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PROSPECTS FOR SUSTAINABLE HEALTH FINANCING IN TANZANIA

Baseline Report

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Prospects for Sustainable Health Financing in Tanzania:

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CONTENTS

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ATF	AIDS Trust Fund
BIA	benefit-incidence analysis
BRN	Big Results Now (Initiative)
CBHI	Community-based Health Insurance
CFS	Consolidated Funds Service
DANIDA	Danish International Development Agency
DFID	UK Department for International Development
DPGH	Development Partners Group-Health
FY	fiscal year
GBS	general budget support
GDP	gross domestic product
GF	Global Fund
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOT	Government of Tanzania
HBF	health basket fund
HFS	health financing strategy
HSSP	Health Sector Strategic Plan
IHI	Ifakara Health Institute
IMF	International Monetary Fund
LGA	Local Government Authority
LOSR	local own-source revenue
MBP	minimum benefits package
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NBS	National Bureau of Statistics
NCG	Nordic Consulting Group
NFM	new funding model
NGO	nongovernmental organization
NHA	National Health Account
NHIF	National Health Insurance Fund
NSSF-SHIB	National Social Security Fund—Social Health Insurance Benefit
OC	other charges
OOP	out-of-pocket
PE	personal emoluments
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	primary healthcare
PHI	private health insurance
PMI	President's Malaria Initiative
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
RBF	results-based funding
SNHI	single national health insurer
SSRA	Social Security Regulatory Authority
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
THE	total health expenditure

TIRA	Tanzania Insurance Regulatory Authority
TZS	Tanzanian shilling
UHC	universal healthcare
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WDI	World Development Indicators
WHO	World Health Organization

INTRODUCTION

A high proportion of Tanzania's total health spending comes from foreign donors and households (out-of-pocket), rather than from sustainable sources such as government tax-based revenue or health insurance. While the country has made enormous strides in improving its population's health, the Government of Tanzania and its development partners recognize that the current health financing structure is not sustainable. The government is now considering several crucial changes to how healthcare in Tanzania is financed; as part of this effort, the country is finalizing a health financing strategy and scaling up new programs to accelerate service delivery coverage and improve quality.

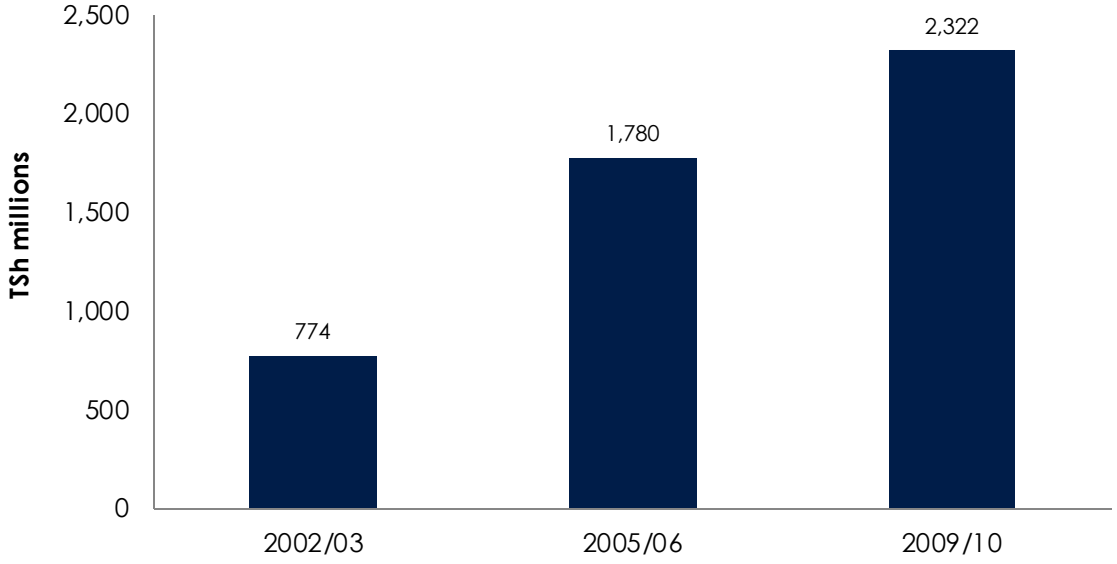
In support of building a sustainable structure, the USAID- and PEPFAR-funded Health Policy Project reviewed the country's healthcare financing situation to provide a baseline against which innovation and policy change can be gauged. The discussion below provides a broad overview of the health financing landscape in Tanzania as of 2014 and aims to highlight those aspects suggesting a greater reliance on domestic and sustainable resources to accomplish Tanzania's health goals (e.g., more health insurance coverage). The analysis highlights major trends in health financing, including the rational allocation of resources to local government authorities (LGAs), as well as reveals areas for further study and policy debate.

LEVELS AND SOURCES OF FINANCING FOR HEALTH

Total and Per Capita Health Expenditure

Total health expenditure (THE) in Tanzania increased during 2002/03 to 2009/10 in nominal terms based on data from successive National Health Accounts (NHAs) (see Figure 1). THE in the 2009/10 NHA round was 8.2 percent of the nominal gross domestic product (GDP) (MOHSW, 2012b), up from 7.6 percent in fiscal year (FY) 2005/06. The increase was driven by private (households and firms) and donor spending. The share of spending by the public sector declined between FY 2005/06 and FY 2009/10. (The results from the most recent NHA for FY 2011/12 have not been released.)

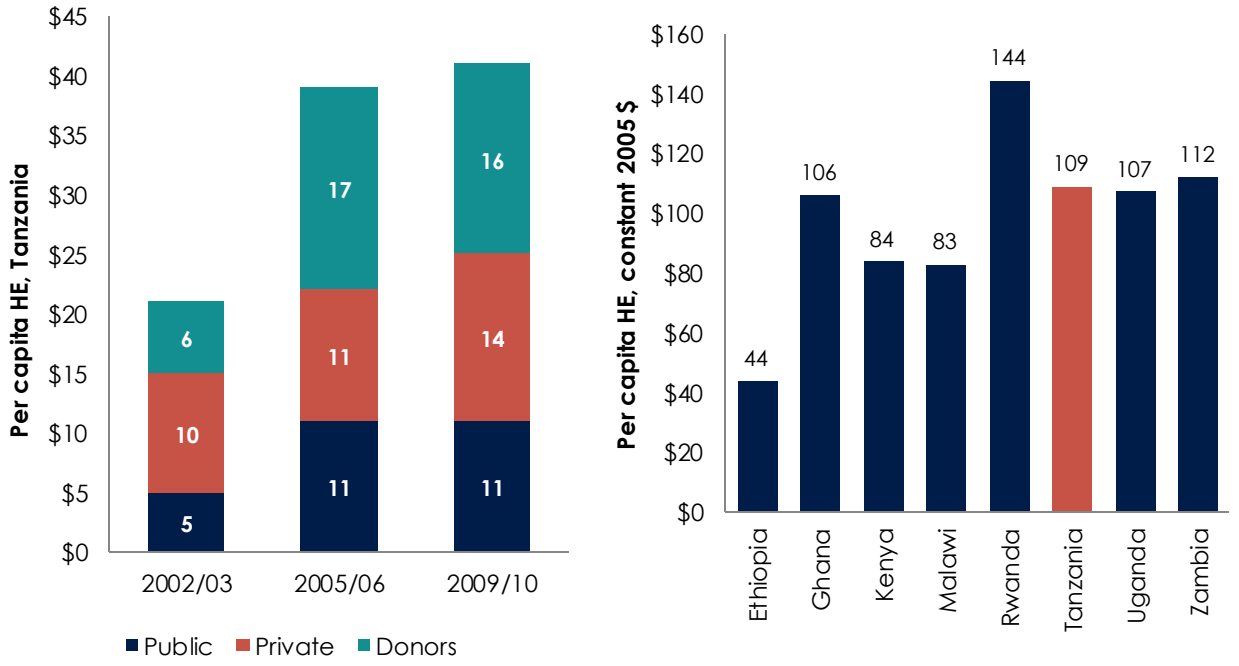
Figure 1. Total health expenditure over time, NHA rounds 2002/03–2009/11 (TZS millions)



Source: MOHSW, 2012b.

Total per capita health expenditure increased from US$21 in FY 2002/03 to $41 in FY 2009/10, comparable with $42 in Kenya[1] (MOHSW, 2012b; MOMS/MOPHS, 2011). Per capita spending has increased slowly. The World Development Indicators (WDI) value in constant 2005 U.S. dollars was $109 for 2012, which places Tanzania at the upper end of its region (WDI, 2014) (see Figure 2).

Figure 2: Per capita health expenditure (US$) in Tanzania (left) and across countries (2012) (right)



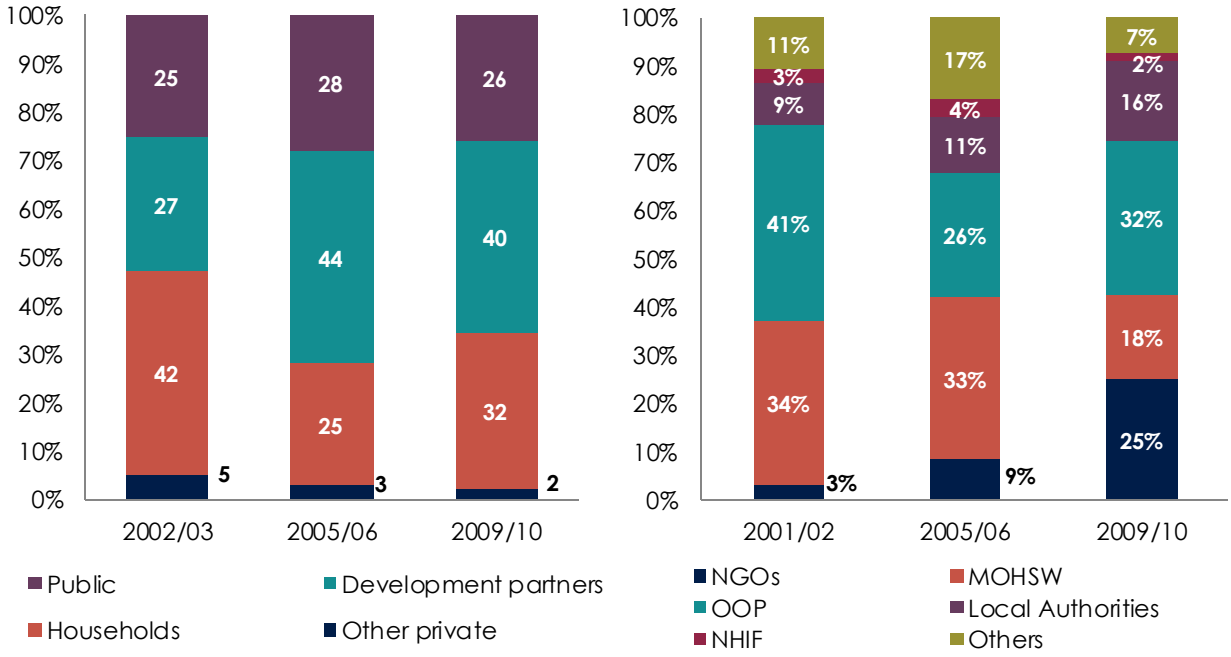
Sources: MOHSW, 2012b; WDI, 2014. NHA values in the left panel are current dollars. WDI values are in 2005 U.S. dollars (right).

