United Republic of Tanzania
Ministry of Health and Social Welfare

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Health Care Financing

October 2013

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Recommended Citation: MOHSW, 2013. Mid Term Review of the Health Sector Strategic Plan III 2009 – 2015, Health Care Financing, Technical Report, Ministry of Health and Social Welfare, United Republic of Tanzania.

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Health Care Financing

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Acronyms

CAG	Controller and Auditor General
CCHP	Comprehensive Council Health Plan
CHAI	Clinton Health Access Initiative
CHF	Community Health Fund
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CSO	Civil Society Organization
DANIDA	Danish International Development Agency
D-by-D	Decentralisation by Devolution
DED	District Executive Director
DMO	District Medical Officer
DP	Development Partner
FBO	Faith-Based Organization
FY	Fiscal Year
GOT	Government of Tanzania
HBF	Health Basket Fund
HFGC	Health Facility Governing Committee
HFS	Health Financing Strategy
HIV/AIDS	Human immuno-deficiency virus/Acquired Immuno-deficiency Syndrome
HSSP III	Health Sector Strategic Plan III (2009 – 2015)
IHI	Ifakara Health Institute
ISC	Inter-ministerial Steering Committee
JAHSR	Joint Annual Health Sector Review
JRF	Joint Rehabilitation Fund
LGA	Local Government Authority
LGCDG	Local Government Capital Development Grant
MDG	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MOFEA/MOF	Ministry of Finance and Economic Affairs

MOHSW	Ministry of Health and Social Welfare
MOL	Ministry of Labour
MUHAS	Muhimbili University of Health and Allied Sciences
MTR	Mid Term Review
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
OOP	Out of Pocket
P4P	Pay for Performance
PER	Public Expenditure Review
PMO-RALG	President's Office – Regional Administration & Local Government
PPP	Public-Private Partnership
SHIB	Social Health Insurance Benefits
SO	Strategic Objective
SOP	Standard Operating Procedures
SSRA	Social Security Regulatory Authority
SWAp	Sector-Wide Approach
SWOC	Strengths, Weaknesses, Opportunities, and Challenges
TASAF	Tanzania Social Action Fund
THE	Total Health Expenditure
TIKA	Tiba Kwa Kadi (CHF in urban areas)
TWG	Technical Working Group
TZS	Tanzania Shillings
USAID	United States Agency for International Development
USD	United States Dollar
VFM	Value for Money

1. Introduction

Building on the progress made in Health Sector Strategy Plan (HSSP) II, the financing objectives set in HSSP III were ambitious. The Ministry of Health and Social Welfare (MOHSW) committed to advocating for increased government funding for health in line with Abuja targets (15% of government budget.) It was anticipated that development of a comprehensive Health Sector Financing Strategy early in HSSP III would serve to guide financing policy, addressing the role of user fees, exemptions and waivers, output-based financing, public funding to non-government providers, and other issues. Although the role of Community Health Funds was not spelled out in the HSSP in detail, the expected results and indicators indicate significant emphasis on the Community Health Fund (CHF) both as an alternative source of funding, as well as a mechanism to improve access for the poor. This report is a working document that is part of the Mid Term Review (MTR) of HSSP III.

2. HSSP III Health Financing Strategic Objectives and Expected Results

Table 1 below details the objectives and expected results as defined in the HSSP III. This report is organized by the five HSSP objectives, providing progress to date based on the expected results and indicators, as well as other issues related to the original objective that should be considered.

Table 1: HSSP III Health Financing Objectives and Expected Results

Objective	Expected Results	Indicator
Reduce the budget gap in the health sector by mobilising adequate and sustainable financial resources	▲ Government health budget to reach 15% of total government budget by 2015 ▲ Comprehensive Health Sector Financing Strategy developed and implemented ▲ Annual budget of Health Basket Fund increased	▲ Percent of government budget for health ▲ Sources of annual budget for health to financing strategy priorities ▲ Annual funding of HBF
Enhance complementary financing for provision of health services, increasing the share in the total health budget to 10% by 2015	▲ Coverage of prepayment schemes, CHF, NHIF, TIKA increased ▲ Community participation in management of CHF generated funds at facility and district level ▲ Regulatory body for prepayment and health insurance schemes in place (NHIS, NSSF, etc) ▲ Maximize NHIF, CHF/TIKA financing options in public and private facilities ▲ Social health insurance development undertaken for introduction in next strategic plan ▲ Private sector investments in infrastructure in health increased	▲ Enrollment in CHF/TIKA and NHIF ▲ Percentage of facilities with functioning Health Facility Committee ▲ Functional insurance regulatory body ▲ Rate of NHIF, CHF/TIKA reimbursement ▲ State of development of SHI ▲ Number of private facilities opened and contracted for services
Improve equity of access to health services	▲ Effective subsidies and waiver mechanisms in place for the poor and vulnerable, using prepayment schemes and other options	▲ Proportion of poor and vulnerable enrolled in insurance schemes
Improve management of complementary funds raised at local level	▲ Efficient and transparent collection of patient fees and CHF/TIKA premiums at public and private health facilities in place, applying Standard Operational Procedures (SOP) ▲ Corruption in the health sector is prevented through adequate control and fair performance management systems	▲ Percentage of facilities using fund management SOPs
Increase efficiency and effectiveness in use of financial resources	▲ Government budgeting, accounting and auditing processes are implemented in a transparent way	▲ Percentage of MDAs and LGAs with clean NAO auditing report

3. Findings and Issues by Strategic Objective

3.1 Strategic Objective One: Reduce the Health Sector Budget Gap

A key objective of HSSP III was to mobilize adequate resources and ensure the sustainability of resources for the health sector. To that end, government budget, donor funding, as well as household contributions were all targeted as sources for reducing the budget gap.

Total Health Expenditure Trends Prior to HSSP III

The period prior to the adoption of the HSSP III saw significant increases in total health expenditures (THE) in Tanzania. Between 2002/03 and 2009/10, THE had tripled. Over this period, donors' share of health expenditures increased from 27% in 2002/03 to 40% in 2009/10. Of the total expenditures in 2009/10, 26% were financed by the Tanzanian government, while donors provided 40% of resources, and households provided 32% of resources. As a share of total resources, government expenditures were generally stable over this period. Details are shown in Table 2.

Table 2: Total Health Expenditures by Source

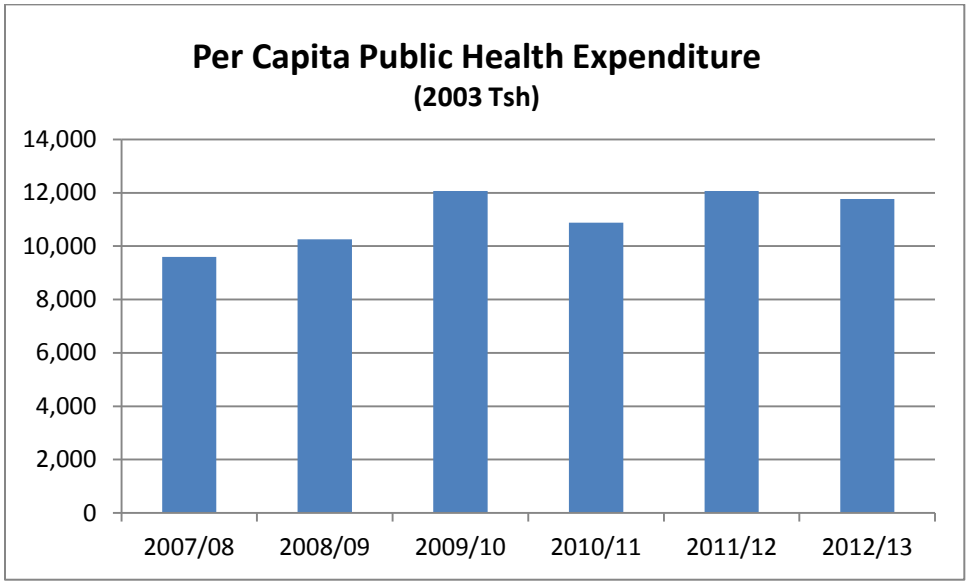
Financing Source	2002/2003		2005/2006		2009/2010	
	Value (Mn Tsh)	Pct of Total	Value (Mn Tsh)	Pct of Total	Value (Mn Tsh)	Pct of Total
Households	325,353	42%	445,003	25%	750,298	32%
Donors	212,412	27%	783,205	44%	919,362	40%
MOF	196,853	25%	498,403	28%	603,922	26%
Other Private	39,479	5%	53,400	3%	49,345	2%
TOTAL	774,097	100%	1,780,011	100%	2,322,927	100%

National Health Accounts 2009/10, MOHSW.

