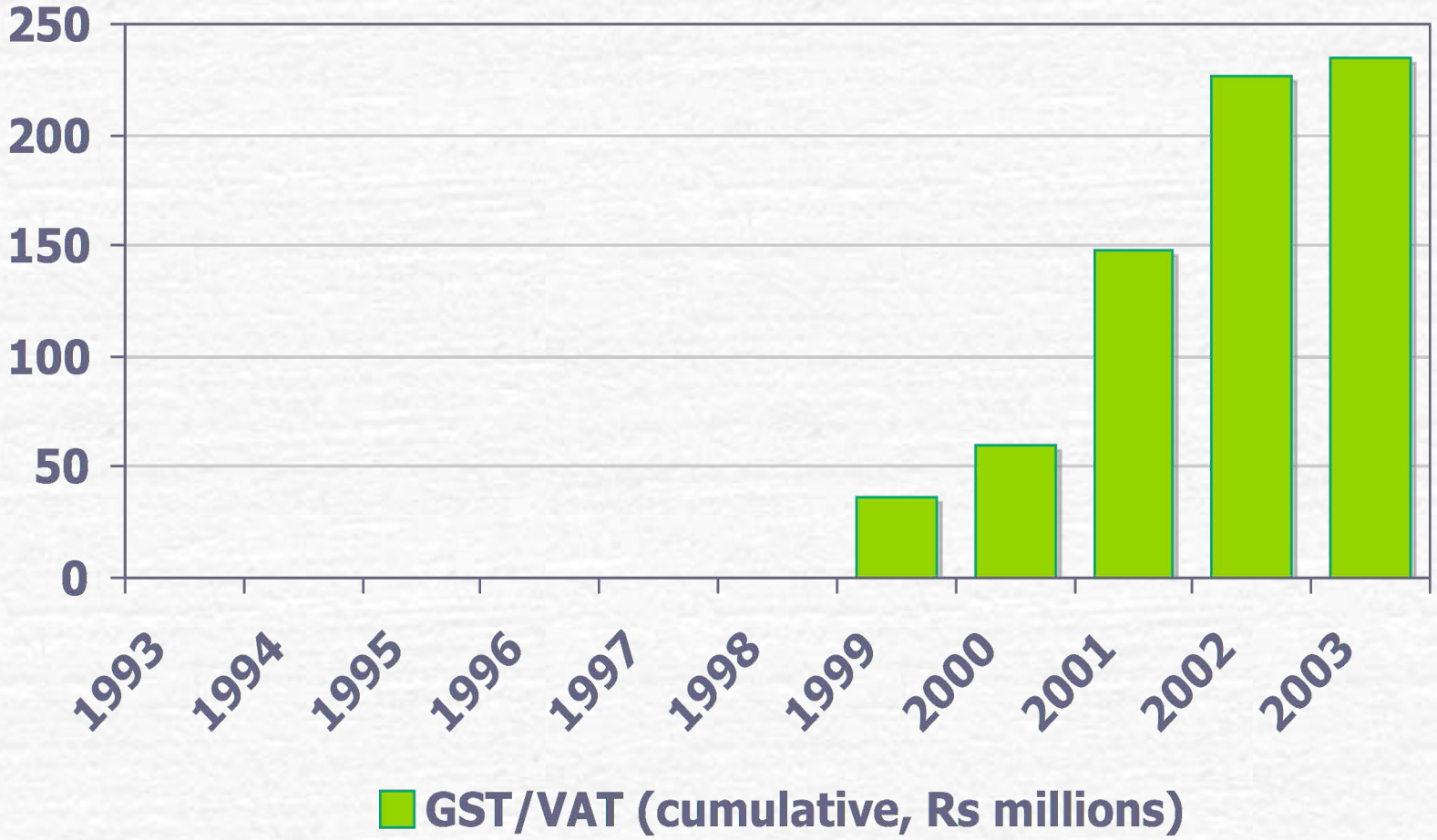
Impact on Supply: Distribution