Composition of Total Health Expenditure

Sources of THE shifted during FY 2005/06 to FY 2009/10. Public sector resources as a proportion of THE declined from 28 percent to 26 percent, while households' out-of-pocket (OOP) spending increased by 7 percentage points to 32 percent, similar to 25 percent in Kenya (MOMS/MOPHS, 2011). Development partner expenditure still contributed a significant amount to THE in 2009/10—at 40 percent (see Figure 3). The results for FY 2011/12 have not been formally released. Preliminary results suggest trends in this area have not fundamentally changed (MOHSW, 2014b).

[1] The Health Policy Project also reviewed the health financing landscape in Kenya; this baseline report can be viewed at www.healthpolicyproject.com.

Figure 3: Composition of THE by financing source (left) and financing agent (right)



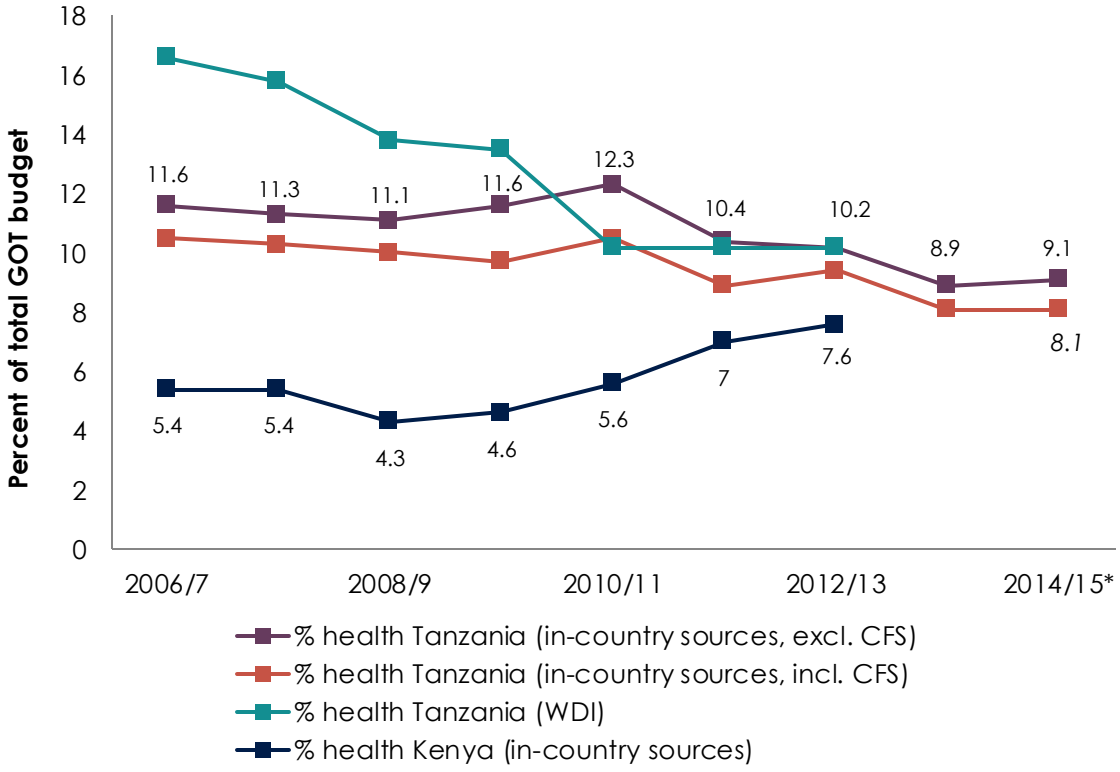
Source: MOHSW, 2012b; "Others" (right) includes regional authorities, parastatals, private firms, and the Tanzania Commission for AIDS (TACAIDS).

The role of LGAs and nongovernmental organizations (NGOs) in managing funds for health has increased. The share of the Ministry of Health and Social Welfare (MOHSW), as a manager of THE, declined as functions were decentralized, with the ministry retaining national stewardship and technical governance alongside the secondary healthcare sector. NGOs dramatically increased their role in managing health funds—from 9 percent in FY 2005/06 to 25 percent in FY 2009/10. LGAs had the third largest role at about 17 percent. The role of the National Health Insurance Fund (NHIF) in managing funds was minor at about 2 percent of THE in the 2009/10 NHA round.

Trends in Public Allocation to and Expenditure on Health

Public sector allocation to health as a percentage of the total public budget has stagnated over time. In both nominal and real terms, the Government of Tanzania's (GOT) resource allocation to health has increased over time, especially in the last two budgets. As a proportion, it has stagnated at 9–11 percent. The GOT allocated 8.9 percent of the discretionary budget to health in FY 2013/14, a drop from the previous year. As a percentage of actual spending, health was 8.7 percent in FY 2013/14 (MOHSW, 2014c). The allocation is on par with other African countries but is lower than the Abuja Declaration threshold. International comparisons are problematic if driven by World Development Indicators (WDI) data, which do not reflect in-country reality (see Figure 4). Also, in Tanzania, as in a few other countries, substantial funding is received as general budget support and as on-budget basket funding for health. A cross-country comparison of government commitments net of on-budget support, using local data, is not available at this time.

Figure 4: GOT allocation to health, as a percentage of total GOT budget, vs. Kenya

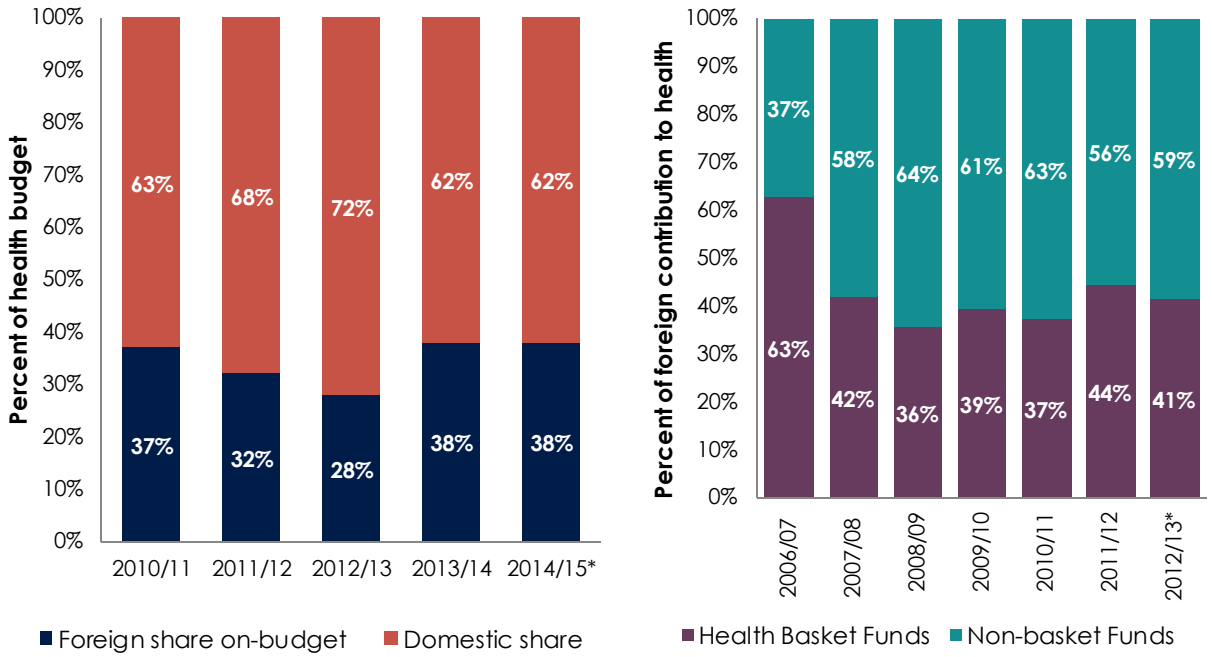


Sources: WDI, 2014; MOHSW, 2014c; DPGH, 2013; MOHSW, 2012a. * Values calculated based on whether the denominator includes or excludes CFS.[2]

Foreign on-budget funding has historically been a large and stable part of the GOT health budget. Tanzania receives general budget support (GBS) from certain donors. For health, it also receives on-budget basket funding as well as non-basket funding. On-budget foreign funding as a share of *actual* GOT health spending increased from 32 percent in FY 2011/12 to 38 percent by FY 2013/14 (MOHSW, 2013b). The health basket fund has declined in proportional significance within this on-budget support (see Figure 5, right).

[2] CFS (Consolidated Funds Service) is a non-discretionary allocation made in the budget for debt service, etc.