Public Sector Expenditures for Health during HSSP III

Although public sector expenditures for health are increasing in terms of total shillings allocated, they have remained flat on a real per capita basis. Figure 1 shows that public expenditures for health in real terms peaked in 2009/10 at Tsh. 12,068, but have remained flat since then.

Figure 1: Per Capita Public Health Expenditure



Provisional data from Public Expenditure Review 2011/12. Data for 2012/13 is budgeted.

While the total shillings per capita for health has increased over time, from Tsh 14,902 in 2007/08 to 29,150 in 2012/13 (budgeted) the increases have not surpassed the rate of inflation. Table 3 provides the detailed nominal and real public health expenditures from 2007/08.

Table 3: Public Health Expenditures 2007/08 to 2012/13

PER CAPITA INDICATORS	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
	Actual	Actual	Actual	Actual	Actual	Budget
Per Capita Health Spending (TZS)	14,902	17,781	22,483	21,943	26,772	29,150
Per Capita Health Spending (USD)	11.81	12.94	15.51	15.13	17.40	18.54
Real Per Capita TZS	9,602	10,259	12,068	10,883	12,066	11,769
Real per Capita USD	7.61	7.47	8.32	7.51	7.84	7.49

Provisional data from Public Expenditure Review 2011/12.

Although HSSP III targeted increased government expenditures for health, government funding as a proportion of total public funding for health has been decreasing. As shown in Table 4, government funding as a share of total public funding was 66% in 2007/08, but decreased to 63% in 2009/10, and stands at 59%, based on the 2011/12 budget. Contrary to the goals of HSSP III, the public health budget has become increasingly reliant on foreign funds, which may not be sustainable.

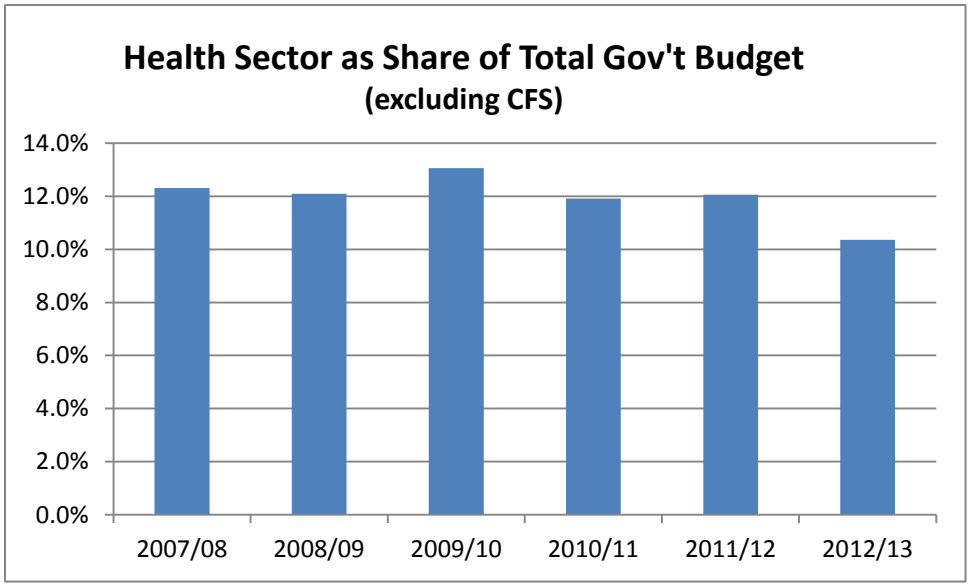
Table 4: Sources of Public Health Funding

	2007/08		2008/09		2009/10		2010/11		2011/12		2012/13	
	Actual	% of Total	Actual	% of Total	Actual	% of Total	Actual	% of Total	Actual	% of Total	Budget	% of Total
Govt Funds	378,114	66%	461,504	65%	578,793	63%	576,858	62%	710,096	67%	848,559	69%
Foreign Funds												
Donor basket	80,957	14%	85,401	12%	128,796	14%	126,822	14%	151,013	14%	159,647	13%
Non-basket	112,003	19%	154,168	22%	200,049	22%	213,979	23%	189,825	27%	226,373	18%
Tot Foreign Funds	192,960	33%	239,569	34%	328,845	36%	340,801	37%	340,839	32%	386,019	31%
Off-budget	5,696	1%	5,858	1%	10,784	1%	14,212	2%	10,414	0%	-	0%
GRAND TOTAL	576,770	100 %	706,931	100%	918,422	100%	931,871	100%	1,061,349	100%	1,234,578	100%

Prioritization of Health Sector

The Government of Tanzania remains fully committed to achieving the MDGs, which are part of the National Strategy for Growth and Reduction of Poverty (MKUKUTA.) As such, the health sector was considered one of the top three priority sectors for investment. The HSSP III envisioned increasing government expenditures for health, targeting the Abuja goal of 15% of government expenditures dedicated to the health sector. Nonetheless, government health expenditure data show that investments in the sector have stalled in the last several years. Figure 2 shows that government health expenditures are declining as a share of total government expenditures.

Figure 2: Share of Government Expenditures Allocated to Health Sector



Provisional data from Public Expenditure Review 2011/12. Data for 2012/13 is budgeted.

Table 5 shows that 13.1% of government spending (excl. CFS) was allocated to health in 2009/10, but that only 10.4% of government budget is allocated to health in the 2012/13 budget. As a share of GDP, government health expenditures have declined from 3.0% in 2009/10 to 2.6% in 2012/13 (based on budget.)

Table 5. Health Expenditures as Share of Total Government Expenditures

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
	Actual	Actual	Actual	Actual	Actual	Budget
Health Spending as Share of Govt budget Excl. CFS	12.3%	12.1%	13.1%	11.9%	12.1%	10.4%
Health Spending as Share of Govt budget Incl. CFS	11.1%	10.8%	9.9%	9.5%	9.5%	8.5%
Health Spending as % of GDP	2.52%	2.67%	3.03%	2.63%	2.80%	2.62%

Provisional data from Public Expenditure Review 2011/12.

More recently, there has been more emphasis on productive sectors as a means to drive economic growth. In February 2013, the President announced the Big Results Now (BRN) initiative, which focuses on six priority areas of the economy**:** i) Energy and natural gas (ii) Agriculture (iii) Water (iv) Education (v) Transport (vi) Mobilization of resources.[1] While the MOH is committed to advocating for additional resources, increasing government allocations to the sector may become even more difficult.

Health Basket Fund

The Health Basket Fund (HBF) is a useful tool for coordinating sector-wide donor support. It represents a significant portion of health expenditure, comprising 14% of public expenditures for health in 2011/12. It is referred to as the most reliable source of health funding, particularly at local government level.

Increasing basket funding is one of the targets of HSSP III. In the first three years, there were positive achievements, with the HBF increasing from US$82 million in 2009/10 to US$104 million in 2012/13, as shown in Table 6. However, over the last two years, three donors representing approximately US$28 million (27%) of the total funding discontinued HBF contributions. Further, the current Memorandum of Understanding (MOU) between GOT and the HBF partners will come to an end in June 2015.

Table 6: Donor Contributions to Health Basket Fund ($)

Donor	2009/10	2010/11	2011/12	2012/13	2013/14
					Estimated
Denmark [Danida]	11,978,678	10,756,303	17,942,000	12,933,264	12,257,000
Ireland [Irish Aid]	10,060,000	8,856,360	8,810,100	8,142,750	9,068,916
Netherlands [RNE]	21,395,924	20,879,911	23,384,874	14,066,811	-
Switzerland [SDC]	5,513,186	3,051,290	3,244,997	4,302,926	4,276,000
UNFPA	600,000	600,000	600,000	600,000	600,000
UNICEF	1,500,000	1,500,000	1,000,000	1,000,000	1,000,000
World Bank [WB]	15,900,000	15,000,000	10,000,000	25,000,000	25,000,000
UN System (UNFPA)	800,000	850,000	-	-	-
Germany [KFW]	5,621,250	10,387,683	9,430,169	8,986,229	-
Canada [CIDA]	-	9,506,655	24,492,995	29,205,000	28,727,395
Norway	5,617,076	6,333,695	5,216,484	-	-

[1] http://www.pmoralg.go.tz/quick-menu/brn/index.php, accessed July 26, 2013.