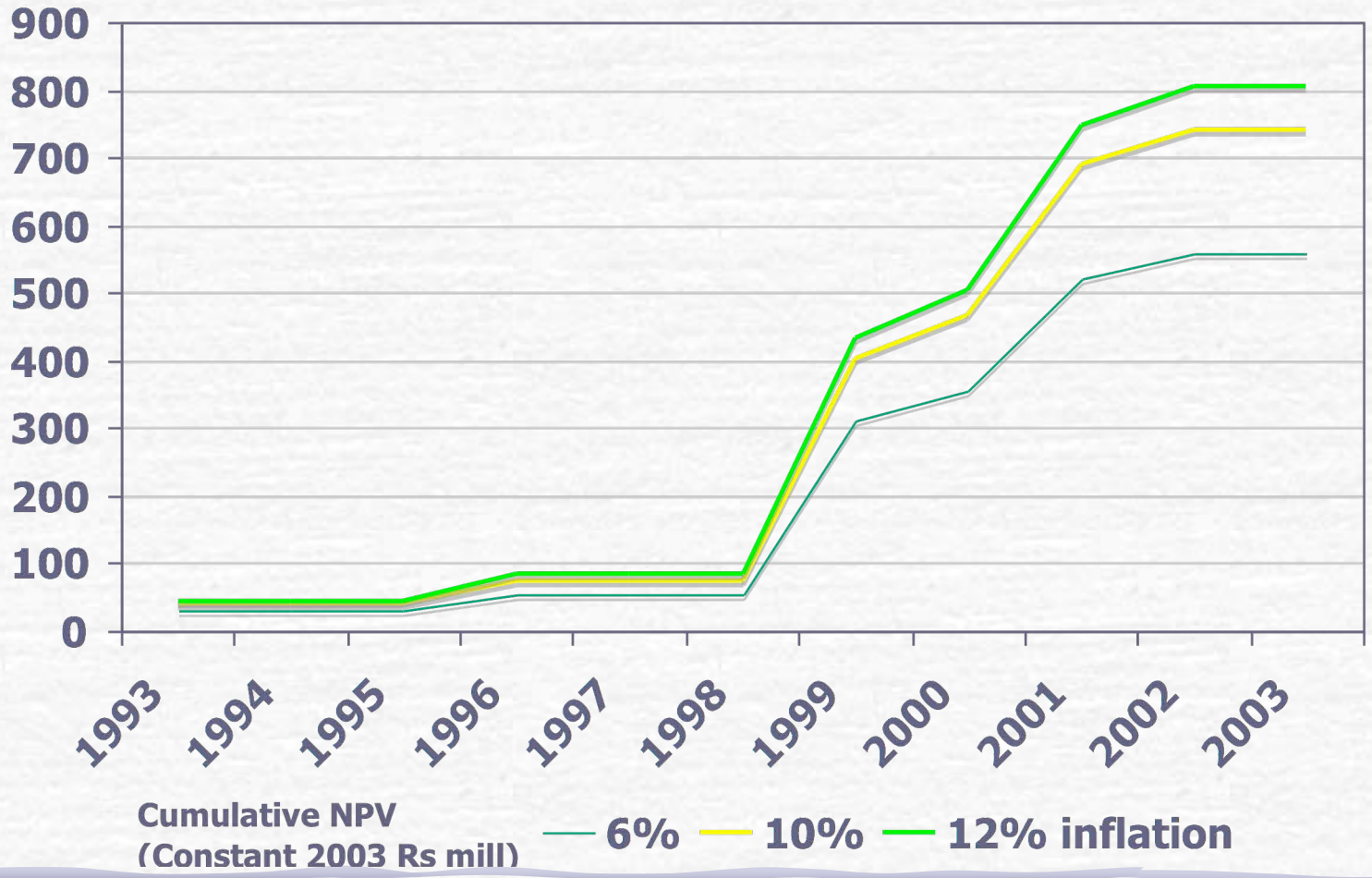
Fiscal Costs: Import Duties



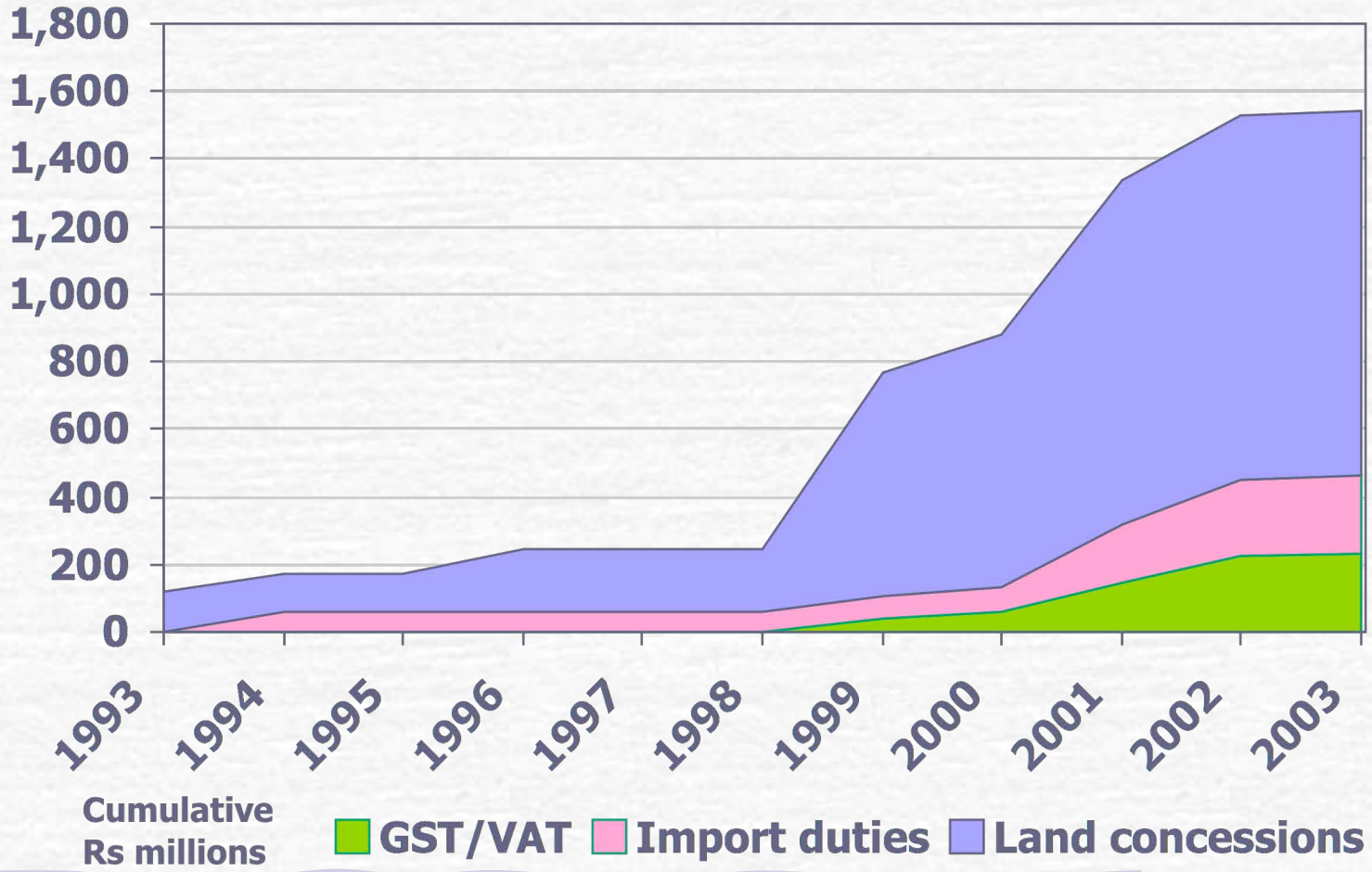