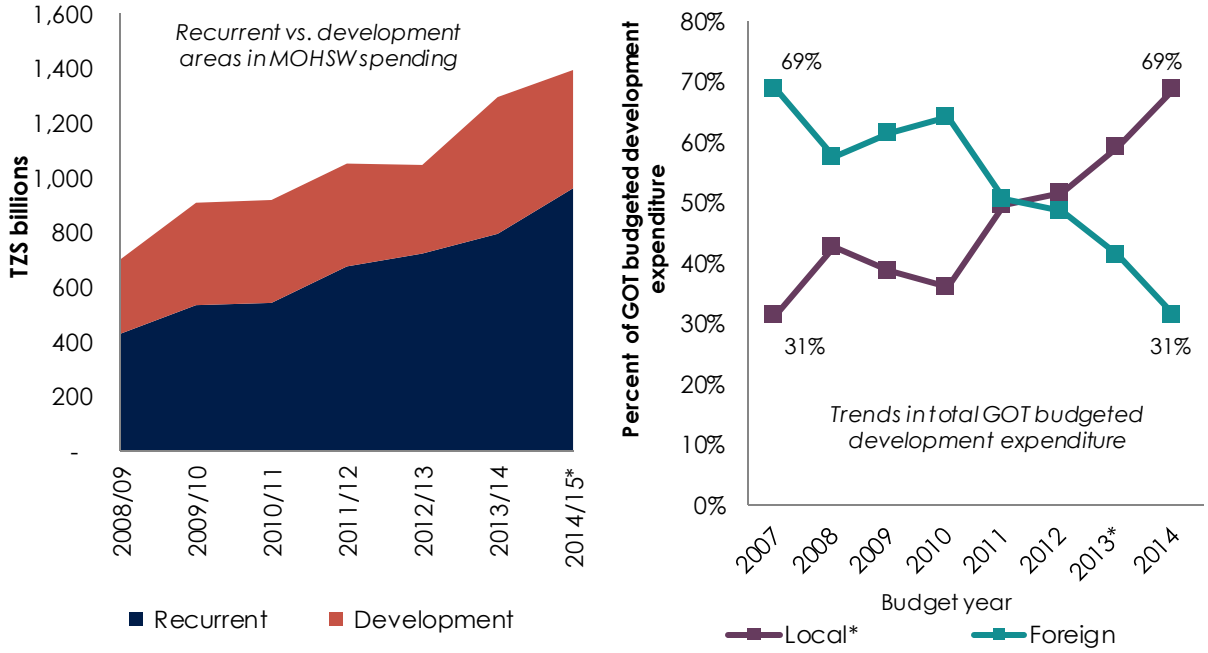
Figure 5: Composition of GOT health budget (left) and of foreign funds on-budget (right)



Sources: MOHSW, 2014c; DPGH, 2013; MOHSW, 2012a; MOHSW, 2013b. * Budget amounts. All other amounts based on actuals. This is examined in more detail further below.

Most government spending on health is on recurrent items, indicating less funding for capital improvements and additions. Over the last six fiscal years, 60–68 percent of GOT health spending went to recurrent items, such as salaries (personal emoluments or PE), commodities, and other charges. The salary bill has been growing rapidly and may grow further if a draft pay and incentives strategy is implemented. In health, the share of development expenditure has stagnated over recent years, even as overall GOT development spending has increased (see Figure 6). Development expenditure in the health budget is exaggerated, as it contains significant recurrent items that are not separated and also includes some contributions from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Across the entire GOT budget, there is evidence of a displacement effect. Changes in external contributions on-budget, situated in the "development vote," have led to countervailing changes in GOT contributions (see Figure 6). With a decline in overall external partner contributions in this area, the GOT's contribution as a share has increased.

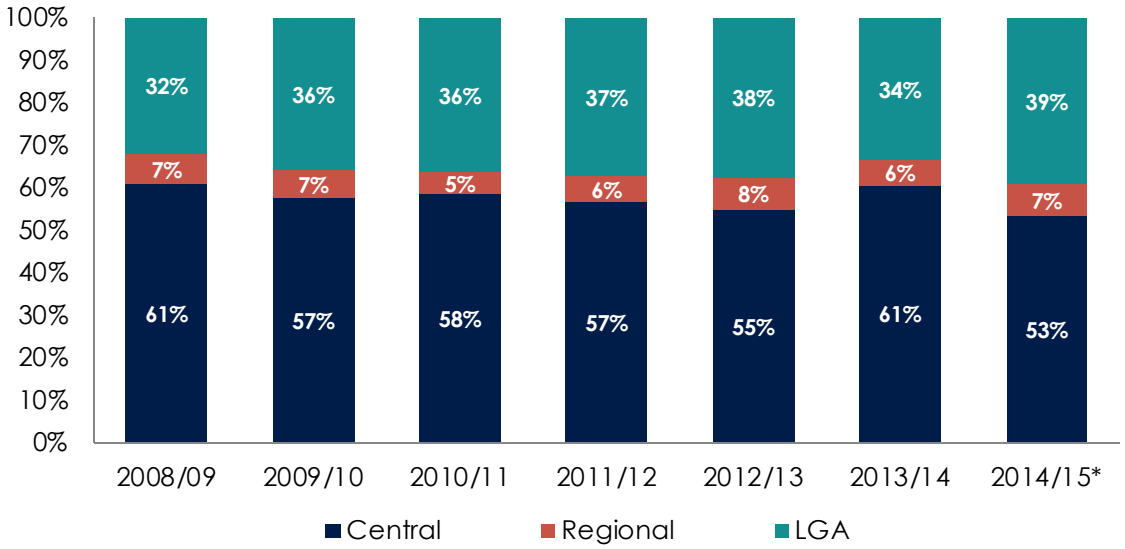
Figure 6: Trends in development expenditure by GOT, by fiscal year



Source: MOHSW, 2014c; MOFEA, 2014. *Left: all values except FY 2014/15 (approved estimate) based on actuals. *Right: all values except 2013 and 2014 Local (approved estimates) based on actuals.

Government spending on health is dominated by the central level. In FY 2013/14, 61 percent of all GOT spending occurred at the central level (the Prime Minister's Office Regional Administration and Local Government or PMO-RALG, MOHSW, NHIF), though this does not account for all spending (MOHSW, 2014c). Centrally, the MOHSW is responsible for national referral hospitals and procurement functions. LGAs are responsible for primary healthcare and district hospitals but not regional hospitals.

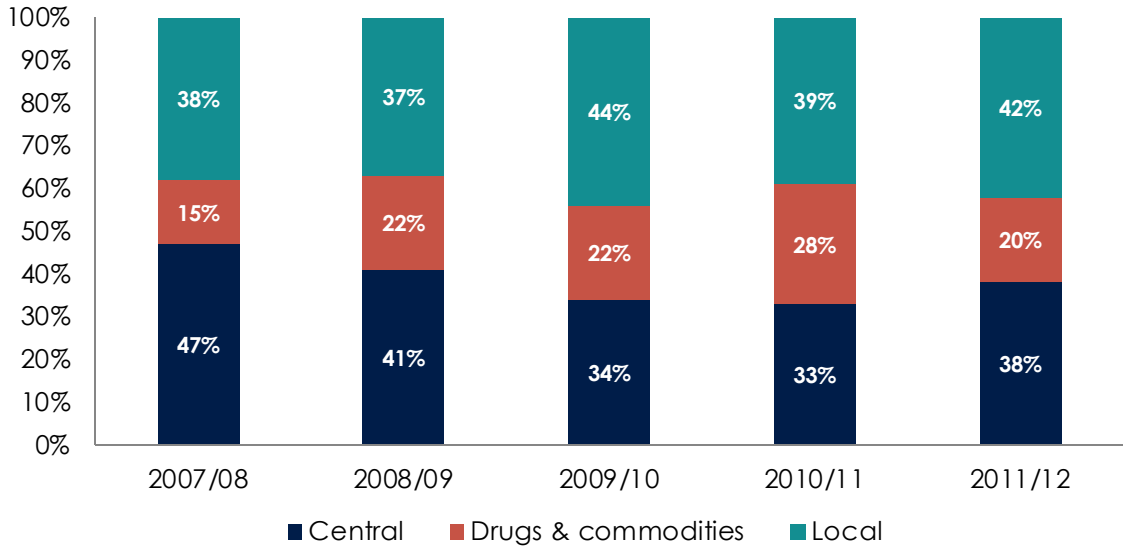
Figure 7: Composition of GOT health sector actual expenditure, by level



Source: MOHSW, 2014c. Central level includes PMO-RALG spending but not TACAIDS. Further disaggregation is needed.

The central level of the health system in Tanzania is large because it manages procurement and wages. The central MOHSW procures the majority of drugs and commodities—which are transferred to the LGAs and higher level hospitals—and the PMO-RALG pays the salaries. LGAs are expected to purchase some commodities using their own sources and a fixed percentage of the basket fund allocations, though the latter has been difficult to implement. Figure 8 shows the composition of the GOT health sector budget by level, with "Local" including the LGAs and regions.

Figure 8: Composition of GOT health sector budget, by level, separating drugs



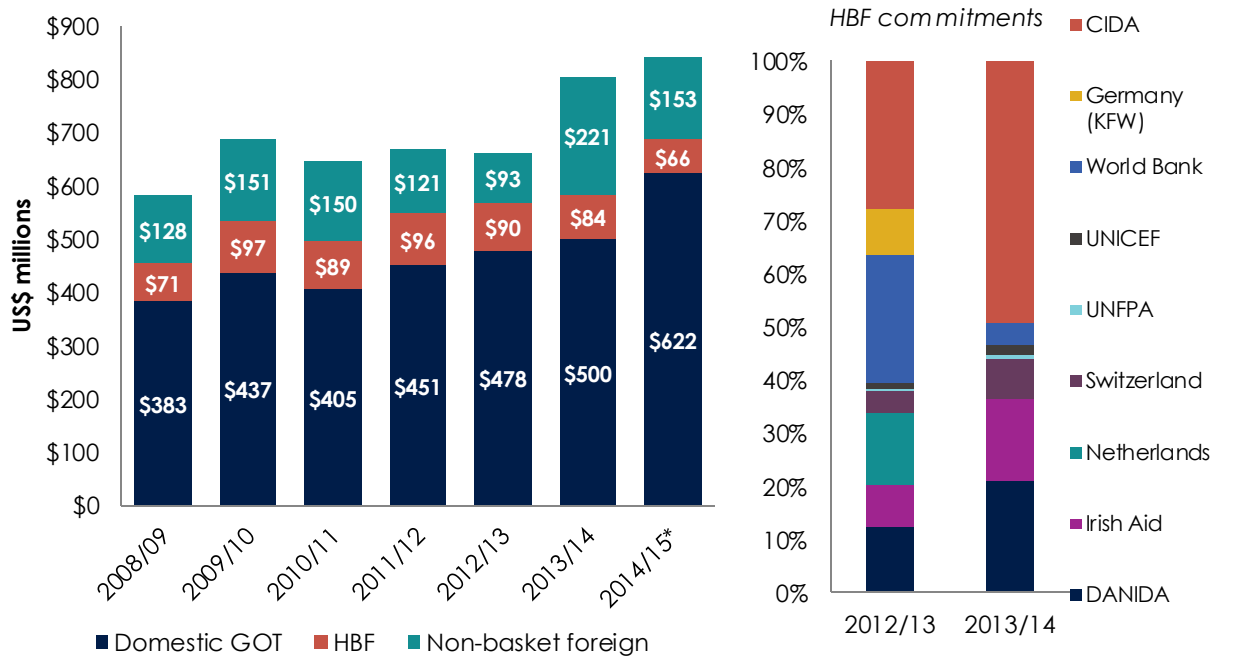
Source: MOHSW, 2012a. Total of central + drugs and commodities may differ from actual expenditures in Figure 7.