Donor	2009/10	2010/11	2011/12	2012/13	2013/14
					Estimated
Refund from MOH	3,120,773				
Totals	82,106,887	87,721,897	104,121,619	104,236,980	80,929,311

Source: MOHSW Basket Finance Reports.

The HBF supported operations at MOHSW, Prime Minister's Office Regional Administration and Local Government (PMO-RALG), and at regional and council levels. Table 7 shows HBF allocations from 2008/09-2013/14. As can be seen, the MOHSW will bear the brunt of the hardship of lower HBF contributions, with a 36% decline in funding from Tsh 36 billion to Tsh 23 billion from 2012/13 to 2013/14.

Table 7: Use of Health Basket Funds

(billion Tsh)	2009/10	2010/11	2011/12	2012/13	2013/14
District	66.40	68.25	80.99	89.30	87.90
MSD*	0.00	10.50	31.15	27.50	20.30
MOHSW	50.00	46.00	41.09	36.20	23.00
Region	4.20	4.20	4.20	4.20	3.80
PMO-RALG	0.79	0.69	0.69	0.69	0.62
Total	121.39	129.64	158.12	157.89	135.62

Source: MOHSW Basket Finance Reports.

* HBF for MSD in 2009/10 may have been included in the MOHSW allocation and not separately reported.

Health Financing Strategy

Development of a health financing strategy was envisioned as an early activity within HSSP III that would be used to guide financing policy. There appeared to have been concerted efforts to develop such as strategy, particularly in the first year, however, a strategy has not yet been developed. Table 8 summarizes discussions and actions toward a financing strategy, based on the Joint Annual Health Sector Review (JAHSR) meeting notes.

Table 8: Discussion of Health Financing Strategy in JAHSR

JAHSR Date	Actions and Discussion
Sep 2010	Contracts with consultants signed and Inception Report for development of Financing Strategy submitted Future milestone – draft strategy completed by Dec 2010 and action plan for implementation to be completed by May 2011
Nov 2011	Eight out of 15 milestones are only partially achieved, including health financing strategy DPs and MOHSW express disappointment that there is no health financing strategy
Oct 2012	Absence of financing strategy raised as an issue Progress made toward financing strategy with clear workplan and inter-ministerial steering committee

In the last year, there have been renewed efforts to develop a comprehensive financing strategy, some pointing to the establishment of an Inter-ministerial Steering Committee (ISC) in August 2012 as one of the first steps of the current process. A roadmap was developed, identifying clear outputs and responsible organizations. As part of the roadmap, partners have agreed to fund the development of nine thematic Options Papers that will feed into development of the strategy, supplementing earlier studies undertaken. Drafts of some papers have been presented and/or circulated, while other studies are still underway. Most informants are optimistic that there is now sufficient commitment and interest that a draft financing strategy will be prepared by the end of 2013.

There is good reason to be optimistic, but development of the strategy is only a first step toward more cohesive financing policies. Coordinated efforts beyond the Financing Technical Working Group (TWG) will be required to ensure that the strategy recommended by the TWG and ISC is adopted and its implementation fully supported.

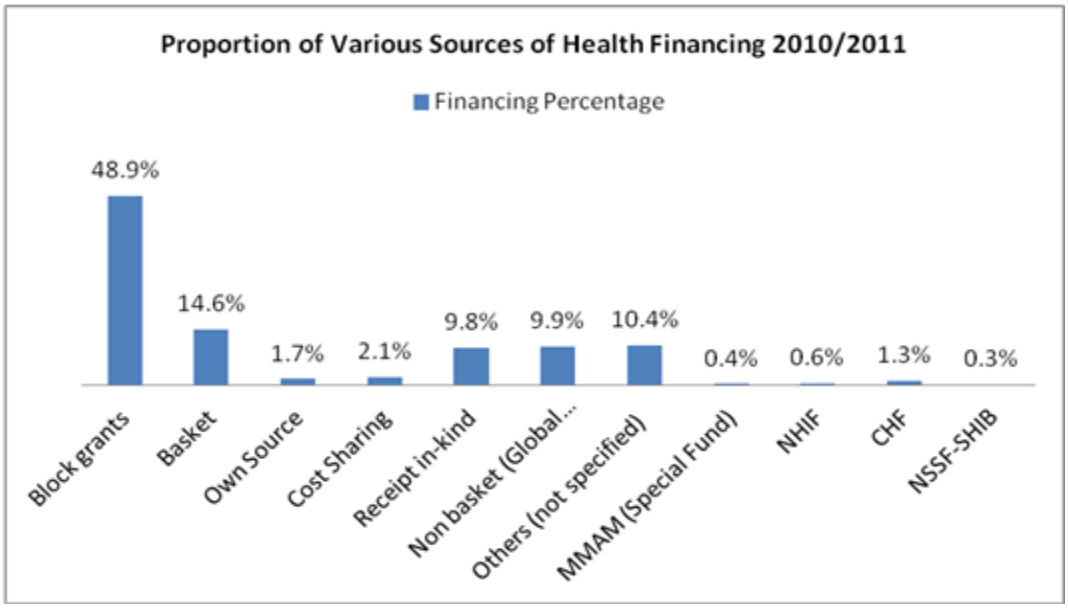
3.2 Strategic Objective Two: Increase Complementary Funding to 10% of Total Financing

A key part of the HSSP III strategy for financing the health sector was to increase complementary funding, consisting of CHF membership fees, user fees, and insurance reimbursements including NHIF and SHIB. The HSSP III identified measures for the achievements in this objective as follows: increased enrolment in NHIF, CHF and TIKA schemes; community participation in management of CHF; institutionalization of the functional health insurance regulatory body; development of Social Health Insurance; and, number of private facilities contracted for services. Both NHIF and CHF together are estimated to cover a total of 5,867,140 beneficiaries which is approximately 13.6% of the total population in the mainland. Progress in each of these indicators is examined.

Breakdown of Complementary Funding

Complementary funding in Tanzania is currently financing only a relatively small portion of health services costs and is below the HSSP III set target of 10% of total financing. According to Health Sector Public Expenditure Review (PER) 2010/11 on aggregate, user fees, NHIF, CHF and SHIB contributed only 4.3% of funding at LGA level against the HSSP III set target of 10% (see Figure 3.) Data for the period prior to 2010/11 were not available. However, based on the 2010/11 data it can be concluded that the progress was far from good.

Figure 3: Sources of Health Funding at LGA Level



Source: Statistics from MOHSW, 2012, Health Sector Public Expenditure Review 2010/11

Trends in NHIF Enrolment

The NHIF is a mandatory public servants' insurance scheme which began operations in July 2001. The scheme covers health insurance costs for the contributing employees, their spouses and up to four children or legal dependents. Contributions are shared equally between the employee and the employer, the government of Tanzania. At the end of 30th June 2010, the fund had a total of 373,326 contributing members which increased to 468,611 members by the end of June 2011, accounting for an annual increase of 26%. About 2.5 million people are currently members of NHIF, representing approximately 5% of the total population. The increase in membership was largely attributed to the amendment of the NHIF Act, extending coverage from only Central Government employees to all public servants.

While there has been significant growth in enrolment and contributions, the proportion of total income paid out as benefits had been persistently very low. As shown in Table 9, the proportion of claims paid to contributions collected was 18% in 2006/07. That percentage has increased, and in the most recent year with data, 2010/11, the claims paid represent 33% of premiums collected. It should be noted that future claims are expected to increase due to aging, increase in non-communicable diseases, and revision of reimbursement rates. Nonetheless, such a low rate of reimbursement means that NHIF is building ever larger reserves, which are partially government-funded.

Table 9: Trends in NHIF Contributions and Claims Paid (million Tshs)

Year	2006/07	2007/08	2008/09	2009/10	2010/11
Contributions	45,516	55,472	79,388	90,084	134,891
Claims Paid	8,269	10,188	16,359	25,154	44,352
Claims as % of Contributions	18	18	20	28	33

Sources: NHIF Actuarial and Statistical Bulletin as of 30th June 2011.