Fiscal Costs: GST/VAT



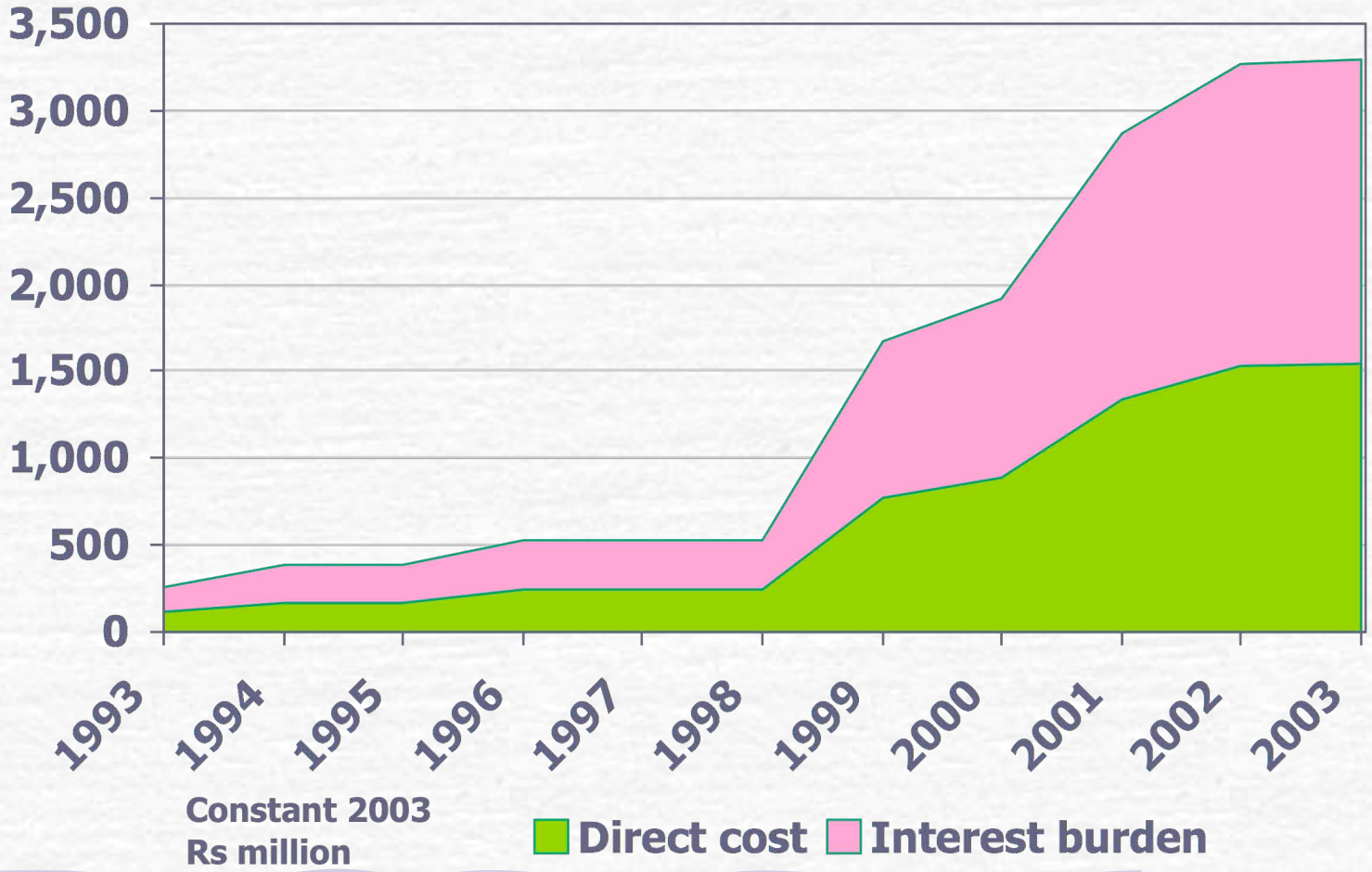