Trends in External Financing for Health in Tanzania

With the Global Fund, non-basket resources for vertical programs have overshadowed the general health basket fund. From FY 2007/08 onward, non-basket funds have dominated the health basket fund (HBF) within resources on-budget (see Figure 5). The HBF expenditures decreased in nominal terms[3] from $97 million in FY 2009/10 to $90 million in FY 2012/13. The main funders of the HBF from FY 2012/13 to FY 2013/14 were the Canadian, Danish, and Irish governments (see Figure 9).

[3] Exchange rate for Tanzanian shillings (TZS) to US dollar calculated as the average of values from the series from World Development Indicators (annual averages) and calculated average of UN Effective Operational Rates.

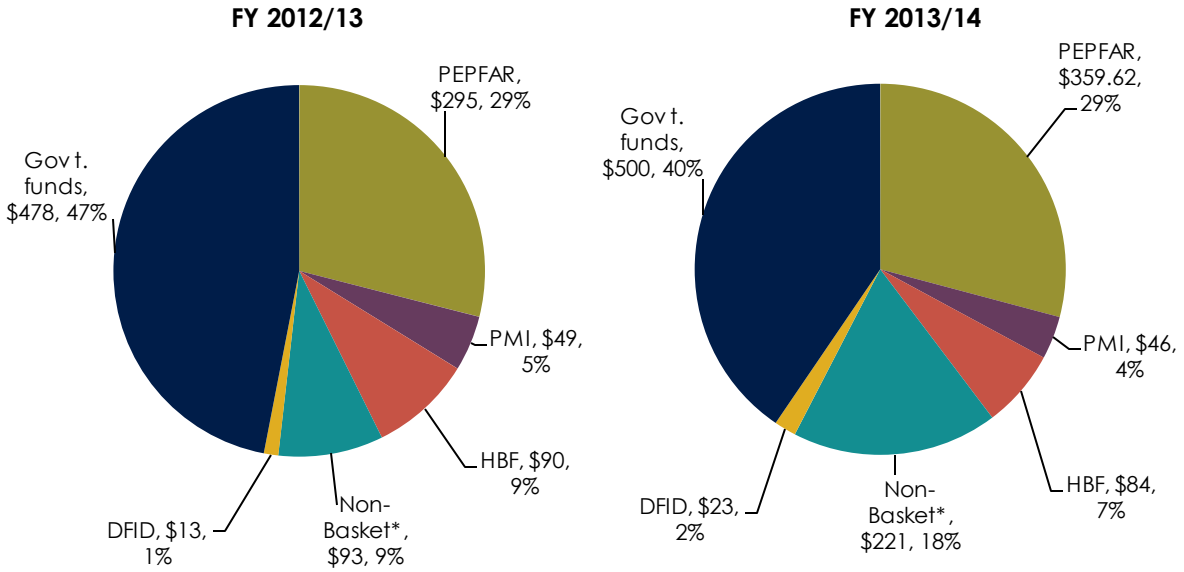
Figure 9: HBF in GOT actual health expenditure (left), and share of commitments (right)



Source: Left: based on author's analysis. * Data for FY based on approved estimates. Right: MOHSW, 2013b.

U.S. government support for HIV and malaria is large compared with all other external resources. Based on the reported expenditures for the U.S. fiscal year (October–September), the President's Emergency Plan for AIDS Relief (PEPFAR) contributed $295 million in 2012–13. In addition, the President's Malaria Initiative (PMI) committed $49 million. These amounts can be imperfectly compared to the actual expenditure on health in the GOT accounts, separated for domestic vs. on-budget support, for the Tanzanian fiscal year (July–June). All other formal external donor support on-budget represented 18–21 percent of the total shown in Figure 10. Some bilateral donors, such as the UK Department for International Development (DFID), provide general budget support and project support to NGOs and other organizations. The reported DFID support to health is also shown in Figure 10. In FY 2013/14, the total of PEPFAR and PMI funding averaged about one-third of the overall total, including GOT health expenditure (with on-budget support) and DFID funding. Regarding HIV-related expenditure, PEPFAR resources accounted for an estimated 80 percent of all specified HIV resources in FY 2012/13, even given mismatch in fiscal years, and an *estimated* 92 percent in FY 2013/14.

Figure 10: PEPFAR, PMI, and DFID, alongside GOT actual health expenditure, US$ millions



Sources: PEPFAR, 2012; PEPFAR, 2013; PMI, 2012; PMI, 2013; DFID, 2013; author's analysis. * Includes on-budget Global Fund expenditures. Values do not include other small bilateral donors' support off-budget. PEPFAR values are inclusive of overhead.

Trends in external funding to the health sector suggest a reduction in the number of active donors and in total volume. Since FY 2013/14, three of the HBF donors have exited the mechanism (MOHSW, 2013b). Regarding the HIV response, the number of active external funders will decline from nine to five. The agreement between GOT and HBF donors will also come to an end in 2015, and it is unclear whether existing partners will maintain the same support levels. Funding for vertical programs will likely remain stable, depending on the United States Government and Global Fund. With a move to the Global Fund's "new funding model," the country has been issued an overall funding envelope of $633 million (both new and existing money) across the fund's three diseases for FYs 2014–16. About 61 percent of this amount is allocated for HIV. Tanzania has applied, like many other countries, for additional "incentive" funding. Generally, funding for these vertical diseases is likely to leave a gap when compared to known requirements.

Budget Execution and Other Challenges

The GOT has challenges in absorbing (executing) the development health budget. The GOT executed 81 percent of the health development budget—across the MOHSW, PMO-RALG, and the local level—for FY 2013/14, compared with 91 percent for the health recurrent budget (MOHSW, 2014c). For the development budget, this was an improvement on FY 2012/13, when the execution was 69 percent and the recurrent expenditure was stable. In previous years, recurrent expenditures had exceeded the budget allocation, mostly due to an overrun in salaries and incentives (PE is part of the recurrent vote in the budget).

Delays in disbursement of funds across certain channels have led to problems in budget execution and planning. The mid-term review of the Health Sector Strategic Plan III suggested that first releases from the holding account for external funds into the HBF have been delayed for FYs 2010/11 to 2012/13 (MOHSW, 2013b). Thereafter, HBF funds are released to LGAs quarterly by the central level. Past summary reports have pointed to delays in the disbursement of HBF and block grants as a potential cause of the under-execution at the LGA level (MOHSW, 2012a; MOHSW, 2013b; Frumence et al., 2013; Frumence et al., 2014). Delays in disbursement often stem from delays in required

reporting from LGAs on a previous period. According to an MOHSW survey in April 2013, sampled LGAs reported delays of 24 days to four months or more in receiving their HBF allocations (MOHSW, 2013b). There may also be delays in the release of other charges (OC) funds from the central level.

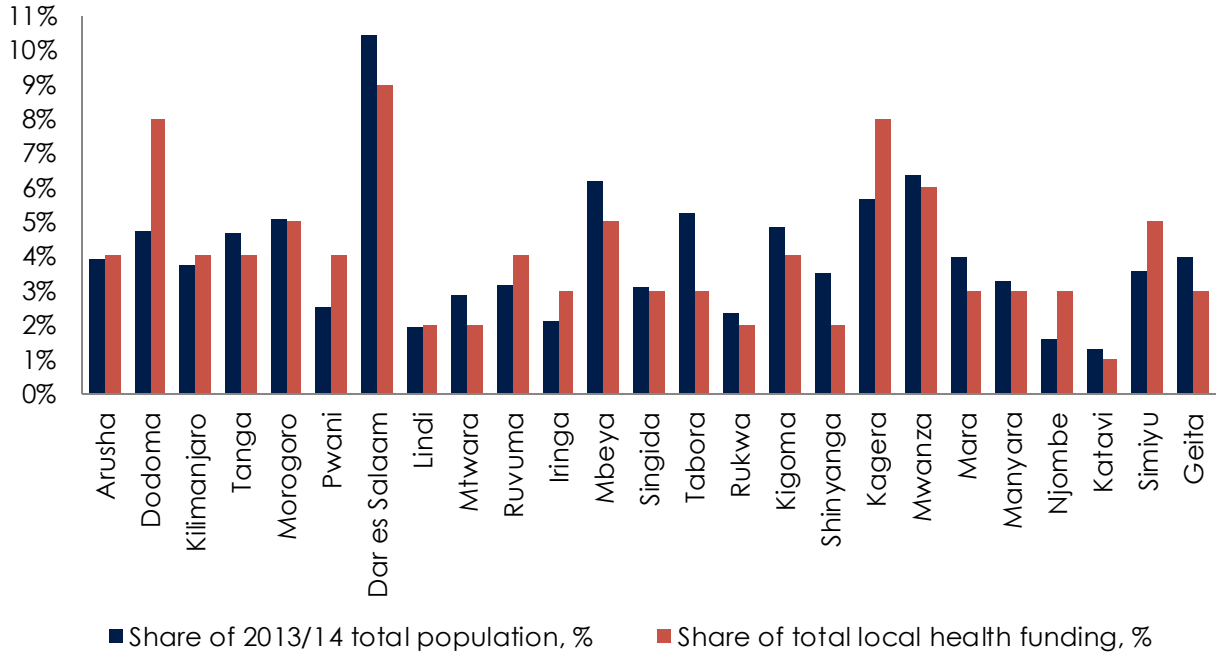
Service delivery inefficiencies and leakages exist, which cause avoidable funding losses or delays. As of mid-November 2014, GBS partners were withholding most of the funding for FY 2014 due to ongoing questions on financing irregularities in the power sector. Since such delays in financing for due diligence or other factors occurred in recent fiscal years, many ministries, departments, and agencies of the GOT face significant resource shortfalls, delaying implementation and project approvals. At the other end of the GOT public service delivery spectrum, independent NGOs find that petty corruption and leakages are common—up to 22 percent of outpatients were asked for a bribe at public facilities in one study (Mkani, 2014).