A larger portion of NHIF funding is directed to faith-based organization (FBO) and private facilities than government facilities. Claims payment data by service provider type for the nine months ending March 2012 (Table 10) reveal several issues. First, although government facilities account for 80% of all accredited facilities, only 43.6% of total claims come from government facilities. Either members prefer to use FBO or private facilities, or government facilities do not file claims and are thus not reimbursed for services to NHIF members. Further, NHIF members are more likely to reside in urban areas, which provide them more access to non-government provider options. Second, despite standard reimbursement rates, government facilities account for only 30.1% of payments by value, even though they represent 43.6% of the number of claims. The lower average claim amount from government facilities (Tsh 12,083 compared with Tsh 20,050 for faith based providers and Tsh 37,321 for for-profit providers) may be due to lower availability of diagnostics and treatment compared with non-government providers.

Table 10: NHIF Payments by Type of Provider, July 2011 – March 2012

Type of Provider	Number of Paid Claims	Percent of Total Claims	Amount Paid (billion Tsh)	Percent of Total Payment	Average Claim Amount
Government facilities	1,013,516	43.6%	12.25	30.1%	12,083
Faith-based facilities	957,433	41.2%	19.20	47.3%	20,050
For-profit facilities	144,479	6.2%	5.39	13.3%	37,321
Private Pharmacies and ADDOs	209,165	9.0%	3.79	9.3%	18,113
Total	2,324,593	100.0%	40.63	100.0%	17,476

Source: NHIF, 2012.

Trends in SHIB Enrolment

The Social Health Insurance Benefits (SHIB) program is part of the seven benefits provided by the National Social Security Fund (NSSF). It was established in July 2006 to provide health insurance cover for the employees of the private sector contributing to this pension scheme. The SHIB scheme is financed through NSSF contributions, which are currently 20 percent of employee salary, of which the employee contributes 10 percent and the employer 10 percent. While contribution to the NSSF automatically qualifies an employee for the SHIB membership, employees must individually register with SHIB to access health benefits.

Although membership in NSSF is mandatory for formal private sector employees, enrolment to the SHIB is voluntary and only about 10% (about 50,000 individuals) of total NSSF members have registered with the SHIB. In total there are about 74,000 beneficiaries of SHIB, which includes principal member dependants. Various factors contribute to this low enrolment rate. These include private sector employers offering their own health benefits arrangements to their employees, and lack of public knowledge about the scheme. In addition, because no additional contributions are required for SHIB enrolment, there is a misconception among members that registering with SHIB may lead to a reduction in pension benefits.

The network of SHIB health facilities is limited (350 public and private accredited facilities in 2012,) which in some areas is a disincentive to enrolment. SHIB pays its providers based on standard capitated fees, although a few specialized facilities have alternative reimbursement arrangements. Two fee levels are set, one for urban hospital or specialised rural hospitals, and another for rural hospitals and health centers (White et al, 2013.) Given its low enrolment and limited provider network, SHIB is not a significant source of complementary funding.

Trends in CHF Enrolment

The Community Health Funds (CHFs) were established as an alternative to user fees at the point of service. The idea is that district residents (usually informal workers and farmers) can join a CHF on a voluntary basis and can get access to primary health care (at health center, dispensary and district hospital) without paying user fees. The MOHSW, PMO-RALG and the NHIF provide regulatory oversight to CHF/TIKA. CHF coverage has remained low over time with enrolment far below the HSSP III enrolment target of 30% of the population.

Studies conducted have identified several reasons for low enrolment including poor quality of service coupled with frequent drug stockouts in health facilities, weak design and management, poor understanding of the concept of risk pooling, and unattractive benefits package (Mtei and Mulligan 2007, Stoermer et al 2012.) The majority of villagers and patients interviewed (generally poor rural population) confirmed that they are willing and able to pay the CHF membership charges (between Tsh 5,000-10,000) provided that "drugs are available" and diagnostic services are available at local facilities. One of the Options Papers that are under development to inform the Financing Strategy focuses on a re-designed CHF.

Reviews of CCHPs show that, as a rule, Councils do not set CHF enrolment targets, nor do they plan activities to increase enrolment. Efforts to sensitize communities about the CHF to increase enrolment are dependent on resources from the central level. Table 11 shows the while CHF membership had grown under NHIF management (discussed below,) it dropped in 2012/13. The reasons for the decrease are uncertain, but many informants point to the problems associated with closure of the CHF Accounts, discussed under Strategic Objective 4.

Table 11: Trends in CHF Members*

Financial Year	Councils with CHF	Households	Beneficiaries
2008/09	69	120,000	NA**
2009/10	99	245,585	1,536,362
2010/11	108	531,370	3,368,220
2011/12	112	614,328	3,685,968
2012/13	120	543,621	3,261,726

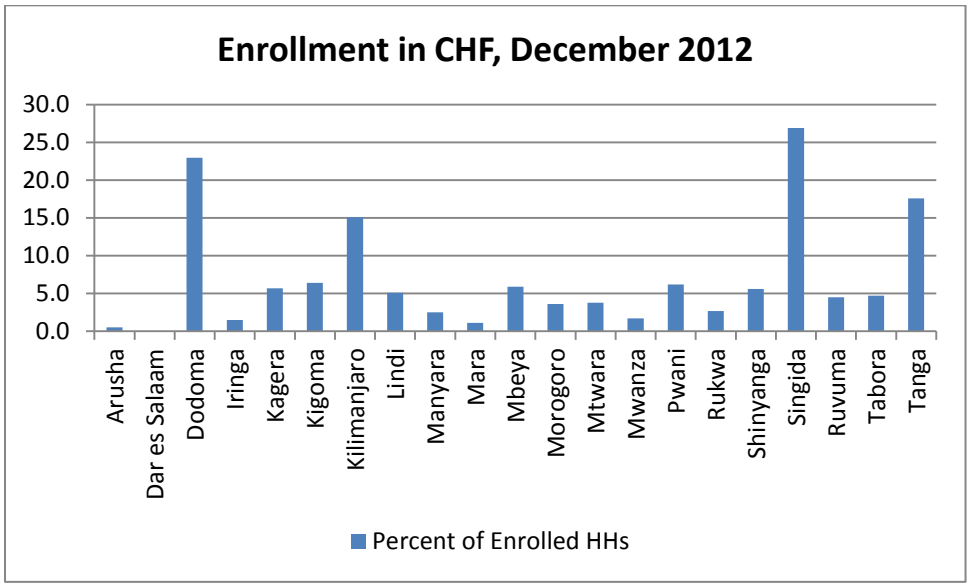
Source: NHIF 2013.

* These figures do not align with enrolment figures provided in Bultman and Mushy, "Options for Health Insurance Market Structuring," June 30, 2103, which reports CHF membership at 593,643 households with 3.8 million beneficiaries.

** Data from NHIF showed 1,200,000 beneficiaries, which is not possible since there is a maximum of six persons covered per household.

The reported national coverage rate of 8.9% masks large variations in regional coverage rates, which range from almost 23% to less than 1% (see Figure 4.)

Figure 4: Regional Coverage of CHF as of December 2012



Source: Annex C.7 Budget Speech for Minister of Health and Social Welfare, FY 2013/14.

NHIF management of CHF

NHIF took over management of CHF in July 2009 under a Memorandum of Understanding between the MoHSW, PMO-RALG and NHIF. The broad objectives are to provide technical and managerial support to CHF, thus extending the scope of coverage. The CHF has been embedded within the NHIF organisational structure, bringing more intensive and qualified supervision closer to the district through the NHIF organizational networks. National CHF membership has more than doubled compared to period prior to NHIF management take over. However, NHIF has not been able to make significant changes to the CHF design or district management structures, which are embedded in the 2001 CHF Act. The NHIF has modified the requirements for matching fund claims to reduce the risk of fraud. However, in both field visits and central level, it was reported that the new requirements for matching fund claims has increased the CHMT/CHSB workload and limited their capacity to claim. Table 12 shows the matching grant received, paid out, in process and balance for the period between 2010 and 2012.

Table 12: Matching Grant Received and Paid Out by NHIF (Tsh.)