Fiscal Costs: Land concessions



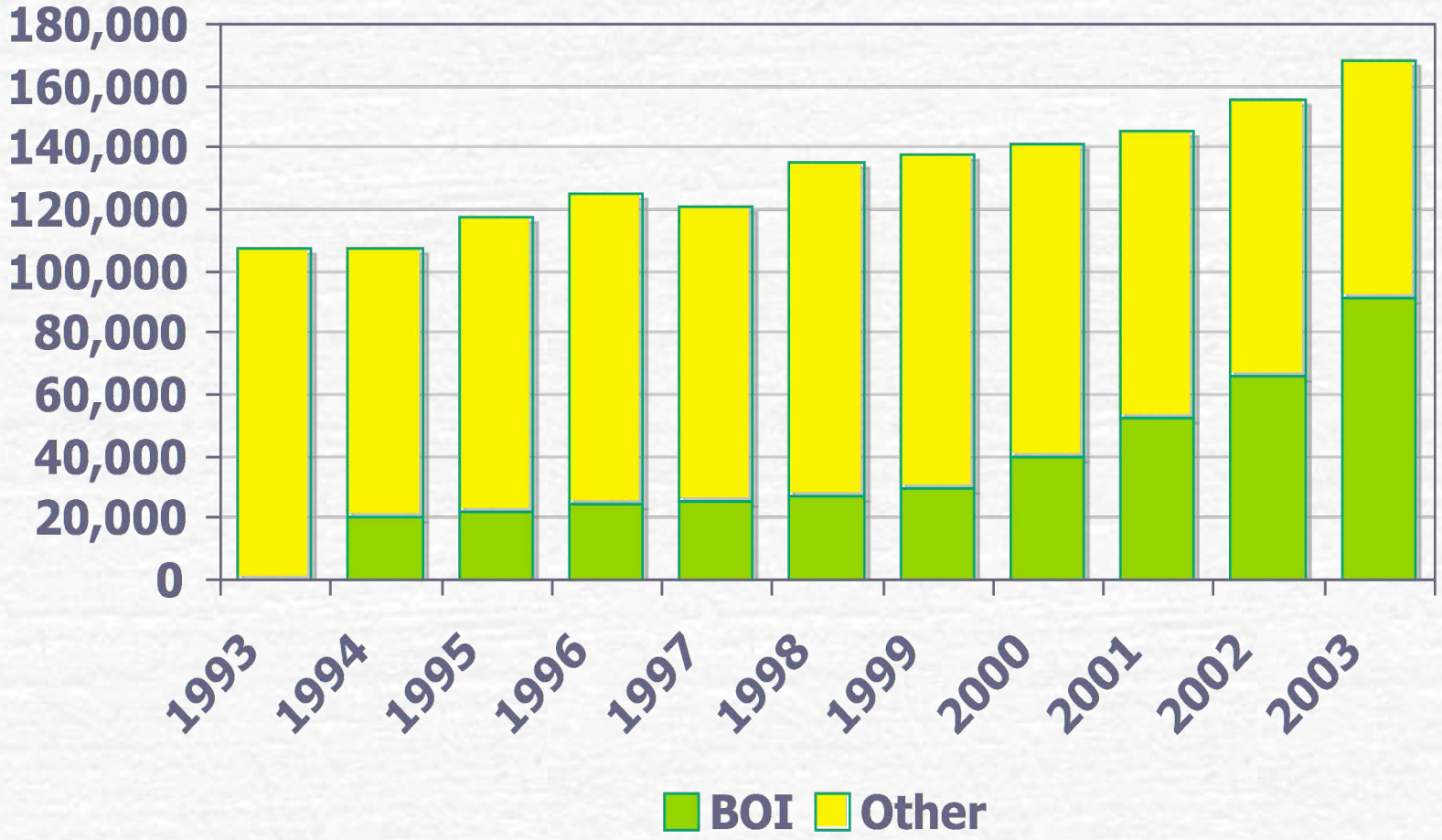