TRENDS IN LOCAL-LEVEL FUNDING FOR HEALTH

Funds for the health sector managed at the local level are generated from multiple sources. The major sources for LGAs are budgetary allocations from the central government (block grants for PE and OC, as well as infrastructure/other development funds), HBF allocations, LGAs' own sources, user fees, contributions from health insurance schemes, and other sources. The analysis of budget data for FY 2013/14 across 161 LGAs suggests that block grants represented 47 percent of resources, HBF and the Global Fund contributions each represented 11 percent, LGA resources accounted for 5 percent, and the remaining quarter was from various sources (MOHSW and PMO-RALG, 2013). In recent years, the Global Fund has grown significantly as a source. Within central government block grants, PE for health worker salaries accounted for 90 percent, and OC accounted for only 10 percent.

Viewed at the region level, total funds for health at the local level appear to be aligned to population. Using data from the FY 2013/14 analysis of LGA health plans, total funding was viewed alongside the regional population. Figure 11 suggests that funding and population are generally aligned except for a few regions (correlation: 0.79). Large shifts occurred in the FY 2012/13 share of funding for a few regions after administrative reforms shifted LGAs and some new regions were formed (MOHSW and PMO-RALG, 2013).

Figure 11: Share of budget at the region level vs. share of total population, FY 2013/14



Source: MOHSW and PMO-RALG, 2013; author's analysis. Population: average of high and low projections using Census 2012 data.

However, at the regional and LGA level, further realignment of funding may be needed to suit current epidemiological and service delivery realities. There is a long-standing perception of inequity in the availability of key health resources across regions and LGAs (Tidemand et al., 2014). The perceptions are partially driven by the variations in health worker recruitment and retention, allocation of medical supplies, etc., which are outside the scope of this review. Such inequities have led to a recent focus on fair health worker distribution under the Big Results Now (BRN) initiative for health, discussed in more detail later in this document. Under PEPFAR, there is a plan to refocus resources on higher HIV prevalence regions, which will be "saturated" with key investments, compared with other regions where services will be "maintained."

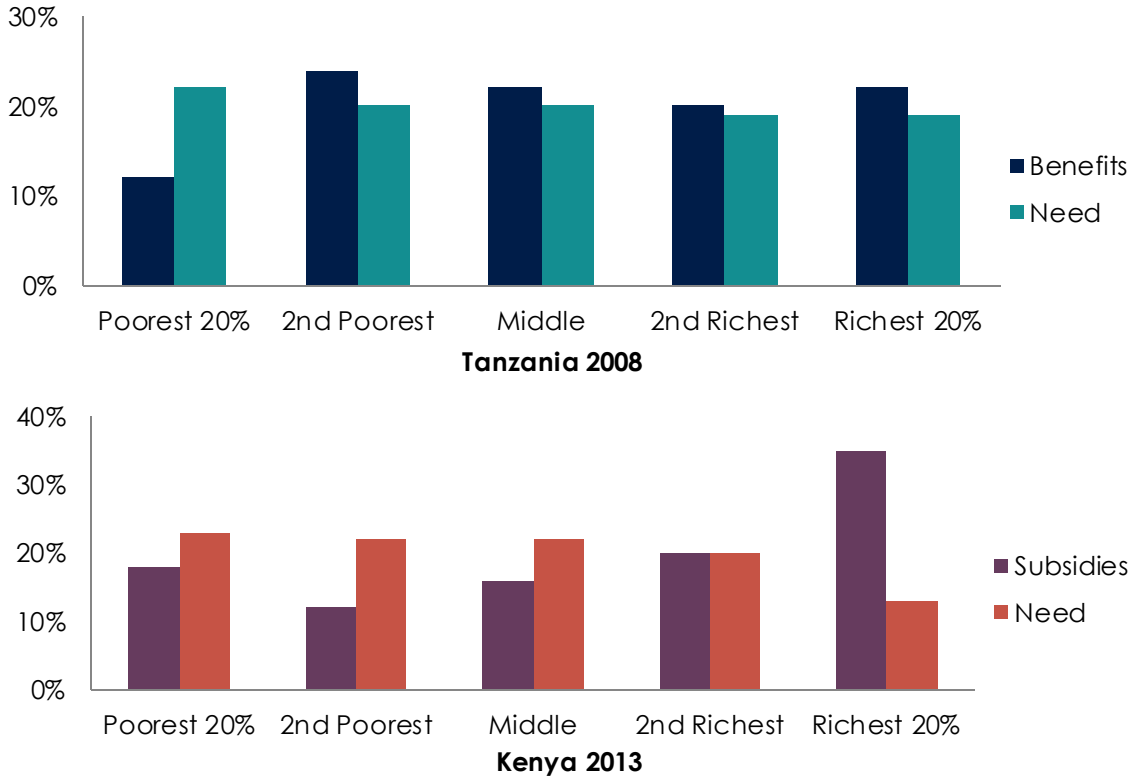
An area of recent focus is the formula used to allocate HBF financing to LGAs. The allocation process is advised by the PMO-RALG and executed by the Ministry of Finance and Economic Affairs (MOFEA). The current formula, adopted in 2004, uses population, poverty level, under-five mortality, and land area; but the underlying data used for the allocations are outdated. As a part of the FY 2014/15 update to the formula, the weight for (capped) land area was increased from 0.1 to 0.2, while the weight for population was reduced from 0.7 to 0.6. A per citizen value of $1.05 is now set for allocations, valued at the current exchange rate. It has also been suggested that this formula be used for allocations of OC from the central level, though this has not yet been implemented. Further analysis being conducted in 2015 by the Urban Institute with the PMO-RALG may inform a decision in this context.

FINANCIAL PROTECTION AND EQUITY IN HEALTH SPENDING

The way health resources are generated impacts the poor in Tanzania unfavorably. Based on research conducted using household data, the poorest quintile in Tanzania contributed about 4 percent of income to healthcare—most of it out-of-pocket (Mtei et al., 2012). In comparison, the second poorest and middle income quintiles contributed a lower share of income for healthcare.

Benefit-incidence analysis suggests that poorer Tanzanians have benefited less from health spending. Benefit-incidence analyses (BIAs) examine household and other data to track where health expenditures occur and whether these match principles of health equity (e.g., whether the poor benefit relatively more from health spending). A BIA conducted using a 2008 survey of 2,234 households suggested that the share of health benefits at public facilities[4] was lowest for the poorest income quintile. Across all facility types, benefit shares were similar except for the poorest (Mtei et al., 2012). This suggests inequity in benefits for the poorest—although the system is more equitable for other groups, unlike in Kenya (see Figure 12).

Figure 12: Health benefits/subsidies vs. self-assessed health need, by income quintile



Sources: WDI, 2014; Mtei et al., 2012.

Healthcare spending for the poor can contribute to impoverishment. Based on an analysis of the 2007 household budget survey, 15 percent or more of the poorest Tanzanians spent 20 percent or more of their non-food household budget on healthcare, and 8.4 percent spent more than 30 percent (Haazen, 2012). This is compared with 6.2 percent and 2.8 percent among the population as a whole, respectively.

[4] In this context, benefits are defined as the product of health service use and the unit cost of the health services.

Health-related expenditure accounted for 4.2 percent of the overall poverty headcount, with an even higher share in urban areas such as Dar es Salaam.

Waivers and exemptions for user fees are not uniformly applied, and health sector crises can lead facilities to implement higher rates. Deriving from policies in effect since 1993, user fees range from TZS 1,000 to 3,000 for health centers and dispensaries, with available exemptions or waivers (IHI, 2013). However, these exemptions are ineffective in practice due to the difficulty in identifying those eligible (targeting), low awareness among the public of the policy, and contrary incentives for facilities and LGAs to implement the policy (Idd et al., 2013; Maluka, 2013; Rohregger, 2014). Rates at hospitals can be high, though exemptions or waivers as well as pre-payment through various insurance schemes are available. Because of recent crises in medical supplies due to debt at the Medical Stores Department, referral facilities such as Muhimbili National had introduced inpatient fees of TZS 9,000 daily, which they were asked to reverse (Mbashiru, 2014).

ROADMAP TO UNIVERSAL HEALTH COVERAGE

The GOT has made a commitment to universal health coverage (UHC). The World Health Organization defines UHC as comprising coverage with comprehensive health services—prevention, promotion, treatment, rehabilitation, and palliative care—and coverage with financial risk protection for everyone (WHO, 2013). While achieving UHC is primarily a health financing challenge, it also requires reorganizing delivery services and increasing healthcare demand and utilization, which imply the need for a broad systemic effort. The GOT committed to UHC under the Third Health Sector Strategic Plan 2009–2015 (HSSP III) via social health insurance (MOHSW, 2009). Like many other low-income countries, Tanzania's health financing system is dominated by a tax- and donor-funded health delivery system, with a modest proportion of the population enrolled in social, community, or private health insurance. The remaining population, reflecting the still large proportion of people working in the informal sector or the very poor, are dependent on the public sector and do not have insurance or are not served by any other risk pooling or sustainable mechanism.

Tanzania is working on a comprehensive health financing strategy but still faces several crucial decisions. A draft of the health financing strategy (HFS) is available, which was preceded by 11 policy option papers covering various aspects of health financing. Current discussion acknowledges the highly fragmented nature of the health financing system, with multiple risk pools and funding sources and high dependency on external funds, especially in a few key programs. Various options were proposed related to consolidation given the current status of insurance schemes. These insurance schemes are discussed in more depth in Section 7 of this report. The draft HFS highlights guiding principles of equity, solidarity, transparency, sustainability, and efficiency. The overarching theme is social health protection, which is a corollary of UHC. After the inter-ministerial steering committee discussed options for the consolidation of risk pools, revenue collection, purchasing, and benefit packages, a consensus emerged that the HFS should be focused on a single national health insurer (SNHI). Table 1 highlights some attributes of such an SNHI and also the "to be determined" issues.

Table 1. Possible HFS structure based on a single national health insurer (SNHI)

Selected policy areas	SNHI—proposed	Selected open issues
Governance: Where will the institution report? How will it be regulated? What will be its internal governance structure? What legal basis is needed?	• Report to the MOHSW • Independent regulator • Independent SNHI board—NGOs, GOT, unions, etc. • New health insurance law	• Who will play an oversight role; will other ministries cede territory? • Should a new regulator be created or should an existing one be strengthened? • When will existing Acts be annulled? When will new law be drafted and tabled?
Revenue collection: What contributions are there to collect? What mechanisms are needed? What provisions will be made for the indigent?	• *Mandatory* contributions • Shared contributions—formal sector employer and employee • Subsidies for the indigent	• Will contribution levels be based on actuarial studies or benefits; and flat and/or income-based? • What is the strategy for informal sector contributions? • Will targeting of full vs. partial subsidization be based on a poverty identification formula?
Benefit package: What will be the minimum set of services to purchase? Will there be any distinctions (tiers)? Will there be any copayments?	• Minimum benefit package (MBP): free for all, essential positive list • MBP+: MBP, plus the NHIF package • Complementary and/or supplementary package purchased from private health insurance	• How can a referral system be enforced to avoid use of higher levels of care? • Which services should be included in the MBP at the secondary health level? Positive list? • Will there be a sliding premium scale to access MBP+? • Will there be a roadmap for extending MBP+ to all? • What is the level of copayment expected?