SN	DATE RECEIVED	CHF TELE KWA TELE
1	25/2/2012	906,280,000
2	15/7/2012	1,131,726,500
3	30/7/2010	700,000,000
4	23/11/2010	1,300,261,000
5	30/6/2011	1,100,000,000
6	24/4/2012	1,100,000,000
7	9/11/2012	1,100,000,000
8	TOTAL	7,338,267,500
TOTAL MATCHING FUNDS RECEIVED FROM MOHSW		7,338,267,500
TOTAL AMOUNT PAID AS MATCHING FUNDS		3,821,574,370
MATCHING FUND ON PROCESS		845,310,248

Source: NHIF, 2013.

"CHF Tele Kwa Tele" is CHF Matching Grant.

Community Participation in Management of CHF Funds

The CHF concept not only envisioned raising funds from communities, but also incorporating community participation in managing the funds raised. Two key steps for establishing the CHF in each Council was establishing a Council Health Services Boards (CHSB,) the primary mechanism for oversight over use of CHF funds, and opening a CHF bank account. Four positions within the CHSB are designated for community members. The CHSB would meet regularly to review the fees collected and agree on how to use the funds. Most reports were that the CHSB was functional and met regularly, however, the extent to which communities provided effective oversight over use of funds or advocated for needed services is not well-documented. Anecdotal reports were that in practice, DMOs provided proposals that were "rubber stamped" by CHSBs.

More recently, however, bank accounts for CHF funds are no longer controlled by the CHSB – they are now consolidated within an account of the District Executive Director (DED.) It is reported that in some Councils, the CHSB continues to approve the use of funds prior to DED signature. In other Councils, however, it is not clear the role of the CHSB, and thus community members, in oversight or approval of expenditures from CHF funds. More discussion is provided in the discussion of Strategic Objective 4. Overall, closing CHF bank accounts may have further diminished the role of communities in managing CHF funds.

Status of Insurance Regulations and Institutions

As with the health finance system in general and health insurance in particular, the legislation covering health insurance areas is fragmented. An overarching regulatory framework is not yet in place; hence, there is no harmonized system of regulation covering the different forms of health insurance, using comparable regulations or a single institution for regulation and oversight.

The NSSF and its SHIB scheme reports to the Ministry of Labour (MOL), while conforming to the National Social Security Fund Act 1997 and its regulations and schedules. The NHIF reports to the MOHSW and is regulated by the NHIF Act and subsidiary legislation as well as the Social Security Regulatory Authority (SSRA) Act with respect to "non-health" technical matters. Both the NSSF and NHIF are subject to oversight by the SSRA established under the SSRA Act, which in turn reports to the MOL. Private health insurers are regulated by the Tanzania Insurance Regulatory Authority5 (TIRA), established by the Insurance Act and reporting to the Ministry of Finance and Economic Affairs (MOFEA). The Insurance Act does not, however, provide for any health insurance-specific regulations. CHFs, through their respective Councils, report to the PMO-RALG and are regulated by the CHF Act.

There is not an over-arching framework to regulate common functions across organizations dealing with health insurance activities; rather, individual laws are in place to regulate individual agencies themselves. Detailed reviews, recommendations and concrete proposals for amending current legislation and sub-level regulations have been provided, based on a report commissioned by the MOHSW. Regulation of health insurance is an important consideration as part of the new financing strategy, particularly if insurance is to play a larger role in the future financing strategy. Depending on the envisioned structure of the health insurance market, capacities of TIRA and SSRA will need to be examined to identify their appropriate regulatory role within the new market structure.

Status of Social Health Insurance

The HSSP III envisioned Social Health Insurance development for introduction in next strategic period. Although there was little progress in the first years of the HSSP III, there are more discussions recently, as part of the development of the health financing strategy. Although there is not yet a decision to pursue social health insurance, several studies recently commissioned will provide input to discussions of strategies for universal coverage, whether through SHI or other insurance mechanisms. A new health

financing strategy that incorporates more effective mechanisms to ensure affordable access to health services for all is needed.

Private Sector Investment in Health Infrastructure

The HSSP envisioned improving health services not only through increasing funding from new sources, but also increasing private sector investments in health. Although identified as targeted indicator, data on the number of new health facilities opened by private providers was not up-to-date. We examined the change in distribution of health facilities in Tanzania by ownership from 2009 to present for a rough gauge of the private sector infrastructure investment in health. The HSSP III 2009-2015, reported in 2009 the public sector was in charge of 60% of the health services in the country, whereas FBOs and private sector were in charge of the other 40% with a growing number of hospitals run by private and civil society sectors. The NHA 2010 reports there are 5,987 health facilities, with 67% owned by public sector and the remaining 33% owned by parastatal, FBO or private sector. Likely as a result of the increased health infrastructure investments through MMAM, the increase in public sector facilities is outpacing that of private facilities.

With regard to contracted private facilities in health service delivery, over 50 service agreements are in place at the time of the MTR review between Councils and private facilities to provide health services to the public. This development demonstrates both the commitment of the government and private partners as well as the benefits of the agreement in improving access and quality, however, there are challenges with the implementation of these agreements, as discussed in a later section.

3.3 Strategic Objective Three: Improve Equity of Access

The HSSP III envisioned equity in health care financing and delivery as a cross cutting theme. It terms of health care financing, ensuring access for the poor and the vulnerable who cannot fund themselves was emphasised through putting in place effective subsidies and waiver mechanisms for the poor and vulnerable, using prepayment schemes and other options. The proportion of identified poor and vulnerable enrolled in insurance schemes was identified as the indicator in measuring the progress in improving equity of access. However, this indicator was not comprehensive because it captures only one dimension of access – affordability – leaving out other dimensions like acceptability, availability, accommodations and physical accessibility. The progress for this indicator and other proxy indicators are discussed.

Enrolling the Poor and Vulnerable in CHF

Although enrolling the poor and vulnerable was identified as an indicator for this strategic objective, data of the proportions of poor enrolled in CHF was not available. However, according to (MoH 2006)[2] Councils may issue exemption letters or give CHF membership to poor households and the Councils are expected to pay for such CHF memberships. The field visits found that there are isolated initiatives to serve the poor in different Councils ranging from issuing IDs to CHF card. However, in most cases Councils do not set aside funds to reimburse facilities for services consumed by the same poor. In addition, the major challenge in most of the Councils is the absence of a systematic framework to identify the poor. With no clear identification/application procedures and screening criteria, the current approach is vulnerable to loopholes that may allow the misuse and sometimes abuse of the system. To inform the financing strategy, an Option Paper to study the issue of enrolling the poor and vulnerable is under development.

[2] MoH (2006). "Mwongozo Wa Utekelezaji Wa Sera Ya Wananchi Kuchangia Gharama Za Huduma Za Afya Katika Vituo Vya Huduma Ya Afya". GOT.

OOP Payments

Out-of-Pocket (OOP) payments constitute a sizeable share of total health care funding in Tanzania. According the NHA 2010, the share of household contribution to THE increased from 25 percent in 2005/06 to 32 percent in 2009/10; in absolute values, the share of household contribution to THE increased by 69% (see Table 13.) Out-of-pocket payments account for a large share of THE, and represent the direct burden of health care funding on households. The increase in OOP payments is a serious equity concern as it limits access to care for the poorest groups.

Table 13: Absolute Value of THE by Financing Source (million Tshs)

Financing Source	202/03	2005/06	2009/10	Percent Change 2005/06-2009/10
Households	325,353	445,003	750,298	68.6%
Donors	212,412	783,205	919,362	17.4%
MoF	196,853	498,403	603,922	21.2%
Other Private	39,479	53,400	49,345	-7.6%
Total	774,098	1,780,011	2,322,927	30.5%

Source: NHA 2010

Equity Watch Report on Equity of Access

According to the Tanzania Equity Watch Report 2012, there have been efforts to improve equity in health services. Approximately 90% of the population lives within five kilometres of a health facility, and the MMAM strategy aims to provide a dispensary in every village. Nonetheless, while there has been limited progress reducing equity gaps in three key areas – immunization, four ANC visits, and deliveries by skilled birth attendant – there are generally widening wealth and geographical inequalities in child survival. The Equity Watch report also highlighted the health worker shortage as an important constraint, particularly in remote rural areas. Lastly, the report calls for reducing OOP payments through a review of exemption and waiver policies (including providing resources to reimburse facilities for exempted patients,) control of informal charges, and review of the flat CHF premium.