Total Direct Fiscal Costs



Overall Fiscal Costs



Outputs: Inpatients treated



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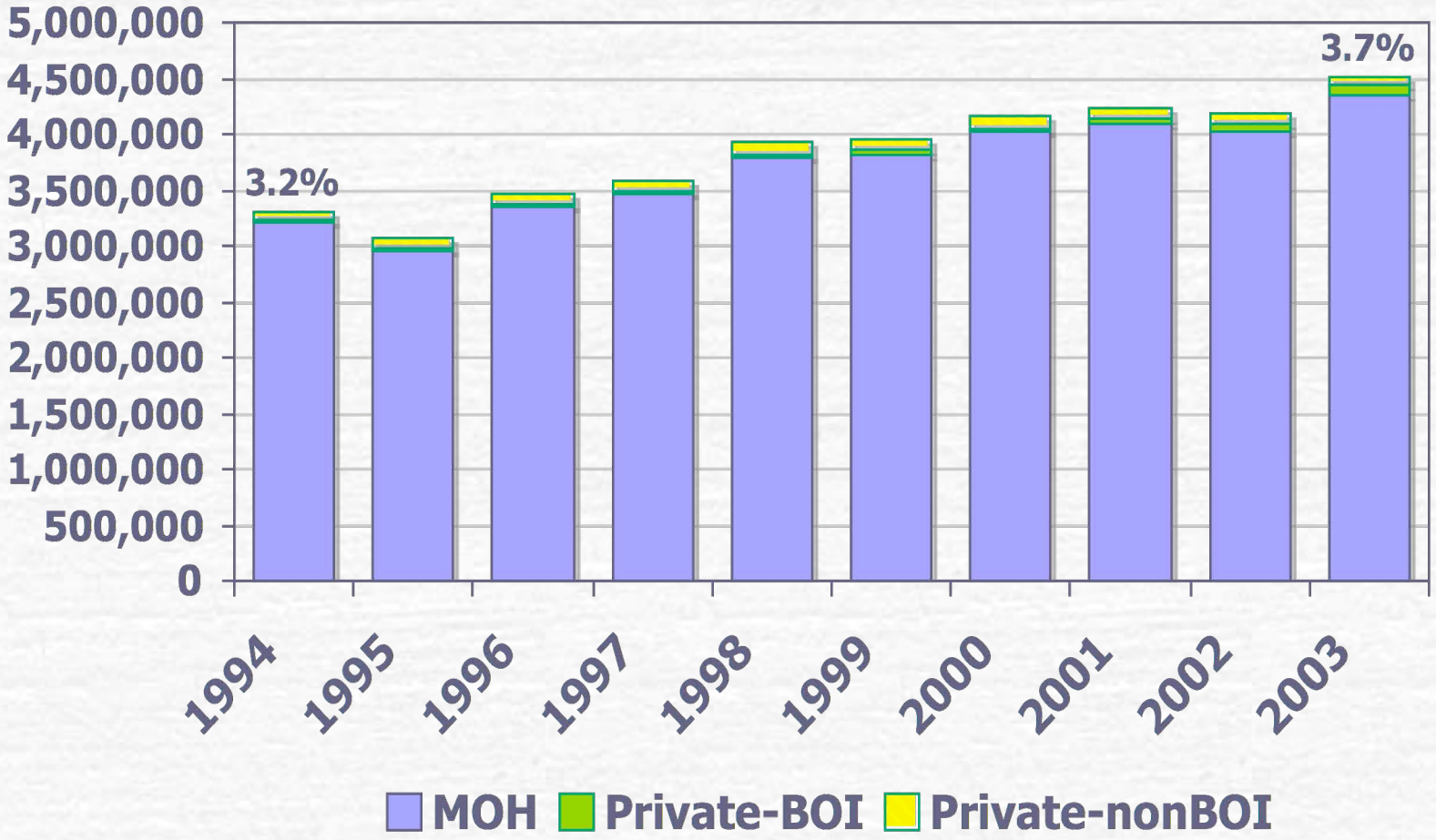