Selected policy areas	SNHI—proposed	Selected open issues
Purchasing: What is the type of provider payment system used? Will payments cover investment costs, repairs, etc.?	• Automatic provision of MBP at public facilities • Combination of payment mechanisms: capitation for primary healthcare (PHC), bundled or case-based for secondary healthcare • Inclusion of incentives for performance • Facilities funded directly	• Will there be a phase-in alongside results-based funding (RBF) roll-out and an eventual phase-out of RBF in favor of SNHI? • Will purchasing be from public, private, and faith-based organizations? • Will differences across provider types be accounted for in setting payment costs? • How will competition and free choice be encouraged in PHC, especially in rural areas with a lack of facility diversity? • What will be included in payments?
Pooling: How will different funding streams be pooled? How will equalization and cross-subsidization be achieved?	• Single risk pool merging existing schemes and external funding flows • Equalization across LGAs • Cross-subsidy: geographical and across healthy and sick individuals	• How will the collected premium and pooled total revenue be managed? • Will the SNHI operate the account or another mechanism? How will the auditing be done? • What are the streamlining processes for SNHI enrollment agents to send contributions into a pool?

Sources: MOHSW, 2014d; Bultman and Mushy, 2014.

Health financing reform toward UHC will be achieved in stages. The draft HFS is currently in the *policy stage*, during which stakeholders are working to build a consensus on broad elements. The inter-ministerial steering committee will then need to review and approve the strategy before it can be tabled for further action by the GOT. This may take until mid-2015. An implementation plan for the HFS is also being finalized. The strategy will likely be linked to the new Health Sector Strategic Plan IV 2015–20 (HSSP IV); thus, there is a sense of urgency, as the HSSP IV should be finalized by March 2015. After the policy stage, the *legislation and implementation stage* comes next, which involves drafting an appropriate Act and reaching an agreement on the details. As Table 1 suggests, significant design decisions as well as an analysis of options is required before the HFS implementation plan can be executed. In addition, significant time will be needed to draft an appropriate insurance law to institutionalize the SNHI, annul existing Acts, and pass the SNHI law in Parliament. Given this, achievement of the SNHI vision may only be fully realized after several years—perhaps by 2020. In the interim, sustainable financing reforms for the health sector require the mobilization of domestic resources and further growth in health insurance coverage using existing schemes, which are discussed on page 18.

SUMMARY OF CURRENT LANDSCAPE

While Tanzania has made significant progress on priority health indicators, the limited effectiveness of health financing impedes its abilities to achieve more. Compared to countries in East Africa, Tanzania spends an equivalent if not higher amount per capita on health (e.g., the amount is on par with Kenya and lower than Rwanda). As per the mid-term review of HSSP III, progress has been less than desirable for maternal and newborn health. For example, Tanzania is not currently on track to meet the HSSP goal of reducing maternal mortality to 265 per 100,000 births by 2015 (MOHSW, 2014a)—the ratio in 2010 was 454 and is predicted to be 346 in 2015 (GOT, 2014). Results in the Lake, Western, and Southern Highlands zones are poor compared to the rest of the country, suggesting long-term needs to reprioritize and allocate health funds more rationally (MOHSW, 2014e). In primary healthcare and for public health, greater allocative efficiency (see Box 1) is stymied by (1) a lack of decision-making power for LGAs on the volume and targeting of healthcare resources available to them, (2) silo funding for certain vertical programs, and (3) a lack of understanding of the different needs at the local level across disease conditions.

Tanzania is on the verge of adopting new facility standards for health facilities at all levels (e.g., mandating levels of staffing and minimum infrastructural requirements). This emphasizes the ability to achieve desirable levels of quality and to execute the National Essential Health Package of Interventions. These changes will require new resources. However, it is not clear that existing resources are utilized fully or most efficiently. The GOT's own resources for health across levels are primarily allocated to staffing (PE), with inadequate funding for medical commodities. For example, the median availability of key World Health Organization (WHO) tracer medicines has declined across two rounds of facility surveys (2008 and 2012) (MOHSW, 2013a).

Box 1. Effectiveness of health financing

Financing for primary healthcare is effective when it procures the maximum amount of health services per dollar spent, after accounting for program overhead costs. This is termed **cost efficiency**.

Health financing should also have **allocative efficiency**, where available resources are allocated in accordance with and in proportion to need. A reasonable rule is that areas with poorer health indicators should receive a larger allocation of funds. Therefore, a system in which areas with poorer health indicators get a larger share of funds will have more allocative efficiency.

Source: Paxton et al., 2014.

The current high dependency on external funding in the health sector creates serious challenges for sustainability. While the GOT allocates about 9 percent of its overall budget to health, nearly 60 percent of this is financed on-budget by development partners, not counting the resources received as general budget support. On-budget support is declining, whether sectoral or general, yet off-budget funds have increased dramatically in recent years and Tanzania will continue to receive a large PEPFAR allocation, even if at plateaued levels. Limited short-term opportunities exist for change, given other sectoral priorities. However, some areas are discussed later in the report, whereby sustainability can increase.

Compared to its peers in Africa, Tanzania's health financing structure is fragmented, with multiple financing channels hindering efficiency. The term "fragmentation" in the health financing domain has been used previously to describe a situation where multiple insurance schemes sub-divide the population insured in terms of contributors and beneficiaries, reducing opportunities for cross-subsidization and risk equalization. This is certainly the case in Tanzania, as discussed in the next section. However, as the draft HFS notes, Tanzania also faces fragmentation in its government tax-funded health system, where the division of roles and responsibilities for channeling and managing funds between the PMO-RALG (block grants for PE and OC), the MOHSW (funds for tertiary hospitals), regional health teams (zonal/regional hospitals), and the LGAs causes governance, delivery, and monitoring/efficiency challenges (see diagram

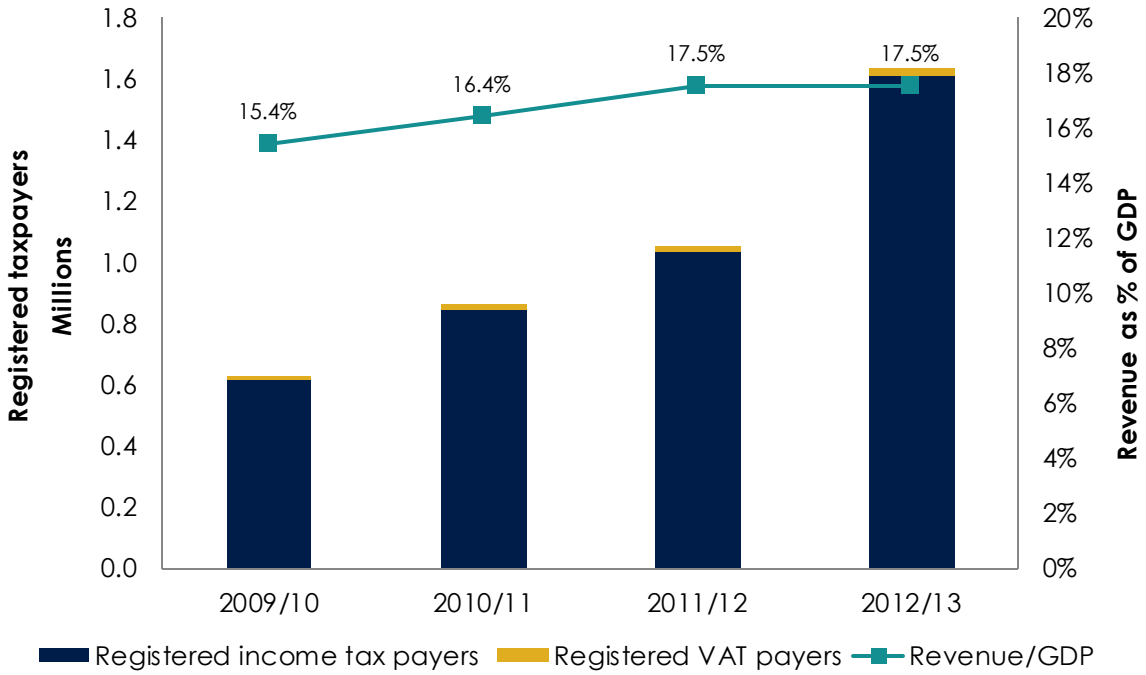
in Annex A). In addition, the regulatory space covering health insurance is also fragmented, with different schemes reporting to different entities and conforming to different articles of legislation (Bultman and Mushy, 2014).

PROSPECTS FOR SUSTAINABLE HEALTH FINANCING

Existing Tax-Funded Sources for Health

Tanzania has a favorable macroeconomic situation, with chances of growth in public revenues. Macroeconomic conditions in Tanzania are favorable, with growth expected to be 7 percent per annum in FY 2014/15 and public debt and inflation stable (MOFEA, 2012). The GOT has a fiscal deficit target of 5 percent. Short-term risks include an upcoming political transition given elections in 2015, ongoing delays in tax policy reform, and current (late 2014) problems in receiving external general budget support, which is putting pressure on the Tanzanian shilling. Longer term positives include ongoing diversification in exports, encouraging developments in off-shore gas exploitation, and continuing political stability. Government revenue collections for FY 2013/14 fell short of the target proposed in the budget because of delays in making tax policy changes (IMF, 2014). As a result, to meet the fiscal deficit target, the GOT restricted discretionary spending, especially on OC (IMF, 2014), even as ambitious targets were announced across sectors for BRN. Future prospects for government revenue growth look positive, with the number of registered income tax payers growing (see Figure 13), even though total revenue as a share of GDP has remained stable. Mobilizing additional revenue will be most dependent on raising the collection of value-added tax, which has been reformed. The IMF predicts a revenue-to-GDP ratio of 20 percent by FY 2015/16 (IMF, 2014).

Figure 13: Prospects for government revenue growth



Sources: IMF, 2014, author's analysis.