Implementation of Exemption and Waivers for Poor and Vulnerable

Exemptions and waivers were introduced to reduce the financial burden on groups of the population who need access to health care and who either cannot afford to contribute to the costs or who have an illness or disease which threatens the public good and for which no direct charges should be imposed. The waiver system, while potentially effective in principle, is not deemed to be working well in practice. Most of the literature consulted finds the waiver system to be widely ineffective and does not meet the objective of ensuring access to quality services for the poor. The poorest who are not able to pay often do not have access to waivers either due to lack of information and/or denial of the waiver by a provider. Waived patients experience stigmatization and disadvantages while attending health services compared to those who pay for services. The identification/application procedures and screening criteria for waivers are unclear because in practice there is no systematic way to identify the poor.[3] Hence the process of identifying the poor remains very subjective. In addition, the waivers procedures have loopholes that allow the misuse and sometimes abuse of the system, thereby benefiting the better off more than the poor. More information is available in a separate report prepared as part of the MTR that reviews the progress in social welfare and social protection.

The exemption policies that provide free care for children under five, people with chronic diseases, people over 60, and pregnant women, seem to be implemented appropriately. Nonetheless, potential conflict between the attempt to generate revenue and protection of these vulnerable groups creates

[3] There are guidelines developed by TASAF to identify the poor, but these are not widely used.

challenges. In field visits, staff complain that they cannot effectively provide quality services when so many exemptions are in effect (Crawford, 2013.) Other non-exempt patients also express resentment that these groups receive special treatment. These exempted groups consume a significant share of health care costs, and the perception is that many of those exempted belong to households which would be able to pay the user fees or CHF fees.

Generally, review of the exemptions and waivers policies and practices, with the objective of making them more patient-friendly and operationally effective, and more focused on targeting the poorest households, is needed.

Charities and NGO Work

Equitable access to primary health care is vital to the overall health and development of a country. Yet achieving the goal of health care for all is especially difficult considering Tanzania's poverty and the high percentage of citizens who live in rural areas, and health care as a scarce resource. Further development and strengthening of government policies is required to protect the most vulnerable.

Very often, charities and NGOs fill the gap in different ways to extend health services to the poor. These programs are often community-based and include identifying the poor and subsidizing their health services, often focusing on maternal and child health services. There are also small scale interventions with NGOs subsidizing CHF premiums for the poor and for orphaned children. Although there have been many successful small and medium scale interventions, there are no mechanisms to bring these to scale or to integrate them within government institutions (Crawford 2013.)

The challenge remains on sustainability of NGOs and charity work once the projects come to end.

3.4 Strategic Objective Four: Improved Management of Complementary Funds

A key part of the HSSP III strategy for financing the health sector was to increase complementary funding, primarily consisting of user fees and CHF membership fees. HSSP III sought to ensure that these funds were managed and used in ways to improve health services, relying on *the percentage of facilities using fund management Standard Operating Procedures* as an indicator of performance.

Guidance for Management of Complementary Funds

CHF premiums and user fees originate from households and communities. Community funding was sought not only to generate additional resources, but also to foster community empowerment over their local health services. Though each Council created their own CHF by-laws, the CHF Act of 2001 stipulated at least four community representatives on Council Health Services Boards (CHSB,) the primary mechanism for oversight over use of complementary funds. The CHF Act also provided guidance that funds should be used for health related purposes as specified in health plans, and approved by the CHSB. Beyond the CHF Act, the MTR team was not able to identify other more specific guidelines or procedures provided to Councils or CHSBs regarding management and use of complementary funds.

Data to evaluate progress in this objective is spotty at best. Nonetheless, since 2009/10, the MTR team did not find new guidelines introduced to improve management of funds, or additional monitoring or review mechanisms to ensure that CHF funds were managed appropriately at LGA level. Guidance was provided related to management of health facility bank accounts,[4] but that is primarily used for MMAM

[4] Interviews with PMO-RALG and MOHSW staff estimate that over 80% of health facilities have bank accounts.

funding, not for complementary funds. According to the CHF Act, a key criteria is that the CHSB actively oversees and approves use of CHF funds. While PMO-RALG tracks the existence of the CHSBs, there is no data on the functionality of these Boards. In some Councils, only the DMO and one or two CHSB members with signatory authority are actively involved in decisions regarding how to use the funds collected. The situation is further complicated by a directive given by PMO-RALG to LGAs approximately a year ago limiting the number of Council bank accounts, which seems to have created significant confusion regarding how funds are accessed and monitored, and who authorizes use of funds (detailed in the next section.)

There is a little data on how funds are used. As shown in Table 14, 21.5% of complementary funds (CHF fees, user fees, and NHIF reimbursements) are used for medicines, while 7.5% of expenditures are for medical equipment. It is encouraging that over 30% of the funds are used to directly improve health services (medicine, medical equipment, rehabilitation.) However, the majority of expenditures (68.3%) are classified in such a way that we cannot accurately identify its use.

Table 14: Use of Complementary Funds* in 68 Councils, July 2009 – June 2013

Expenditure Item	Amount	Percent of Total
Procure medicine	3,492,623,160	21.5%
Procure medical equipment	1,212,284,576	7.5%
Rehabilitation	433,155,244	2.7%
Other expenses	2,687,013,667	16.5%
Expenses with undisclosed details	8,424,295,051	51.8%
TOTAL	16,249,371,698	100.0%

Source: NHIF, 2013.

* Complementary funds includes CHF fees, user fees, and NHIF reimbursements.

CHF Accounts and PMO-RALG Direction

In 2011, the PMO-RALG, based on direction from the MOFEA and the CAG as part of the on-going public financial management reforms, instructed LGAs to consolidate their bank accounts to a maximum of six. This directive created confusion regarding what to do with CHF accounts. After some time, guidance was provided to deposit complementary funds into the DED Miscellaneous Account. Although that guidance is now clear, it has continuing negative effects. First, having the CHF funds in a co-mingled account make it more difficult for Councils to provide the necessary documentation to access government matching funds for CHF membership fees. Secondly, facility staff and the DMO are reportedly less motivated to encourage CHF membership because they no longer can directly access the funds. Thirdly, there is no longer a clear role for community members in approving use of the funds, as control of the funds now rests with the DED and DMO (although it is reported that in some Councils, CHSBs continue to approve the use of complementary funds prior to DED authorization.) Lastly, there are reports that all complementary funds are to be deposited into health facility accounts at MSD, which would also limit community involvement in use of CHF funds.

The MTR team learned that some Councils have continued to maintain their CHF account, even though that contradicts PMO-RALG guidance. Some informants argue that CHF accounts should not be considered LGA accounts, because the account owner is the CHSB, not the Council.

The implementation of this directive provides a good case to analyse issues in health sector management. Based on interviews conducted by the MTR team, there does not appear to have been discussion of the impact of this directive with the MOHSW, or with LGAs, prior to its dissemination. Such consultation would have brought out the potentials risks and complications, and allowed a discussion of whether to include the CHF Account in this directive. In general, new policies and guidelines (whether from PMO-RALG or MOHSW) are not broadly disseminated for feedback or questions with relevant stakeholders prior to their implementation.

This situation also illustrates the need for better collaboration between MOHSW and PMO-RALG. The MOHSW only received notice from LGAs that they were closing CHF Accounts after the directive was issued. The NHIF reported a similar situation, where they were suddenly notified of Councils closing their CHF Accounts. Advance consultation with the MOHSW may also have avoided the confusion, and possibly provided other options that would have avoided the unintended negative results that are currently found. In the future, any effort to improve management of user generated funding must be undertaken through a collaborative effort of MOHSW and PMO-RALG.

3.5 Strategic Objective Five: Increase Efficiency and Effectiveness of Funds

HSSP III aimed to increase the efficiency and effectiveness of limited funds within the health sector. Given that health funding was increasingly decentralized to local governments, indicators in the HSSP III targeted financial management at LGA level. One of the Options Papers under preparation to inform the Financing Strategy focuses on public financial management. While strong financial management is certainly important, it is only one component of effective use of funds. The MTR team also reviewed the implementation of additional measures such as resource allocation formulas, provider payment and purchasing mechanisms, and performance incentives.