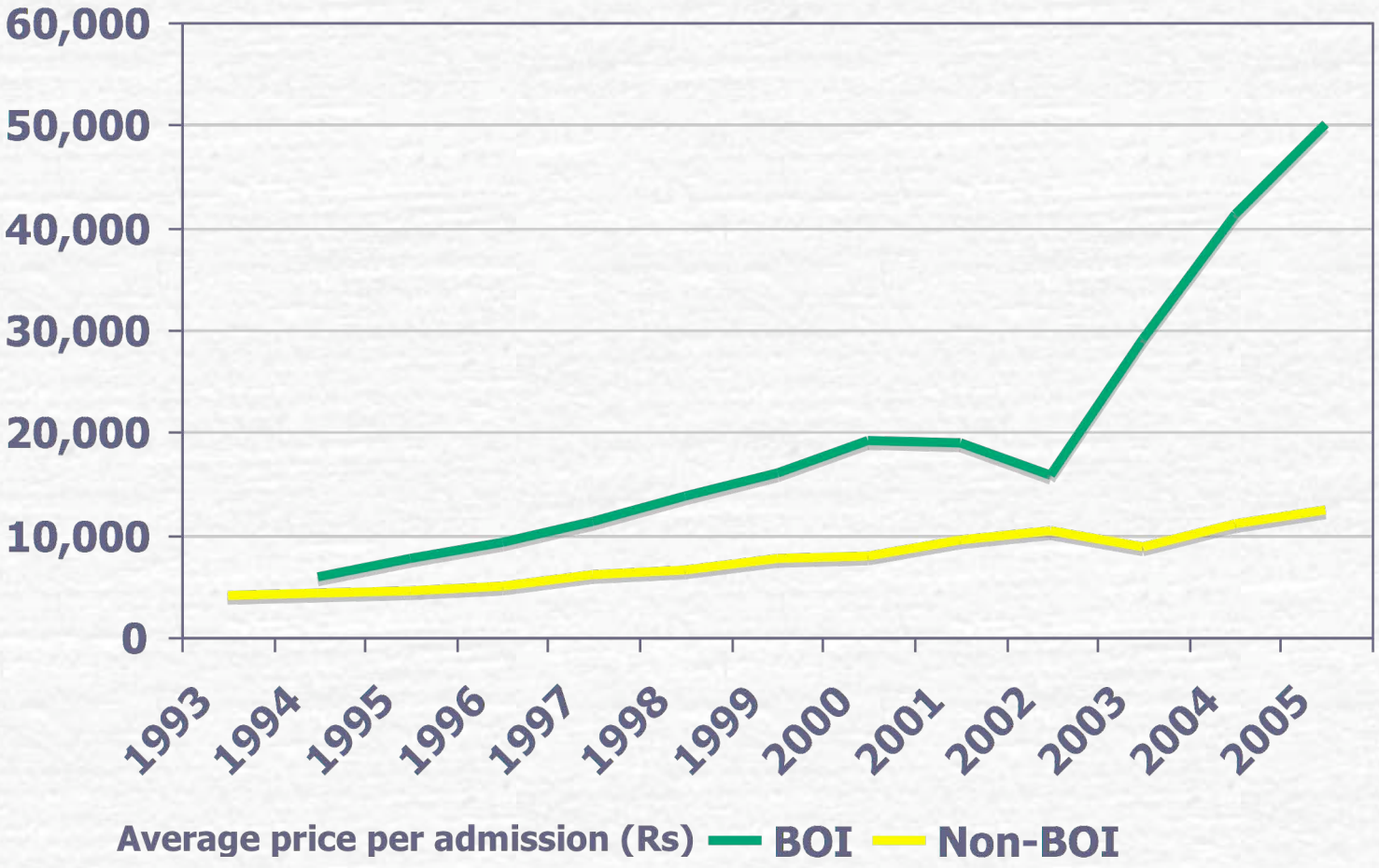
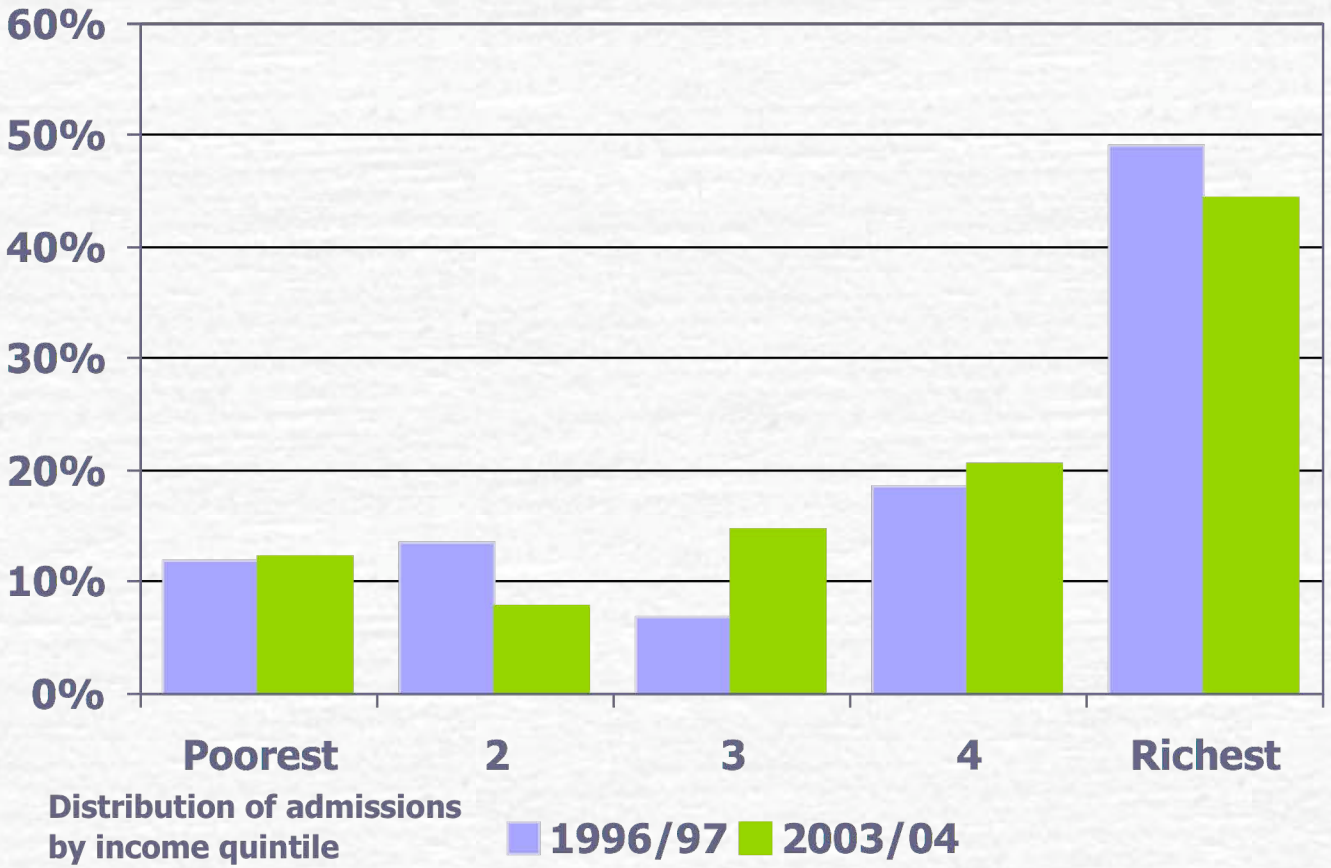