New sources of national revenue can emerge, especially in the natural gas sector. Tanzania has significant revenue possibilities from recoverable off-shore natural gas reserves. The potential future investment of US$20–40 billion has been touted for the development phase (2018–21), with gas

production starting in 2020 or later (IMF, 2014). This investment will boost growth—though the impact on the fiscal space for the social sector is unclear. If the GOT were to "buy in" to the development of these reserves, it would need to raise significant financing, which its stable external debt position could allow but which would restrict flexibility to raise resources for other national priorities in the short term. However, in the long term, after full production begins, the GOT could realize revenues of US$3–6 billion annually (IMF, 2014). Such revenues would be transformative for the country.

Increasing the LGAs' own source revenue has been and will be a challenge. Local own-source revenue (LOSR) amounted to TZS 268 billion in FY 2013/14 (estimate), which can be compared with TZS 10,100 billion in central government non-grant revenue. Therefore, LOSR amounts to only 3 percent of domestic revenues, excluding loans and grants, and less than 2 percent of all national revenue (MOFEA, 2014). Recent reviews have suggested that LOSR is an insignificant source (less than 1%) of all health spending at the local level (MOHSW and PMO-RALG, 2013). There has been a long-standing effort to support LGA revenue generation, with projects such as Support to Local Governance (SULGO). However, significant obstacles remain, such as a small local tax base for the areas open for LGA taxation, low collection rates as a function of lack of data and incentives, low awareness and willingness to pay among LGA tax payers, and revenue collection outsourcing challenges (Mzenzi, 2013; Fjeldstad et al., 2008). In addition, despite SULGO and other efforts, LGA administrative ability to raise and manage LOSR is low overall, with some LGAs significantly worse off than others. The opportunities to raise more funds are limited, including a restricted borrowing ability under law. A Local Government Loans Board was formed to support domestic borrowing by LGAs but in practice has little utility. Loans are estimated to be less than 1 percent of resources available to LGAs. It is expected that LGAs will remain dependent in the short term on resources transferred from the central level and donor support.

Health Insurance Schemes

Health insurance coverage in Tanzania is stagnant and the depth of benefits is limited. Health insurance coverage, across all schemes, has remained about 15–16 percent in Tanzania in recent years (see Table 2 and Figure 14). In FY 2012/13, 16 percent translated to a coverage of 7.2 million individuals, compared with about 28 percent and 12.3 million in Kenya (KIPPRA, 2013; NHIF, 2013a) across members and dependents. The schemes in operation vary, such as the NHIF, which has the largest number of primary policyholders (536,829 as of FY 2012/13) vs. community-based health insurance schemes with limited benefits. The NHIF has significant challenges with efficiency, paying out approximately 41 percent of contributions as benefits, compared to an improved 55 percent for the National Hospital Insurance Fund in Kenya (FY 2011). NHIF members in urban areas were more likely to utilize outpatient care from private facilities (IHI, 2012).

Table 2: Health insurance schemes in operation in Tanzania, 2014

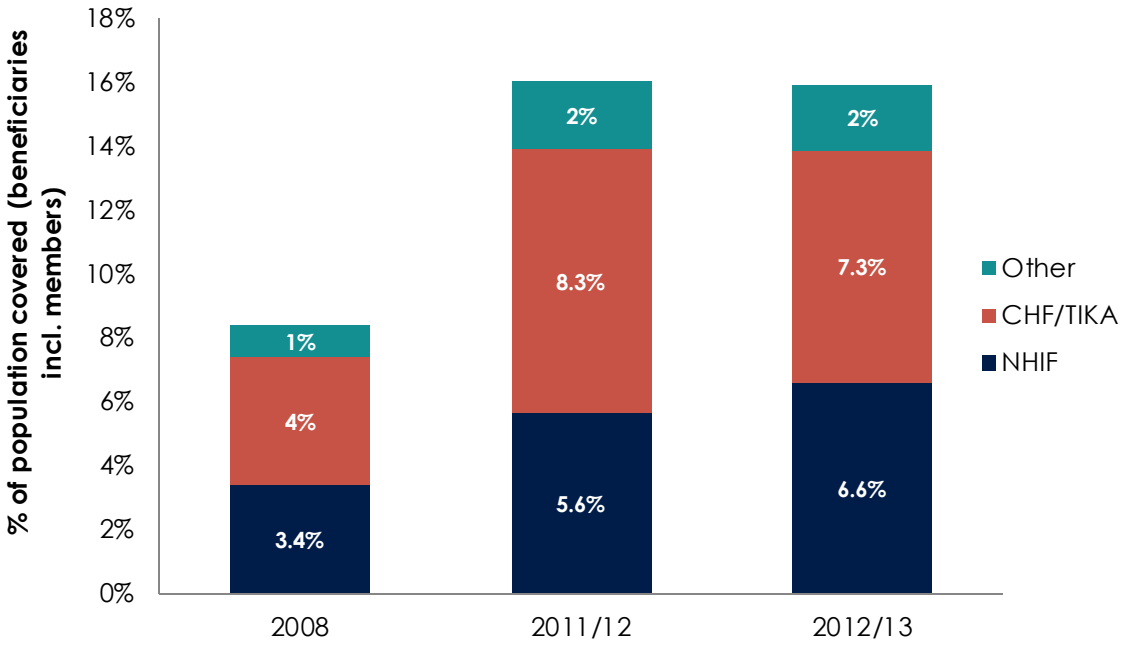
Topic	National Health Insurance Fund (NHIF)	Community Health Fund (CHF)/ Tiba Kwa Kadi (TIKA)	National Social Security Fund—Social Health Insurance Benefit (NSSF-SHIB)	Private Health Insurance (PHI)	Community-Based Health Insurance (CBHI)
Coverage*	6.6%	7.3%	0.12%*	1.02%*	1%*
Beneficiaries	Civil servants (+ private)	Informal sector, low-income	Formal sector, semi-formal sector	Private market	Informal sector, low-income
Enrolment	Mandatory	Voluntary	Voluntary	Voluntary	Voluntary
Collection	Payroll	Remit at facility	Payroll	Remit to PHI	Remit to CBHI
Premium	6% of salary, shared equally by employer and employee	TZS 5,000—20,000 per year, matched by GOT	Part of 20% of salary contributed per month	TZS 300,000 to 950,000 per year	TZS 30,000 to 40,000 per year
Benefits	Inpatient + outpatient at accredited health facility	Primary health and limited hospital care	Similar to NHIF	Full range	Primary health and limited hospital care
Provider payment	Fee for service	Capitation	Capitation	Fee for service	Capitation
Regulator	Social Security Regulatory Authority (SSRA)	SSRA	SSRA	Tanzania Insurance Regulatory Authority (TIRA)	Unregulated

Sources: Bultman and Mushy, 2014; IHI, 2012; SSRA Act, 2008; TIRA Insurance Act #10 2009. * All values based on 2011/12 data, except NHIF, CHF/TIKA; author estimates, FY 2012/13.

Despite that creating a single national health insurer will take time, no interim plans exist to raise insurance coverage. According to data reported by the NHIF, the average annual growth rate in its membership was approximately 14 percent between FY 2001/02 and FY 2005/06, slowing to 9 percent per annum between FY 2006/07 and FY 2011/12 (NHIF, 2013b). In FY 2012/13, the increase was 13 percent over the previous year. Though mandatory, NHIF membership is not yet universal for public sector workers. In 2010, 5 percent of the NHIF membership were students and the rest were public sector workers (NHIF, 2010). The total number of public sector workers in 2013 was estimated to be 625,900 (NBS, 2013), and NHIF membership as of June 2013 was 536,829. Once universal enrolment in the public sector is reached, it is unclear where further growth will come from, even though the scheme is open to voluntary enrolment from the formal and informal private sectors. No plans exist to increase informal sector participation and subsidize premiums for the very poor. The CHF and TIKA are analogous schemes under district and municipal LGAs, respectively, and are relatively inexpensive to join but do not provide comprehensive benefits (see Table 2). The CHF has been administered by NHIF since 2009. The CHF contributions should be matched by GOT, but in practice, it has been challenging for LGA-level bodies to claim this funding due to administrative issues (Borghi et al., 2013). The number of households enrolled in CHF dropped between FY 2011/12 and FY 2012/13 (NHIF, 2013b), but recent trends appear to be positive. The third phase of the Tanzania Social Action Fund (TASAF) involves a

conditional cash transfer with a health component, providing evidence from 2014 of a relative increase in CHF membership among the beneficiary households (TASAF, 2014).

Figure 14: Recent trends in population-level health insurance coverage in Tanzania