NAO Audits of LGAs

The specific indicator of performance included in the HSSP III for this strategic objective was *percentage of MDAs and LGAs with clean NAO auditing report,* with no reference to the specifics of the health sector. NAO audit reports of LGAs for the fiscal year ending June 2012 show improvements in audit results. Table 15 shows a positive five year trend for LGAs receiving clean audits, with 78% of Councils receiving unqualified or clean audits in 2011/12[5].

Table 15: Percentage of Clean (unqualified) Audit Opinions issued to LGAs

Year	Total Councils	Number with Unqualified Audits	Percent
2007/08	133	72	54%
2008/09	133	77	58%
2009/10	134	66	49%
2010/11	133	72	54%
2011/12	134	104	78%

Annual General Report of the CAG, FY ended June 2012.

This result is very positive, and continuing efforts to improve financial management are encouraging. The MOFEA and PMO-RALG have introduced EPICOR, an electronic financial management system, throughout the country. Ongoing monitoring is needed, as connectivity issues in some Councils limit EPICOR's usefulness. While financial management at LGAs is under PMO-RALG oversight, strong coordination is needed to ensure that health sector funds are used effectively.

[5] These results represent general audits of LGAs, which include health expenditures, but are not specific to health expenditures.

Alignment of Resources

While compliance with acceptable audit and financial management standards is important to ensure funds are not misused, it is insufficient to ensure that limited funds are used effectively. Even when funds are managed and used as per the guidance provided, they may not necessarily be used effectively. The findings of a value for money (VFM) audit of Health Sector Development Grants (HSDG) conducted for PMO-RALG provide good examples of potential issues even when there is appropriate financial management (DEGE Consult 2012.) The HSDG to LGAs supports the sector strategy to improve access in remote areas by investing in health infrastructure. The PMO-RALG commissioned an audit of contracts implemented using these grants in 2012.

The audit found that funds were generally used as intended and in accordance to guidelines, with 62% used for construction of new facilities, 29% for rehabilitation of existing facilities, and 9% for equipment (DEGE Consult 2012.) Of the 16 LGAs audited, all were deemed fair or good with regard to procurement and management of the contracts. Of the 56 major facilities inspected for quality, 93% were deemed fair or good. Financial management and contract execution were considered acceptable.

Nonetheless, the audit noted several concerns that limit the potential impact that these expenditures might have. Because the funding is very small compared with actual needs and there is political pressure to spread the funds throughout the district, funding may to allocated for new facilities that is insufficient to construct staff housing or toilets, or to equip and furnish the facility (DEGE Consult 2012.) The facility then does not have the required equipment to function, and lack of housing makes it difficult to attract and retain staff. Another issue raised in the audit was that the expansion of health facilities is progressing faster than deployment and budgets for staff at the new facilities. In these cases, although procurement and contract management proceeded appropriately, the investment is not effective in improving access to services.

Human resource production is another example where lack of a holistic system approach results in in efficiency. While there has been significant investment in production of health workers, there is not a clear plan for deployment, nor sufficient resources to employ them where they are most needed. These types of discrepancies limit the potential effectiveness of the investments in health.

Budgets and Disbursements

Informants at all levels pointed to unreliable budgets and disbursement delays as factors that hindered effective operations. The MTR team tried to get data on dates of funding disbursements, budget disbursements by quarter, and budget execution rates through various sources within the MOHSW, MOFEA, and PMO-RALG. Overall, the data available is very incomplete, but does paint a picture of late disbursements and poor budget execution.

Table16 provides data on when funds were released from the holding account for donor contributions to HBF – these dates do not represent when funds were received by the intended recipient, but only when they were disbursed from the donor account. First quarter (Jul-Sep) funding was disbursed within the first quarter only in 2009/10. In the last three years, the first disbursement was not made until October or November. In some years, given the late date of the last disbursement, it was documented that funds are not received until the next fiscal year.

Table 16: Date of Disbursements from HBF Holding Account

Year	Date of First Disbursement	Date of Last Disbursement
2009/10	Sep 3, 2009	Jun 28, 2010
2010/11	Oct 20, 2010	Jun 24, 2011
2011/12	Nov 3, 2011	Jun 29, 2012
2012/13	Nov 6, 2012	Not available

Source: MOHSW Basket Finance Reports.

In response to reports of particularly long delays in funding, the MOHSW conducted a survey in April 2013 to gather data from CHMTs. Based on information from 67 out of 132 councils responding to an email questionnaire, there is data on receipts of HBF at LGA level. The survey found that 81% of CHMTs (54 of 67 respondents) received the first quarter HBF in December 2012, implying a processing period of over 24 days from disbursement from the donor account (Nov 6, 2012) to receipt in the LGA account. Three other CHMTs each received their funding in January, February, and March 2013, up to four months after disbursement from the donor account. Even more worrisome is that 10 CHMTs reported not having yet received their first tranche of funding for 2012/13 at the time of the survey in April 2013. This survey also found that late notification from the LGA accountant was not a major issue as most informed the CHMT the day the funds were received, and nearly all informed the CHMT within a week of receipt. It is unclear what follow-up investigations were made related to those CHMTs that had not yet received any HBF after nine months of the fiscal year.

At the time of the MTR, total health expenditures at LGA level for 2010/11 were not yet available. The MOFEA did provide information on budget execution at MOHSW for 2010/11 and 2011/12, as shown in Table 17.

Table 17: MOHSW Budget Execution

	2010/11		2011/12	
	Budget	**Actual**	**Budget**	**Actual**
OC	105,758,645,000	76,253,138,895	98,371,633,000	97,159,554,265
PE	118,575,828,140	144,684,298,165	120,995,743,000	149,588,950,809
DEV: LOCAL	9,873,761,000	6,972,730,600	9,873,761,000	9,850,000,000
DEV: FOREIGN	438,568,754,000	239,955,033,831	354,920,726,000	252,338,244,820
TOTAL	672,776,988,140	467,865,201,491	584,161,863,000	508,936,749,894

Source: MOFEA, 2013.

Budget execution in 2010/11 was 70%, improving to 87% in 2011/12. In both years, actual PE expenditures (for salaries and allowances) were higher than budget – it is unclear whether this higher than expected expenditure affected the ability to fully fund the OC budget. The MTR team did not have time to examine the low execution rate of the Foreign Development budget in particular, which may be due to delays in one of two large procurements.

Through the Health Sector Resource Secretariat, the MTR team also obtained information on disbursements of OC budget for 2010/11 and 2011/12. This data seemed to indicate that late budget disbursement was not the primary cause of low budget execution, with over 40% of the budget released in the first six months. The main problem in 2010/11 was drastically reduced budget disbursements, with only 29.7% of the annual budget released in the second half of the year.

Table 18: Timing of Disbursements of MOHSW OC Budget

	2010/11	2011/12
OC Budget	105,758,645,000	98,371,633,000
Disbursed Jul-Dec	44,890,431,193	39,950,106,300
% of Annual Budget	42.4%	40.6%
Disbursed Jan-Jun	31,362,707,702	57,209,447,965
% of Annual Budget	29.7%	58.2%

Despite scant information, the available data confirm the complaints of unreliable budgets and funding delays heard at all levels. These delays constrain the ability of staff to conduct planned activities effectively. However, LGAs are allowed to carry forward prior funding into the next year for a limited period, so it is unclear whether adaptions in planning to account for such delays would resolve some of the problem of late disbursement. More difficult to address is the problem of Block Grants for OC that are below budgets, which are already very tight. In line with the earlier discussion on alignment of resources, high investments in staff, which is not supported by investments in other needed inputs or which limit the funding available for other inputs, limit the overall efficiency of health sector funding.

Service Agreements

Public-private partnerships were identified as a key strategy in the HSSP III to improve performance of the sector. The most visible part of this strategy to date has been promotion of Service Agreements between LGAs and non-government health providers, especially FBO facilities. Within the CCHP Guidelines, and directed by a PMO Circular in 2008, LGAs may enter into Service Agreements with private providers that will receive Council funding. To date, over 50 service agreements have been signed by LGAs. Part of the rationale of collaborating with private providers was to ensure that all available resources are put to best use to maximize equity and access.