Efficiency: Impact on prices



Equity: Who benefits?



Impact on net fiscal burden

- Analysis of BOI hospital activities (1994-2003)
  - Total direct fiscal cost to 2003 = Rs 1,542 mill
  - Total inpatients treated in BOI hospitals = 422,000
  - Average fiscal cost per inpatient = Rs 3,654
- Analysis of public sector hospital spending (1994-2003)
  - Average spend per MOH inpatient = Rs 2,908
- =>
  - Average fiscal cost of inpatient in BOI sector 20% > public sector
  - BUT
    - **Fiscal cost of marginal patient in BOI sector MORE THAN 500% GREATER than MOH average cost**

Conclusions

- Did it expand private supply?
  - YES, BUT
    - Half the expansion was balanced by contraction in non-BOI supply
    - Partly a shift of private sector operations from tax to non-tax regime
    - Increase in inpatient supply only marginally faster than public sector -> no significant increase in private sector market share

Conclusions

- Did it reduce prices for private patients?
  - NO
    - Tax incentives led to increased capital intensity of operations, medical arms race and substantial price inflation
- Did it increase technical efficiency in health sector?
  - NO
    - Increased pressures for high technology services in both private and public sectors
    - Reduced macro-cost efficiency of health system

Conclusions

- Did it improve equity?
  - NO
    - No significant shift of higher income patients out of public sector
    - Minimal impact on targeting of public spending
    - Government tax expenditures on average BOI patient more than budgetary spending on average MOH patient
- Did it reduce fiscal burdens?
  - NO
    - Cost benefit ratio very low. Fiscal costs per additional private patient at least 4-5 times more than fiscal gains from reduced public sector burden

Final thoughts

- Avoidance of tax incentives better than removal
- Need for strengthening national capacity for health policy research and analysis to strengthen policy process and counter interest group lobbying
- Need for automatic scepticism about proposals to invest in private sector on grounds of efficiency - Should require full evaluation of value for money
- Donors to address ideological biases on private sector and taxes