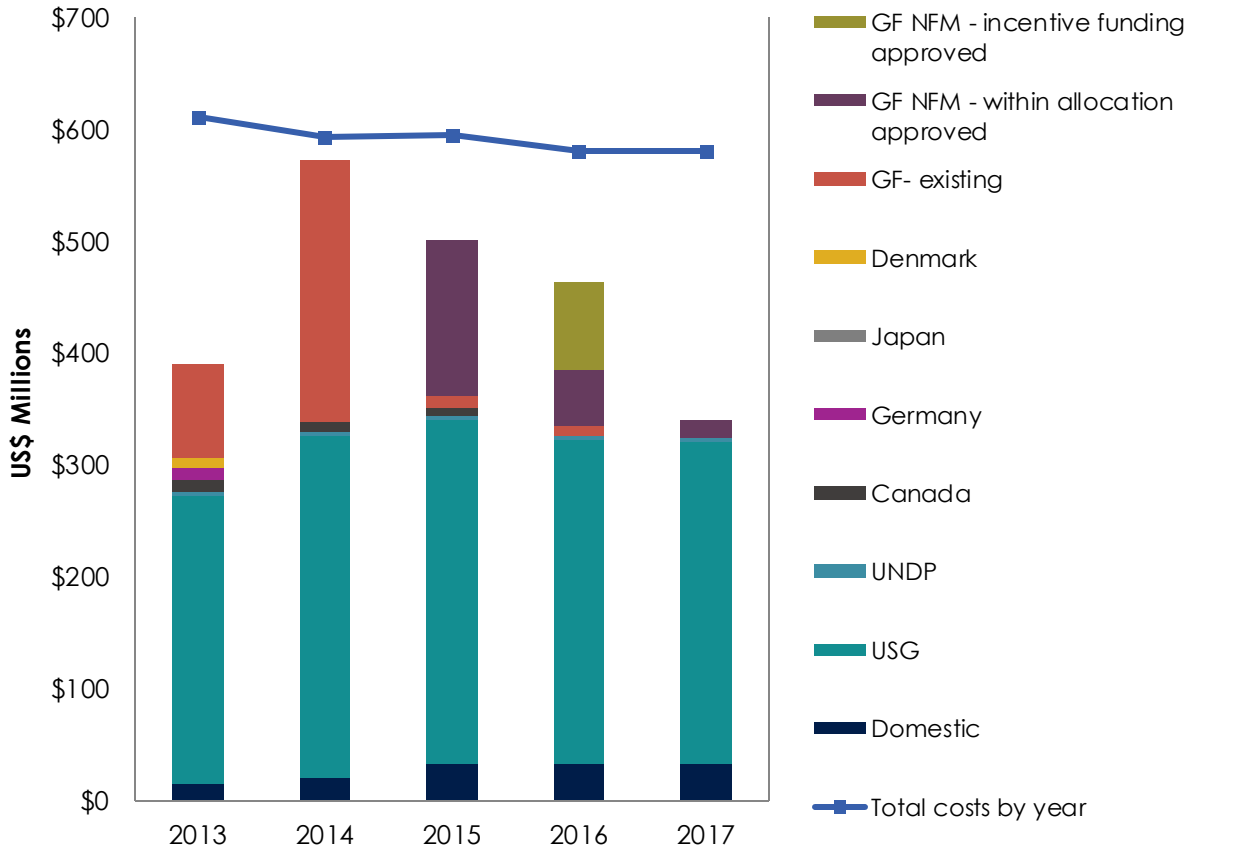


Sources: Bultman and Mushy, 2014; IHI, 2012; NHIF, 2013b and author's analysis using Census 2012 (NBS, 2012). Other: PHI, CBHI, NSSF-SHIB.

Innovative Financing Solutions

An AIDS Trust Fund could reduce the financing needed from traditional sources for HIV, freeing up funds for other health priorities; however, its future is unclear. Tanzania is likely to see large financial gaps for the HIV response, especially for critical commodities, which are predominantly financed by the Global Fund (see Figure 15 and Annex A). Current financial projections suggest gaps in antiretroviral availability even though the entirety of Tanzania's request under its allocated amount was approved by the Global Fund, as well as US$79 million of "incentive funding" to be applied specifically for antiretroviral treatment in 2016 (see Figure 15 and Annex A, Figure A.2). Given these and other trends, including substantial dependence on PEPFAR for HIV-related health system strengthening, logistics, training, and laboratory strengthening, the GOT has been looking for more sustainable options. Following the Zimbabwe National AIDS Levy, Tanzania, like Kenya, has been discussing establishing an AIDS Trust Fund (ATF) since the National AIDS Policy of 2001. The ATF would be coordinated by TACAIDS. Its aim would be to reduce dependence on external funders by 36 percent in the short term (not defined), reaching 50 percent ATF contribution of a total need by 2028 (NCG, 2014; Beng'i Issa, 2014). The ATF requires due process to establish it legally and Parliament's approval of an amendment to the TACAIDS Act No. 22 of 2001. The amendment would allow the ATF governance and funding mechanisms to be developed. However, it is unclear whether the ATF will be a holding account for a line item for HIV in the general budget or a trust, which will allow broader funding.

Figure 15: Predicted HIV financing sources and needs in Tanzania



Sources: Author analysis; Tanzania Global Fund New Funding Model (NFM) joint tuberculosis/HIV concept note 2014, and Global Fund, 2015.

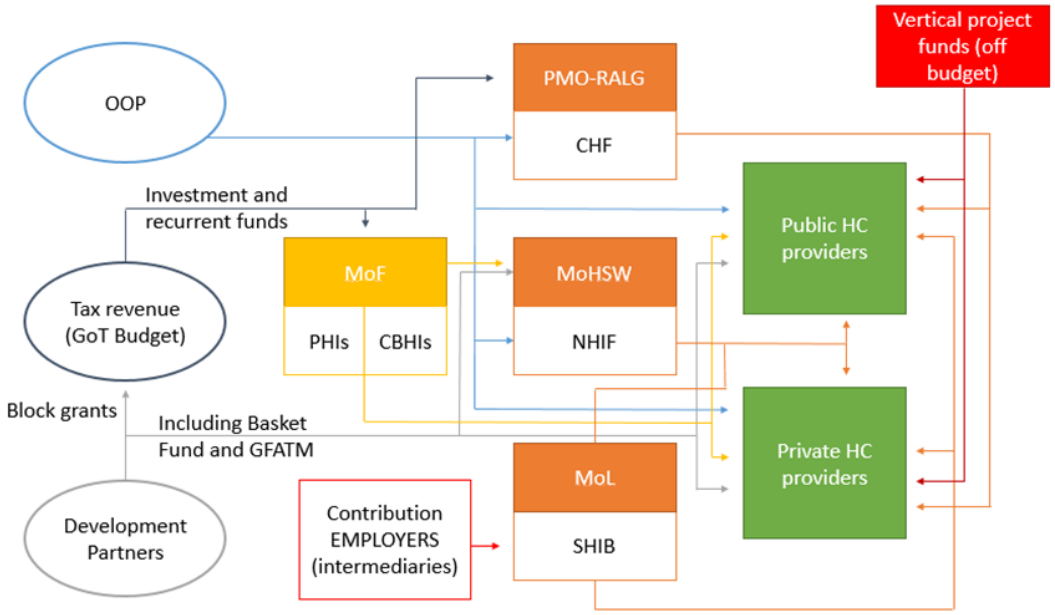
Long-term financing for an AIDS Trust Fund is unclear. The TACAIDS request for the ATF from the FY 2015/16 GOT budget has not been confirmed but may be about TZS 170 billion (US$98 million at current exchange rates) (Beng'i Issa, 2014). It is unclear whether this full amount will be approved. Anecdotally, a lower range of TZS 50–60 billion is considered feasible. However, this will still leave a funding gap in certain areas, which grows over time (see Figure 15). This implies that the ATF will need to seek additional sources of financing. To attract private sector contributions of any form, it would be useful for the ATF to have legal status as a trust fund, rather than a line item holding account. Ideas proposed so far include seeking contributions from general taxation, tax-exempt contributions from individuals and corporations, investments, and general public "crowdsourcing" (Beng'i Issa, 2014). The Tanzania Revenue Authority did not concur on any new taxes in the feasibility analysis for the ATF. In the short-term, special line allocations from taxes such as VAT may be the only option. The Zimbabwe AIDS levy amounts to 3 percent of income taxes sequestered to serve various HIV and AIDS financing needs. However, as of early 2014, this levy was under review, with the intent to remove it in favor of a comprehensive fund for health (Maponga, 2013).

Premium subsidies could help to include the poor in expanding NHIF coverage. Stakeholders in Tanzania do not see the dominant social health insurance scheme, NHIF, as the vehicle toward UHC, preferring consolidation around a new single insurer (SNHI). The roadmap for the SNHI is long, and there is no strategy to grow health insurance coverage in the interim. Following discussions in Kenya, stakeholders in Tanzania could consider removing obstacles for the poor to sign up for the broader benefit

package of the NHIF vs. the current CHF/TIKA, which has shallow benefits and limited appeal. Subsidies to bridge the premium gap between CHF and NHIF contributions, currently large, could be considered, but have not been analyzed. A progressive contribution structure (e.g., slab-based, rather than flat at 6%) into NHIF has also not been proposed, where the former may be useful for informal sector participants. Tanzania may consider such approaches (e.g., the proposed Health Insurance Subsidy Programme in Kenya); the TASAF poverty identification method already exists and could be adapted for selecting households for such a subsidy.

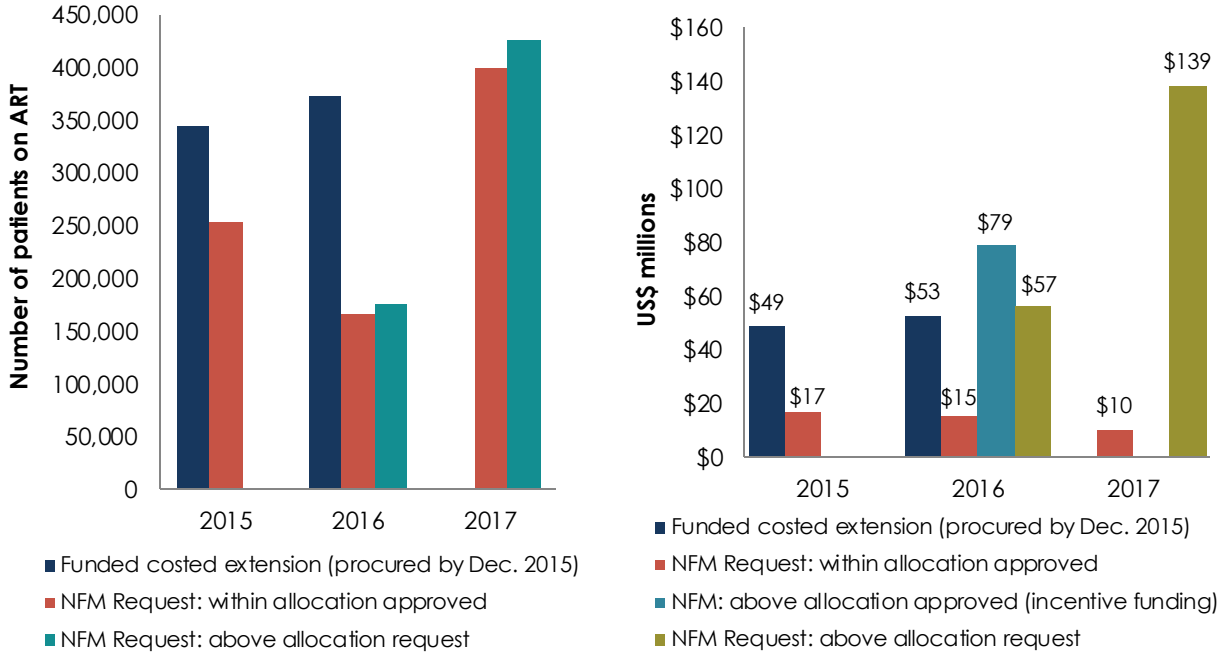
ANNEX A.

Figure A.1 Representation of fragmentation in the health financing domain, Tanzania



Source: MOHSW, 2014d.

Figure A.2 Global Fund NFM support to antiretroviral therapy in Tanzania, 2015–2017



Sources: Author analysis, Tanzania Global Fund NFM Joint tuberculosis/HIV concept note 2014. Note: Approved incentive funding for 2016 will be used to support 656,974 patients for the last six months of 2016.

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