MUHAS conducted an assessment in December 2012 to see how service agreements were performing, with several findings pertinent to the health financing discussion. LGAs committed to service agreements without adequate funding to support payments to the private provider. The inability of LGAs to reimburse providers as stipulated in the agreements negatively affected cash flow at some providers, resulting in shortages of medicines and materials. Lastly, some LGAs continue to build public facilities even where private facilities are available (MUHAS 2012.) Tools to support CHMTs in analysing whether contracts with private providers are the best way to extend services, the estimated cost of the services contracted, and the capacity needed to manage the contract and payments is needed.

The future financing strategy should consider carefully how to make use of existing private providers in ways that are aligned with overall budget constraints, minimizes duplication of resources, improves service quality, and maximizes access for all. Consideration of how to allocate scarce resources between public and private providers is needed to ensure that resources are not spread so thinly that neither provider can operate effectively.

Mechanisms to Incentivize Performance

In 2008, the Government of Tanzania approved a Payment for Performance (P4P) strategy as a means to motivate staff and improve health service delivery. The concept of performance based payments was incorporated into CCHP Guidelines and budgets. However, Health Basket Fund (HBF) partners questioned the design of the program and would not commit HBF to the initiative. Government funding also was not available to fund this strategy on a national basis.

In 2011, the MOHSW, with support from the government of Norway and in collaboration with the Clinton Health Access Initiative (CHAI) and the Ifakara Health Institute initiated a pilot in Pwani region. The preliminary results from this pilot show that staff are more motivated and proactive in solving challenges (Ifakara Health Institute 2013.) More rigorous impact data will not be available until later this year. An assessment of P4P currently underway found general consensus throughout the country of the potential power of P4P to strengthen health services (P4P Assessment Team 2013.) Within the MOHSW, there appears to be broad commitment to some element of performance-based payments as a means to motivate staff and improve services.

An important part of the current P4P assessment is a projection of the costs required for national scale-up. If P4P is to be a component of a successful financing strategy, it should be integrated into both the planning and budgeting process, as well as the HRH management strategy. Identification of an on-going

funding stream is critical, whether that is through identifying additional government health funding, or adapting the P4P design in ways that assure DPs of its effectiveness, so that HBF can be allocated for P4P payments.

4. Health Financing TWG and Governance of Financing Issues

The Health Financing TWG was cited by many MTR contacts as one of the best functioning TWGs. Meetings are held regularly and development partners actively participate. In the past year, many TWG members have contributed to activities aimed at development of a comprehensive health financing strategy by year-end.

Nonetheless, there are two critical shortcomings of the TWG. First, the most active members are MOHSW staff, development partners, and civil society groups like SIKIKA and CSSC. Important related ministries, such as MOFEA and PMO-RALG, are seldom in attendance. As such, it is difficult to generate the needed support to undertake necessary decisions. Secondly, given the critical role of financing in underpinning all activities, the TWG does not receive sufficient attention from senior management within the MOHSW. The TWG and development partners must find new ways to generate additional attention to ensure future success.

These weaknesses described are symptoms of the insular nature of all of the TWGs. There are two mechanisms designed for coordination between the various streams of work. First, TWG Chairs should report on TWG discussions to their respective Directors, who would take up relevant issues with MOHSW senior management. In practice, it is difficult for the Chairs to brief their Directors regularly, and there is little coordination between the TWGs. The second mechanism is through the SWAp Technical Committee, which meets twice yearly. In practice, that forum is too large and meetings too infrequent to have in-depth discussion of issues. New ways for TWGs to discuss issues of joint concern, and to seek input from MOHSW senior management are needed.

A critical activity during the remainder of HSSP III that will have critical impact on the future of the health sector is the development and adoption of a comprehensive financing strategy. To-date, the absence of a financing strategy is partially to blame for the lack of cohesion, and sometimes conflicting objectives, among the various financing mechanisms. For example, NHIF faces conflicting expectations as an insurance scheme for public servants charged with preserving its assets, and as a source of funding for public health facilities.

The TWG is effectively undertaking in-depth technical analyses of a range of issues to inform the financing strategy. However, adoption of the financing strategy is as dependent on broad political and public support as it is on technical soundness. To ensure the success of the newly proposed policies, the TWG will need to engage broad support within the MOHSW, to access the highest leaders within the MOHSW, and to engage other critical government actors, including MOFEA and Parliament.

5. Cross-cutting SWOC Analysis

The MTR team used a SWOC analysis to assess the strategic factors to be considered through the remainder of HSSP III and beyond. Table 19 presents an analysis of strengths, weaknesses, opportunities, and challenges in addressing these priorities.

Table 19: SWOC Analysis of Health Financing

Strengths	**Weaknesses**
▲ Roadmap for development of financing policy by year-end 2013 generally on track ▲ Financing TWG is active, open, and has a range of engaged members ▲ Efficient NHIF revenue collection through use of the TRA mechanism	▲ TWG does not receive sufficient attention from MOHSW senior management ▲ Community capacity in management of complementary funds is weak ▲ CHF design is not attractive to users and is not financially sound (does not cover cost of services) ▲ Neither CHF nor the waiver system is effective in ensuring access for the poor ▲ Respective roles of MOHSW, PMO-RALG, NHIF is not clearly defined ▲ Very low claims ratio in NHIF, current reserves represent 11 years of claims ▲ Lack of transparency, unreliable budgets, and funding delays constrain effectiveness and efficiency at all levels
Opportunities	Challenges
▲ Inter-ministerial committee Steering Committee provides forum to engage MOFEA, PMO-RALG and other key sectors ▲ Upcoming election may also be an opportunity for public discussion of health financing ▲ Financial management systems at LGAs are improving ▲ Potential benefit from better collaboration with external organizations to improve efficiency (PMO-RALG) and equity (TASAF) ▲ Reserves at NHIF could be used to subsidize CHF or other insurance mechanism ▲ Compulsory SHI would boost population coverage and mobilize funds ▲ NHIF seems to have capacity to mobilize Councils to promote CHF or other insurance mechanism	▲ Overall resources for health from government and external sources likely to remain flat ▲ NHIF expenditure is expected to increase significantly due to aging, NCDs, pending revision of reimbursements rates, and further increase in claims ▲ Inadequate funding reduces the usefulness of service agreements and hinder scale-up ▲ Informal fees and corruption may discredit the whole system ▲ Availability of medicine and poor perceived quality

6. Recommendations

The MTR team identified two areas for prioritization through the remainder of the HSSP III period:

- Adoption of a comprehensive financing strategy that mobilizes adequate funding and provides financial risk protection for all, including improved insurance options, and funded waiver and exemption systems.
- Strengthening systems for planning, funding allocation, and disbursement to increase effectiveness and efficiency.

Within those priorities, we offer the following recommendations for the Financing TWG and the TC SWAP:

(i) Seek opportunities for engagement with the Inter-ministerial Steering Committee, relevant Parliament Committees, and civil society to solicit feedback and buy-in for financing reforms

(ii) Improve coordination between the TWGs within the MOHSW, and between TWGs and senior management to ensure commitment and smooth implementation

(iii) Re-design CHF or create alternative insurance options to meet the goals of risk protection and mobilizing funds, considering the option of mandatory enrolment

(iv) Strengthen management of complementary funds, including:

- revisiting (and possibly revising) practical guidelines to Councils regarding management of CHF funds, including where to deposit funds, community oversight of expenditures, and appropriate signatories
- improving data collected through NHIF on use of complementary funds

(v) Revisit the existing waiver system by putting in place a systematic framework for identifying the poor and financing their health services, building on the work of the TASAF

(vi) Strengthening the facility governing committees through training in leadership, management and governance

(vii) Building on the opportunity provided by the new PMO-RALG Deputy PS for Health, strengthen coordination with PMO-RALG to allow for more tailored resource allocation at Council level and below, moving away from a one-size-fits-all approach by:

- establishing additional coordination points (establishing counterparts at HRH sections, Finance sections, etc) and/or
- establishing a sub-group of TWG Chairs that meet with PMO-RALG Health Sector Working Group regularly

(viii) Increase focus on improving efficiency by:

- strengthening public financial management in ways that ensure not only clean audits, but effective use of funds
- improving planning starting with clear resource limits
- integrating planning for infrastructure, HR, medicines
- improving systems for financial disbursements to ensure reliable funding
- incorporating performance-based incentives at individual, facility, and Council levels.

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